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PUBLIC HEALTH PLANNING AND GRANTS

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HEARINGS BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE EIGHTY-NINTH CONGRESS

SECOND SESSION

ON

S. 3008

A BILL TO AMEND THE PUBLIC HEALTH SERVICE ACT TO PROMOTE AND ASSIST IN THE EXTENSION AND IMPROVEMENT OF COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES, TO PROVIDE FOR A MORE EFFECTIVE USE OF AVAILABLE FEDERAL FUNDS FOR SUCH PLANNING AND SERVICES, AND FOR OTHER PURPOSES

MARCH 16 AND 17, 1966

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



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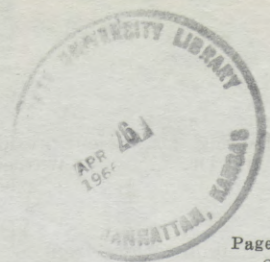
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PUBLIC HEALTH PLANNING AND GRANTS

WEDNESDAY, MARCH 16, 1966

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

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 4232, New Senate Office Building, Senator Lister Hill, chairman, presiding.

Present: Senators Hill, Yarborough, Pell, and Javits.

Committee staff members present: Stewart E. McClure, chief clerk; Robert W. Barclay, professional staff member; and Roy H. Millenson, minority clerk.

The CHAIRMAN. The subcommittee will kindly come to order.

The Subcommittee on Health is meeting this morning to receive testimony on S. 3008, the proposed Comprehensive Health Planning and Public Health Services Amendments of 1966, that would improve and expand the grant-in-aid programs of the Public Health Service so that more comprehensive health services of high quality might be available throughout the Nation.

(The bill, S. 3008, and the President's health and education message follow:)

89TH CONGRESS
2^D SESSION

S. 3008

IN THE SENATE OF THE UNITED STATES

MARCH 2, 1966

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 to promote and assist in the extension and improvement of comprehensive health planning and public health services, to provide for a more effective use of available Federal funds for such planning and 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 "Comprehensive Health
4 Planning and Public Health Services Amendments of 1966".

5 FINDINGS AND DECLARATION OF PURPOSE

6 SEC. 2. (a) The Congress declares that fulfillment of our
7 national purpose depends on promoting and assuring the
8 highest level of health attainable for every person, in an en-

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1 vironment which contributes positively to healthful individ-
2 ual and family living; that attainment of this goal depends
3 on an effective partnership, involving close intergovernmental
4 collaboration, official and voluntary efforts, and participation
5 of individuals and organizations; and that Federal financial
6 assistance must be directed to support the marshaling of all
7 health resources—national, State, and local—to assure com-
8 prehensive health services of high quality for every person.

9 (b) To carry out such purpose, and recognizing the
10 changing character of health problems, the Congress finds
11 that comprehensive planning for health services, health man-
12 power, and health facilities is essential at every level of gov-
13 ernment; that desirable administration requires strengthen-
14 ing the leadership and capacities of State health agencies;
15 and that support of health services provided people in their
16 communities should be broadened and made more flexible.

17 SEC. 3. Section 314 of the Public Health Service Act
18 (42 U.S.C. 246) is amended to read as follows:

19 "GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND
20 PUBLIC HEALTH SERVICES

21 "Grants to States for Comprehensive State Health Planning

22 "SEC. 314. (a) (1) AUTHORIZATION.—In order to as-
23 sist the States in comprehensive and continuing planning
24 for their current and future health needs, the Surgeon Gen-
25 eral is authorized during the period beginning July 1, 1966,

3

1 and ending June 30, 1972, to make grants to States which
2 have submitted, and had approved by the Surgeon General,
3 State plans for comprehensive State health planning.

4 “(2) STATE PLANS FOR COMPREHENSIVE STATE
5 HEALTH PLANNING.—In order to be approved for purposes
6 of this subsection, a State plan for comprehensive State
7 health planning must—

8 “(A) designate, or provide for the establishment
9 of, a single State agency as the sole agency for admin-
10 istering or supervising the administration of the State’s
11 health planning functions under the plan;

12 “(B) provide for the establishment of a State
13 health planning council, which shall include represent-
14 atives of State and local agencies and nongovernmental
15 organizations and groups concerned with health, and
16 of consumers of health services, to advise such State
17 agency in carrying out its functions under the plan;

18 “(C) set forth policies and procedures for the ex-
19 penditure of funds under the plan, which, in the judg-
20 ment of the Surgeon General, are designed to provide
21 for comprehensive State planning for health services
22 (both public and private), including the facilities and
23 persons required for the provision of such services, to
24 meet the health needs of the people of the State;

25 “(D) provide for encouraging cooperative efforts

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1 among governmental or nongovernmental agencies, or-
2 ganizations and groups concerned with health services,
3 facilities, or manpower, and for cooperative efforts be-
4 tween such agencies, organizations, and groups and simi-
5 lar agencies, organizations, and groups in the fields of
6 education, welfare, and rehabilitation;

7 “(E) contain or be supported by assurances satis-
8 factory to the Surgeon General that the funds paid under
9 this subsection will be used to supplement and, to the
10 extent practicable, to increase the level of funds that
11 would otherwise be made available by the State for the
12 purpose of comprehensive health planning and not to
13 supplant such non-Federal funds;

14 “(F) provide such methods of administration (in-
15 cluding methods relating to the establishment and main-
16 tenance of personnel standards on a merit basis, except
17 that the Surgeon General shall exercise no authority
18 with respect to the selection, tenure of office, and com-
19 pensation of any individual employed in accordance with
20 such methods) as are found by the Surgeon General to
21 be necessary for the proper and efficient operation of the
22 plan;

23 “(G) provide that the State agency will make
24 such reports, in such form and containing such infor-
25 mation, as the Surgeon General may from time to time

1 reasonably require, and will keep such records and afford
2 such access thereto as the Surgeon General finds neces-
3 sary to assure the correctness and verification of such
4 reports;

5 “(H) provide that the State agency will from time
6 to time, but not less often than annually, review its State
7 plan approved under this subsection and submit to the
8 Surgeon General appropriate modifications thereof;

9 “(I) provide for such fiscal control and fund ac-
10 counting procedures as may be necessary to assure
11 proper disbursement of and accounting for funds paid to
12 the State under this subsection; and

13 “(J) contain such additional information and assur-
14 ances as the Surgeon General may find necessary to
15 carry out the purposes of this subsection.

16 “(3) (A) STATE ALLOTMENTS.—From the sums ap-
17 propriated for such purpose for each fiscal year, the several
18 States shall be entitled to allotments determined, in accord-
19 ance with regulations, on the basis of the population and
20 the per capita income of the respective States; except that
21 no such allotment to any State for any fiscal year shall be
22 less than 1 per centum of the sum appropriated for such fiscal
23 year pursuant to paragraph (1). Any such allotment to a
24 State for a fiscal year shall remain available for obligation
25 by the State, in accordance with the provisions of this sub-

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1 section and the State's plan approved thereunder, until the
2 close of the succeeding fiscal year.

3 “(B) The amount of any allotment to a State under
4 subparagraph (A) for any fiscal year which the Surgeon
5 General determines will not be required by the State, during
6 the period for which it is available, for the purposes for
7 which allotted shall be available for reallocation by the Sur-
8 geon General from time to time, on such date or dates as he
9 may fix, to other States with respect to which such a de-
10 termination has not been made, in proportion to the original
11 allotments to such States under subparagraph (A) for such
12 fiscal year, but with such proportionate amount for any of
13 such other States being reduced to the extent it exceeds the
14 sum the Surgeon General estimates such State needs and
15 will be able to use during such period; and the total of such
16 reductions shall be similarly reallocated among the States
17 whose proportionate amounts were not so reduced. Any
18 amount so reallocated to a State from funds appropriated pur-
19 suant to this subsection for a fiscal year shall be deemed part
20 of its allotment under subparagraph (A) for such fiscal year.

21 “(4) PAYMENTS TO STATES.—From each State's allot-
22 ment for a fiscal year under this subsection, the State shall
23 from time to time be paid the Federal share of the expendi-
24 tures incurred during that year or the succeeding year pur-

1 suant to its State plan approved under this subsection. Such
2 payments shall be made on the basis of estimates by the
3 Surgeon General of the sums the State will need in order to
4 perform the planning under its approved State plan under
5 this subsection, but with such adjustments as may be neces-
6 sary to take account of previously made underpayments or
7 overpayments. The 'Federal share' for any State for pur-
8 poses of this subsection shall be all, or such part as the Sur-
9 geon General may determine, of the cost of such planning,
10 except that in the case of the allotments for the fiscal year
11 ending June 30, 1970, and for each of the next two fiscal
12 years, it shall not exceed 75 per centum of such cost.

13 "Project Grants for Areawide Health Planning

14 "(b) The Surgeon General is authorized, during the
15 period beginning July 1, 1966, and ending June 30, 1972,
16 to make, with the approval of the State agency administering
17 or supervising the administration of the State plan approved
18 under subsection (a), project grants to any other public or
19 nonprofit private agency or organization to cover not to ex-
20 ceed 75 per centum of the costs of projects for developing
21 (and from time to time revising) comprehensive regional,
22 metropolitan area, or other local area plans for coordination
23 of existing and planned health services, including the facilities
24 and persons required for provision of such services; except

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1 that in the case of project grants made in any State prior to
2 July 1, 1968, approval of such State agency shall be re-
3 quired only if such State has such a State plan in effect
4 at the time of such grants.

5 "Project Grants for Training, Studies, and Demonstrations

6 "(c) The Surgeon General is also authorized, during
7 the period beginning July 1, 1966, and ending June 30,
8 1972, to make grants to any public or nonprofit private
9 agency, institution, or other organization to cover all or any
10 part of the cost of projects for training, studies, or demon-
11 strations looking toward the development of improved or
12 more effective comprehensive health planning throughout
13 the nation.

14 "Grants for Comprehensive Public Health Services

15 "(d) (1) AUTHORIZATION OF APPROPRIATIONS.—

16 There are authorized to be appropriated for the fiscal year
17 ending June 30, 1968, and each of the next four fiscal years
18 such sums as may be necessary to enable the Surgeon Gen-
19 eral to make grants to State health or mental health authori-
20 ties to assist the States in establishing and maintaining
21 adequate public health services, including the training of
22 personnel for State and local health work. The sums so
23 appropriated shall be used for making payments to States
24 which have submitted, and had approved by the Surgeon
25 General, State plans for provision of public health services.

9

1 “(2) STATE PLANS FOR PROVISION OF PUBLIC HEALTH
2 SERVICES.—In order to be approved under this subsection,
3 a State plan for provision of public health services must—

4 “(A) provide for administration or supervision of
5 administration by the State health authority or, with
6 respect to mental health services, the State mental health
7 authority;

8 “(B) set forth the policies and procedures to be
9 followed in the expenditure of the funds paid under this
10 subsection;

11 “(C) contain or be supported by assurances satis-
12 factory to the Surgeon General that (i) the funds paid
13 to the State under this subsection will be used to make a
14 significant contribution toward providing and strength-
15 ening public health services in the various political sub-
16 divisions in order to improve the health of the people;
17 (ii) such funds will be made available to other public
18 or nonprofit private agencies, institutions, and organi-
19 zations, in accordance with criteria which the Surgeon
20 General determines are designed to secure maximum
21 participation of local, regional, or metropolitan agencies
22 and groups in the provision of such services; and (iii)
23 such funds will be used to supplement and, to the extent
24 practical, to increase the level of funds that would other-

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1 wise be made available for the purposes for which the
2 Federal funds are provided and not to supplant such
3 non-Federal funds;

4 “(D) provide for the furnishing of public health
5 services under the State plan in accordance with such
6 plans as have been developed pursuant to subsection
7 (a) and, effective July 1, 1970, provide that except to
8 the extent permitted in regulations, such services will
9 be provided thereunder only to the extent included in
10 and in accordance with the plans so developed;

11 “(E) provide that public health services furnished
12 under the plan will be in accordance with standards
13 prescribed by regulations, including standards as to the
14 scope and quality of such services;

15 “(F) provide such methods of administration (in-
16 cluding methods relating to the establishment and main-
17 tenance of personnel standards on a merit basis, except
18 that the Surgeon General shall exercise no authority
19 with respect to the selection, tenure of office, and com-
20 pensation of any individual employed in accordance with
21 such methods) as are found by the Surgeon General to
22 be necessary for the proper and efficient operation of
23 the plan;

24 “(G) provide that the State health authority or,
25 with respect to mental health services, the State mental

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1 health authority, will from time to time, but not less
2 often than annually, review its State plan approved
3 under this subsection and submit to the Surgeon Gen-
4 eral appropriate modifications thereof;

5 “(H) provide that the State health authority or,
6 with respect to mental health services, the State mental
7 health authority, will make such reports, in such form
8 and containing such information, as the Surgeon General
9 may from time to time reasonably require, and will keep
10 such records and afford such access thereto as the Sur-
11 geon General finds necessary to assure the correctness
12 and verification of such reports;

13 “(I) provide for such fiscal control and fund ac-
14 counting procedures as may be necessary to assure the
15 proper disbursement of an accounting for funds paid to
16 the State under this subsection; and

17 “(J) contain such additional information and as-
18 surances as the Surgeon General may find necessary to
19 carry out the purposes of this subsection.

20 “(3) STATE ALLOTMENTS.—From the sums appro-
21 priated to carry out the provisions of this subsection the
22 several States shall be entitled for each fiscal year to
23 allotments determined, in accordance with regulations, on
24 the basis of the population and financial need of the respec-
25 tive States.

1 “(4) (A) PAYMENTS TO STATES.—From each State’s
2 allotment under this subsection for a fiscal year, the State
3 shall be paid the Federal share of the expenditures incurred
4 during such year under its State plan approved under this
5 subsection. Such payments shall be made from time to
6 time in advance on the basis of estimates by the Surgeon
7 General of the sums the State will expend under the State
8 plan, except that such adjustments as may be necessary shall
9 be made on account of previously made underpayments or
10 overpayments under this subsection.

11 “(B) For the purpose of determining the Federal share
12 for any State, expenditures by nonprofit private agencies,
13 organizations, and groups shall, subject to such limitations
14 and conditions as may be prescribed by regulations, be
15 regarded as expenditures by such State or a political sub-
16 division thereof.

17 “(5) FEDERAL SHARE.—The ‘Federal share’ for any
18 State for purposes of this subsection shall be 100 per centum
19 less that percentage which bears the same ratio to 50 per
20 centum as the per capita income of such State bears to
21 the per capita income of the United States; except that
22 in no case shall such percentage be less than $33\frac{1}{3}$ per centum
23 or more than $66\frac{2}{3}$ per centum, and except that the Federal
24 share for the Commonwealth of Puerto Rico, Guam, Amer-
25 ican Samoa, and the Virgin Islands shall be $66\frac{2}{3}$ per centum.

1 “(6) DETERMINATION OF FEDERAL SHARES.—The
2 Federal shares shall be determined by the Surgeon General
3 between July 1 and September 1 of each year, on the basis
4 of the average per capita incomes of each of the States and
5 of the United States for the most recent year for which
6 satisfactory data are available from the Department of Com-
7 merce, and such determination shall be conclusive for the
8 fiscal year beginning on the next July 1. The popula-
9 tions of the several States shall be determined on the basis
10 of the latest figures for the population of the several States
11 available from the Department of Commerce.

12 “(7) ALLOCATION OF FUNDS WITHIN THE STATES.—
13 At least 15 per centum of a State's allotment under this sub-
14 section shall be available only to the State mental health
15 authority for the provision under the State plan of mental
16 health services. At least 70 per centum of such amount and
17 at least 70 per centum of the remainder of a State's allot-
18 ment under this subsection shall be available only for the
19 provision under that State plan of services in the commu-
20 nities of the State.

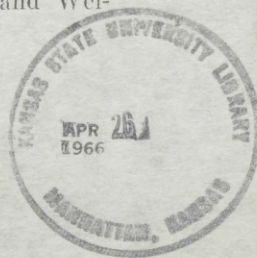
21 “Project Grants for Health Services Development

22 “(e) There are authorized to be appropriated for the
23 fiscal year ending June 30, 1968, and each of the next four
24 fiscal years such sums as may be necessary for grants to any

1 public or nonprofit private agency, institution, or organiza-
2 tion to cover part of the cost of (1) providing services to
3 meet health needs of limited geographic scope or of special-
4 ized regional or national significance, (2) stimulating and
5 supporting for an initial period new programs of health
6 services, or (3) undertaking studies, demonstrations, or
7 training designed to develop new methods or improve exist-
8 ing methods of providing health services. Such grants may
9 be made pursuant to clause (1) or (2) of the preceding
10 sentence with respect to projects involving the furnishing of
11 public health services only if such services are provided in
12 accordance with such plans as have been developed pur-
13 suant to subsection (a) and, effective July 1, 1970, except
14 to the extent permitted in regulations, only to the extent
15 such services are included in and are furnished in accordance
16 with plans so developed.

17 "Interchange of Personnel With States

18 "(f) (1) For the purposes of this subsection, the term
19 'State' means a State or a political subdivision of a State, or
20 any agency of either of the foregoing engaged in any activ-
21 ities related to health or designated or established pursuant
22 to subparagraph (A) of paragraph (2) of subsection (a);
23 the term 'Secretary' means (except when used in paragraph
24 (3) (D)) the Secretary of Health, Education, and Wel-



1 fare; and the term 'Department' means the Department of
2 Health, Education, and Welfare.

3 “(2) The Secretary is authorized, through agreements
4 or otherwise, to arrange for assignment of officers and em-
5 ployees of States to the Department and assignment to
6 States of officers and employees in the Department engaged
7 in work related to health, for work which the Secretary
8 determines will aid the Department in more effective dis-
9 charge of its responsibilities in the field of health as author-
10 ized by law, including cooperation with States and the pro-
11 vision of technical or other assistance. The period of
12 assignment of any officer or employee under an arrange-
13 ment shall not exceed two years.

14 “(3) (A) Officers and employees in the Department
15 assigned to any State pursuant to this subsection shall be
16 considered, during such assignment, to be (i) on detail to
17 a regular work assignment in the Department, or (ii) on
18 leave without pay from their positions in the Department.

19 “(B) Persons considered to be so detailed shall remain
20 as officers or employees, as the case may be, in the Depart-
21 ment for all purposes, except that the supervision of their
22 duties during the period of detail may be governed by agree-
23 ment between the Department and the State involved.

1 “(C) In the case of persons so assigned and on leave
2 without pay—

3 “(i) if the rate of compensation (including allow-
4 ances) for their employment by the State is less than
5 the rate of compensation (including allowances) they
6 would be receiving had they continued in their regular
7 assignment in the Department, they may receive sup-
8 plemental salary payments from the Department in the
9 amount considered by the Secretary to be justified, but
10 not at a rate in excess of the difference between the
11 State rate and the Department rate; and

12 “(ii) they may be granted annual leave and sick
13 leave to the extent authorized by law, but only in cir-
14 cumstances considered by the Secretary to justify ap-
15 proval of such leave.

16 Such officers and employees on leave without pay shall, not-
17 withstanding any other provision of law, be entitled—

18 “(iii) to continuation of their insurance under the
19 Federal Employees' Group Life Insurance Act of 1954,
20 and coverage under the Federal Employees Health
21 Benefits Act of 1959, so long as the Department con-
22 tinues to collect the employee's contribution from the
23 officer or employee involved and to transmit for timely
24 deposit into the funds created under such Acts the
25 amount of the employee's contributions and the Govern-

17

1 ment's contribution from appropriations of the Depart-
2 ment; and

3 " (iv) (I) in the case of commissioned officers of the
4 Service, to have their service during their assignment
5 treated as provided in section 214 (d) for such officers
6 on leave without pay, or (II) in the case of other
7 officers and employees in the Department, to credit the
8 period of their assignment under the arrangement under
9 this subsection toward periodic or longevity step in-
10 creases and for retention and leave accrual purposes, and,
11 upon payment into the civil service retirement and dis-
12 ability fund of the percentage of their State salary, and
13 of their supplemental salary payments, if any, which
14 would have been deducted from a like Federal salary for
15 the period of such assignment and payment by the Sec-
16 retary into such fund of the amount which would have
17 been payable by him during the period of such assign-
18 ment with respect to a like Federal salary, to treat (not-
19 withstanding the provisions of the Independent Offices
20 Appropriation Act, 1959, under the head 'Civil Service
21 Retirement and Disability Fund') their service during
22 such period as service within the meaning of the Civil
23 Service Retirement Act;

24 except that no officer or employee or his beneficiary may re-

1 ceive any benefits under the Civil Service Retirement Act,
2 the Federal Employees Health Benefits Act of 1959, or the
3 Federal Employees' Group Life Insurance Act of 1954,
4 based on service during an assignment hereunder for which
5 the officer or employee or (if he dies without making such
6 election) his beneficiary elects to receive benefits, under any
7 State retirement or insurance law or program, which the
8 Civil Service Commission determines to be similar. The De-
9 partment shall deposit currently in the funds created under
10 the Federal Employees' Group Life Insurance Act of 1954,
11 the Federal Employees Health Benefits Act of 1959, and the
12 civil service retirement and disability fund, respectively, the
13 amount of the Government's contribution under these Acts
14 on account of service with respect to which employee contri-
15 butions are collected as provided in subparagraph (iii) and
16 the amount of the Government's contribution under the Civil
17 Service Retirement Act on account of service with respect to
18 which payments (of the amount which would have been de-
19 ducted under that Act) referred to in subparagraph (iv) are
20 made to such civil service retirement and disability fund.

21 " (D) Any such officer or employee on leave without
22 pay (other than a commissioned officer of the Service) who
23 suffers disability or death as a result of personal injury sus-
24 tained while in the performance of his duty during an assign-
25 ment hereunder, shall be treated, for the purposes of the

19

1 Federal Employees' Compensation Act, as though he were
2 an employee, as defined in such Act, who had sustained such
3 injury in the performance of duty. When such person (or
4 his dependents, in case of death) entitled by reason of injury
5 or death to benefits under that Act is also entitled to benefits
6 from a State for the same injury or death, he (or his depend-
7 ents in case of death) shall elect which benefits he will
8 receive. Such election shall be made within one year after
9 the injury or death, or such further time as the Secretary of
10 Labor may for good cause allow, and when made shall be
11 irrevocable unless otherwise provided by law.

12 “(4) Assignment of any officer or employee in the
13 Department to a State under this subsection may be made
14 with or without reimbursement by the State for the com-
15 pensation (or supplementary compensation), travel and
16 transportation expenses (to or from the place of assignment),
17 and allowances, or any part thereof, of such officer or em-
18 ployee during the period of assignment, and any such reim-
19 bursement shall be credited to the appropriation utilized for
20 paying such compensation, travel or transportation expenses,
21 or allowances.

22 “(5) Appropriations to the Department shall be avail-
23 able, in accordance with the standardized Government travel
24 regulations or, with respect to commissioned officers of the
25 Service, the joint travel regulations, the expenses of travel

20

1 of officers and employees assigned to States under an ar-
2 rangement under this subsection on either a detail or leave-
3 without-pay basis and, in accordance with applicable law,
4 orders, and regulations, for expenses of transportation of
5 their immediate families and expenses of transportation of
6 their household goods and personal effects, in connection
7 with the travel of such officers and employees to the location
8 of their posts of assignment and their return to their official
9 stations.

10 “(6) Officers and employees of States who are assigned
11 to the Department under an arrangement under this subsec-
12 tion may (A) be given appointments in the Department
13 covering the periods of such assignments, or (B) be con-
14 sidered to be on detail to the Department. Appointments
15 of persons so assigned may be made without regard to the
16 civil service laws. Persons so appointed in the Department
17 shall be paid at rates of compensation determined in accord-
18 ance with the Classification Act of 1949, and shall not be
19 considered to be officers or employees of the Service for
20 the purposes of (A) the Civil Service Retirement Act,
21 (B) the Federal Employees' Group Life Insurance Act of
22 1954, or (C) unless their appointments result in the loss
23 of coverage in a group health benefits plan whose premium
24 has been paid in whole or in part by a State contribution,
25 the Federal Employees Health Benefits Act of 1959. State

1 officers and employees who are assigned to the Department
2 without appointment shall not be considered to be officers
3 or employees of the Department, except as provided in sub-
4 section (7), nor shall they be paid a salary or wage by the
5 Service during the period of their assignment. The super-
6 vision of the duties of such persons during the assignment
7 may be governed by agreement between the Secretary and
8 the State involved.

9 “(7) (A) Any State officer or employee who is as-
10 signed to the Department without appointment shall never-
11 theless be subject to the provisions of sections 203, 205,
12 207, 208, and 209 of title 18 of the United States Code.

13 “(B) Any State officer or employee who is given an
14 appointment while assigned to the Department, or who is as-
15 signed to the Department without appointment, under an
16 arrangement under this subsection, and who suffers disability
17 or death as a result of personal injury sustained while in the
18 performance of his duty during such assignment shall be
19 treated, for the purpose of the Federal Employees' Compen-
20 sation Act, as though he were an employee, as defined in
21 such Act, who had sustained such injury in the performance
22 of duty. When such person (or his dependents, in case of
23 death) entitled by reason of injury or death to benefits under
24 that Act is also entitled to benefits from a State for the same
25 injury or death, he (or his dependents, in case of death)

1 shall elect which benefits he will receive. Such election shall
2 be made within one year after the injury or death, or such
3 further time as the Secretary of Labor may for good cause
4 allow, and when made shall be irrevocable unless otherwise
5 provided by law.

6 “(8) The appropriations to the Department shall be
7 available, in accordance with the standardized Government
8 travel regulations, during the period of assignment and in the
9 case of travel to and from their places of assignment or ap-
10 pointment, for the payment of expenses of travel of persons
11 assigned to, or given appointments by, the Service under
12 an arrangement under this subsection.

13 “(9) All arrangements under this subsection for as-
14 signment of officers or employees in the Department to States
15 or for assignments of officers or employees of States to the
16 Department shall be made in accordance with regulations
17 of the Secretary.

18 “General

19 “(g) (1) All regulations and amendments thereto with
20 respect to grants to States under subsection (a) shall be
21 made after consultation with a conference of the State health
22 planning agencies designated or established pursuant to sub-
23 paragraph (A) of paragraph (2) of subsection (a). All
24 regulations and amendments thereto with respect to grants
25 to States under subsection (d) shall be made after consulta-

1 tion with a conference of State health authorities and, in
2 the case of regulations and amendments which relate to or
3 in any way affect grants for services or other activities in
4 the field of mental health, the State mental health authorities.
5 Insofar as practicable, the Surgeon General shall obtain the
6 agreement, prior to the issuance of such regulations or amend-
7 ments, of the State authorities or agencies with whom such
8 consultation is required.

9 “(2) The Surgeon General, at the request of any recipi-
10 ent of a grant under this section, may reduce the payments
11 to such recipient by the fair market value of any equipment
12 or supplies furnished to such recipient and by the amount of
13 the pay, allowances, traveling expenses, and any other costs
14 in connection with the detail of an officer or employee to the
15 recipient when such furnishing or such detail, as the case
16 may be, is for the convenience of and at the request of such
17 recipient and for the purpose of carrying out the State plan
18 or the project with respect to which the grant under this
19 section is made. The amount by which such payments are
20 so reduced shall be available for payment of such costs (in-
21 cluding the costs of such equipment and supplies) by the
22 Surgeon General, but shall, for purposes of determining the
23 Federal share under subsection (a) or (d), be deemed to
24 have been paid to the State.

24

1 “(3) Whenever the Surgeon General, after reasonable
2 notice and opportunity for hearing to the health authority or,
3 where appropriate, the mental health authority of a State
4 or a State health planning agency designated or established
5 pursuant to subparagraph (A) of paragraph (2) of sub-
6 section (a), finds that, with respect to money paid to the
7 State out of appropriations under subsection (a) or (d),
8 there is a failure to comply substantially with either—

9 “(A) the applicable provisions of this section;

10 “(B) the State plan submitted under such sub-
11 section; or

12 “(C) applicable regulations under this section;

13 the Surgeon General shall notify such State health authority,
14 mental health authority, or health planning agency, as the
15 case may be, that further payments will not be made to the
16 State from appropriations under such subsection (or in his
17 discretion that further payments will not be made to the
18 State from such appropriations for activities in which there
19 is such failure), until he is satisfied that there will no longer
20 be such failure. Until he is so satisfied, the Surgeon General
21 shall make no payment to such State from appropriations
22 under such subsection, or shall limit payment to activities
23 in which there is no such failure.

24 “(4) For the purposes of this section—

25 “(A) The term ‘nonprofit’ as applied to any pri-

1 vate agency, institution, or organization means one
2 which is a corporation or association, or is owned and
3 operated by one or more corporations or associations, no
4 part of the net earnings of which inures, or may law-
5 fully inure, to the benefit of any private shareholder or
6 individual; and

7 “(B) The term ‘State’ includes the Commonwealth
8 of Puerto Rico, Guam, American Samoa, the Virgin
9 Islands, and the District of Columbia, and, except with
10 respect to paragraphs (5) and (6) of subsection (d),
11 the term ‘United States’ means all such States.”

12 SEC. 4. Effective July 1, 1967, section 309 of the Public
13 Health Service Act is amended by adding after subsection
14 (b) the following new subsection:

15 “(c) There are also authorized to be appropriated
16 \$5,000,000 each for the fiscal year ending June 30, 1968,
17 and the fiscal year ending June 30, 1969, to enable the
18 Surgeon General to make grants, under such terms and con-
19 ditions as may be prescribed by regulations, for provision,
20 in public or nonprofit private schools of public health accred-
21 ited by a body or bodies recognized by the Surgeon General,
22 of comprehensive professional training, specialized consultive
23 services, and technical assistance in the fields of public
24 health and in the administration of State or local public
25 health programs, except that in allocating funds made avail-

1 able under this subsection among such schools of public
2 health, the Surgeon General shall give primary consideration
3 to the number of federally sponsored students attending
4 each such school.”

5 SEC. 5 Effective July 1, 1967, section 311 of the
6 Public Health Service Act is amended by adding at the end
7 thereof the following new sentence: “The Surgeon General
8 is also authorized to train personnel for State and local health
9 work.”

10 SEC. 6. The amendments made by section 3 shall be-
11 come effective, and section 318 of the Public Health Service
12 Act shall be repealed as of July 1, 1966, except that the
13 provisions of sections 314 of the Public Health Service Act
14 as in effect prior to the enactment of this Act shall be effec-
15 tive until July 1, 1967, in lieu of the provisions of subsec-
16 tions (d) and (e), and the provisions of subsection (g)
17 insofar as they relate to such subsections (d) and (e), of
18 section 314 of the Public Health Service Act as amended
19 by this Act. Effective July 1, 1967, section 316 of the
20 Public Health Service Act is repealed.

89TH CONGRESS } HOUSE OF REPRESENTATIVES { DOCUMENT
2d Session } { No. 395

HEALTH AND EDUCATION

M E S S A G E

FROM

THE PRESIDENT OF THE UNITED STATES

TRANSMITTING

REVIEW OF ACHIEVEMENTS IN THE FIELDS OF HEALTH AND
EDUCATION AND FURTHER RECOMMENDATIONS FOR ATTAIN-
ING GOALS

MARCH 1, 1966.—Referred to the Committee of the Whole House on the State
of the Union and ordered to be printed

To the Congress of the United States:

A nation's greatness is measured by its concern for the health and welfare of its people. Throughout the history of our democracy, this commitment has grown and deepened.

The education of our people is a national investment. The health of our people is essential to the pursuit of happiness.

Today we can set ambitious goals for the future:

Full education for every citizen to the limits of his capacity to absorb it;

Good health for every citizen to the limits of our country's capacity to provide it.

The 88th and 89th Congresses have moved toward these goals. During the past three sessions, Congress has—

enacted 20 landmark measures in health and 19 in education; doubled the appropriations for health programs and increased the budget for our Office of Education more than fivefold.

The achievements of the past 3 years promise a dramatic enrichment of American life. They already include in the field of health:

1. The medicare program which, on July 1, will make benefits available to more than 19 million older Americans.

2. Health services for more than 200,000 migrant workers in 34 States.

3. Maternal and infant care for mothers and children previously receiving inadequate services.
4. Expanded services for crippled children.
5. Thirty-two new clinics for retarded children.
6. Construction assistance for 1,300 hospital and health facilities to add more than 56,000 new hospital beds.
7. Financial support for more than 16,000 medical research projects and advanced training for 25,000 scientists.
8. Construction starts for 62 institutions to enroll more than 2,400 additional students each year for training in the health professions.

Our achievements in education are equally impressive. Among them are:

1. Funds to improve educational opportunities for nearly 7.5 million underprivileged children in 20,000 school districts.
2. Summer Head Start programs for 560,000 preschool children in 13,350 community education projects and year-round programs for 120,000 children.
3. Textbooks and other learning materials for more than 40 million children in every State.
4. College work-study programs for more than 110,000 needy college students.
5. Construction aid for 1,300 institutions of higher learning—including new classrooms, laboratories, and libraries.
6. Twelve million books to improve public libraries and training programs for more than 400 librarians.

HEALTH

With these programs and those I am recommending today, we can move closer to attainment of our goals—

- to bring every child the care he needs to develop his capacity to the fullest;
- to reduce infant mortality, concentrating particularly on those minority groups whose death rate is highest;
- to eradicate major communicable diseases as a threat to life and health in the United States;
- to reduce the burden of mental illness, and mental retardation; and
- to cut the toll of the three great killers—heart disease, cancer, and stroke.

The health budget which I have proposed for fiscal year 1967 is \$4.67 billion—an increase of almost \$1 billion. In addition more than \$3 billion in social security trust funds will be spent under medicare to assist our older citizens.

Funds for health manpower, facilities, and services are up \$707 million. Funds for environmental activities and consumer protection are up \$158 million. Funds for health research activities are up \$78 million.

- To insure continuing progress, we must—
- improve the administration of Federal health activities;
- develop comprehensive health planning and services on the State and community level;
- strengthen our system of health care;
- train needed health workers;
- increase our research efforts; and
- take additional steps to meet special health problems.

I. TO IMPROVE ADMINISTRATION OF FEDERAL HEALTH SERVICES

Our first concern must be the efficient and effective administration of the Federal health programs.

Over the last 12 years the budget of the Public Health Service for research, training, and services has grown almost tenfold—from \$250 million to \$2.4 billion. Yet major elements of the basic structure of the Public Health Service remain set by a law that is more than 20 years old.

The Secretary of Health, Education, and Welfare and the Surgeon General of the United States have consulted leading experts—physicians, administrators, scientists, and public health specialists—in a thorough search for the best means to improve the administration of Federal health programs. They all agree that the need to modernize the administration of the Public Health Service is urgent.

To fulfill that need, I will shortly submit to Congress a proposed reorganization of the health functions of the Department of Health, Education, and Welfare.

The ultimate success of Federal health programs depends on the men and women who direct them. At present, the personnel system of the Public Health Service is inadequate to recruit and retain the talent needed for its rapidly changing and expanding role.

I will recommend legislation to improve the personnel system of the Public Health Service.

This legislation will—

- promote career development;
- encourage more flexible use of health workers;
- provide them with broader opportunities; and
- stimulate higher standards of performance.

II. TO DEVELOP COMPREHENSIVE HEALTH PLANNING AND SERVICES ON THE STATE AND COMMUNITY LEVEL

The focus of our efforts is the individual and his family, living in their own community. To meet their health needs requires the cooperation of many agencies, institutions, and experts—of State and local government, of doctors, nurses, and paramedical personnel.

These are the frontline fighters in our battle against disease, disability, and death. As in military battle, a winning strategy demands wise and well planned use of manpower. It demands coordinated use of all the resources available.

I recommend to Congress a program of grants to enable States and communities to plan the better use of manpower, facilities, and financial resources for comprehensive health services.

At present, the Federal Government offers the States formula grants for categorical programs dealing with specific diseases. This leads to an unnecessarily rigid and compartmentalized approach to health problems.

Our purpose must be to help redirect and reform fragmented programs which encourage inefficiency and confusion and fail to meet the total health needs of our citizens.

I recommend a program to initiate new State formula grants for comprehensive public health services. This program would begin in fiscal 1968.

At the same time, we must recognize that special health problems occur in some parts of our Nation and not in others. Certain diseases, such as tuberculosis and venereal disease, are concentrated in metropolitan communities. Others, such as rabies and parasitic diseases, are prevalent in certain geographic areas.

Resources to serve health needs are not evenly distributed throughout the Nation. Special problems arise in remote rural areas and the city slums. We need greater flexibility to pinpoint our attack.

To make certain we have that flexibility, I recommend a program, to commence in fiscal 1968, of grants to States, communities, medical schools, and hospitals to meet special health problems.

III. TO STRENGTHEN OUR SYSTEM OF HEALTH CARE

The Hill-Burton program for hospital construction is an outstanding example of creative federalism in action. Now in its 19th year, this Federal-State-local partnership has added more than 300,000 hospital and nursing home beds to our Nation and more than 2,000 other health facilities in areas of great need.

My budget requests the full authorization of \$270 million for facilities construction under the Hill-Burton Act.

Medical advances demand new equipment and up-to-date laboratories. Intensive care units, as well as ambulatory and extended care facilities, require changes in the structure and function of aging hospitals, particularly in urban areas.

General hospitals containing 260,000 beds—one-third of our Nation's—are now in obsolete condition.

When medicare becomes operative this July, the pressure on many hospitals will grow even more intense.

To begin to meet this urgent need, I recommend legislation to mobilize public and private resources to revitalize our obsolete hospitals. This will require a loan and grant program to assist in the long-term financing of hospital renewal projects.

The need for modernization goes beyond the bricks and mortar of construction. We must find new ways to lower the cost and raise the quality of health care, to organize health services more efficiently, to develop information systems. It will take the combined efforts of university, hospital, industry, group practice clinics, and many other organizations.

I am directing the Secretary of Health, Education, and Welfare to conduct systems analyses and other studies to determine the most effective means of bringing high quality medical services to all the people at the lowest cost.

I also propose a 5-year program of grants for research and demonstration projects in the organization, financing, utilization, and delivery of health services.

As medical practice becomes more complex, specialization becomes more common. The number of general practitioners is declining—66,000 today compared to 95,000 15 years ago. In 1950, there was 1 family physician for every 1,600 Americans. Today 2,900 Americans must depend on 1 family doctor.

Group practice benefits both physicians and patients. It makes expert health care more accessible for the patient. It enables the physician to draw on the combined talents of his colleagues.

High initial capital requirements and a shortage of long-term financing have restricted the development of this form of medical and dental practice.

I recommend that the Congress consider legislation now pending making mortgage insurance available for group practice facilities.

The first session of this Congress has liberated our citizens from the haunting fear of an inability to meet the cost of medical care in their later years. This landmark legislation assures that community hospitals, physicians, and others who provide for their health will be paid the reasonable cost and customary charges for such services. I propose that this same principle be extended to the care of patients in our own Federal hospitals and I recommend legislation to permit the reimbursement of these hospitals in the same manner.

IV. TO TRAIN NEEDED HEALTH WORKERS

Trained men and women continue to be in critically short supply in the field of health. Congress has already acted to help meet that need by enacting—

the Health Professions Educational Assistance Act to provide assistance to both schools and students;

the Nurse Training Act to provide Federal aid to increase the supply of professional nurses; and

the Vocational Education Act to provide for training of practical nurses and other health workers.

But critical specialties remain dangerously understaffed—medical technologists, biomedical engineers, dental hygienists, and other college-trained health workers.

These personnel, allied with doctors, dentists, and nurses, constitute the modern health care team. They extend the reach and the scope of the physician.

I recommend a 3-year program to provide grants for training in allied health professions—

to construct and to improve needed educational facilities;

to offer fellowships for students in advanced training; and

to stimulate institutions to develop new types of health personnel.

Last year, in the Higher Education Act of 1965, Congress enlisted the resources of our private banking community to make low-interest student loans. By this means, greatly increased financial assistance can be provided at minimal cost.

I recommend legislation to convert the health professions student loan program to privately financed and federally subsidized loans for students in the health professions.

V. TO ADVANCE RESEARCH

Over the past 10 years, Congress has increased the budget for health research thirteenfold. The dividends from this investment are incalculable. Miraculous progress in medical discovery is making possible—

development of support devices for the failing heart—and even replacement of a human heart by an artificial organ;

advances toward the cure of cancers such as childhood leukemia and Hodgkin's disease;

development of a less expensive and more efficient treatment for kidney failure; and
isolation of viruses causing respiratory infections and production of vaccines to immunize against them.

My fiscal 1967 budget provides increased funds for health research. If research makes major new breakthroughs in lifesaving discoveries, I will submit requests for necessary additional funds. My overall budget provides for this contingency.

VI. TO MEET SPECIAL HEALTH PROBLEMS

1. *Mental retardation*

We have begun to ease the tragic burden of the mentally retarded and their families. By construction of research and service facilities, and by support of State programs, the Federal Government helps combat this dread handicap.

We shall continue our increasing attack on this problem. It deserves the concern and attention of our most able specialists. Therefore, I intend to appoint a Committee on Mental Retardation to assess our progress, to seek out new and better ways to cope with this terrible disability, and to recommend a long-range and comprehensive plan of action.

2. *Nutrition for the needy*

It is hard to teach a hungry child. This fact, known to parents and teachers alike, underlies the school lunch program throughout the Nation.

This year 18 million schoolchildren will enjoy lunches prepared and served in their schools under this program. Yet too many children still fail to get a good lunch even though the cost is low. Some cannot afford the 25- to 35-cent lunch charge. Others in low-income districts go to schools which lack lunch facilities.

Demonstration programs conducted in poverty areas in Colorado and North Carolina provided lunches this year at sharply reduced rates. The results were amazing. Virtually all the children purchased the school lunch—less than one-third had done so before. The children were more alert and interested in learning. The absentee rate fell by as much as 37 percent. School dropouts were reduced.

Too little of the Federal assistance in the school lunch program has been directed toward children who need it most. Too much of our subsidy, particularly in the special milk program, goes to children who already get a federally supported school lunch, including milk, and whose parents can afford to pay for additional milk.

I am submitting to the Congress the Child Nutrition Act of 1966 to redirect our efforts to provide food to those who need it most. The act will—

- extend the school lunch program to more needy children and give greater flexibility in providing low cost or no cost meals;
- assist schools serving low-income districts to acquire kitchen and lunchroom facilities;

- provide pilot school breakfast programs for those children who start the day hungry;

- direct the special milk program to those schools without food service, to schools serving children from low-income families, and to needy schoolchildren at whatever school they attend;

start demonstration summer programs to provide food service for needy children at child-care centers and playgrounds; and help State educational agencies strengthen their staffs to improve child nutrition programs.

I am requesting \$50 million from the Congress for programs designed to provide adequate nutrition for disadvantaged children. This money is an addition to the \$329 million in cash and commodities already included in the budget for school nutrition programs. The total Federal program of \$379 million is a major redirection of our child nutrition efforts to children who otherwise would grow up hungry, suffer the diseases that come from being ill nourished, and lack the energy so essential to learning.

No child in an affluent America should be without an adequate diet. The new program will move us far toward that goal. But it will not do the job alone.

I am directing the Secretary of Health, Education, and Welfare, in cooperation with the Secretary of Agriculture and the Director of the Office of Economic Opportunity, to examine means by which the benefits of sound nutrition can be extended to every child who needs our help.

We now know that among elderly Americans, a poor diet is a root cause of poor health. It adds to the burden of our hospitals and health manpower. It contributes unnecessary misery to the burdens of old age.

I have directed the Secretary of Health, Education, and Welfare to initiate a special food service program at multipurpose centers authorized by the Older Americans Act of 1965. Local organizations will be able to offer balanced, nutritious meals to the elderly—without charge or at reduced prices to those who are in need.

3. *Alcoholism*

The alcoholic suffers from a disease which will yield eventually to scientific research and adequate treatment. Even with the present limited state of our knowledge, much can be done to reduce the untold suffering and uncounted waste caused by this affliction.

I have instructed the Secretary of Health, Education, and Welfare to—

- appoint an Advisory Committee on Alcoholism;
- establish in the Public Health Service a center for research on the cause, prevention, control, and treatment of alcoholism;
- develop an education program in order to foster public understanding based on scientific fact; and
- work with public and private agencies on the State and local level to include this disease in comprehensive health programs.

4. *Family planning*

We have a growing concern to foster the integrity of the family, and the opportunity for each child. It is essential that all families have access to information and services that will allow freedom to choose the number and spacing of their children within the dictates of individual conscience.

In the fiscal 1967 budget, I have requested a sizable increase in funds available for research, training, and services in this field. The National Institute for Child Health and Human Development will expand its own research and its grant program to study human

reproduction. The Children's Bureau and the Office of Economic Opportunity will support family planning to the maternal and infant care programs in local communities when requested. State agencies will be aided by Federal welfare funds to provide family planning services to mothers.

EDUCATION

I have proposed a total Federal investment in education and training during the coming year in excess of \$10 billion—a threefold increase since 1961.

Our education programs must be administered wisely and well. Shortly after passage of the Elementary and Secondary Education Act of 1965, I directed that the Office of Education be reorganized to carry out its expanded responsibilities more effectively and efficiently. This reorganization has now been completed.

In addition, we established the new post of Assistant Secretary for Education in the Department of Health, Education, and Welfare to strengthen program coordination throughout the Government.

The Congress has already put this Nation on the path toward the achievement of goals to—

1. extend special educational help to 12 million disadvantaged and handicapped children;
2. eliminate illiteracy within a decade;
3. bring public library services to 15 million more Americans;
4. reduce by half the rate of high school dropouts over the next 5 years;
5. guarantee the opportunity for education beyond high school on the basis of ability to learn, rather than ability to pay; and
6. provide college building and facilities to meet the needs of 9 million students expected by 1975.

Full educational opportunity for every citizen requires that we build on the beginnings we have already made. I recommend measures—

- to expand the Head Start program for preschool children;
- to strengthen the Elementary and Secondary Education Act of 1965;
- to expand Federal assistance to higher education; and
- to improve the Nation's libraries.

I. TO EXPAND THE HEAD START PROGRAM FOR PRESCHOOL CHILDREN

Few programs have had the visible success of Operation Head Start. The disadvantaged children who have benefited from this program are already entering first grade—with new confidence in themselves and greater eagerness to learn.

I have requested funds almost to double the Head Start program during the coming year to insure—

- full year programs for 210,000 children; and
- summer programs for 500,000 children.

This marks a significant step in providing greatly expanded preschool assistance for 5-year-olds from disadvantaged homes, and summer nursery programs for 3- and 4-year-olds.

II. TO STRENGTHEN THE ELEMENTARY AND SECONDARY EDUCATION
ACT OF 1965

Though funded only 4 months ago, the Elementary and Secondary Education Act of 1965 has already begun to bring its benefits to the Nation:

Special help is being provided the disadvantaged—remedial teaching, health and food services, augmented teaching, and counseling staffs.

More books—interesting and up to date—have begun to appear on school library shelves.

New approaches to old problems are being tried; instruction for the student extends beyond the classroom—to museums, hospitals, factories.

Regional education laboratories are being developed to stimulate new techniques of teaching and learning in our schools.

State educational agencies are strengthening their staffs and assuming greater responsibilities.

Educational deprivation cannot be overcome in a year. And quality cannot be achieved overnight.

I propose that the Elementary and Secondary Education Act be extended for 4 years.

My budget includes increased funds for each title of the act.

In addition, I propose that coverage of the act be enlarged—

to raise from \$2,000 to \$3,000 the family income formula for allocating aid for education of the disadvantaged commencing in fiscal 1968; and

to earmark additional funds for child of American Indians and migrant workers.

Careful study of the "incentive grant" provision of title I shows that payments would be made to many districts unrelated to need.

I therefore recommend repeal of the "incentive grant" provisions of title I in order to focus Federal aid on basic grants to more than 20,000 local school districts.

Too many schools in urban and rural slums are ancient and in disrepair. Obsolete schools aggravate the problem of eliminating de facto segregation in our northern communities, thus depriving children of full educational opportunities.

There is a pressing need for long-range, community-wide planning to bring innovation and imagination in school construction.

I propose that \$5 million be added to title III to help communities in planning school construction to encourage innovation and to deal with obsolescence, overcrowding, and special problems such as de facto segregation.

A recently completed study of the federally impacted area program, requested by Congress, has concluded that certain provisions should be revised.

I recommend revision of the existing law—

to require school districts to absorb a uniform and fair share of the burden of educating children in federally affected districts;

to base payments on school expenditures in local districts rather than on National or State average per-pupil cost; and

to eliminate eligibility for Federal impacted area assistance in those cases where Government property is leased to private enterprises that pay local taxes.

III. HIGHER EDUCATION

Today, young people are seeking advanced learning in greater numbers than ever before; 1,430,000 new students will enter our colleges next September—more than the total enrollment only 20 years ago.

Our colleges and universities must keep pace with this growing influx of young Americans. And the Federal Government must be prepared to continue its assistance.

I recommend extension of the Higher Education Facilities Act for 3 more years, with authorization of \$458 million for construction grants for fiscal 1967.

In a society that is growing more complex, advanced training is essential; 640,000 students will enroll in universities and institutions across the Nation at the postgraduate level next fall. This number will grow by another quarter million in the next 5 years.

I recommend that the grant program for graduate facilities be continued, and I propose that \$200 million be made available for loans to build both undergraduate and graduate facilities.

In addition, I will soon send to Congress legislation to permit more effective use of Federal resources in certain loan programs by applying credit from private financial institutions. This will make possible an additional \$100 million for academic facility loans in fiscal 1967.

One out of every four of our institutions of higher learning is not good enough to get accreditation. Congress recognized this need last year by providing assistance to developing colleges.

I recommend that title III of the Higher Education Act of 1965 be continued for 2 years, with its authorization increased from \$5 million to \$30 million next year.

By June, 890,000 students at 1,700 institutions will have borrowed \$800 million to invest in college education under the student loan program of the National Defense Education Act. Last year, Congress expanded the opportunity for student loans by establishing a subsidized program through the Nation's private banking system. Together with opportunity grants and the work-study programs, there now exists a wide range of student-assistance programs to help finance higher education.

To increase loan funds available to students who want college educations, I recommend the conversion of the direct loan program to a program in which loans will be made from funds provided by the private capital market, with the Government subsidizing these loans. The teacher "forgiveness" features for students eligible under the national defense education program will be retained.

I am proposing an orderly transition to the new student loan program so that no eligible student will be deprived of the needed financial assistance, and I will ask for the necessary funds to accomplish this purpose.

I also recommend that the "forgiveness" provision be extended to medical personnel who will settle in rural areas where the doctor shortage is most critical.

There are more than 12,000 unfilled vacancies for qualified social workers, at a time when we need their skills more than ever before. These workers are important to the success of our poverty, health, and education programs.

A task force on social work manpower and education has just completed an extensive study of the problem. I have asked the Secretary of Health, Education, and Welfare to consult with educational leaders and other specialists and to submit recommendations to me to overcome this shortage in the ranks of our social workers.

IV. TO IMPROVE THE NATION'S LIBRARIES

Those who do not read are not much better off than those who cannot read. More than 100 million Americans have inadequate public library services. More than 15 million have none at all.

A library must be a living institution with trained staff and funds to obtain new books, periodicals, films, records, and other material.

As the boundaries of learning are pushed back, our need for storehouses of knowledge grows greater. They offer man his link with the past and his vision of the future.

Most public libraries in the United States are poorly equipped to perform this vital role.

I recommend that Congress extend the Library Services and Construction Act for 5 more years, authorizing \$57.5 million for fiscal 1967.

DEPARTMENT OF THE PEOPLE

Through the programs entrusted to its care, the Department of Health, Education, and Welfare exercises continuing concern for the social well-being of all our people. Already, as I have indicated in this message, it has become possible to set ambitious goals for the future.

To improve our ability to chart our progress, I have asked the Secretary to establish within his Office the resources to develop the necessary social statistics and indicators to supplement those prepared by the Bureau of Labor Statistics and the Council of Economic Advisers. With these yardsticks, we can better measure the distance we have come and plan for the way ahead.

In health and education, we build with a double purpose: to meet today's needs, and to match tomorrow's hopes.

We look toward the time—

when every disease which need not happen will not happen;
when every citizen can confidently expect care—competent,
convenient care—if he is ill or injured; and
when every American receives the education and training he
wants to enrich his life and fulfill his hopes.

With pain and ignorance no longer such fearsome enemies, our people will find a new freedom. Our society will be great as never before.

It is too early for self-congratulations. We must continue to plan and act. We march in a campaign which can have no retreats, no truce, no end, only new victories.

LYNDON B. JOHNSON.

THE WHITE HOUSE, March 1, 1966.

The CHAIRMAN. The first program of Federal health grants was authorized in 1918 by the Chamberlain-Kuhn Act, but it was not until 1935 that legislation was enacted to provide Federal support on a continuing basis for public health activities through grants-in-aid.

In contrast to the \$3 million awarded in formula grants in 1936, the 1967 budget proposes \$108 million to be awarded through 15 separate grants-in-aid on a formula or project basis to fund the Federal share of public health programs against cancer, chronic illness, heart disease, mental illness, tuberculosis, venereal diseases, dental diseases, neurological diseases, and mental retardation. In addition, these grants at the State and local level would contribute to the general support of public health programs, to community health services, to radiological health programs, and to the training of personnel for home health services.

Despite the fact that the categorical grants are a most valuable source of financial support to States and communities, there is increasing realization among health officers and other leaders in the field of health that the Federal funds could be most effectively used if the purposes for which the funds can be spent were expanded and if provision was made for comprehensive planning. Such planning would give recognition to health problems of particular significance in the individual States and communities.

In recognition of the need for comprehensive health planning, S. 3008 would authorize formula grants and project grants to assist in financing comprehensive health planning at State, regional, metropolitan, and local levels. In addition, the bill would authorize training, studies, and demonstrations to improve comprehensive health planning.

Effective July 1, 1967, the Surgeon General would be authorized to award grants-in-aid on a formula basis to State health and mental health authorities to establish and maintain adequate public health services so that the health needs identified in the planning might be met.

To supplement the grants to States, the Surgeon General would be authorized to award project grants (a) to assist in meeting health needs of limited geographic scope, (b) to stimulate new health services, and (c) to develop new or improved methods of furnishing health services.

Finally, S. 3008 would provide for the exchange of personnel between the States and the Department of Health, Education, and Welfare.

We are very happy to have with us Secretary Cohen, Under Secretary of Health, Education, and Welfare, and we will be delighted to hear from you at this time, Secretary Cohen.

STATEMENT OF HON. WILBUR J. COHEN, UNDER SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY: RALPH K. HUITT, ASSISTANT SECRETARY FOR LEGISLATION; DR. PHILIP R. LEE, ASSISTANT SECRETARY, HEALTH AND SCIENTIFIC AFFAIRS; DR. LEO J. GEHRIG, DEPUTY SURGEON GENERAL, PUBLIC HEALTH SERVICE; AND DR. PAUL PETERSON, ASSOCIATE CHIEF, BUREAU OF HEALTH SERVICES

Mr. COHEN. Thank you, Chairman Hill.

I have with me today Assistant Secretary for Health and Scientific Affairs, Dr. Philip Lee; the Acting Surgeon General, Dr. Leo Gehrig;

Ralph Huitt, the Assistant Secretary for Legislation; and Dr. Paul Peterson, the Associate Chief of the Bureau of State Services of the the Public Health Service.

The CHAIRMAN. We are happy to have all these gentlemen.

You may proceed in your own way, sir.

Mr. COHEN. I am pleased to be here today to give the Department's wholehearted and enthusiastic support to S. 3008, the "Comprehensive Health Planning and Public Health Services Amendments of 1966," introduced by the distinguished chairman of this committee, Senator Hill.

S. 3008 embodies one of three major health legislation proposals made by President Johnson in his March 1, message on health and education. These measures deal with three vital areas; the organization and delivery of health services; the modernization of obsolete facilities; and the training of additional manpower.

The President in his March 1, 1966, message on health and education said that:

The focus of our efforts is the individual and his family, living in their own community. To meet their health needs requires the cooperation of many agencies, institutions, and experts—of State and local government, of doctors, nurses, and paramedical personnel.

These are the frontline fighters in our battle against disability, and death. As in military battle, a winning strategy demands wise and well planned use of manpower. It demands coordinated use of all the resources available.

The President recommended that State and community planning for health be broadened and strengthened; and that a system to assure comprehensive public health services be developed through a redirected and flexible State grant program. S. 3008 would carry out those recommendations.

It would add to and strengthen the capacity of the States to provide public health services in two ways: By emphasizing comprehensive health planning and by providing funds in such a way that health resources can be used flexibly and efficiently.

Mr. Chairman, our Nation is committed to promoting and assuring the best level of health attainable for every person. The magnitude and complexity of this commitment requires that we marshal all our available health resources—public and private; local, State, and Federal in a vital partnership to achieve this objective.

We must strengthen and expand our partnership for health.

We must extend and improve the kind of partnership in a dynamic Federal-State system that has been demonstrated so effectively in the Hill-Burton hospital construction program.

This kind of partnership, embodied in S. 3008, will allow us to pursue national goals through State and local planning and decisionmaking.

The expansion and the wise and efficient use of our health manpower and facilities is one of the primary purposes of this important legislation. The Social Security Amendments of 1965, including titles XVIII, medicare, and XIX, medical assistance to the needy aged, which supersedes the Kerr-Mills program, as well as those amendments to title V providing for comprehensive medical services for pre-school and school aged children in low income areas, have highlighted the need for additional personnel, facilities, and services, for careful planning and for effective use of our scarce manpower resources. In

addition, they have again emphasized the great importance of effective and energetic State and local health agencies in the carrying out of many of the important health programs passed by Congress.

S. 3008 is designed to serve as a new legislative basis for expanding the capabilities of States and communities to plan, develop, and provide public health services.

S. 3008 creates a new section 314(d) of the Public Health Service Act to provide formula grants to States for comprehensive health services which would replace the several categorical programs now carried out almost wholly under the present section 314, for which \$55 million has been requested in the fiscal 1967 budget. The proposed new section 314(e), to provide project grants for health service development would replace existing authorities in the present section 316 and annual appropriation acts, for which \$53 million has been requested in the fiscal 1967 budget. In addition, the authorization for areawide health facility planning now found in section 318, (for which present appropriations were \$5 million) would be contained in the new planning provisions, and the authorization for assistance to schools of public health, with the present \$3.5 million appropriation, would be transferred to section 309 of the act. In summary, there is a total of somewhat more than \$116.5 million in the 1967 budget for the existing programs which would be covered by the provisions of this bill plus \$10 million in the budget for the new authorizations in S. 3008 for planning.

The 88th and 89th Congresses have enacted landmark health legislation, most of which came out of this committee. I need not detail the significant legislation for increasing our health facilities, or for financing medical care.

The important point is that State and local health agencies must shoulder the major responsibility for assuring the availability of high quality public health services. The proposed legislation will provide the State and local health departments with Federal financial support with which to meet their responsibilities and provide the leadership and coordination that is so urgently needed.

S. 3008 has two principal objectives:

First, to increase the capacity for continuing, comprehensive planning for health—statewide, regionally, and locally—in partnership with the Federal Government. This would form the foundation. The bill would provide support to enable States and communities to determine the needs in every area of health: services, manpower, and facilities; and it would enable them to develop plans and methods for meeting these needs, both in the short run and in the long run. It will permit expansion of regional and metropolitan health planning, and enable wide cooperation and coordination of health plans with agencies, both public and private, throughout the State.

Second, to redirect the focus of health-grant programs to revitalize local and State health effort and to focus program activities more clearly on bringing services to people. This would be accomplished by providing noncategorical formula grant support for comprehensive public health services. This approach will give localities and States greater flexibility in using Federal assistance to meet their most important problems. At the same time, S. 3008 provides a means of supporting programs to meet health problems which are nationally important, but not nationwide in their incidence. Through the project grants for developing health services, narrower, targeted

attacks can be mounted on such problems as narcotics and drug abuse, alcoholism, and venereal disease. The project grants offer a way to develop new approaches to combating particular health problems, and new approaches to the organization and delivery of health services.

Mr. Chairman, our national health goals are but an expression of the justifiable expectations of the American people—that this country can and will provide the best in health care to all its citizens; that it can and will, under the legislation already enacted, remove financial barriers to health care for our older citizens, and reduce the toll of major killer diseases; that it can and will reduce infant mortality and provide every child with the health care he needs to develop his capacities to the fullest.

These desires create demands—for manpower, for facilities.

We are moving to meet them; under the Health Professions Educational Assistance Act, and the Nurse Training Act, we are both training and expanding the capacity to train additional health workers; under the Hill-Harris amendments we have begun a limited amount of hospital modernization. And this year the President's program includes proposals to train people in the allied health professions, and to modernize a very large portion of this country's obsolete hospital facilities.

We have known since 1963, when the President's Consultant Group on Nursing made its report, that there would be a shortage of trained nurses; we also know that there are increasing shortages of subprofessional health manpower; and we can expect that there will be some pressure on hospitals and other health facilities when medicare becomes an operating program on July 1 of this year.

Thus, if we are to achieve our national health goals notwithstanding short-run pressures, we must have an economy, not just of dollars, but of time and talent; economy of organization to make the most of the trained people and the facilities we now have and will have in the future.

The provisions of S. 3008 seek to encourage the most efficient use of all our health resources through planning at the State, local, and regional levels. S. 3008 provides for the development of additional manpower, and of new ways to utilize existing manpower. It will allow the States to increase their role in training the public health workers we need.

Mr. Chairman, these are the important elements of this bill: planning, as the foundation for a rational and efficient use of all our health resources; flexibility, to put the kinds and amounts of resources where they are needed to serve the health of people in local communities; and development, to find new methods of organizing and delivering health services, new approaches to disease control, and to discover and use new sources of health manpower.

Mr. Chairman, I have here with me six tables which, with your permission, I would like to put in the record at the conclusion of my remarks.

The CHAIRMAN. Those tables will appear at the conclusion of your remarks.

Mr. COHEN. They deal with illustrative allotments by States, and some supplementary information about the development of appropria-

tions through the formula grants which should be useful to the committee in the consideration of this legislation.

Thank you, Mr. Chairman, for the opportunity to appear here today to express our very strong support for this bill, and to urge its enactment.

(The tables referred to follow:)

TABLE 1.—*Tentative allotment¹ to States for comprehensive health planning under new subsec. 314(a), Public Health Service Act, in proposed legislation*

Total	\$2,500,000	\$5,000,000	\$10,000,000	\$20,000,000
Alabama.....	52,200	104,400	208,900	417,800
Alaska.....	25,000	50,000	100,000	200,000
Arizona.....	25,000	50,000	100,000	200,000
Arkansas.....	31,200	62,500	125,000	250,000
California.....	158,200	316,300	632,600	1,265,300
Colorado.....	25,000	50,000	100,000	200,000
Connecticut.....	25,000	50,000	100,000	200,000
Delaware.....	25,000	50,000	100,000	200,000
District of Columbia.....	25,000	50,000	100,000	200,000
Florida.....	68,000	136,100	272,200	544,300
Georgia.....	59,200	118,300	236,600	473,300
Hawaii.....	25,000	50,000	100,000	200,000
Idaho.....	25,000	50,000	100,000	200,000
Illinois.....	92,300	184,700	369,400	738,700
Indiana.....	50,700	101,300	202,700	405,300
Iowa.....	30,600	61,300	122,600	245,200
Kansas.....	25,100	50,200	100,500	201,000
Kentucky.....	45,800	91,700	183,300	366,600
Louisiana.....	49,700	99,400	198,700	397,400
Maine.....	25,000	50,000	100,000	200,000
Maryland.....	32,400	64,800	129,500	259,000
Massachusetts.....	47,600	95,200	190,300	380,700
Michigan.....	78,700	157,400	314,800	629,600
Minnesota.....	39,500	79,000	157,900	315,800
Mississippi.....	42,600	85,200	170,300	340,700
Missouri.....	45,600	91,300	182,500	365,100
Montana.....	25,000	50,000	100,000	200,000
Nebraska.....	25,000	50,000	100,000	200,000
Nevada.....	25,000	50,000	100,000	200,000
New Hampshire.....	25,000	50,000	100,000	200,000
New Jersey.....	59,500	118,900	237,900	475,800
New Mexico.....	25,000	50,000	100,000	200,000
New York.....	150,800	301,600	603,200	1,206,400
North Carolina.....	67,800	135,500	271,100	542,200
North Dakota.....	25,000	50,000	100,000	200,000
Ohio.....	102,200	204,300	408,600	817,200
Oklahoma.....	31,400	62,900	125,700	251,500
Oregon.....	25,000	50,000	100,000	200,000
Pennsylvania.....	116,900	233,700	467,400	934,800
Rhode Island.....	25,000	50,000	100,000	200,000
South Carolina.....	40,500	81,000	162,100	324,200
South Dakota.....	25,000	50,000	100,000	200,000
Tennessee.....	54,600	109,100	218,300	436,500
Texas.....	127,200	254,500	508,900	1,017,800
Utah.....	25,000	50,000	100,000	200,000
Vermont.....	25,000	50,000	100,000	200,000
Virginia.....	52,500	105,000	210,100	420,100
Washington.....	29,900	59,900	119,800	239,500
West Virginia.....	25,000	50,000	100,000	200,000
Wisconsin.....	43,900	87,800	175,600	351,300
Wyoming.....	25,000	50,000	100,000	200,000
American Samoa.....	25,000	50,000	100,000	200,000
Guam.....	25,000	50,000	100,000	200,000
Puerto Rico.....	48,400	96,700	193,500	386,900
Virgin Islands.....	25,000	50,000	100,000	200,000

¹ Computed on basis of population and per capita income, with a minimum allotment of 1 percent of the appropriation to any State.

TABLE 2.—*Illustrative allotments to States for public health services under new subsec. 314(d), Public Health Service Act, in proposed legislation (using illustrative per capita allocations)*¹

State	50 cents	75 cents	\$1	\$1.25
Alabama.....	\$2, 539, 592	\$3, 809, 387	\$5, 079, 183	\$6, 348, 979
Alaska.....	126, 500	189, 750	253, 000	316, 250
Arizona.....	923, 898	1, 385, 847	1, 847, 796	2, 309, 745
Arkansas.....	1, 470, 000	2, 205, 000	2, 940, 000	3, 675, 000
California.....	9, 301, 000	13, 951, 500	18, 602, 000	23, 252, 500
Colorado.....	984, 500	1, 476, 750	1, 969, 000	2, 461, 250
Connecticut.....	1, 416, 000	2, 124, 000	2, 832, 000	3, 540, 000
Delaware.....	252, 500	378, 750	505, 000	631, 250
District of Columbia.....	401, 500	602, 250	803, 000	1, 003, 750
Florida.....	3, 308, 670	4, 963, 005	6, 617, 340	8, 271, 675
Georgia.....	2, 877, 010	4, 315, 515	5, 754, 020	7, 192, 525
Hawaii.....	355, 500	533, 250	711, 000	888, 750
Idaho.....	439, 523	659, 284	879, 046	1, 098, 808
Illinois.....	5, 322, 000	7, 983, 000	10, 644, 000	13, 305, 000
Indiana.....	2, 463, 622	3, 695, 434	4, 927, 245	6, 159, 056
Iowa.....	1, 490, 353	2, 235, 530	2, 980, 706	3, 725, 882
Kansas.....	1, 221, 749	1, 832, 624	2, 443, 498	3, 054, 372
Kentucky.....	2, 228, 774	3, 343, 162	4, 457, 549	5, 571, 936
Louisiana.....	2, 415, 622	3, 623, 432	4, 831, 243	6, 039, 054
Maine.....	597, 570	896, 355	1, 195, 140	1, 493, 925
Maryland.....	1, 759, 500	2, 639, 250	3, 519, 000	4, 398, 750
Massachusetts.....	2, 074, 000	4, 011, 000	5, 348, 000	6, 685, 000
Michigan.....	4, 109, 000	6, 163, 500	8, 218, 000	10, 272, 500
Minnesota.....	1, 919, 908	2, 879, 862	3, 839, 816	4, 799, 770
Mississippi.....	1, 740, 750	2, 611, 125	3, 481, 500	4, 351, 875
Missouri.....	2, 248, 500	3, 372, 750	4, 497, 000	5, 621, 250
Montana.....	402, 220	603, 329	804, 439	1, 005, 549
Nebraska.....	806, 722	1, 210, 084	1, 613, 445	2, 016, 806
Nevada.....	220, 000	330, 000	440, 000	550, 000
New Hampshire.....	361, 097	541, 646	722, 194	902, 742
New Jersey.....	3, 387, 000	5, 080, 500	6, 774, 000	8, 467, 500
New Mexico.....	646, 844	970, 265	1, 293, 687	1, 617, 109
New York.....	9, 036, 500	13, 554, 750	18, 073, 000	22, 591, 250
North Carolina.....	3, 265, 694	4, 943, 542	6, 591, 389	8, 239, 236
North Dakota.....	392, 178	588, 267	784, 356	980, 445
Ohio.....	5, 122, 500	7, 683, 750	10, 245, 000	12, 806, 250
Oklahoma.....	1, 528, 760	2, 293, 139	3, 057, 519	3, 821, 899
Oregon.....	949, 500	1, 424, 250	1, 899, 000	2, 373, 750
Pennsylvania.....	5, 760, 000	8, 640, 000	11, 520, 000	14, 400, 000
Rhode Island.....	469, 514	704, 272	939, 029	1, 173, 786
South Carolina.....	1, 906, 500	2, 859, 750	3, 813, 000	4, 766, 250
South Dakota.....	480, 016	720, 023	960, 031	1, 200, 039
Tennessee.....	2, 653, 650	3, 980, 475	5, 307, 300	6, 634, 125
Texas.....	6, 136, 900	9, 280, 351	12, 373, 801	15, 467, 251
Utah.....	589, 132	883, 699	1, 178, 265	1, 472, 831
Vermont.....	231, 628	347, 443	463, 257	579, 071
Virginia.....	2, 553, 966	3, 830, 948	5, 107, 931	6, 384, 914
Washington.....	1, 495, 000	2, 242, 500	2, 990, 000	3, 737, 500
West Virginia.....	1, 183, 102	1, 774, 653	2, 366, 204	2, 957, 755
Wisconsin.....	2, 135, 242	3, 202, 862	4, 270, 483	5, 338, 104
Wyoming.....	178, 706	268, 058	357, 411	446, 764
American Samoa.....	15, 825	23, 738	31, 650	39, 562
Guam.....	53, 250	79, 875	106, 500	133, 125
Puerto Rico.....	1, 977, 000	2, 965, 500	3, 954, 000	4, 942, 500
Virgin Islands.....	32, 175	48, 262	64, 350	80, 438
Total.....	108, 638, 162	162, 957, 243	217, 276, 323	271, 595, 403

¹ Allotments are computed on the basis of indicated per capita amounts multiplied by population. Allotments for States with lower per capita income than that of the United States also include an additional amount (up to 50 percent more for the lowest per capita income State) based on the extent to which the per capita income of the State is less than that of the United States 1965 population and 1964 per capita income data are used in this table. Allotments will be higher in most instances when later data are available for fiscal year 1968 and subsequent allotments. Provision will also be made at that time to insure that no State's allotment is smaller than the sum of its fiscal year 1967 allotments under existing legislation.

TABLE 3.—“Federal shares” used for matching under new subsec. 314(d) of proposed legislation (1964 per capita income)

Alabama	65.92
Alaska	39.28
Arizona	56.49
Arkansas	66.67
California	39.54
Colorado	50.00
Connecticut	36.07
Delaware	33.33
District of Columbia	33.33
Florida	56.14
Georgia	62.14
Hawaii	48.91
Idaho	60.64
Illinois	40.74
Indiana	50.43
Iowa	53.70
Kansas	54.29
Kentucky	64.34
Louisiana	63.43
Maine	58.46
Maryland	44.13
Massachusetts	42.23
Michigan	46.32
Minnesota	53.72
Mississippi	66.67
Missouri	49.34
Montana	56.12
Nebraska	54.23
Nevada	36.71
New Hampshire	53.68
New Jersey	41.45
New Mexico	60.23
New York	38.39
North Carolina	62.72
North Dakota	58.44
Ohio	48.44
Oklahoma	59.41
Oregon	49.22
Pennsylvania	49.32
Rhode Island	51.01
South Carolina	66.67
South Dakota	63.39
Tennessee	63.78
Texas	57.37
Utah	57.99
Vermont	57.15
Virginia	56.37
Washington	48.66
West Virginia	61.71
Wisconsin	51.48
Wyoming	52.44
Guam	66.67
Puerto Rico	66.67
Virgin Islands	66.67
American Samoa	66.67

TABLE 4.—PHS formula grant allotments for public health services¹ (by State)

States	Total fiscal year 1966 allotments
Alabama	\$1, 250, 200
Alaska	371, 100
Arizona	549, 000
Arkansas	847, 000
California	3, 763, 500
Colorado	587, 300
Connecticut	628, 500
Delaware	364, 200
District of Columbia	394, 200
Florida	1, 801, 900
Georgia	1, 361, 100
Hawaii	394, 300
Idaho	425, 100
Illinois	2, 386, 200
Indiana	1, 288, 900
Iowa	881, 100
Kansas	716, 400
Kentucky	1, 155, 400
Louisiana	1, 148, 000
Maine	461, 400
Maryland	820, 400
Massachusetts	1, 332, 600
Michigan	1, 994, 100
Minnesota	1, 048, 000
Mississippi	1, 033, 300
Missouri	1, 270, 600
Montana	411, 900
Nebraska	531, 400
Nevada	375, 800
New Hampshire	391, 500
New Jersey	1, 497, 800
New Mexico	463, 400
New York	4, 002, 800
North Carolina	1, 538, 000
North Dakota	411, 700
Ohio	2, 508, 100
Oklahoma	852, 700
Oregon	592, 200
Pennsylvania	3, 038, 800
Rhode Island	405, 900
South Carolina	927, 300
South Dakota	420, 500
Tennessee	1, 340, 200
Texas	2, 858, 100
Utah	446, 800
Vermont	378, 900
Virginia	1, 256, 400
Washington	827, 600
West Virginia	677, 800
Wisconsin	1, 150, 800
Wyoming	373, 800
Guam	298, 700
Puerto Rico	1, 041, 200
Virgin Islands	256, 100
Total	57, 550, 000

¹ Includes grant programs for cancer control, chronic illness and aged, dental health, general health, heart disease control, home health services, mental health, radiological health, and tuberculosis control.

TABLE 5.—Appropriations for PHS formula grants to States for public health services, fiscal years 1936-66

[In thousands of dollars]

Year	Total	General health	Tuberculosis control	Cancer control	Mental health	Heart disease	Home health services	Chronic illness and aged	Radiological health	Dental health
1966	57,550	10,000	3,000	3,500	6,750	9,500	9,000	12,300	2,500	1,000
1965	45,020	10,000	3,000	3,500	6,750	7,000	-----	11,750	2,500	520
1964	53,350	14,000	2,900	3,500	10,950	7,000	-----	13,000	2,000	-----
1963	54,200	15,000	3,250	3,500	10,750	7,000	-----	13,000	1,500	-----
1962	39,750	15,000	3,500	3,500	6,000	5,000	-----	6,000	-----	-----
1961	34,000	17,000	4,000	3,500	5,000	3,600	-----	6,000	-----	-----
1960	29,375	15,000	4,000	2,250	4,000	3,125	-----	4,000	-----	-----
1959	27,875	15,000	4,000	2,250	4,000	2,125	-----	4,000	-----	-----
1958	24,875	15,000	4,500	2,250	4,000	2,125	-----	4,000	-----	-----
1957	20,600	12,000	4,500	2,250	3,000	1,125	-----	3,000	-----	-----
1956	19,925	9,725	4,500	2,250	3,000	1,125	-----	3,000	-----	-----
1955	20,110	10,135	4,275	2,250	2,325	1,125	-----	2,325	-----	-----
1954	25,950	13,000	5,300	3,050	3,100	1,500	-----	3,100	-----	-----
1953	27,000	13,500	5,800	3,100	3,300	1,700	-----	3,300	-----	-----
1952	27,991	13,541	6,350	3,200	3,550	2,000	-----	3,550	-----	-----
1951	30,040	14,200	6,790	3,500	3,550	2,000	-----	3,550	-----	-----
1950	24,055	11,215	6,790	2,500	3,000	-----	-----	3,500	-----	-----
1949	23,507	11,217	6,790	2,500	3,000	-----	-----	3,500	-----	-----
1948	21,130	14,250	6,880	-----	-----	-----	-----	-----	-----	-----
1947	16,200	11,000	5,200	-----	-----	-----	-----	-----	-----	-----
1946	12,370	11,000	1,370	-----	-----	-----	-----	-----	-----	-----
1945	11,000	11,000	-----	-----	-----	-----	-----	-----	-----	-----
1944	11,000	11,000	-----	-----	-----	-----	-----	-----	-----	-----
1943	11,000	11,000	-----	-----	-----	-----	-----	-----	-----	-----
1942	11,000	11,000	-----	-----	-----	-----	-----	-----	-----	-----
1941	11,000	11,000	-----	-----	-----	-----	-----	-----	-----	-----
1940	9,500	9,500	-----	-----	-----	-----	-----	-----	-----	-----
1939	8,000	8,000	-----	-----	-----	-----	-----	-----	-----	-----
1938	8,000	8,000	-----	-----	-----	-----	-----	-----	-----	-----
1937	8,000	8,000	-----	-----	-----	-----	-----	-----	-----	-----
1936	3,333	3,333	-----	-----	-----	-----	-----	-----	-----	-----

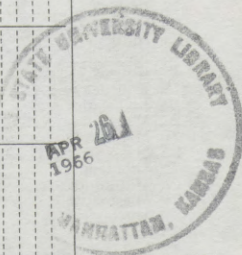


TABLE 6.—Health service grants awarded by Public Health Service (fiscal year 1965)

	Formula ¹	Project ²	Total
Total.....	\$45,020,000	\$28,010,783	\$73,030,783
1. Alabama.....	987,600	747,087	1,734,687
2. Alaska.....	272,000	80,836	352,836
3. Arizona.....	428,700	343,969	772,669
4. Arkansas.....	657,100	240,008	897,108
5. California.....	2,962,000	2,845,060	5,807,060
6. Colorado.....	473,100	420,299	893,399
7. Connecticut.....	491,400	345,600	837,000
8. Delaware.....	263,800	41,389	305,189
9. District of Columbia.....	287,600	1,144,858	1,432,458
10. Florida.....	1,327,700	716,366	2,044,066
11. Georgia.....	1,082,500	937,886	2,020,386
12. Hawaii.....	293,200	135,456	428,656
13. Idaho.....	320,400	66,995	387,395
14. Illinois.....	1,872,800	1,351,706	3,224,506
15. Indiana.....	1,012,800	300,002	1,312,802
16. Iowa.....	680,500	75,743	756,243
17. Kansas.....	555,100	276,315	831,415
18. Kentucky.....	904,500	458,284	1,362,784
19. Louisiana.....	911,600	367,902	1,279,502
20. Maine.....	353,900	74,936	428,836
21. Maryland.....	660,900	358,139	1,019,039
22. Massachusetts.....	1,041,000	1,021,121	2,062,121
23. Michigan.....	1,598,900	977,968	2,576,868
24. Minnesota.....	813,100	394,761	1,207,861
25. Mississippi.....	824,100	242,287	1,066,387
26. Missouri.....	984,700	544,788	1,530,488
27. Montana.....	308,800	60,101	369,901
28. Nebraska.....	417,900	73,698	491,598
29. Nevada.....	273,900	24,094	297,994
30. New Hampshire.....	289,300	17,663	306,963
31. New Jersey.....	1,163,000	691,470	1,854,470
32. New Mexico.....	356,300	85,007	441,307
33. New York.....	3,158,900	3,774,289	6,933,189
34. North Carolina.....	1,235,400	579,667	1,815,067
35. North Dakota.....	308,900	15,867	324,767
36. Ohio.....	1,999,400	895,769	2,895,169
37. Oklahoma.....	666,800	333,777	1,000,577
38. Oregon.....	468,600	445,528	914,128
39. Pennsylvania.....	2,386,000	1,669,351	4,055,351
40. Rhode Island.....	302,200	194,900	497,100
41. South Carolina.....	746,100	240,625	986,725
42. South Dakota.....	319,200	19,324	338,524
43. Tennessee.....	1,053,500	613,111	1,666,611
44. Texas.....	2,250,200	1,184,514	3,434,714
45. Utah.....	340,200	221,582	561,782
46. Vermont.....	278,800	50,728	329,528
47. Virginia.....	1,013,300	420,658	1,433,958
48. Washington.....	662,500	480,473	1,142,973
49. West Virginia.....	528,800	373,856	902,656
50. Wisconsin.....	896,400	451,896	1,348,296
51. Wyoming.....	275,300	7,564	282,864
52. Guam.....	207,900	-----	207,900
53. Puerto Rico.....	875,900	551,917	1,427,817
54. Virgin Islands.....	174,500	13,593	188,093

¹ Includes cancer control, chronic illness and aged, dental health, general health, heart disease, control, mental health, radiological health, and tuberculosis control.

² Total obligations include cancer, community health, mental retardation, neurological and sensory diseases, TB special projects and venereal diseases.

The CHAIRMAN. Let me ask you this question, Mr. Secretary: In your statement you speak of the budget estimates for the coming fiscal year for the different programs. But the bill itself is a general authorization—it does not authorize specific sums; is that correct?

Mr. COHEN. That is correct, Senator.

The CHAIRMAN. And naturally the question will come, either here in this committee or on the floor of the Senate, "Senator, may I ask you what is it going to cost?" What is the answer?

Mr. COHEN. Well, if you were to ask me, I think I could present a table that would give the subcommittee some idea of the potential obligations that might be required if you passed this legislation.

We have made some estimates of what would be required in the future years.

These are, of course, subject to further review by the Director of the Bureau of the Budget each year.

The CHAIRMAN. It is a 5-year bill—it is contemplated these programs are for 5 years.

Mr. COHEN. Yes, the regular program. Although if you include the planning grant authorization for this year, it is a 6-year program. And I have a table that gives our best thinking as of this time.

The CHAIRMAN. Your best estimates?

Mr. COHEN. Best estimate at this time, subject to, of course, the review each year, with the Appropriations Committee, of how the States are implementing this program, and how fast they can digest the increased authority and responsibility that would be given them.

The CHAIRMAN. What you are saying is, sir, when you come before the Subcommittee on Appropriations that handles these funds, you will not necessarily be bound by the figures you give today, is that right?

Mr. COHEN. That is correct, Senator. Just like the bill has a certain amount of flexibility in it, I would like to retain a certain amount of flexibility when I appear before you on the appropriations.

The CHAIRMAN. I think we ought to put this table in the record showing these estimates. That is our best judgment as of today, is that right?

Mr. COHEN. Yes, sir.

(The table referred to follows:)

TABLE 7.—Estimated new obligation authority required for fiscal years 1967-72 under "Comprehensive Health Planning and Public Health Services Amendments of 1966" (S. 3008)

[In millions of dollars]

New obligation authority	Fiscal year 1967	Fiscal year 1968	Fiscal year 1969	Fiscal year 1970	Fiscal year 1971	Fiscal year 1972
1. Planning Grants.....	10.0	20.0	25.0	45.0	45	45
To States.....	2.5	5.0	10.0	20.0	20	20
To local areas.....	5.0	10.0	10.0	15.0	15	15
For demonstration, etc.....	2.5	5.0	5.0	10.0	10	10
2. Health Service formula grants.....		170.5	230.7	292.6	297	300
3. Health Service project grants.....		100.0	125.0	150.0	200	200
4. Grants to schools of public health.....		5.0	5.0			
Total.....	10.0	295.5	385.7	487.6	542	545

NOTE.—The projections contained in this table represent departmental predictions and do not represent the administration position on the future program or budget requirements. Personnel requirements will be dependent on program developments and budget factors which at this time cannot be fully predicted.

The CHAIRMAN. Do any of the States now carry out comprehensive planning to identify health needs?

Mr. COHEN. I think the various States are in different stages of development on the planning. But I think I would have to say in terms of real comprehensive planning, there are probably only a few States that have this broad approach, trying to relate personnel, facilities, services, and all programs in a related way. And I think that is where this bill will make a great deal of progress.

The CHAIRMAN. What States are those?

Mr. COHEN. Well, I think that States like New York, California, Michigan have been attempting this kind of broad approach.

I think you have got to keep in mind, Senator, that just as in the Federal Government all health functions are not in one place, in most of the States all health functions are not in one agency. You have States which have a State health authority, a State mental health authority, the welfare department may administer the provisions of the Kerr-Mills program for the medically indigent. There are health functions relating to children and to the prisons and to specialized areas. In order to really get comprehensive planning, this bill provides, as one of the requirements, that there be establishment of a State health planning council.

Now, that is new.

The CHAIRMAN. We have never required that in the past.

Mr. COHEN. We have never required that before. I would like to read to you what it says on page 3 of the bill, line 12.

It says that in order for the State plan to be approved for the planning grants, among the other factors, it must "provide for the establishment of a State health planning council which shall include representatives of State and local agencies and nongovernmental organizations and groups concerned with health, and of consumers of health services, to advise such State agency in carrying out its functions under the plan."

Now, no one fixed pattern of planning or composition of State agency would be required. Our idea there is that the States should have possibilities as broad as it wants, consistent with its tradition and its experience. But it is our hope that this would bring all kinds of people concerned with health together in the State, including all of the State agencies that are involved—the mental health agency, the mental retardation agency, the rehabilitation agency, the local health departments, the medical, dental, and nursing school people in the States, the medical and nursing societies, people from the hospital field, the voluntary health agencies, the lay public—so that each State could now begin to really lay the groundwork for comprehensive review. To ascertain where the State is today, what it wants to do, what the program should be, where it will get the money, what the local financing will be, what the State financing will be, what money can be obtained from voluntary agencies, and then how additional Federal money will be used as a supplement to expand programing.

The CHAIRMAN. You say to date very little of this has been done; is that true?

Mr. COHEN. I think the State health agencies have desired to do this but I think there hasn't been the focus and stimulation which this legislation would give.

Now, if I might take a moment, a couple of years ago the Congress passed a special grant program for comprehensive planning both in the mental health field, and then one in the mental retardation field.

I can report to you that this legislative and financing responsibility did a great deal; it enabled the States to make a great deal of progress in pulling their efforts together in these areas.

Similarly, when you passed the Hill-Burton Act, giving the States the responsibility to look at all of their hospital facility needs, it did a tremendous job in pulling health facility construction together.

Now, based on the experience of those three laws, we would like to see the State health planning agency do this overall.

The CHAIRMAN. Would they have an advisory committee, too?

Mr. COHEN. I would think that it would be most important for them to have lay groups on this very organization, and also in the statute it says that the State plan must provide for encouraging cooperative efforts among governmental or nongovernmental agencies, organizations, or groups concerned with health services, facilities or manpower, and for cooperative efforts between such agencies, organizations, and groups, and similar agencies, organizations, and groups in the field of education, welfare, and rehabilitation.

So I would think they would be bringing in a great many people from throughout the State to act in this advisory capacity.

The CHAIRMAN. I notice your bill on page 26 provides sums to train personnel for State and local health work. What kinds of personnel do you contemplate training?

Mr. COHEN. May I say, first, Senator, this specific authorization is in the existing law. This merely is a technical amendment which transfers that provision from section 314 to section 311.

I think what we envisage there is that there is a great need to train personnel for the new kinds of programs and the new kinds of interests that States have.

There may be difficulty in getting trained personnel in some of the smaller States and in some of the States with special problems. As you know, there are only 12 schools of public health in the country, so that every State does not have a school of public health. And in order to get some of these public health workers in some of the small States the Surgeon General has to assist in training this type of personnel and make them available to the States.

The CHAIRMAN. Now, when you say train them, how does he train them? What *modus operandi* does he use?

Dr. GEHRIG. I think a good example of this training function relates to the training of laboratory workers in State laboratories by our activity at the Communicable Disease Center in Atlanta. Under this provision, it is possible to bring State employees into Atlanta and introduce them into the laboratory work there.

This same type of effort occurs at the Sanitary Engineering Center in Cincinnati, and also some of our environmental health programs.

The CHAIRMAN. You would contemplate more training than the training that might be possible there at the Communicable Disease Center in Atlanta?

Dr. GEHRIG. You are quite right, Senator. This would only be one example of the type of work to be done.

The CHAIRMAN. What would be another example of the type of training you would do?

Dr. LEE. An additional example, Senator Hill, would be the inservice training or career development of career State public health workers, so that they could get advanced training—they could continue this education. As we have advances in the health sciences, they need to be updated. And this would permit return to academic institutions or the development of inservice training programs within the State health departments, which is an ongoing program at the present time.

It would strengthen that operation.

The CHAIRMAN. Thank you very much.

Dr. Gehrig, do you have a statement?

Dr. GEHRIG. Mr. Chairman, I have a statement, if I may read it.

The CHAIRMAN. Please proceed.

**STATEMENT OF DR. LEO J. GEHRIG, DEPUTY SURGEON GENERAL,
PUBLIC HEALTH SERVICE**

Dr. GEHRIG. Mr. Chairman and members of the subcommittee, I am pleased to appear here today to support S. 3008 which has been introduced by the distinguished chairman of the committee, Senator Hill. This bill would carry out the President's recommendations relating to the development of comprehensive health planning and public health services in the States and communities of the Nation. The ultimate focus of our programs to promote the health of the American people should be in the local communities where services and people meet.

Mr. Chairman, the two principal objectives of this legislation are:

First, to encourage and facilitate the development of comprehensive planning within States and within local communities to meet current and future needs for health services, health facilities, and health manpower.

Second, to encourage and facilitate the development of comprehensive State and locally administered public health services which can meet the needs of the people.

Over the past several years, national health purposes have been expressed in a variety of ways.

In response to a series of new situations and demands, the number of Federal health grants programs has rapidly grown. Their administration has been in various agencies. While the programs have grown more numerous, the development of coordinating mechanisms has lagged.

Increasingly, the Federal Government has asked the States to assume large new functions and responsibilities. The medicare program, with all its benefits, will enlarge again the responsibilities which the States—particularly State health departments—must assume.

The existing patterns of Federal financial assistance must be modified and new and expanded Federal-State-local cooperative efforts must be initiated, if we are to make maximum use of our national health resources. The bill which is before you today provides the legislative framework within which Federal financial participation can best be directed to reform and rationalize the cooperative relationships between the Federal, State, and local governments. In its essence, it would delete the current provisions of sections 314, 316, and 318 of the Public Health Service Act and substitute a new section 314.

STATEWIDE PLANNING

A pattern of continuous and comprehensive planning, undertaken in a cooperative and coordinated manner by official health agencies, hospitals, professional schools, voluntary agencies, members of the health professions, and the public is essential to the wise and economical development of health programs within States and within local communities and to the most effective use of our health manpower and facilities resource.

Today, a number of federally sponsored health programs may be in operation in a State or community. Frequently, they are not related, one to the other. They may not meet at the points where together they would serve some common, larger purpose, such as the improvement of child health. The narrower focus may be to develop facilities or services for a particular region, to serve those who live or migrate through rural America, to improve the life in American cities, or expand the number of health professionals, to reduce the incidence of heart disease, cancer, or stroke, or to increase the number of hospital or nursing home beds. Several Federal agencies provide some form of funding for constructing patient care and other health facilities. Several Federal agencies provide funding for developing health manpower of all levels. Each of these has an impact on a State's health resources and their development. But the sum total of these impacts does not go as far toward improving the health of people in communities as it would if a coordinated State program were developed.

This bill would establish a continuing health planning process. Its scope is the whole of health. It is not limited in time or scope as previous categorical health planning efforts have been.

The purpose of the State and local health planning assistance proposed in S. 3008 is to encourage and to assist in truly cooperative planning on a comprehensive basis which can strengthen the capabilities of health agencies and organizations at every level to carry out their functions most effectively. It will provide a mechanism for better coordination of programs throughout the States and communities of the Nation.

The bill embodies three complementary approaches to strengthen comprehensive planning efforts:

The first approach is through formula grants to the States to assist them in comprehensive and continuing planning for their current and future health needs. In order to qualify for such a grant, a State would need to establish or designate a State health planning agency and provide for the establishment of a representative State health planning council to advise and assist the State health planning agency in its planning function. The responsibility of the State begins here and carries on through every part of the bill. The State health planning agency would be responsible for administering or supervising the administration of the State health planning functions with the advice of its planning council. The council would be composed of representatives of State and local governmental and nongovernmental agencies and groups concerned with health matters; and of representatives of consumers of health services.

Statewide planning, under the provisions of S. 3008 would be comprehensive in scope. It would be carried out in cooperation with organizations and groups in the State concerned with health and health-related activities. Federal funds for planning would have to supplement rather than supplant existing non-Federal resources. A State's annual allotment of planning grant funds would remain available for expenditure for 2 years in order to provide continuity in the funding of planning operations.

To aid the States in mounting this essential planning effort, greater Federal support would be needed at the start. Thus the bill provides that the entire cost of projects for statewide planning could be paid from Federal grant funds for the first 3 fiscal years of the

program. In subsequent years, the Federal share could be up to 75 percent of the cost.

Mr. Chairman, we envision that through this program of comprehensive State health planning, the States will be encouraged and assisted to employ professional health planning staff. They will be stimulated to undertake fundamental and continuing assessments of health needs and resources. They will be helped to strengthen the capabilities of existing health agencies and organizations to plan cooperatively and effectively to develop priorities of program and geographical needs for health services, manpower, and facilities; and to create a cooperative partnership of planning effort among public, voluntary, and private health agencies and individuals throughout the State. The most effective expenditure of the variety of Federal aid funds, and the most efficient utilization of scarce health manpower, and health facilities depends upon the creation of a strong foundation of statewide planning.

LOCAL, METROPOLITAN, AND REGIONAL PLANNING

S. 3008 would also authorize the Surgeon General to assist projects directed at the development and support of comprehensive health planning on a local, metropolitan area, regional or interstate basis. Grants could be made to public or other nonprofit community agencies to pay up to 75 percent of the costs of such projects. Once again, Mr. Chairman, it is our feeling that these planning efforts are essential to bringing together the often fragmented activities of the numerous health agencies, both public and private, which operate within a community. Moreover, as the growth of metropolitan areas continues, the problem is compounded by agencies operating within a complex of governmental substructures, not necessarily related to meeting the health needs of the people of the area.

This new authorization for local planning would replace the current section 318 of the Public Health Service Act under which grants are made for local planning principally related to the need for and utilization of hospitals and other health facilities. Planning grants under the new authority would include health facility planning, but would be directed at more comprehensive planning related as well to assessing and meeting needs for health manpower and services.

Only those local planning grant applications which are approved by the State health planning agency would be eligible for approval by the Surgeon General. As part of the State health planning agency's appraisal of such local planning which relate to health facility needs, we would expect also to require the participation of the State Hill-Burton agency.

TRAINING, STUDIES, AND DEMONSTRATIONS

The third planning provision of the bill—section 314(c)—authorizes the Surgeon General to make project grants to public and nonprofit agencies and organizations for training, studies, or demonstrations looking toward the development of, or improved or more effective comprehensive health planning throughout the Nation. This provision is, very simply, designed to "improve the state of the art" of health planning by undertaking on a selective basis those types of

developmental measures which will increase the capabilities of personnel and agencies to plan effectively for meeting health needs.

PROVIDING COMPREHENSIVE PUBLIC HEALTH SERVICES

Very largely, the financial assistance made available at the present time under the Public Health Service Act to States and communities to assist them in developing and providing public health services is in the form of separate categorical grants—both on a formula and project basis—each of which is earmarked for use only in meeting a specific disease problem.

Separate formula grants to States are now available under the authorizations in section 314 of the Public Health Service Act and annual appropriation acts for general public health services, tuberculosis control, chronic disease service, heart disease control, cancer control, mental health services, dental health services, radiological health services, and home health services. With the exception of the grants for tuberculosis control, heart disease control, and cancer control, all of these formula grants are made under subsection 314(c), the authorization for which expires June 30, 1967.

But at the service level—where health programs take visible, tangible form—we should focus our concern on the people of the community, not on disease entities. All of the disease conditions for which earmarked formula grant support is now available are problems of significant national concern. All clearly warrant continuing and intensified attack. But experience over the past several years has shown that the current system of relatively small earmarked categorical grants leads to an unnecessarily rigid and compartmentalized approach to community health problems.

To deal effectively with today's health problems we need new approaches. The bulk of health care needed by people, ranging from preventive through diagnosis, treatment and rehabilitation services, may not always lend itself to categorical programing direct to specific disease or problem targets. We need to give new concentrated attention to developing a broad base of health services, readily available to all. This is a task involving full partnership of all public and private health resources.

S. 3008 embodies, therefore, a fundamental revision of the Federal health grant structure. Federal grant funds would be made available to States and through them to local communities, on a noncategorical basis for the provision of comprehensive public health services. States and communities would be able to use these funds to provide services which are focused on individuals and on families in their communities rather than on separate disease conditions. Through this flexible grant structure comprehensive public health services will be developed, expanded, and supported to maintain physical and mental health; to detect, prevent, control, or reduce the impact of diseases, injuries, and disabilities; to maintain a healthful environment; and, generally, to make available to all persons within the State a continuum of public health services based on the most up-to-date scientific knowledge and techniques.

Among the kinds of public health programs which would be covered by grants under S. 3008 would be expansion of activities now being undertaken with the formula grants for disease categories. Addi-

tionally, other types of public health programs, identified by the States through their planning processes, such as programs in mental retardation, arthritis, alcoholism, drug addiction, family planning, health appraisal and disease detection, injury control, and laboratory services, would also be eligible.

Under the provisions of the bill, funds would be allotted among the States on the basis of population and financial need. It is our intention to develop annual appropriation requirements and to make allotments to States on the basis of providing each State a minimum allotment. Those States with a per capita income which is less than the national average would receive allotments which would range somewhat above the minimum.

We believe that the capabilities of States and communities to develop and expand their health service programs and the opportunities which such expanded programs hold for more adequate health protection and services to the people would warrant an increasing per capita commitment of Federal funds into these cooperative programs over the period of authorization.

The bill provides that at least 15 percent of a State's allotment will be available to the State mental health authority for State and local mental health services. This limitation is necessary since in most States mental health programs are the responsibility of the State mental health agency rather than the State health department and some provision needs to be made for determining how much of a State's allotment will be available for mental health services.

The bill also provides that at least 70 percent of a State's allotment will be available only to develop and support local community services. Whether these local services are provided by local agencies or, in part, by State agencies will vary among States depending on their patterns of organization and division of responsibility between State and local governments. It is clearly intended, however, that only those services provided in and for local communities would be paid from the 70 percent of the allotments reserved for this purpose. With the remaining portion of the funds, State health and mental health agencies would be able to expand their resources and capabilities for directing, planning, and evaluating programs and for providing consultation and technical assistance.

The bill authorizes the Federal grant funds to be used to pay what is called the Federal share of the costs of services provided in accordance with the approved State plan. The Federal share for any State would be determined on the basis of the relationship of its per capita income to the per capita income of the United States within a range of between 33½ percent for States with the highest per capita income and 66⅔ percent for States with the lowest per capita income. States are required, however, to provide assurances that the Federal funds will be used to supplement and not to replace State, local, and other non-Federal funds available for these programs.

One of the key provisions in the bill relating to formula grants for comprehensive public health services is that the programs and services provided with these funds must be in accord with the planning decisions which have been made by the State health planning agency and its planning council. The purpose of this requirement is to insure

that the kinds of services, their distribution throughout the State, and the priorities and emphasis of program development and expansion will be based on comprehensive State health planning. It is designed to reflect the judgments and decisions of those charged with this responsibility in the State. Because some leadtime is necessary for State health planning agencies to complete the initial stages of comprehensive planning, the effective date for the State planning conformity provision is set at July 1, 1970.

HEALTH SERVICES DEVELOPMENT

New approaches to the solution of important health problems can best be developed by concentrated, direct effort. For example, a new or improved approach to control of a particular disease is best tried out where the disease is most prevalent. New methods of delivering health services are best demonstrated by well-defined projects which include built-in evaluation. S. 3008 authorizes the Surgeon General to make grants on a project basis to public and other nonprofit organizations and agencies for the provision of services to meet health needs of limited geographical scope or of special regional or national significance. Additionally, it provides for the stimulation and initial support of new programs of health services; and for undertaking studies, demonstration, or training designed to develop new or improve existing methods of providing health services.

Experience has shown that these purposes can be best achieved through the project grant mechanism. Funds need to be focused in appropriate amounts and at appropriate times to those geographical areas where the needs are greatest and to those agencies or organizations which are best able and prepared to undertake the activity.

This provision of S. 3008 would replace the present authorization in section 316 of the Public Health Service Act under which project grants are made for the development of new or improved methods of providing out of hospital community health services as well as the authorizations now contained in annual appropriation acts under which project grants are made for cancer control, mental retardation activities, neurology and sensory disease activities, and for continuing support of venereal disease and tuberculosis control activities. In addition, Mr. Chairman, this proposed authority would make it possible for project grants to be made for these same kinds of program support, program development, and demonstration purposes in other health program areas such as heart disease control, dental health, injury control, urban health, family planning, alcoholism, drug addiction, and rural health development.

Considering the variety and scope of program areas which this proposed project grant authorization would serve, the identified need for intensified support in such programs as venereal disease and tuberculosis control, and the opportunities for more rapid development of new program services and techniques which the project grant mechanism makes possible, we believe a reasonably substantial increase in the funding requirements for project grants under this proposed authorization would be required for 1968 and subsequent fiscal years.

OTHER PROVISIONS

The various provisions relating to comprehensive health planning and services which I have just described are the major features of the bill. Additionally, however, the bill would:

(1) Preserve the authorization now contained in section 314(c) of the Public Health Service Act for making training grants to schools of public health by transferring and adding this identical authorization to section 309 of the act;

(2) Incorporate in section 311 of the Public Health Service Act the authorization now in section 314(c) for the Surgeon General, as part of the direct operating responsibility of the Public Health Service, to train personnel for State and local health work;

(3) Carry over into the new legislation various provisions now in section 314, such as those relating to consultation with State authorities in the development of grant regulations and to the conditions under which and procedures by which grant funds shall be withheld from States;

(4) Authorize and prescribe the conditions under which exchange agreements may be entered into between the Secretary and State and local governments for the temporary interchange of Federal and State personnel engaged in work related to health. This provision, Mr. Chairman, is patterned closely along the lines of a similar provision in the filed of education enacted last year as part of the Elementary and Secondary Education Act of 1965, Public Law 89-10.

Senator YARBOROUGH. The Elementary and Secondary Education Act of 1965, would allow for a schoolchild in the State of New York \$340 a year, and for a State down at the bottom in education, like Mississippi and Alabama, \$120 and \$140 a year, for children, as against \$340 in New York State. I hope this doesn't have a similar allocation of money—that you pay three times as much for service in New York as you do in a State that has a lower health level, because it has lower income.

Is this patterned on that kind of allocation?

Dr. GEHRIG. Senator, this just relates to an authority for the Secretary to arrange for exchange of personnel working in State health departments and permitting them to come to the Federal Government—

Senator YARBOROUGH. I assume what you read didn't relate to allocation of money.

Dr. GEHRIG. No, it didn't.

Senator YARBOROUGH. Knowing what happened last year, in that bill, hopefully we will get some reform in the allocation in that bill this year. I don't want to see another bill go through with such great disparity.

Dr. GEHRIG. Before concluding my testimony, Mr. Chairman, I should like to emphasize that we view this bill as a means by which the concept of cooperative Federal, State, local, and private effort, which has for so long been a dominant characteristic of public health in the United States, can be further strengthened to meet the needs and expectations of the American people in the years ahead. This bill has been called by some the partnership-for-health bill. I be-

lieve that is a very accurate and descriptive identification. That concept has certainly been dominant in the development of the legislation, and will characterize the operation of the program when S. 3008 becomes law.

My colleagues and I will be pleased to answer any questions which you and members of the subcommittee may have.

The CHAIRMAN. Senator Yarborough?

Senator YARBOROUGH. Mr. Chairman, I have been reading through Secretary Cohen's statement on this. Perhaps this has been covered. This reference to allocation that has come up has stimulated a question.

I believe section 3(a) says—page 5: "State allotments."

Mr. COHEN. Senator, there are several allotment formulas in the bill. There is one that relates to the planning grants, and then one that relates to the comprehensive services.

The central one is the comprehensive services, and I believe that is the one you have reference to, is it not?

Senator YARBOROUGH. It says on page 11:

determined in accordance with regulations on the basis of population and financial need of the respective States.

Are those regulations to be drawn in the future? Is there no formula spelled out in the bill?

Mr. COHEN. That is correct. Those regulations would be developed in the future. I can tell you the general principles upon which we propose to do so.

First, let me say that with respect to the allotment to the States for the planning grants, that would be based on population and per capita income with a minimum allotment of 1 percent of the appropriation to any State. And I submitted, before you and Senator Javits came in, a series of tables to show how these work out for individual States.

Senator JAVITS. I notice in your summary you say, "determine by the Surgeon General on the basis of population and per capita income."

But you just said population.

Mr. COHEN. I thought I said per capita income, too. If I didn't, I misspoke. I am sorry.

Senator JAVITS. All right.

Mr. COHEN. If I did omit it, I should have stated it.

Senator YARBOROUGH. Have these tables been put in the record, Mr. Chairman?

The CHAIRMAN. They have been.

Senator YARBOROUGH. In the interests of time, I will study those tables and may have questions later.

I want to express my regret for not having been here from the beginning, but we are marking up a bill in executive session in the Appropriations Committee, a very important bill. That being executive session, it was necessary that I be there—but not through any lack of interest in this important subject.

Mr. COHEN. With regard to the allotments for comprehensive services in the section you referred to, at page 11 of the bill, our intent under that section is subject to the amount of money that Congress would appropriate.

We would first allot an amount to every State on the basis of population, and then for those States whose per capita income was below the national average, we would allot an additional amount within the total.

So that there are approximately now, I would say, about 31, 32 States below the national average—about 17 or 16 in a given year that are above, and about 30, 32 that are below. A very primary amount of this allotment would be based on population, and then a residual amount would be based on per capita income. We would use those two factors.

But I think I should make this point. It uses them in—while using both factors, it uses them in a somewhat different way than is used, let's say, in the Hill-Burton formula with which you are all familiar. In the Hill-Burton formula you use population times per capita income squared, which, of course, gives a very high degree of the allotment based upon the per capita income, because the per capita income is used in inverse relationship with the per capita income of the States, and thus you give the poorer States more than you do the richer States. But every State is ranked in relation and weighted in relation to per capita income.

Under the formula that we are proposing in this bill, while you use both factors, every State would get its money by population, and then only those States which are below the national average on per capita income would get the additional amount based on per capita income. That tends—if I can oversimplify it—to restrict the element of per capita income to a lesser proportion of the total than you do when you use per capita income for all States.

Senator YARBOROUGH. Mr. Chairman, it might be well, so we have this described for the record—a comparison of how this formula would work in comparison with the Hill-Burton formula.

The CHAIRMAN. Without objection.

(The information referred to follows):

TABLE 8.—Comparison of illustrative allotments to States under formula contemplated in subsec. 314(d) of S. 3008 and under the Hill-Burton formula

State	S. 3008 ¹	Hill-Burton ²
Alabama.....	\$3,809,387	\$4,841,623
Alaska.....	189,750	134,929
Arizona.....	1,385,847	1,549,886
Arkansas.....	2,205,000	2,870,329
California.....	13,951,500	9,033,535
Colorado.....	1,476,750	1,489,592
Connecticut.....	2,124,000	1,150,967
Delaware.....	378,750	177,737
District of Columbia.....	602,250	281,753
Florida.....	4,963,005	5,758,420
Georgia.....	4,315,515	5,408,499
Hawaii.....	533,250	536,618
Idaho.....	659,284	778,284
Illinois.....	7,983,000	5,577,538
Indiana.....	3,695,434	3,924,173
Iowa.....	2,235,530	2,457,232
Kansas.....	1,832,624	2,036,314
Kentucky.....	3,343,162	4,115,485
Louisiana.....	3,623,432	4,543,737
Maine.....	896,355	1,087,414
Maryland.....	2,639,250	2,170,590
Massachusetts.....	4,011,000	3,036,871
Michigan.....	6,163,500	5,846,906
Minnesota.....	2,879,862	3,168,867
Mississippi.....	2,611,125	3,818,414
Missouri.....	3,372,750	3,464,960
Montana.....	603,329	664,051
Nebraska.....	1,210,084	1,314,902
Nevada.....	330,000	167,683
New Hampshire.....	541,646	607,993
New Jersey.....	5,080,500	3,589,785
New Mexico.....	970,265	1,167,322
New York.....	13,554,750	8,360,847
North Carolina.....	4,943,542	6,193,842
North Dakota.....	588,267	668,451
Ohio.....	7,683,750	7,624,606
Oklahoma.....	2,293,139	2,765,221
Oregon.....	1,424,250	1,470,363
Pennsylvania.....	8,640,000	8,969,981
Rhode Island.....	704,272	744,878
South Carolina.....	2,859,750	3,686,582
South Dakota.....	730,023	796,698
Tennessee.....	3,980,475	4,997,899
Texas.....	9,280,351	10,965,230
Utah.....	883,699	1,006,424
Vermont.....	347,443	423,689
Virginia.....	3,830,948	4,598,165
Washington.....	2,242,500	2,150,710
West Virginia.....	1,774,653	2,214,263
Wisconsin.....	3,202,862	3,466,263
Wyoming.....	268,058	271,324
American Samoa.....	23,738	39,273
Guam.....	79,875	122,218
Puerto Rico.....	2,965,500	4,591,157
Virgin Islands.....	48,262	72,190
Total.....	162,957,243	162,957,243

¹ From column labeled 75 cents on table 2, submitted to subcommittee on Mar. 15, 1966.

² For comparison purposes, no adjustment has been made for minimum allotments prescribed in Hill-Burton program.

Senator YARBOROUGH. The average annual per capita income is \$2,588. What is the national average?

Mr. COHEN. It is something like that. I happen to have here—this might be, just for the sake of getting into the record the relationship—I don't have the last one here, but I happen to have 1962 figures, in which the U.S. average is \$2,366 and 1963 was \$2,443, so that sounds about right.

Senator YARBOROUGH. It is \$2,500 and something now.

Mr. COHEN. This is what I think is the significance, and what we will be talking about. It ranged in 1962 from \$3,278 in Nevada, to \$1,285 in Mississippi. And using the United States as a hundred, that meant Nevada was 138.5 percent; namely, per capita income in Nevada was 38.5 percent higher per capita than for the United States as a whole, and Mississippi was 54.3, in other words, was a little bit more than one-half of what the national average is.

Texas, for instance, was in the middle of that range; it was 85.1. New York was 123.8 and Alabama was 66.2.

Senator YARBOROUGH. Well, I think if you take the 10 States now that are above 3,000, the 10 highest States, drop out the small areas of population like the District of Columbia, Delaware, that you will find New York, California, and Illinois now are among the top 10 with over \$3,000 apiece.

We congratulate them on that high income and envy them. We hope that other States, through their health and educational improvements, can catch up.

Senator JAVITS. I might say I am completely unmoved by that propaganda.

Senator YARBOROUGH. Mr. Chairman, I should think that the distinguished Senator from New York would appreciate the fact that the 31 States below the median average are pouring their riches of talent, not only money but talent, into New York, to help them keep up that high average, and that they would want to bring up the hinterlands and provinces to some level like theirs.

Senator JAVITS. You have fine provinces in Houston, Tex.—that is great hinterland.

The CHAIRMAN. Senator Javits?

Senator JAVITS. Now, Mr. Secretary, this allocation formula will come under a great deal of scrutiny from now on, I assure you.

In the first place, will you tell us how this chart was made up? In other words, what percentage of the estimated appropriation in the different categories did you put on a per capita basis, what percentage on an income basis?

Mr. COHEN. I believe that it worked out so that for the allotments on the comprehensive health service about 85 percent was based on population, and roughly 15 percent on the per capita income.

Senator JAVITS. Now, to what extent do you compensate, or do you feel you compensate, for the following variables—let me list the variables, and then you can answer them all.

One is density of population, which presents health problems.

The second is the cost of the services, which are called for under the bill.

And the third is the cost of living in a particular area, as a good deal of this money naturally goes for personnel.

Those are the three criteria, as I see them.

The other question, I think, that always presents itself in these matters is where is a variable, if there should be one, for any special problems that you might have in a particular community?

Take New York for example, with narcotics addiction, which is a special health problem. Do you at all compensate for that?

Mr. COHEN. Well, you are raising some very fundamental questions I would like to comment on each of them. Also may I say in connec-

tion with your first three that I think that there are a number of other factors that you should give consideration to.

Senator JAVITS. Please—I would appreciate your listing them.

Mr. COHEN. I can list a number of other factors for you—which I will identify—but one of our big problems is that we don't have information on them. Let me take, for instance, your third factor: The cost of living.

I think that is pertinent, and when related to your second factor, cost of service, there is no question in my mind that cost of services vary tremendously in this country—exactly the same service. In the medical field, they vary quite extensively.

But we have no method at the present time—at least we have no statistical series—by which that can be embodied into either a State formula or even less than a State formula.

So that while I would certainly agree that density and cost of service are pertinent factors, there would be great difficulty in applying them. I would think cost of living is less significant than the other two because it varies less.

Senator JAVITS. Except you have a series for it. That is the one thing you have a series for.

Mr. COHEN. You do. But you only have a series for a selected group of cities—the cost-of-living series that you have. I don't know whether you have it for New York City. You don't have it for the State of New York, as far as I know. I know you don't have a cost-of-living series for other States. And I don't think it would be pertinent to have it for a State, because it would cover a whole range of everything from rural to urban; and cost of living data, insofar as it is pertinent, is for a homogeneous area in which people live.

On the other hand, I do think cost of services, which would probably have a very high degree of correlation with cost of living, would reflect that, if we had a series that related to cost of service.

Now, I think there are other factors and if we had the appropriate series, if we had the information, we should then use that input.

For instance, in this field that we are talking about, I think a most significant factor is the tremendous variation in the country in both personnel and facilities.

As you know, there is a wide range in the number of physicians, dentists, nurses per capita; hospital beds, and nursing homes per capita; home health services, too, all of the things we are talking about. And if you start at a given moment of time, it would seem to me you have to take these differentials into account as well as its relation to density of population, and the people to be served.

My comment on that again is that these are pertinent factors, but we don't have a national index which can be used for an allotment formula at this time.

Senator JAVITS. Now, I notice a certain internal seeming contradiction in this bill, in that you have an allotment basis on formula grants. Then when you get down to comprehensive health planning, you have a Federal share, but no definition as to how you are going to distribute it. And the same is true in areawide health planning. And the same is true as to project grants for training studies and demonstrations. All of that—all you do is fix an overall percentage of Federal participation.

But when you get down to comprehensive public health service grants, you again go to the State ratio based upon, at least to some extent, per capita income. And the first one is the one we are talking about now, to wit, formula grants. You give part population and part per capita income.

Now, what is the justification for all these different schemes in one bill?

Mr. COHEN. I think we would have to take each one up individually, because the rationale is different for each type.

I neglected, however, to answer one of your questions that you did ask, which is pertinent to this, and that is how do you take into account special health problems like the narcotic problem in New York. That was a question.

I think that would be taken care of in the special project grants, Senator. That is one of the reasons for project grants, which is to take care of a problem that might be very highly localized in two or three States, or two or three communities of a State, without necessarily taking the amount of money and distributing it all over the country.

Now, the Federal share for the comprehensive health planning is specified in the bill for the years 1967-69 is up to a hundred percent. And then after that, it is up to 75 percent.

Now, the rationale for that was—the same sort of problem we had when we dealt with the education bill. When you first start with a new Federal grant, and the State legislatures have already met, and their budgets have been determined, in many instances for a year or two in advance. If you are going to put this Federal money in, you really have to assume it will be supplemental to what they are doing without any State participation for a period of time if you are going to get the program in operation.

So, on the comprehensive planning, we in effect said that it would be up to a hundred percent, where a State could not put up the money for the first 3 years, but then after the 3-year period, State legislatures and the Governors being on notice, we would assume there would be some State matching in it of around 25 percent. That is the rationale for the distinction in time there and between the two amounts.

Senator JAVITS. Do you contemplate exercising any discretion in the words “up to a hundred percent” and “up to 75 percent”?

Mr. COHEN. Yes; we would, under these circumstances. The discretion would be used, assuming that the congressional Appropriations Committees appropriated less than the total amount that was really needed on the basis of the projects that came in, in which case, then, the Surgeon General would have to take into account after, determining priorities, where that money could be best utilized.

If the Appropriations Committee appropriated sufficient to take care of all projects, I don't think it would be taken into account.

Senator JAVITS. So when you use the words “up to” you are merely talking about priority which projects deserve rather than that you are going to negotiate with every State or every city, based upon a whole set of criteria. You might give them less or more.

Mr. COHEN. Yes. I don't think it is a matter of negotiation, but I do think there might be some individual circumstances to take

into account, where some locality had a project going, where they already had some local money in it, that might be taken into account—and they might get a little bit less Federal money.

But I really think the overwhelming factor in it would be this point of priority.

Senator JAVITS. Priority of projects. The standard would be 75 percent.

Now, is the same thing true of project grants for areawide health planning?

Mr. COHEN. Yes. Project grants for areawide health planning could be funded up to 75 percent.

Now, when you come to the project grants for training, there, of course, it is up to 100 percent, and the reason is that experience has always shown that this is one of the most difficult areas in which to get States and others to put up money. The whole matter of personnel usually comes last in the consideration of budget directors, and because of its importance, we thought here that in order to get it started, it should have the authority for the Surgeon General to fund as much as 100 percent.

Senator JAVITS. There, too, would you define the "up to a 100 percent" as dealing with the priority of projects or dealing with how much percentage you are going to give them?

Mr. COHEN. I think it would be priority of projects relating to the priority of need for the training of some particular group of people. We would certainly want to deal with the major shortage areas first, and then if that was done, and there wasn't enough money, I think the reduction in it would come in the training in areas that were of less national significance.

Senator JAVITS. Then you get to the formula grants for comprehensive health services.

Again, you get to the per capita income business, to the extent of 15 percent of the amount.

Mr. COHEN. Yes, sir.

Senator JAVITS. Well, now, what is the rationale for that?

Mr. COHEN. Well, let me say this: I think that when you view the country as a whole, or the population at risk, the variation in per capita income and the ability of the States to finance some share of the costs certainly to some extent would be a factor in determining the ability of the State to accept and implement this program.

STATE EFFORT INDEX

Senator JAVITS. In that case, why don't you have a State-effort ratio?

I notice you haven't got that in this whole bill.

Mr. COHEN. No; and I think that I would have to say that there is some merit to a State-effort factor. I certainly could not argue that it isn't pertinent, however, when you get into matters of State effort on health, you then are faced with the next question that if a State is doing less effort on health but doing more effort on education, should you only look at State-effort education to education and health to health, or should you look at State effort overall.

Senator JAVITS. I will tell you right now—you should look at State effort overall. I am not parochial about it. But you have not even got it in here as one of the criteria.

I agree with you about the fact you cannot be narrowminded about it. But at least it ought to be a criterion, with a certain amount of discretionary authority based upon that as also one of the criteria—namely, the State effort.

Mr. COHEN. I would have to look into it further because I think your point is well taken.

I don't know how much to give weight to it, and I don't know what its ultimate significance would be if we gave x , y , or z weight to it.

But I do think that both the factors have pertinence in regard to this bill: maintenance of effort—the Federal funds being supplementary, and also some recognition of State effort, has pertinence.

COMPREHENSIVE PUBLIC HEALTH GRANTS

Senator JAVITS. Now, the other question I would like to ask you is what are you going to do about the other 50 percent in these comprehensive Public Health Service grants? Is that going to be on population?

Mr. COHEN. The other?

Senator JAVITS. The other 50 percent. The per capita income relates to 50 percent. You say, "Federal share: a minimum of 33 $\frac{1}{3}$ percent; maximum of 66 $\frac{2}{3}$ percent; determined on the basis of 100 percent less percentage bearing same ratio to 50 percent as per capita income of State bears to per capita income of United States."

Mr. COHEN. I think we have a little misunderstanding there.

If I recall, you are reading the mathematical determination of the Federal and State shares. When you determine the Federal share, the reciprocal of that is the State share.

Senator JAVITS. That is true. But I say—the first item of the summary says State allotments "determined by the Surgeon General on the basis of population and financial need."

Am I to assume, therefore, in that particular category there will be only two criteria, to wit, population and financial need, financial need being defined in this formula as per capita income?

Mr. COHEN. I don't think it is that formula. It is the residual distribution after the 85 percent allotted on the basis of population—

Senator JAVITS. We are talking about something else. You distribute it on the basis of 85 percent of the population, on the first program, "formula grants for comprehensive State health planning."

Now, we are down to formula grants for comprehensive health services.

Mr. KIMBLE. The material you are speaking about, Senator, is what amounts to the matching arrangements, the Federal shares.

Senator JAVITS. Right.

Mr. KIMBLE. And the formula that you were reading out of the bill in essence says that the State, with the same per capita income as that of the United States, would have a Federal share of 50 percent of the costs. In other words, the Federal funds could be used to pay 50 percent of the costs covered under the State plan. A State with a lower per capita income than that of the United States would have a

Federal share that ranges above 50 percent up to a maximum of 66% percent, with, as Mr. Cohen was saying, the State share then being the reciprocal of that.

The State with a higher per capita income than that of the United States would have a Federal share of less than 50 percent, ranging down as far as 33% percent, and the State share again would be the reciprocal of that.

Senator JAVITS. I go for that. But how about the State allotment business? How are you going to allot?

Mr. KIMBLE. As Mr. Cohen said earlier the State allotment on this particular program, the comprehensive public health service program, is specified in the bill as being on the basis of population and financial need.

Senator JAVITS. What does that latter mean?

Mr. KIMBLE. The latter means, as Mr. Cohen was saying, our contemplations would be—that each State would get a minimum allotment based on its population, and that those States with a per capita income of less than that of the United States as a whole would get some additional amount over and above that.

Senator JAVITS. So you are compensating for lower than national average per capita income twice—once on the basis of the allocation and once on the basis of a matching share.

Mr. KIMBLE. That is correct. Those States with a lower than average per capita income would get somewhat proportionately more per capita in the allocation and they would have to put up proportionately less of their own funds in order to match.

Senator JAVITS. On that basis, you would have one variable which was discretionary, I gather—the 75-25—you can shift that any time you please—and one formula which was fixed, to wit, the per capita.

Now that you have analyzed that, does that stand up as your rationale? Do you want to stand for that here?

Mr. COHEN. Well, I would say, Senator, that while one could develop alternatives, that might have a great deal of merit, in our development of this, these formulas in the bill seemed to be reasonably related to attaining the objective of getting improvement in the financial aspects, and in the health services in these States.

Senator JAVITS. But you are ready to add criteria for effort. You are ready to add a discretionary standard, another standard.

Mr. COHEN. I would certainly be willing to entertain it as a discretionary item, to see whether it worked out, because in principle, certainly in principle, it seems to me appropriate. Whether it can be worked out, and to what extent it can be taken into account, I am not prepared to say today.

Senator YARBOROUGH. Mr. Chairman, I would like to ask how this compares with the Hill-Burton law.

I would like to have that for comparison. I want to point out that in our whole foreign-aid program, we don't require matching from other governments. We have States in this Union with average per capita income, \$1,200, and many nations on earth with a higher average per capita income than our poorer States.

Our national average is higher than any in the world except Kuwait.

We have States with average annual per capita income of less than

\$1,200. And any formula that doesn't recognize that freezes in this old adage, "If you are poor you will be kept poor." I think any formula must make allowance for effort. The fact that these poor States, what they do pours money into the richer States that have a manufacturing economy.

Senator JAVITS. The richer States are pouring money into the poorer States for oil, vegetables, and cotton.

Senator YARBOROUGH. But the producer of the raw materials doesn't get much in this world. My State produces 23 percent of all the mineral value produced in this country in a year, one of the top three agricultural States, tops in lumber. But you add all of this together, and the total value of that a year is far less than the difference, for our population in Texas alone, in average per capita annual income.

It is the manufacturing that adds the great value.

FORMULAS OUTDATED

Senator JAVITS. I don't think we need to cry for Texas. But I don't think that is the point. I think the problem with these formulas is that they are over 30 years old, and there are two things that have happened to them.

One, they have become too rigid, and, two, there are too many vested interests in them. I can show you areas of my State that are abysmally poor, just as you can show me areas in your State. But I can also show you areas of your State of Texas that are richer than any in my State. I think these are the things that need to be compensated for.

In addition, the population has moved. The farm population is now down to around 15 million. Seventy percent of the people live in the big cities. We are strangling, and we are going to do something about this. That doesn't mean we are not ready to pay more taxes and get back less. There is no question about that. We probably will continue to. The whole thing is too lopsided and the criteria are out of date. I hope that we will now start a process of reevaluation. The people who were poor yesterday are not necessarily poor today. And the problems which were met yesterday are not those of today. However, the formula has remained the same. Every time you renew these bills, the natural feeling is "Why fight about it, let's take the old formula."

Well, if we can help it, we are not going to do that any more.

I don't say that Texas, Alabama, or Mississippi shouldn't have more in proportion than New York. I have always voted that way here and I will continue to. But I think we have to take another look at this.

Senator YARBOROUGH. I am perfectly willing to have a new formula, but not to freeze poverty in place by saying, "You don't have much, therefore we won't give you much."

Senator JAVITS. I am not going to argue figures right now. But I don't think your figures are quite appropriate to what we are discussing. I don't think the figures are as bad as what you say.

But all I am pleading for is let us now take these formulas one by one and find out why we have them and whether they are apposite to the present social organization of the country.

Mr. COHEN. Could I just say one thing to, maybe, ease Senator Yarborough's mind. When I said that I was willing to take effort into account, I had in the back of my mind, from previous analysis of the statistics, that some of the poorer States, by per capita income tests, are making a greater effort and would benefit. So that while effort is not correlated exactly with per capita income, I am quite well aware of the fact that States like Mississippi and Alabama are making a greater effort than other States, and this is what is impeding this further expansion in health and education, because in relation to income they are doing more than other States.

Senator YARBOROUGH. Yes. In relation to its wealth, Mississippi is making one of the greatest efforts in America in education. The table from the Statistical Abstract, page 423, shows now in taxes, and the effort they are making, from their own sources, that Mississippi is now making a greater effort than the State of New York for all State revenue.

I would like to put this table in the record.

The CHAIRMAN. Without objection, we will put that in the record.

Senator YARBOROUGH. I must leave, Mr. Chairman. I thank the Senator. He was very courteous to yield to me.

(The tables referred to follow:)

[Excerpt from Statistical Abstract of the United States]
 No. 561.—General revenue of State and local governments—Total, per capita, and relation to personal income, by States: 1962

State	Total amount (million dollars)	Per capita (dollars) 1						Amount per \$1,000 of personal income during calendar year 1962 2 (dollars)				
		Total	From Federal Government	From own sources			Total	From Federal Government	From own sources		Charges and miscellaneous	
				All taxes	Property tax	Other			Taxes	Total		
United States.....	58,214	313.28	42.28	223.46	102.55	120.91	47.53	132.41	17.87	114.53	94.44	20.09
Alabama.....	753	227.04	54.69	131.66	26.77	104.89	40.69	143.15	34.48	108.67	83.01	25.66
Alaska.....	135	557.38	189.55	214.48	47.39	167.08	153.35	205.64	69.97	135.67	79.12	56.55
Arizona.....	498	334.90	54.95	223.05	108.65	114.40	56.90	157.30	25.82	131.48	104.74	26.74
Arkansas.....	421	228.54	54.76	138.77	40.47	99.30	34.01	153.54	36.80	116.74	93.91	22.83
California.....	7,142	419.38	58.71	303.68	152.92	150.76	56.99	145.21	20.33	124.88	105.15	19.73
Colorado.....	716	378.19	60.09	255.15	123.77	131.38	62.95	158.41	25.18	133.23	106.86	26.37
Connecticut.....	881	335.72	36.05	257.10	136.10	121.00	42.58	109.83	11.79	98.04	84.12	13.63
Delaware.....	157	336.59	32.91	241.56	50.51	191.06	62.12	108.04	10.58	97.46	77.55	19.63
District of Columbia.....	291	369.33	98.94	231.89	85.85	146.05	38.49	115.45	30.94	84.51	72.50	12.04
Florida.....	1,541	283.65	30.51	197.86	82.68	115.19	55.28	138.14	14.86	123.98	96.36	26.92
Georgia.....	1,003	245.65	47.99	152.43	48.08	104.35	45.23	139.04	27.16	111.88	86.29	23.61
Hawaii.....	1,271	391.22	75.70	250.75	40.11	210.64	64.77	170.24	27.46	137.29	109.10	23.19
Idaho.....	214	305.84	66.77	191.37	91.24	100.13	48.20	158.23	34.46	123.76	98.89	24.87
Illinois.....	3,189	315.82	35.36	241.74	128.51	113.22	38.72	110.51	12.37	98.14	84.59	13.55
Indiana.....	1,314	281.72	30.41	203.13	113.98	89.15	48.18	118.59	12.80	105.79	85.50	20.28
Iowa.....	882	318.02	39.11	230.41	130.49	99.92	48.50	145.15	17.85	127.30	105.17	22.13
Kansas.....	716	323.35	42.32	233.21	130.57	102.64	47.81	147.49	19.30	128.19	106.38	21.81
Kentucky.....	790	296.52	47.88	194.07	46.89	150.28	38.43	138.27	27.99	110.27	87.81	22.46
Louisiana.....	1,065	315.82	63.06	150.21	43.80	104.82	58.68	150.50	37.44	115.22	115.22	34.84
Maine.....	277	283.58	41.82	212.05	117.75	94.30	29.72	144.80	21.36	123.45	108.35	15.10
Maryland.....	977	302.17	36.33	220.83	92.23	128.59	45.02	111.78	100.39	83.48	98.95	16.50
Massachusetts.....	1,798	346.48	38.59	270.62	162.58	108.04	37.27	125.79	14.01	111.78	98.37	13.41
Michigan.....	2,604	324.30	43.18	236.54	116.93	119.62	51.78	134.86	14.96	119.90	98.37	21.53
Minnesota.....	1,223	353.23	43.18	250.51	137.38	113.13	59.04	140.10	19.23	138.11	111.58	26.53
Mississippi.....	510	225.72	46.61	140.07	41.79	98.28	39.04	176.67	36.48	140.19	109.62	40.56
Missouri.....	1,163	269.46	48.56	187.36	79.63	107.73	33.54	112.24	20.23	92.01	78.04	13.96
Montana.....	253	362.59	75.93	231.86	131.30	100.56	54.80	161.47	33.80	127.67	108.26	24.41

Nebraska.....	400	276.71	184.24	139.53	54.71	49.87	118.76	18.28	100.47	79.07	21.40
Nevada.....	152	433.16	272.99	189.25	133.74	81.65	138.71	25.68	113.02	88.98	20.05
New Hampshire.....	178	286.05	178.56	125.77	72.74	37.00	127.01	22.81	105.94	88.22	16.50
New Jersey.....	1,622	302.97	224.04	162.09	82.54	41.22	106.56	31.81	107.52	82.72	14.55
New Mexico.....	345	345.58	257.05	145.91	140.50	81.25	183.38	41.56	143.82	100.77	43.55
New York.....	6,837	340.28	309.05	185.69	173.56	54.03	134.11	16.50	124.01	106.75	28.54
North Carolina.....	1,232	277.74	217.23	143.97	113.36	35.68	130.73	23.82	130.83	90.25	30.00
North Dakota.....	2,753	266.64	216.28	118.97	100.01	41.98	139.08	14.50	120.11	94.04	39.89
Ohio.....	2,753	280.08	198.52	118.38	100.01	56.44	116.05	14.50	121.80	92.00	39.30
Oklahoma.....	653	327.45	186.35	132.71	128.63	54.65	101.34	23.55	126.30	97.81	28.09
Oregon.....	694	322.45	229.38	173.49	121.49	38.55	150.47	23.55	121.96	95.56	26.40
Pennsylvania.....	3,247	273.73	207.35	173.88	133.47	96.49	150.47	12.55	103.22	87.77	15.45
Rhode Island.....	247	581.43	177.91	133.90	112.15	23.48	120.52	16.53	104.09	88.65	23.28
South Carolina.....	911	338.62	186.26	133.97	102.40	55.80	135.72	23.78	104.09	88.65	23.28
South Dakota.....	344	358.69	206.50	119.72	102.40	55.80	135.72	23.78	104.09	88.65	23.28
Tennessee.....	310	221.70	144.29	88.42	66.78	32.32	130.95	26.55	104.40	85.19	15.45
Texas.....	2,734	270.14	133.42	83.49	69.68	49.65	134.30	18.45	105.86	85.19	24.98
Utah.....	306	319.74	214.00	124.00	121.40	41.75	132.01	30.42	121.39	101.74	19.89
Vermont.....	144	311.49	231.79	101.94	129.85	30.39	133.89	18.21	129.84	104.71	19.89
Virginia.....	944	222.89	146.70	124.99	93.90	59.49	112.06	18.21	133.84	73.74	19.89
Washington.....	1,137	322.25	232.54	78.38	174.16	77.32	194.81	21.83	132.98	101.74	31.23
West Virginia.....	494	348.20	270.68	46.49	124.19	33.85	141.40	26.98	134.42	105.48	18.94
Wisconsin.....	1,300	323.73	243.70	136.14	107.56	43.63	139.20	13.98	123.63	104.80	18.78
Wyoming.....	160	483.09	246.45	131.89	113.57	86.29	203.04	63.16	139.57	103.54	36.20

1 Based on provisional estimates of U.S. population as of July 1, 1962, excluding Armed Forces abroad.
 2 Based on personal income estimates reported in Department of Commerce, Office of Business Economics, Survey of Current Business, August 1963.

Source: Department of Commerce, Bureau of the Census; annual report, Governmental Finances in 1962.

[Excerpt from Statistical Abstract of the United States]
 No. 482.—Consumer price indexes—All items, 1940 to 1963, and commodity groups, 1963, for selected cities
 [1957-59=100. As of December, except where noted]

City	All items									
	1940	1945	1950	1955	1959	1960	1961	1962	1963	
Total (46 cities) 1	49.1	63.4	87.1	93.5	102.3	103.9	104.5	105.8	107.6	
Atlanta	47.7	62.7	86.0	94.6	102.1	103.2	103.4	104.5	105.8	
Baltimore	47.1	63.3	85.8	93.3	102.1	104.2	104.4	105.7	107.5	
Boston	49.7	62.6	85.8	92.4	102.3	104.2	105.4	108.2	110.0	
Chicago	47.0	59.6	85.4	94.0	102.3	103.6	103.8	104.7	105.8	
Cincinnati	48.6	63.3	87.0	93.8	101.7	102.6	102.6	104.0	105.1	
Cleveland	48.2	62.7	84.9	93.6	101.8	103.0	103.1	103.7	105.0	
Detroit	48.5	63.3	87.1	94.6	100.6	102.0	100.9	102.5	103.6	
Houston	49.0	61.2	89.2	94.7	101.8	102.6	103.9	104.5	106.6	
Kansas City, Mo.	49.5	64.3	84.9	93.9	102.6	103.6	104.6	108.7	108.7	
Los Angeles	49.1	64.3	85.6	93.3	103.4	105.1	105.8	107.1	108.7	
Minneapolis	49.9	61.6	86.7	94.1	102.3	103.4	104.4	107.2	107.4	
New York	50.6	65.8	88.0	92.9	103.1	104.8	105.3	106.9	109.9	
Philadelphia	48.5	62.9	87.1	93.5	103.0	104.2	104.8	105.7	108.5	
Pittsburgh	48.3	62.5	86.0	92.4	102.9	104.7	105.0	106.3	108.5	
Portland, Oreg.	47.5	64.2	85.9	93.8	101.9	102.7	104.6	105.3	107.1	
St. Louis	48.8	62.0	86.3	93.6	103.1	103.1	104.4	106.0	107.3	
San Francisco	46.8	63.7	83.7	91.3	103.9	105.5	106.5	107.8	109.9	
Scranton	50.1	64.6	87.3	93.0	101.8	103.9	104.6	106.5	107.9	
Seattle	47.5	63.2	85.2	93.4	102.8	103.8	105.7	106.5	109.3	
Washington, D.C.	50.4	66.0	87.8	94.4	101.1	102.8	104.2	105.3	107.1	

1963

City	Housing							Apparel	Trans- porta- tion	Medical care	Personal care	Reading and recrea- tion	Other goods and services ⁵
	Food ⁴	Total ⁵	Rent	Gas and electric- ity	Solid petro- leum fuels	Honse- furnish- ings	House- hold opera- tion						
Total (46 cities) ¹	105.4	106.9	107.3	108.1	105.8	98.8	110.9	105.5	108.9	117.5	108.8	113.1	108.3
Atlanta.....	103.8	104.7	104.5	111.4	111.2	93.9	117.8	103.0	111.4	113.5	109.9	111.6	102.9
Baltimore.....	105.7	106.8	107.2	103.4	108.1	97.0	114.5	106.8	110.1	127.7	107.9	104.5	104.8
Boston ⁶	108.1	112.0	117.2	104.2	107.7	99.4	114.3	109.9	119.9	116.4	110.4	116.2	102.8
Chicago.....	105.2	105.2	105.7	105.7	104.7	100.9	108.8	102.7	107.0	121.2	111.4	99.7	101.6
Cincinnati.....	102.7	103.1	102.6	110.6	107.7	98.7	110.0	103.7	109.5	116.1	106.4	111.8	105.6
Cleveland ²	101.6	102.3	104.4	107.4	109.3	95.1	110.4	103.9	109.3	127.5	104.1	108.2	107.6
Detroit.....	100.8	98.3	94.2	105.3	100.6	99.0	106.2	105.8	104.8	123.4	107.1	111.1	109.1
Houston.....	105.0	105.5	100.2	132.5	115.0	98.2	114.1	106.9	107.8	111.2	111.9	112.8	108.1
Kansas City, Mo. ³	105.1	106.9	103.9	114.4	115.0	99.0	113.5	106.9	110.7	115.4	115.0	117.0	113.9
Los Angeles.....	107.8	108.9	114.4	114.4	115.0	100.2	106.0	106.1	110.8	116.3	106.6	103.7	107.3
Los Angeles.....	103.9	106.1	107.4	104.0	102.8	97.9	105.4	104.1	109.5	129.8	108.3	111.3	106.5
Minneapolis ³	107.8	110.8	114.0	105.4	109.3	104.0	113.7	107.1	106.9	117.5	107.6	119.6	111.6
New York.....	104.3	108.5	107.4	103.7	110.1	98.2	117.2	107.2	113.3	122.0	106.0	112.0	110.1
Philadelphia.....	102.0	107.1	106.4	102.5	102.8	97.3	115.4	103.8	110.0	123.7	104.0	113.7	111.5
Pittsburgh ⁶	105.2	107.2	106.4	102.5	102.8	97.3	110.4	105.4	106.6	118.6	110.0	113.4	104.9
Portland, Oreg. ³	103.5	104.1	104.0	109.6	105.1	98.1	112.4	106.1	110.2	115.6	110.6	120.7	111.2
St. Louis.....	103.8	112.5	107.9	105.5	101.5	95.1	115.4	105.7	110.6	119.2	113.2	108.8	108.9
Scranton ²	107.4	111.0	110.1	100.1	104.0	97.7	112.3	104.4	107.9	116.0	115.0	132.0	112.5
Seattle ²	107.4	111.0	110.1	100.1	104.0	97.7	115.5	109.4	108.7	110.9	105.6	106.9	110.4
Washington, D. C. ²	104.0	105.8	110.2	103.8	106.0	93.5	112.9	107.0	108.7	126.2	106.6	113.3	103.6

¹ Prior to 1955, 34 cities except that indexes for food are based on prices in 51 cities in 1940 and 56 cities in 1950. Separate city indexes not compiled for 26 medium- and small-sized cities included in the national average.
² As of November.
³ As of October.
⁴ Includes restaurant meals and other food bought and eaten away from home.
⁵ Source: Department of Labor, Bureau of Labor Statistics; Monthly Labor Review, and unpublished data.
⁶ Includes home purchase and other homeowner costs.
⁷ Comprises tobacco, alcoholic beverages, and miscellaneous services such as legal services, banking fees, and burial services.

Senator JAVITS. Mr. Chairman, I wish to emphasize—I don't know how this reevaluation will work out, but I think it will work out better in terms of the present social organization of the United States.

MENTALLY RETARDED STAFFING AMENDMENT

I have just one last question, Mr. Secretary. You have been very kind and courteous.

And that is to ask you about this amendment, which I intend to propose, to provide for personnel, staffing of personnel in the retardation field. Does the department have any opinion on that? It is the substance of S. 2836, which I introduced on January 26, 1966.

Mr. COHEN. Does that include any extension of the existing legislation?

Senator JAVITS. No, this is just staffing for mental retardation which was omitted when we dealt with mental health staffing last year.

Mr. COHEN. We gave a good deal of thought to that this year, Senator Javits. After considering the various problems in connection with it, the President, as you know, in his health message, decided to recommend a committee on mental retardation, to make recommendations to him for legislation next year on the whole mental retardation field, because this issue, as well as three or four others, are involved. There is the question of the extension of two other pieces of mental retardation legislation which terminate next year. There were some proposals for broadening the program. And the President, in his health message, suggested that a distinguished advisory committee be appointed. I will just read you the pertinent sentence:

Therefore I intend to appoint a committee on mental retardation to assess our progress, to seek out new and better ways to cope with this terrible disability, and to recommend a long-range and comprehensive plan of action.

Senator JAVITS. Well, has he appointed such a committee?

Mr. COHEN. No, the committee is not yet appointed. I would hope it would be appointed shortly.

Senator JAVITS. Our feeling is that this has been studied to death. We had a study in 1961 by President Kennedy's Panel on Mental Retardation. We have had State studies which were completed by 1965. We have an Interdepartmental Committee on Retardation in the Executive Department.

All of these things are actually in being. Now, we have another study—just another way of putting it off for a year.

Mr. COHEN. Well, let me say this, Senator. There is no question in my mind that staffing of mental retardation centers is a desirable objective. We have done it already, as you indicated, in connection with staffing in community mental health services. So I think the issue is not so much the basic question, it is a matter of timing and its relationship to the other proposals in the mental retardation field.

I would like to put into the record, if you would permit, the total amount of obligations on mental retardation that we have undertaken since the so-called Mayo report that was filed under appointment by

President Kennedy, which would indicate to you what progress has been made. As of the moment, I am not prepared to say that that legislation should be enacted this year with 1967 appropriation authority.

Senator JAVITS. I ask unanimous consent that the table be inserted in the record.

The CHAIRMAN. Without objection.

(The table referred to follows:)

TABLE 9.—Department of Health, Education, and Welfare obligations for programs on mental retardation¹

Agency and appropriation	1955	1963	1964	1965	1966 estimate	1967 estimate
Office of education:						
Defense educational activities (new educational media research).....	-----	\$80,217	\$82,935	\$148,119	\$20,000	\$9,945
Educational improvement of the handicapped.....	-----	996,433	6,753,364	7,234,956	9,117,000	10,925,000
Cooperative research.....	-----	366,848	185,612	189,450	163,921	75,950
Salaries and expenses.....	-----	61,250	153,900	228,892	250,000	250,000
Total, Office of Education.....	-----	1,504,748	7,175,811	7,801,417	9,550,921	11,271,895
Vocational Rehabilitation Administration:						
Grants to States.....	\$375,000	3,900,000	5,500,000	7,500,000	13,300,000	21,700,000
Research and demonstration projects.....	99,000	1,148,000	2,287,000	3,690,000	3,425,000	3,599,000
Training and traineeships.....	-----	139,000	878,000	1,213,000	1,691,000	1,810,000
Special rehabilitation research and training centers.....	-----	-----	-----	385,000	500,000	750,000
Research and training (special foreign currency program).....	-----	-----	175,000	93,000	193,000	250,000
Total, Vocational Rehabilitation Administration.....	474,000	5,187,000	8,840,000	12,281,000	19,109,000	28,019,000
Public Health Service:²						
Chronic diseases and health of the aged.....	0	629,728	1,975,000	2,204,000	10,683,000	10,813,000
Exclusively mental retardation.....	0	0	0	(2,204,000)	(10,683,000)	(10,813,000)
Hospital construction activities.....	0	3,552,000	338,000	3,750,800	3,290,451,000	3,246,774,000
Exclusively mental retardation.....	0	0	0	(7,508,000)	(29,451,000)	(24,674,000)
National Institute of Child Health and Human Development.....	0	0	5,991,000	7,279,000	10,911,000	12,000,000
Exclusively mental retardation.....	0	0	0	(3,642,000)	(5,529,000)	(6,095,000)
National Institute of Mental Health.....	923,000	5,743,000	7,303,000	11,466,000	14,882,000	15,000,000
Exclusively mental retardation.....	0	0	0	(8,325,000)	(11,431,000)	(11,500,000)
National Institute of Neurological Diseases and Blindness.....	919,000	14,887,000	20,376,000	22,636,000	23,808,000	23,861,000
Grants for construction of health research facilities.....	0	0	0	14,745,000	6,590,200	6,000,000
Exclusively mental retardation.....	0	0	0	(13,740,000)	(6,234,200)	(6,000,000)
National health statistics.....	0	0	10,000	11,000	34,000	29,000
Total, Public Health Service.....	1,842,000	24,811,728	35,691,000	65,849,000	96,359,200	92,377,000
Total, exclusively mental retardation.....	0	0	0	(35,419,000)	(63,328,200)	(59,082,000)
Welfare Administration:						
Bureau of Family Services:						
Grants to States for public assistance ⁴	12,000,000	33,000,000	38,000,000	44,000,000	51,000,000	57,000,000
Salaries and expenses.....	7,000	20,000	25,000	44,000	55,000	65,000
Children's Bureau:						
Grants for maternal and child welfare.....	88,000	2,519,000	12,858,000	23,029,000	49,600,000	53,700,000
Salaries and expenses.....	3,000	99,000	330,000	737,000	1,030,000	1,100,000
Total, Welfare Administration.....	12,098,000	35,638,000	51,213,000	67,810,000	101,685,000	111,865,000

Social Security Administration:	0	(62,800,000)	(63,700,000)	(70,900,000)	(84,500,000)	(88,400,000)
Estimated benefit payments from trust funds.....	0	(1,600,000)	(1,600,000)	(1,900,000)	(2,100,000)	(2,200,000)
Trust fund obligations incurred to adjudicate claims of beneficiaries.....	0					
Total, Social Security Administration.....	0	(64,400,000)	(65,300,000)	(72,800,000)	(86,600,000)	(90,600,000)
Office of the Secretary:	0	0	22,000	42,000	44,000	46,000
Office of the General Counsel (legal services).....	0	0	0	0	0	0
Intra-Agency Committee on Mental Retardation.....	0	0	0	0	0	0
Grand total, general funds.....	14,414,000	67,141,476	102,941,811	153,783,417	226,748,121	243,578,895
Grand total, trust funds.....	0	64,400,000	65,300,000	72,800,000	86,600,000	90,600,000
Grand total, all funds.....	14,414,000	131,541,476	168,241,811	226,583,417	313,348,121	334,178,895

1. Figures in parentheses under Social Security Administration are for obligations from the old-age, survivors, and disability insurance trust funds. All others are obligations from appropriated general funds.

2. Beginning with 1965 represents that part of the funds listed which have been identified by the Public Health Service as being used specifically and exclusively for mental retardation activities. The remaining amounts are for activities where mental retardation has relevance and can be expected to benefit directly, but where mental retardation is not the exclusive focus.

3. Represents programs authorized by the mental retardation facilities and Community Mental Health Centers Construction Act of 1963; namely, construction of university-affiliated facilities for mentally retarded, and assistance to States for construction of mental retardation facilities. Not possible to estimate for regular hospital construction program.

4. Exact information is not available on the costs due to mentally retarded people who are receiving public assistance because data secured does not single out this one cause as a factor of disability or dependency. However, it is known that mental retardation is an important cause of disability for those receiving aid to the permanently and totally disabled under the Federal-State public assistance program. The amounts shown here are estimates based on a constant percentage of total payments under this part of the program.

5. Includes \$10,300,000 for mental retardation under proposed supplemental.

6. These amounts are shown as nonadd items since they are derived by transfer from funds available to the Department for mental retardation activities.

Senator JAVITS. Mr. Secretary, if you are not ready to give an opinion on the amendment, would you give us an opinion as to whether we might usefully provide for a planning stage, say, this fiscal year which will look toward a definitive participation in staffing—that will enable you to get going on the preliminary stages and also to get the report of whatever the committee of the President was? Suppose we gave you a year for that? At least you save that year, because you actually begin to do something in the way of a program. Would you think about that?

Mr. COHEN. Yes, I would be glad to.

NEED FOR FORMULA RESTUDY

Senator JAVITS. The other thing I would like to ask you is this: We are going to go after all these formulas. And I would hope very much that the Department could also begin to rethink this question and give some recommendations to the President and ultimately to the Congress. It is a very serious one. Cities are strangling. The great bulk of the population has moved to the cities. Formulas are pretty much what they were for 30-odd years, and most of them are quite inflexible. I notice now more and more you people are tending to a little bit of administrative discretion.

Now, it seems to me, just curbstone, that a greater emphasis will now have to be placed upon population, that you have to be much more selective, so as to take care of the factors of density and cost, and so you would have to have at least some part of these appropriations discretionary. And we will just have to rely upon the legislative oversight power of the Congress, and the screams of the minority, to be sure that you don't use it politically. I am being very frank about it.

But really it seems to me, Mr. Chairman, regarding the ratio of effort, a stimulus to people to do better, that I am delighted that the poorer States are likely to do better. That is great. It suits me fine.

But I think here are the things, Mr. Secretary, which I would like to use this hearing to present to your Department, because this is the beginning of an effort to begin to modernize this situation.

Mr. COHEN. I would like to say something off the record.

Senator JAVITS. I ask unanimous consent.

The CHAIRMAN. So ordered.

(Discussion off the record.)

CENSUS DATA

Senator JAVITS. We solved that problem in the Civil Rights Act of 1964, by giving the Attorney General the authority to call upon the Director of the Census for interim information.

Now, we knew that that would not be statistically completely accurate, but it would be a guide. And, therefore, there is no reason why—as this is a discretionary matter for the Secretary of Health, Education, and Welfare—that he cannot have the best resources of the Federal Government for his use. And the Director of the Census agreed. They do have continuing surveys and studies. Also, if necessary, the Census Director would go out and do something special

about it, if he really felt he could not give reliable advice based upon what he had or through extrapolation.

But they seemed to be satisfied that they could comply with the spirit of what we directed.

So I would suggest that you have a look at that, that we have dealt with that problem exactly in the Civil Rights Act of 1964.

The CHAIRMAN. Any questions, Senator Pell?

Senator PELL. Thank you, sir.

Mr. Secretary, how many States have these planning councils now—how many do not have them?

Mr. COHEN. No States have the type of planning council that we have envisaged in this bill, Senator Pell.

Senator PELL. No States at all?

Mr. COHEN. None have them in this form. I am sure there are some States that maybe one or two State agencies have gotten together to focus on planning for State health. But the kind of planning council we envisage, which would presumably include not only all of the State agencies, but also the local agencies with the participation of the medical societies and the voluntary health agencies and lay participation—I don't believe any State in the Union has that kind of a planning council at the present time, sir.

Senator PELL. Would this planning council only be for this particular bill, or would this be a general planning council?

Mr. COHEN. I think what we are trying to do is while giving them some money and encouraging them to do it for this bill, it would then be a focus for rationalizing, improving, and expanding all health services for each State, and therefore for the Nation.

Senator PELL. One other point. I found myself a little dizzy trying to follow these formulas.

How many different formulas does HEW have with regard to grants to the States, roughly?

Mr. COHEN. Oh, I would say 150. And I think that is probably on the low side. Every statute that has been passed provides either directly by law or by authorization to the Secretary and the Commissioner to set up some type of formula and some type of matching. And these have become quite different and quite varied, quite complicated, and might I say one has to be very mathematically minded to be an administrator of one of these programs, because they get very complex.

Senator PELL. Is any thought being given to the idea of maybe having half a dozen basis formulas instead of all these varieties?

Mr. COHEN. Well, I would say this, that was the original intent when they first started. I had the opportunity to work on the original Hill-Burton one of 1946. But what has happened, I think, in the course of time is each one of these formulas has come to a congressional committee, and at that particular moment and in the light of the problem as they saw it, they tended to modify either the formula or the matching in relation to their evaluation of the problem. And so the formulas began to get more disparate and different. And when you finally look at the formula that is in the public assistance program, which originally started in 1935 as a very simple one—50-50, dollar for dollar—if you read the formula now, it is so complicated—it starts with 83 percent for the first \$37, plus 50 to 65 percent of the next

amount, but notwithstanding 15 percent additional for this—and you are lost before you can even describe to anybody what the formula is.

But that is a result of the Congress over 30 years of amending and trying to improve it, trying to take care of special circumstances, to see that certain States didn't lose money, and the money right in the right programs at the right time. And I think we ought to take a look at it now.

Senator PELL. In connection with the bill under discussion, have you submitted a table as to what would go to each State?

Mr. COHEN. Yes, sir; that is in the record.

Senator PELL. Thank you.

The CHAIRMAN. Mr. Secretary, do you think you would like to add anything?

Dr. LEE. No, sir; thank you, Senator Hill.

The CHAIRMAN. How about you, Mr. Huitt?

Mr. HUITT. No, sir; thank you.

The CHAIRMAN. Dr. Peterson?

Dr. PETERSON. No, sir; thank you very much.

The CHAIRMAN. Any other questions, Senator Pell?

Senator PELL. No, thank you.

The CHAIRMAN. Gentlemen, we want to thank you very much. We appreciate your presence and your testimony.

Now, we will hear from Dr. William J. Peeples, of the State of Maryland, a member of the Legislative Committee of the Association of State and Territorial Health Officers, and commissioner of health, Maryland Department of Health.

STATEMENT OF WILLIAM J. PEEPLES, M.D., M.P.H., COMMISSIONER, MARYLAND STATE DEPARTMENT OF HEALTH, ON BEHALF OF ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

Dr. PEEPLES. Mr. Chairman, and members of the subcommittee, it is a pleasure for me to be here, to be able to testify before this subcommittee for the State and territorial health officers of this Nation.

Our association has served for many years as a sounding board for the Surgeon General of the Public Health Service and the Chief of the Children's Bureau; and as a mechanism for presenting the consensus of the thinking of the heads of the State-level health agencies of the Nation to the Federal health authorities. In essence, we have a Federal-State partnership for the discovery of knowledge in the health field and for developing arrangements for the delivery of health services throughout the Nation. We believe very strongly that health services can best be delivered to the people by organizations which are responsive to neighborhood needs; so really, we are intimately involved and keenly aware of the opportunities for health at the crossroads and the corners, as well as at the Capitol. We are also keenly aware of the forces which limit the exploitation of those opportunities for health.

The Association of State and Territorial Health Officers is most appreciative of this opportunity to present its views concerning S. 3008. At the outset, let me make it clear that we strongly urge your favorable consideration of this legislation.

The core problem which this bill is designed to overcome is that the health industry, to which more than 6 percent of the gross national product is devoted, does not operate as cohesively as it must, if it is to take prompt and maximum advantage of rapidly developing research outputs.

The CHAIRMAN. We do not have the team we should have; is that right?

Dr. PEEPLES. The team effort has not been there. We have not gotten together and talked enough as you do in your committee meetings.

The CHAIRMAN. It has all sort of grown up like Topsy; is that right?

Dr. PEEPLES. Yes, sir; I think you are absolutely right.

Each of us holds health high in his value scale, but unfortunately only when we are sick or disabled.

One of the keys to a strong economy is a high level of health of the citizenry.

We work and pursue happiness only to the extent that our health permits. Lacking health, a society functions as though it were on a treadmill—and fades into mediocrity. On the other hand, if we have the will to invest our talents and other resources toward the enhancement of health, our society will be able to take major steps forward.

Two years ago, it was manifestly clear that new scientific discoveries would stagnate unless we developed some mechanism to overcome the fragmentation which had come upon us because of our enthusiasm for addressing ourselves to a wide variety of individual goals—each within a narrow field of health—without paying enough attention to coordination of those efforts.

It doesn't do much good just to clean up the air, if the water we drink or play in, or the food we eat, is disease producing. We serve nobody's interest by using resources which the public has entrusted to us to build hospitals, if the professional personnel to staff those hospitals are not available and cannot reasonably be expected to become available. A program for rehabilitating children must be aimed at educational goals as well as optimal physical function and mental health. It becomes increasingly apparent that our efforts must be focused on the entire problem rather than in specific entities.

The Association of State and Territorial Health Officers joined with the Association of State and Territorial Mental Health Authorities and the Public Health Service in studying the present situation and developing a proposal under which we could embark on a new course which would give us greater potential for success. The result of those efforts is embodied in S. 3008. This proposal is predicated on the fact that health agencies are potential centers of excellence for the delivery of health service to the public and that they are uniquely in that position. It embodies a mechanism for progressively reducing the gap between personal and environmental health services actually available and those which can be provided by practical exploitation of existing scientific knowledge changes in methodology and future discoveries.

Public health has changed markedly since the Society Security Act in 1936 established the Federal-State financial partnership in health. The act provided a general health grant which was available to support any part of a State's public health program. At that time,

programs were simple and consisted mainly of environmental health services, communicable disease control, and limited services relating to maternal and child health.

Knowledge and techniques have expanded significantly over the years. The scope of public health responsibility has expanded with new knowledge and the increased complexity created by metropolitan development, urbanization, and population expansion. From time to time, attention has been focused on a specific public health problem isolated for attack with an earmarked grant. This has been repeated time and time again, until today we have many such separate categories, with little attention being given to providing a base from which even categorical services can be given.

Effective use of the tools at hand in the health field requires that the parts be synthesized into a functional entity, focusing on the individual, as he functions as a member of a family unit, and in a geographic community. We have come in public health to the place where the numerous categories into which we have subdivided impede a balanced logical attack on the entire health problem.

Conceptually, the proposal before you will require us to develop firm and practical health plans, by the joint efforts of all of the health interests—public, private, professional, and institutional—at the local, metropolitan and regional, State, and Federal levels. This planning will be comprehensive; it will include preventive, as well as treatment and rehabilitation services and environmental health services. It will take the several echelons of health services and key resources—manpower, money, and facilities—into account.

Local, regional, State, and Federal health forces will be synchronized. Within broad guidelines set at the Federal level, State, regional, and local jurisdictions will take the initiative in designing their programs and in proposing future goals and guidelines. A true partnership in planning will be the result if this bill is adopted.

A financial structure which is predictable and known to all parties at interest will be established.

More briefly stated, S. 3008 proposes a system of planning, programing, and budgeting for health, in a fashion which we in the States are confident is sound, timely, and necessary.

The key features of the proposal are:

- A mechanism for planning and updating of plans;
- A system for delivering comprehensive health services;
- Provision for focusing resources on projects with limited scope (adapted to special circumstances) and for limited time periods;
- Emphasis on training of essential manpower;
- An innovation whereby key personnel may be interchanged between the Federal and the State scenes; and
- Provision to insure that operations will be governed by the plans which are developed well in advance.

Now that I have indicated to you the fact that the ASTHO, as a body, supports this legislation, let me make a few specific suggestions for improvement:

(a) We strongly believe that the statutory language should require that the health officer of each State be a member of the planning agency in his State.

The CHAIRMAN. Do you think a State would set up an agency, a planning agency, on health and not include the State health officer?

Dr. PEEPLES. It could be, sir, and we think if a law is to be passed, it should not be possible to do so. I do not think it would happen too often, but it might.

The CHAIRMAN. You want a safeguard against that possibility.

Dr. PEEPLES. Yes, sir. Returning to the specific suggestions:

(b) The project grants for areawide planning should be available on an interstate, as well as an intrastate basis. Such regional metropolitan areas as the one here in the Nation's Capital, involving three major jurisdictions, can be treated as an entity; and sharp focus can be put on natural resources such as the Potomac or the Susquehanna River Basins.

(c) The provision on page 12, for incorporating the financial resources of nonprofit private agencies and other similar organizations, would be strengthened if there were a statutory stipulation that such funds must be turned over to the public authority of the jurisdiction if they are to be regarded as public funds.

We have had some experience in Maryland with this, and it has worked out rather well when voluntary and nonprofit agencies have included their funds in local budgets to gain State matching, and this has worked out very well. We would suggest this as an addition to the bill.

The CHAIRMAN. Have they done that voluntarily?

Dr. PEEPLES. Yes, sir.

The CHAIRMAN. In the State of Maryland.

Dr. PEEPLES. Continuing with the suggestions:

(d) The concept of a weighted financial formula is set forth on page 17 of the bill. The ASTHO concurs in this principle as the best means of financing health services on a national basis. Our concern is that basic health services be available in all jurisdictions because health is no respecter of political boundaries. The use of per capita income is feasible now and, therefore, it is probably the best criterion for the moment. However, if studies later show that there is a more accurate method for weighting the formula, a change could and should be programmed at that time.

(e) We believe that the unique idea for interchange of personnel will be of considerable value to all concerned.

(f) We support wholeheartedly the proposition on page 24 that we be required to perform according to our plans.

The CHAIRMAN. You think this interchange of personnel would be a good thing?

Dr. PEEPLES. I think it could possibly be a good thing. We have benefited from some exchange—not exchange of personnel, but certainly the assignment of personnel from the Public Health Service to various parts of our State.

The CHAIRMAN. You have found that beneficial, have you?

Dr. PEEPLES. Very much so; very much so.

The CHAIRMAN. How long have you been a State health officer, sir?

Dr. PEEPLES. Since February of last year.

The CHAIRMAN. Were you in the—

Dr. PEEPLES. I was in Montgomery County for about 9 years prior to that, and in California prior to coming to Maryland.

The CHAIRMAN. You have been in Maryland over 9 years?

Dr. PEEPLES. Yes, sir. We are sorely disappointed that no funds to implement the support grant are specifically identified and request that they be made a part of this legislation.

The CHAIRMAN. No funds for what?

Dr. PEEPLES. No funds to implement the support grant. There are no funds identified in this legislation at all, and we believe that they should be included as a part of it.

In conclusion, let me ask: Must we continue the folly of dedicating our major resources to correcting situations and cases which weren't prevented, or shall we, in our time, come to the point that we plan our efforts and use our resources in a fashion which balances prevention and treatment?

Do we have the fortitude to concentrate on the whole person, his family, his neighbors, and his neighborhood?

To do so will require that many bureaucracies change. Federal, State, regional, and local authorities and governments will have to develop a new fabric of services and a new spirit of mutual concern and partnership.

S. 3008 is designed to take deliberate steps in response to those concerns—as a whole and comprehensive effort.

The scientific means to take major strides are at hand. Shall we capitalize on them or shall we suffer the economic and humanistic consequences of overlooking them?

The stakes are high. In the general public interest, shall we raise, "stand pat," or fold? If this is the time to consider the primacy of the general public interest, no structure of bureaucracy—Federal, State, regional, or local; no professional interest; no special interest—public or private—should be an inviolate territory in the effort.

I suggest, as the bill suggests, that we rise to the occasion and get on with the public purpose; leaving the fragmentors, the special interests, the limited concerns to accommodate themselves to the overwhelming purpose embodied in this legislation.

The CHAIRMAN. Doctor, let me ask you this: This bill would require at least 15 percent of the formula grants to be spent on mental health services. Does this seem to be an adequate amount on the basis of your experience there in the State of Maryland?

Dr. PEEPLES. Yes, sir. I would feel that this actually divides, it seems to me, the formula grants at the State level, 15 percent between mental health and 15 percent for State public health departments. The other funds go to the local communities. I do not see how the State can plan without encompassing and incorporating local plans, nor how the Federal Government can plan unless they really take a good look at the State plans.

The CHAIRMAN. You have to bring in all the different elements.

Dr. PEEPLES. Yes, sir. This should be a concentrated effort, working from the bottom to the top.

The CHAIRMAN. Well, Doctor, you have brought us a splendid statement. We certainly appreciate it. We want to thank you.

Dr. PEEPLES. Thank you.

I would like to submit for the record a statement of the American Public Health Association and another for the Association of State and Territorial Health Officers.

The CHAIRMAN. What do they deal with?

Dr. PEEPLES. They deal with this legislation.

The CHAIRMAN. In a little more detail in some respects?

Dr. PEEPLES. Yes, sir.

The CHAIRMAN. We will put them in the record.
(The prepared statements of Dr. Peeples follow.)

PREPARED STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

The American Public Health Association is pleased to have this opportunity to testify on the bill, S. 3008. Our association, which represents approximately 16,000 members who are physicians, dentists, nurses, engineers, medical-care administrators, statisticians, health educators, and others working full time in Federal, State, and local official and voluntary agencies, has long been concerned over the inadequate and, in many instances, uncoordinated support made available by the Federal Government for State and local health services. This in no way should be construed as a criticism of the concept of Federal support, rather the methods used. We believe such assistance to be laudable, completely justified, and necessary to the further development of health services which are needed throughout this country. These methods of support differ, are in many instances administratively restrictive, and, in our view, not as productive as they might be because of these handicaps. If enacted, we believe that the provisions contained in S. 3008 would provide a fresh new coordinated approach to this problem and materially improve the capabilities of State and local health agencies which, in the last instance, must be the agency capable of providing health services to people. The competencies of health agencies is dependent in large measure upon the support which they receive. Without well-trained and experienced personnel, health services cannot be what they should be. We believe the authority proposed in S. 3008 will serve to increase these competencies, and it is for that reason we are in enthusiastic support of this legislation.

One of the problems which has been plaguing conscientious efforts to provide more comprehensive and better health services has been the fragmentation resulting from various agencies being given responsibility for the conduct of different programs. For example, Federal funds for health programs in States and localities are provided by the Public Health Service, the Welfare Administration, the Social Security Administration, the Vocational Rehabilitation Administration, the Office of Education, all within HEW. Add to these the Office of Economic Opportunity, the Department of Housing and Urban Development, Agriculture, Commerce (Appalachia), and you have some idea of the melange of sources of support. We accept the fact that every activity which has a health connotation cannot fit neatly into one superagency. It would be naive to consider this as the panacea for all our problems. On the other hand, we believe that it is not only possible but essential to coordinate to a much greater degree all activities which are intended to provide health service but which perhaps through unintentional overlapping, duplication, or omission results in a lack of services to people. It is because of this situation that we hold such high hopes for the proposals contained in S. 3008 for grants to a single State agency to plan and to set out in a priority fashion those activities and those health services which should receive the first and most emphatic attention. A cursory review of the multitude of different health programs within each State and within each community, all of which provide a needed service, is the most cogent proof of a need for better planning.

The task of coordinating all of these programs is an awesome one for a public health administrator. A reasonably typical example of this situation are the duties of Dr. John J. Hanlon, director of the Detroit City Health Department and public health director of the Wayne County Health Department. First, he is administratively responsible for public health programs, health affairs under the poverty program, health services for preschool, school and adolescents, among others. Secondly, he is contractually responsible for services at Detroit General Hospital and the University of Detroit School of Dentistry on community dental health programs, to mention but two of his extensive commitments in this area. In addition, Dr. Hanlon has partnership relationships with other segments of the poverty program and the Wayne County General Hospital and an influencing relationship with the Greater Detroit Hospital Council, medical societies, voluntary health agencies, and the United Fund, to cite but a few. Finally, it is necessary for Dr. Hanlon to work with the Supervisors Intercounty Committee on mutual health problems and with contiguous county, State, and Federal agencies and institutions.

Not to plan intelligently is wasteful of tax funds, the time of hard-to-find personnel, and the use of extremely expensive facilities and equipment. We believe

the Advisory Planning Council envisioned by this legislative proposal, including representatives of the official public health agencies of the State, mental health authorities, private sectors of medicine, hospital planning councils, voluntary health agencies, and users and consumers of health services would add much to the orderly development within a State of the health services and facilities which are needed. It is essential in this instance that through the authority or through regulations a strong leadership role by the State health authority and the State mental health authority be assured in order that the product of the planning agency and the activation of the plans and programs will be consistent with the best interests of the people of each State. Certainly no argument is needed as to the desirability of persons within each State deciding the health activities that need highest priority consideration. We would hope that in addition to at least an annual review of the State plan that there will be an evaluation made by the State planning agency of the progress which had been made by the operating agencies during the interim period. Also in the context of the principle of the planning agency, in this instance the areawide health planning activities, it would be the hope of the APHA that areawide health planning agencies will consist of persons representing interests similar to those outlined for the State planning agency. We question, therefore, the language contained in the bill which would make project grants available to a public or nonprofit private agency or organization to develop health plans. We believe this planning should be done by a council which is broadly representative of the interest of the area.

We strongly support the authority contained in the bill which would make it possible to train personnel and support studies and demonstrations relative to the art and science of planning. This is an area in which we admit, with some embarrassment, that there is a dearth of trained, experienced, competent personnel. We fear that we have perhaps been too long preoccupied by our sometime frantic efforts to provide services without due consideration to a logical, intelligent development of health services in their totality.

GRANTS FOR COMPREHENSIVE PUBLIC HEALTH SERVICES

We are on one hand delighted and on the other somewhat disappointed by the provisions of the bill relative to grants for comprehensive public health services. In our view, the responsibility of the Federal Government to support basic, essential public health services has not been met. The Federal contribution to basic health services through the general health grants to States amounts to approximately 5 cents per capita. This is so inadequate as to border on the ludicrous. Without strong health departments, it is impossible to utilize to their fullest funds which are provided for specific disease problems. The proposed basic health grant would materially improve the capacities of health departments.

Our disappointment relates to the absence of an appropriations level for these basic support grants. We believe the level of Federal support for basic programs should be increased 10-to-12 fold. Our conviction is strengthened by the provisions of the bill which would require that not less than 70 percent of Federal grants must be made available to health agencies in local communities so they can more effectively deliver public health services to their immediate population.

We support the concept of project grants to deal with specific disease problems or health problems of limited geographic areas and for the instituting of new innovative programs of health services. This also is needed, this mechanism of building the specifics upon a strongly founded public health program. We believe this to be the best procedure to develop an effective total health program.

The APHA supports the provisions of the bill which would authorize an interchange of personnel between the U.S. Public Health Services and States and local health departments. This interchange will provide an educational experience extremely helpful to both the Federal agency and State and local agencies. As you know, it is a procedure which is authorized for the education programs of our country and, just as in the case of education, we believe it would be of significance in the development of improved health services throughout our Nation.

In summary, Mr. Chairman and members of the committee, it is the view of the American Public Health Association that, if enacted, this legislative proposal would make a valuable contribution to the elevation of health services to the people of our Nation. We have long sought a more orderly, more effective method of accomplishment. We believe this proposal provides an appropriate vehicle to this end.

PREPARED STATEMENT OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

Mr. Chairman and members of the subcommittee: Our association, consisting of the health directors of the 50 States, Guam, Puerto Rico, District of Columbia, the Virgin Islands is most appreciative of this opportunity to comment on the bill, S. 3008, introduced by the chairman, Senator Hill, who has authored almost innumerable health legislative proposals and who has also stalwartly supported this Nation's health services through his efforts as chairman of the Appropriations Subcommittee on Labor—HEW. We believe it especially opportune that this legislative proposal, so important to the orderly development of our Nation's health services, is to be considered by this subcommittee who, by its judicious action in the past, has contributed much to the health programs of this Nation and the world. For the issue with which S. 3008 is concerned is of utmost importance to us as officials legally responsible for the public's health in our respective States.

As this committee knows, we have been long concerned with the problem of how best to discharge our duty. For the past year and more we, along with representatives of the State mental health authorities and the U.S. Public Health Service, have been engaged in an in-depth study of ways and means whereby the optimum in health services could result. Here were involved many factors including, among others, the best organization and administration of health programs, the most efficient use of facilities and the most effective use of a dangerously insufficient supply of trained health manpower. And you, we are confident, are not unmindful of the added responsibilities resulting from recent Congressional enactments such as medicare, including a vastly broadened program of health services to welfare recipients and the medically indigent; and the regional medical programs, to cite but two. Our study of this problem and the conclusions which were arrived at, we are pleased to say, are contained in great measure in S. 3008. Our members were consulted on the principles which were to be incorporated in what is now S. 3008, and by official action of the association, these principles were approved.

With your indulgence, we would like to comment on the specific proposals contained in S. 3008. We are in hearty accord with the findings and declaration of purpose. Unless and until more sophisticated planning can be accomplished, our progress will be spasmodic and opportunistic. We want legislation to assist us to do a better job. We approve the instigation of planning activities 1 year prior to activation of the new grant arrangement. Our association subscribes to the concept of the broadly representative advisory health planning council and to the essentiality of comprehensive statewide planning for health services, both public and private, including facilities for care and treatment and the personnel required for the provision of health services. We are agreed that cooperative efforts between all agencies involved in the provision of health services, including governmental and nongovernmental, is absolutely necessary if we are to even approach our desired level of health service. Active participation and supervision of health programs by persons trained and experienced in health specialties is essential to programs which provide adequate health services. We agree that the grants for planning activities should not supplant existing State or other funds used for this purpose. As we understand the bill, the requirement for at least an annual review of each State plan would include an evaluation of progress.

We approve of the provision of Federal funds to support both statewide and areawide planning activities although we are disappointed by the absence of an appropriation specified in the bill. We urgently request that an amount commensurate with the problem be authorized by this committee and requested by the administration. We do have a question relative to areawide health planning. With approval of the State agency required, which we endorse, is the language adequate to include interstate, metropolitan, or comprehensive regional areas? Should this not include the possibility of involvement by more than one State agency?

In regard to authority for grants for training, studies, and demonstrations, isn't the intent of this mechanism the development of improved or more effective comprehensive health planning "methods" throughout the Nation? There is need for a greatly increased level of training in the art and science of health planning.

Our association strongly supports the proposed grants for comprehensive public health services. The Federal Government must assume a more realistic share of the responsibility in financing basic public health programs. Providing

all the preventive safeguards, which most of our population takes for granted, is a complex and expensive undertaking. The constant advent of new, sometimes subtle health challenges resulting from our increasingly sophisticated society also requires ever greater emphasis on training health personnel. We have, and we continue to be ready, to accept these challenges but we must have help. This concept of a Federal support grant for basic health services and staffing is of paramount importance in the opinion of the ASTHO. We question the advisability of the unlimited availability of public funds for nonprofit private agencies. This appears to us to be contributing to fragmentation.

We are in complete agreement with the proposed 15 percent of each State's grant being devoted to activities under the mental health authority, and we agree, too, to the requirement that 70 percent of the amounts received be earmarked for health services in communities. We are persuaded of the necessity of a variable in grant allotment which would provide additional funds to low economic areas. But we would impress upon the committee the fact that, irrespective of the affluence of any particular area, an irreducible expenditure is required to provide needed basic health services. And since disease, especially communicable disease, is no respecter of political boundaries, minimum basic public services are needed throughout our Nation.

We respectfully caution the committee, however, on one point, illustrated by the absence of inclusion of a specific amount to be appropriated for this support grant. Rearrangement of mechanisms for granting funds or for their administration can result in limited improvement in the quality of health service programs. Essential, however, to the principal objective is a considerable increase in the level of Federal financial participation. Until the Federal Government bears its legitimate share of these basic programs, we in the States will not be able to realize our long-held aspirations. Until State and local health programs have strong foundations, specific disease and disability problems such as mental health, mental retardation, vaccination assistance, migrant health, tuberculosis, venereal disease, chronic disease, alcoholism, nutrition, family planning, heart disease, cancer, and water and air pollution control programs—these and other programs will not be adequate to the needs of our people.

We wish also to support the provisions for the interchange of trained personnel between the Federal Public Health Service and State and local health agencies. This cross-fertilization would, in our view, be a most beneficial educational experience both to the individual and to the respective organizations. Essential to any true partnership arrangement is a mutual understanding of problems, potentials, and capabilities. As of now, the loan of Federal personnel is possible, an exchange is not. We believe this feature of the bill to be most desirable.

In summary, the ASTHO believes this legislative proposal to be a much needed authority whereby the Federal, State, and local health service agencies can provide to the American people a markedly improved quantity and quality of the health care needed and desired. We urge your favorable consideration.

The CHAIRMAN. Now, Mrs. Fitzhugh W. Boggs, chairman of the Committee on Governmental Affairs, National Association for Retarded Children, Inc.

We are always glad to have you with us.

You may proceed.

STATEMENT OF MRS. FITZHUGH W. BOGGS, CHAIRMAN, COMMITTEE ON GOVERNMENTAL AFFAIRS, NATIONAL ASSOCIATION FOR RETARDED CHILDREN, INC.

Mrs. BOGGS. Thank you very much, Senator.

We appreciate very much indeed your recognition of the impact which this legislation will have on the field of mental retardation. It is a pleasure to appear here once again.

As you know, we turn up fairly frequently when health or education or mental health or rehabilitation or employment subjects come up, and this means frequently, before your subcommittee.

The reason for this, of course, is that mentally retarded people are affected by each of these kinds of programs, and we have a stake in each of them.

From the point of view of the mentally retarded person, this means that services are and will continue to be somewhat fragmented, because I anticipate that in spite of what is said about being comprehensive, we are only comprehensive in health or comprehensive in education or comprehensive in mental health or rehabilitation, or whatever it is.

So, we, in the field of mental retardation, have had a rather full course in the need for coordination and planning and all this sort of thing.

As a matter of fact, I was glad to hear Under Secretary Cohen refer to the effectiveness of the State planning operations vis-a-vis mental retardation, because this has demonstrated not only the breadth of needs in the area of service to the mentally retarded, but it has also been a good demonstration of the interesting variations among the States in the way they can tackle problems of this kind.

In respect to mental retardation planning, no preconceived notions were established by the Federal Government as to how these plans ought eventually to turn out to be. The main basic requirement was that all the major agencies that had a stake in this should be involved and included in the process of planning.

Now, as a result of all of this, the States have come forward and are coming forward with a number of plans, each of them with a comprehensive mental retardation plan. Some of these have already been published and are in hand; others will be forthcoming in the next few weeks.

It has become quite apparent to us, as a result of this planning, that there are needs that are urgent in the States and the communities and that the States and communities need encouragement, and they need it now, in terms of what kind of assistance they might reasonably expect, what kind of partnership with the Federal Government they might expect.

They need to begin to know now what this might consist of, so that they can capitalize on the impetus and enthusiasm that has been created by this planning process.

In my opinion, for some of these purposes, next year will be too late. The CHAIRMAN. We ought to start now.

Mrs. BOGGS. I think there are some things that should be done now, and these are logical in the overall development of the Federal program in mental retardation.

Now, you may have thought, and I am sure there are other Members of Congress who may have thought, that the Federal program is very generous in the area of mental retardation. But I think it should be emphasized that something less than 15 percent of what the Federal Government is now putting up in the area of mental retardation does filter down into support and encouragement and assistance for direct services to the retarded, and most of this money that is channeled is channeled through just two agencies.

Now, we did have, as Senator Javits has mentioned, in 1962 a President's Panel on Mental Retardation, and there are a number of recommendations of that Panel which are still unfilled, and they are coming due.

One of the recommendations that was made was that an evaluation should be made by HEW of the gaps in its own authority to carry

forward and implement and assist in the implementation at the State and local level of the spectrum of services that the retarded need. And I have to say that we asked for that evaluation for a couple of years, and when it was not forthcoming, we did it ourselves.

The Secretary's Committee on Mental Retardation does an excellent job in telling you what the Federal Government does do, what the Department does do, but they are very careful not to mention anything that it does not do or is not able to do.

This analysis on our part led to the conclusion that there are gaps in relation to the promotion of health and health-related services to the retarded.

Now, some of the gaps are related to the construction area, and we believe it would be proper this year to extend and amend Public Law 88-164, and I hope we may have the privilege of presenting our thoughts on this subject to you.

Right now I want to direct attention more particularly to the area of services and the questions raised by S. 3008, which is the subject of this hearing.

Now, I was reminded when I was contemplating this bill, and the processes by which it had been derived, of a wise, little book published in 1908 in England, a guide for the young academic politician, written by a renowned British classical scholar, Prof. F. M. Cornford. With your permission, I would just like to quote a couple of excerpts here.

He defines the parties in academic politics and he says:

A Conservative Liberal is a broadminded man who thinks that something ought to be done, but something which was not done in 1881 to 1882. A Liberal Conservative is a broadminded man who thinks that something ought to be done, and that most things done in 1881 and 1882 ought to be undone. The Non-Plackets are people who think that nothing should be done. The Adullamites are dangerous because they know what they want, and that is all the money there is going. They are not refined like classical men, and that is why they succeed in getting all the money there is going. Finally, there are the young men in a hurry. The young man in a hurry is a narrowminded and ridiculously youthful prig who is inexperienced enough to imagine that something might be done before very long, and even to suggest definite things.

We, in NARC, are the young men in a hurry, and we think definite things can and should be done now, and we are prepared to suggest some of them.

I would carry this analogy further by saying it seems to us that the Conservative Liberals and the Liberal Conservatives and the Adullamites have been caucusing, and they have come up with what Cornford would call a wildcat idea.

Now, "wildcat" is an epithet applicable to persons who bring forward a scheme unanimously agreed upon by experts after 2 years of exhaustive consideration of 35 or more alternative proposals.

And we have before us, I think, a "wildcat" proposition in that sense.

Now the only reason we are raising any questions about this fine bill is that we are not experts, we are merely representatives of what is called in the language of your legislation, "the consumers of services," the people whom all this is supposed to benefit.

From our outside position, not having been in the caucus of the parties concerned with the drafting of this legislation we would respectfully like to make some comments on how we think it might perhaps be still further improved.

Before I do this, I want to make clear that where the mentally retarded are concerned, we have a great variety of services, even within a field such as health.

We have services that can be performed within a generic setting. We have services to individuals. We have services to be performed where groups of individuals are brought together. We have services that are special but are purveyed in a general setting, for example, a special clinic in a hospital. And we have services which may be purveyed within facilities that are called in the language of our present legislation "facilities for the mentally retarded," which means they are constructed primarily for this purpose.

So, we consider that S. 3008, to the extent it may benefit the retarded, would make it possible to contribute to the cost of services in all these categories—would make it possible. But in particular, we think that it would be, could be, used to strengthen services which are interwoven with other more general services.

Now you have, I think, received a copy of our formal prepared statement. I would be grateful if we might have this inserted in the record, and then I would just touch on one or two points.

The CHAIRMAN. We will have that appear in full in the record.
(The prepared statement of Mrs. Boggs follows:)

PREPARED STATEMENT OF MRS. FITZHUGH W. BOGGS, CHAIRMAN, COMMITTEE ON GOVERNMENTAL AFFAIRS, NATIONAL ASSOCIATION FOR RETARDED CHILDREN, INC.

STATUS OF HEALTH SERVICES FOR THE RETARDED IN THE FRAMEWORK OF COMPREHENSIVE PUBLIC HEALTH SERVICES

Mr. Chairman, the National Association for Retarded Children, which I have the honor to represent here today, is grateful for your invitation to be heard on the proposed "Comprehensive Health Planning and Public Health Services Amendments of 1966"—embodied in S. 3008. We appreciate your recognition that the country's mentally retarded children and adults, for whom we speak, have important health needs and hence an important stake in this major revision of the Public Health Service Act. We heartily support the general objectives of S. 3008: "strengthening the leadership and capacities of State health agencies," and broadening and making more flexible the "support of health services provided people in their communities."

Among these people are the mentally retarded, many of whom have some rather special health needs. We are concerned that in the global approach proposed under this act these mentally retarded people will not receive their fair share of the attention of the health agencies to be aided.

To be specific, the current Federal budget is supposed to obligate close to \$8 million for mental retardation activities under section 314 and section 316 of the present act. This is in addition to \$8.5 million annually which the Children's Bureau has been making available to the States for special projects for retarded children under their maternal and child health and crippled children's programs. Both of these amounts are included in a total of slightly more than \$300 million which the Department of Health, Education, and Welfare identifies with mental retardation when all agency activity in research, training, construction, income maintenance, prevention, and planning are pulled together. It is significant that, of all funds identified, less than 15 percent is being invested in any kind of direct service to the retarded.

The \$8 million first mentioned will, of course, be directly affected by the repeal of the present section 314(c). The maternal and child health and crippled children's programs will certainly be indirectly affected by the proposed "comprehensive" health planning within the States.

As the members of this committee well know the mentally retarded are people, who have needs which in some respects resemble and in other respects differ from those of other people; these needs are apparent in almost every aspect of their lives, affecting their health, their education, their employment opportunities, their

living arrangements, their leisuretime activities, and their ability to look after themselves and their own interests. Therefore mentally retarded are and must be a special concern of all agencies—Federal, State, and local—with responsibility in health, education, and welfare broadly defined.

We have some specific recommendations, for amendments to S. 3008 which reflect our ideas on how concern for the retarded can be given appropriate emphasis within the field of health. What follows is by way of background for these recommendations.

RESULTS OF STATE COMPREHENSIVE PLANNING IN MENTAL RETARDATION

Responsibility in the field of public health is twofold—to prevent where possible and to identify, treat, and alleviate when prevention has not been effective. Most State departments of health are increasingly contributing significantly to the prevention of mental retardation through a great variety of activities, from emphasis on prenatal care to immunization for measles and control of syphilis and lead poisoning. None of these activities are targeted narrowly on mental retardation. Indeed, they are good examples of public health measures which cannot be "categorized."

A heightened awareness of the implications of mental retardation for health agencies and of the need for intensified effort in prevention has come about in some States as a result of the last 2 years of federally aided comprehensive planning in mental retardation.

With respect to alleviation through available forms of treatment the impact of planning has been less clear. The comprehensive mental retardation planning reports are now being published. The first dozen or so to come in show great variability in recognition of the health and health-related needs of the retarded themselves and the role that health agencies can play in meeting them. Generally speaking, where there was already some interest—some commitment within State government—the recommendations indicate how much more can be done. Where health department efforts have been weak, the voice of need is more often heard but weakly; for, make no mistake, despite what may be said about including "consumers of services" and "nongovernmental organizations" as "advisers" in planning, when a State agency receives a Federal grant for planning, its views (and those of its sister agencies, if represented) are the ones most likely to come through clearly.

By Federal regulation, State health authorities were represented and involved in this planning. To the extent that their involvement may be reflected in continuing interest and thus in incorporation of new emphasis on mental retardation within the comprehensive public health planning, the new legislation may advance the cause of prevention and amelioration of mental retardation and associated chronic disability originating in childhood. To the extent that such prior commitment does not now exist, S. 3008 in its present form would, we feel, tend to perpetuate this neglect.

Most State mental retardation plans, for example, stress the need for early case finding, diagnosis, and evaluation of the young retardate. The recognition of this real need is in no small measure the result of 10 years of consistent effort and support by the Children's Bureau for services of this type. This is why the most significant advance for the retarded which President Johnson could find to pinpoint in his recent health and education message was the establishment of 32 new clinics in the last 3 years. Emphasis in the State mental retardation plans on adapting health services whose values have been demonstrated, such as visiting nurse and homemaker services, speech and hearing therapies, physical therapy, information and referral services, and specialized dental care is erratic, for all age groups. Very little attention indeed is given to the retarded adult, although the larger numbers of mentally retarded who were born in the postwar years are about to pass beyond the legal purview of the Children's Bureau and the State programs it supports. There are two broad modes of service to the retarded the need for which should be recognized here, individual case management, care, and treatment and group care and treatment. It is quite apparent that support and encouragement are needed for both types. Programs of group care on a daily basis (whether day or residential) for children or adults with multiple handicaps so severe as to preclude participation in programs likely to receive support by way of the Elementary and Secondary Education or Vocational Rehabilitation Acts have been initiated in a few States and are being advocated in the State plans of additional States. These retardates have complex physical and sensory as well as emotional disabilities requiring prolonged multidisciplinary care and treatment. Although the numbers of persons requir-

ing such care are small—perhaps 1 per 1,000 in the age groups from 3 to 30—the per capita cost will be considerable. Such care is a component of service in many of the facilities to be constructed under part C of Public Law 88-164. The time is ripe to give impetus to this concept. Since there is at present no Federal aid particularly adaptable to this type of service, we would favor authorizing this year a special program of Federal aid to take effect in fiscal 1968. We expect to make this need the subject of a separate communication to the committee.

Under title III of the Public Health Service Act, however, we would stress flexibility and a long-term commitment to developing all modalities of health care for the retarded not only in specialized facilities but within the framework of generic health services, which have heretofore so frequently slighted the retarded. To accomplish this will, in our opinion, require allotment of some funds specifically reserved for this purpose within S. 3008.

PRESENT NEED TO RESERVE HEALTH FUNDS FOR USE ON BEHALF OF THE RETARDED

It is in the areas of amelioration rather than prevention of mental retardation that the proposed legislation appears to offer inadequate protection even for those precarious gains made in the last few years. For example, that most States have not yet "got the message" relative to the health needs of adults disabled by mental retardation has been demonstrated by the paucity of response to Federal funds made available for this purpose in the last budget. You may recall that, in anticipation of the legislation now before us, all 1966 appropriations for formula grants under section 314 of the U.S. Public Health Service Act were held at prior levels—all except one, chronic diseases and health of the aging, which was permitted to advance by a small amount. The effective increase of \$2.5 million was justified to Congress on the grounds that States would be "encouraged" to use their additional allotments to assume a greater share of the responsibilities outlined for them in the course of the comprehensive planning for the mentally retarded. Since there was no actual earmarking, the States have felt legally free to ignore this "encouragement" and most of them have. When this amount, together with project grants for training, are subtracted from the \$8 million mentioned earlier, we find that only about \$2¼ million in funds available through the Bureau of State Services under section 314 have gone into services for the retarded all in the form of project grants.

This experience has led us to believe that where new and little recognized needs are concerned, there is a proper and legitimate place for categorical allotments. Indeed, when we consider how programs of control in heart disease, cancer, tuberculosis, and the like, were brought to their present well-established position within the context of "comprehensive health services," we become convinced that special nurture in the form of categorical assistance is necessary to speed the development of new and relatively unfamiliar programs. Health services for the mentally retarded are certainly in this category and in need of such nurture now in many States.

Some State mental retardation plans do propose significant responsibilities for State health department and a few departments have already moved ahead. Presumably they may use their general formula money under S. 3008 to expand their programs, yet they will receive no extra help for this as compared to the State whose health department does little. The parallel might be stated for those State mental health authorities to whom major responsibilities for care of the retarded may have been assigned. This variability from State to State in departmental structures as they apply to services to the retarded appears to us to be another reason why funds should be identified for mental retardation within the State allotment, as they are for mental health by the 15-percent provision (sec. 314(d)(7)).

The segregation of funds for mental health appears to be made on bureaucratic rather than "disease centered" grounds; this argument applies to mental retardation also, but in a more complicated way.

Our recommendation (recommendations Nos. 1 and 2, p. 11) is for a 10-percent allotment for mental retardation and related disorders which might be used entirely by the State health authority or assigned by it in part to another State agency or agencies (including but not limited to the State mental health authority) to the extent appropriate within the particular State.

Since there is a great need for both short-term and more formal training of a wide variety of health personnel to understand the particular needs of the retarded, we propose that part of such an allotment be available for training, as is

intended in the overall formula. Persons receiving such training would be expected to use this knowledge either in specialized or so-called generic agencies.

In this connection we suggest (recommendation No. 3) that in section 314(d) (2)(C) the word "State" be inserted on line 21 for two reasons. We believe that the State health authority should be encouraged to make use of both public and nonprofit agencies at the State level as well as to use regional, local, and metropolitan agencies, since we can well imagine situations in which it would be efficient and desirable to allocate funds for health purposes to a State labor department, education department, planning department, etc. Also, there are statewide health and welfare councils, and voluntary agencies working against heart disease, crippling conditions, mental illness, mental retardation, and in many other areas; the State agency should be free to utilize these groups within its overall plan, as may be appropriate.

ROLE OF PRIVATE FUNDS

The proposed legislation contemplates greater involvement of non-Government agencies than has been the case under present law, and makes express provision for use of voluntary dollars as matching for Federal dollars. We believe this can be useful in a variety of situations but that the tendency for some States to rely on voluntary effort and local initiative can be carried too far. For example, those communities, or those groups in our population most needing service are often those that have the least in resources, both in funds and in leadership and grantsmanship. It is our view that some limit should be placed on the proportion of the non-Federal share that can come from non-public funds in order to assure that governing bodies assume their proper responsibilities. Surely it is the intent of Congress that the States not merely maintain but expand their own fiscal effort. We suggest therefore that an overall limitation of 20 percent be placed on the use of contributed funds (recommendation No. 4). This limit would apply overall, but not necessarily to any one particular grant which the State authority might make within its plan. We believe this provision is especially needed in view of the fact that, for more than one-third of the States, S. 3008 would effect a reduction in the Federal percentage share.

RESPONSIBILITY OF STATE HEALTH AUTHORITIES TO SERVE ALL CITIZENS

Connected indirectly with the degree of reliance on private agencies is the question of securing adequate coverage and accessibility for all citizens. Regardless of what private groups are willing to do, the public system must bear the responsibility to see to it that all citizens have equal access, in fact as well as in principle, to the health protection they need. We are therefore suggesting (Recommendation No. 5) the insertion in section 314(d)(1)(C) of an additional proviso relative to coverage and eligibility which we believe will accomplish several things:

(1) It puts a responsibility for "statewideness" on the State agencies. Such requirements are or will be in effect with respect to Federal aid in vocational rehabilitation and public assistance, so there is precedent.

(2) The provision with respect to economic status is designed not only to make sure that those unable to pay do receive service but also that publicly supported services not be denied to someone who can and will pay for them. A situation came to our attention recently in a Midwestern State where a crippled child was denied service in a unique State operated facility because the child's parents were deemed able to pay. It may be appropriate for a public agency to charge a fee for service to a person, his spouse, or parent if he is a minor, but surely service not otherwise available to him should not be denied because he can pay.

(3) It protects against discrimination on some irrelevant basis. The fact that a person is mentally retarded or the fact that he is receiving some form of training or care in a residential or other facility operated by a public agency other than the State health authority should in no way impair his right to benefit from appropriate public health services. It has taken 10 years of effort to remove some of the more stubborn State laws which deny to crippled retarded children the benefits available to crippled children. We believe that the Federal Government should not tolerate the use of Federal funds under State laws or State plans that permit this kind of discrimination, and that this should be clear in the statutes.

In particular we believe that public health services (both environmental and personal) should be offered to residents of institutions for the mentally retarded on a basis comparable to that which would apply to similar persons who are not in residence. It should be made clear that references in the bill to "community" services do not exclude persons in residential care, for several reasons: (a) such institutions, in the mental retardation field at least, should be regarded as part of

the continuous spectrum of needed services and not apart from "the community"; (b) it is impractical to make arbitrary distinctions between facilities that are localized in the sense of having a limited geographical service area and those that (in the best interest of persons with highly specialized needs) serve a somewhat larger region or population base.

The Vocational Rehabilitation Administration has set a good example to other State and Federal agencies in encouraging State rehabilitation agencies to make their various programs available in and to residential facilities.

THE PLANNING PROCESS—BOON OR BAR TO PROGRESS?

Finally we call your attention to the need to safeguard the planning process itself. Since there is a provision of present law (continued in S. 3008) which gives the State health and mental health authorities virtual veto power over Federal regulations (a power which, so far as we can determine, is without precedent in other HEW programs), it is especially important that Congress make its intentions known. The provisions of S. 3008 would do much to sanctify and institutionalize the State plans. While there is a requirement for review, it is not specified by whom, nor is there any guarantee that interests excluded in the plan will be heard and noted. Our experience to date in other State planning efforts has indicated that because an advisory council is appointed does not necessarily mean that it will meet or that its advice will be given consideration. Newspaper "publication" of a legal notice that a plan exists and may be consulted in an office in the capital city scarcely protects the public or professional interests in such vital matters. If the objectives of the act are to be achieved, participation, or at least opportunity for effective intervention by groups and individuals representative of a wide range of interests must be more than "encouraged." Moreover, there must be assurance that innovation is not limited to such ideas as may be initiated internally. It is our hope that the legislative history of S. 3008 will show that section 314(a)(2)(D) is intended to be more than a polite gesture.

It might be pointed out here that whereas State mental health plans have been and continue to be recognized and legitimated under part III of the Public Health Service Act, the Federal Government has no means other than the small temporary "implementation grants" with which to undergird the States mental retardation plans. We believe that the health aspects of these plans should be expressly coordinated with and, preferably, integrated into the States comprehensive health plan, and that where the proposals for health services to the mentally retarded are inadequate, these should be reviewed and modified in a positive direction.

In view of the pace of our times, we would question whether so much of the project grant authority should be tied to State plans (see 314(e)). In particular it would seem desirable to permit the Surgeon General more discretion relative to grants "to meet health needs of limited geographic scope or of specialized regional or national significance." Should conflict between State plans on two sides of a river boundary really be allowed to prevent support for a nonprofit organization to initiate specialized services in a metropolitan area which straddles the waterway?

Our experience indicates that representatives of most comparable HEW grant programs do, in fact, cooperate with responsible State officials whether this is required by law or not. To tie Federal action to the least common denominator of State vision, however, does not appear to us to be in the interest of progress.

We trust that these observations will find merit in your eyes, and thank you most warmly for giving us this opportunity to present them.

RECOMMENDATIONS FOR AMENDING S. 3008

(1) Page 13, line 16, S. 3008: Insert the following sentence: "At least 10 per centum of a State's allotment under this subsection shall be available only for the provision of health and health related services (including training of personnel) for the mentally retarded or persons who have related developmental disorders."

(2) Page 13, line 16, S. 3008: Insert "each" before "such amount".

(3) Page 9, line 21, S. 3008: In place of "or metropolitan", insert "metropolitan, or State".

(4) Page 12, line 16, S. 3008: Delete period and add ", but not to the extent of more than 20 per centum of the non-Federal share."

(5) Page 9, line 22, S. 3008: Delete "and (iii)" and insert: "(iii) services will be expanded and extended in an orderly manner so as to be reasonably available in all parts of the State and to all persons within the State without regard to economic status, age, disability, or place of care or domicile; and (iv)".

(6) Page 14, line 9, S. 3008: Delete "(1) or".

Mrs. BOGGS. Now, I would like to first call your attention to how S. 3008 affects the status quo.

In one of the pieces of material that has been recently circulated by HEW relative to its support of mental retardation programs, the Department indicates something over \$10 million being spent under the heading of "Chronic Diseases and Health of the Aged" for mental retardation.

Now, if we analyze this, we find that \$2,750,000 of it is for the implementation of planning, for coordination, and so on, which is temporary, desirable, needed, and we support it strongly, but it is certainly not direct service.

Something over \$3 million of it is being put into training of personnel for service. We think this is also very important.

A little over \$2 million is going into project grants which are for demonstration service, and this is the portion which is in fact targeted to services for the retarded at the present time, a little over \$2 million—and all of it in project grants, under the project authority in 314(c).

There is, however, \$2.5 million in the \$10 million that I mentioned which is alleged to be spent for the mentally retarded, because it was so appropriated by Congress as part of the formula grant for chronic diseases. It was justified to the Appropriations Committee on the grounds that the States would be encouraged to use this money to enlarge their health programs for the mentally retarded.

We have to say that while this extra money was made available (it was the only formula grant that was increased in fiscal 1966) and while it was increased on this justification, there was no legal mandate that it be spent for the purposes for which it was appropriated, and the States felt free to do as they saw fit on this subject.

Now, all of this—with the exception of the planning money, the implementation money which is under another act—all of what I have been talking about would, of course, be affected by the repeal of 314 in its present form.

So, we want to assure ourselves that what comes in place of it is going to have real relevance.

Now, I understand, and we sympathize quite genuinely with the general philosophy of the integrated health program and generally speaking, the merging of categories. We understand this very well.

But we also have to recognize that the reason some of these categorical programs can now be neatly merged is because they have, in fact, become established, and this establishment has come about in many instances precisely because there has been a period during which some categorical support was available, in which the States could receive additional Federal money if they extended and improved their programs in certain directions, and now that they have accepted the responsibilities, it is convenient and appropriate that the exact accounting for funds, as between the different programs, be abandoned.

We hold that the experience I just mentioned indicates that in mental retardation we are dealing with a subject which has only just now begun to be accepted by people in the health field, and then only by

the leaders, as being a subject to which they should give more attention. I am talking about services, health and health-related services to the mentally retarded at this point.

Prevention is also an important aspect of the health department's work, but this is one in which categorization as far as mental retardation is concerned is quite meaningless.

So we would point out to you that in our view the position of mental retardation is that of a rather junior participant in the health field; it does require a little special attention at the present time.

We think there is another justification for special attention. The bill calls for a segregation of at least 15 percent of the funds to be directed to the State mental health authorities.

Now, the argument for this is not on the basis of a disease entity but on the basis of a bureaucratic division of responsibility; this same argument is just as applicable to mental retardation—in fact, it is a little more so, because the States are much more diverse in the way in which they are organized to approach the problem of mental retardation, and the way in which they propose to step up their health and health-related services to the retarded.

The responsibilities are differently assigned in different States. We therefore feel it would be desirable to allocate a comparable percentage for mental retardation activities under the general heading of health, and we would suggest that there be a 10 percent allotment for mental retardation and related developmental disorders which could be used in one of several different ways. It might be used entirely by the State health authority or part of it might be assigned to some other State agency which in that State has responsibilities in functions related to health.

The CHAIRMAN. You mean 10 percent in addition to the 15 percent?

Mrs. BOGGS. Yes; we suggested 10 percent for mental retardation and 15 percent for mental health. And we have made the purposes for which this could be used fairly broad, in the sense that, for example, it would include training of health personnel, people who are in the generic health services, so that they are better attuned to the needs of mental retardation.

We have had some very nice experiences with public health nursing services. But in order for these to be effective, the public health nurses have to know a little bit more about mental retardation than they were taught in school. And we can see in some States attention might be directed toward that kind of effort.

We are also using the language "related developmental disorders," because we recognize the overlap between mental retardation and cerebral palsy, epilepsy, and sensory disorders, and so on. So, we are deliberately suggesting that the language here give a little bit of the latitude and blurring of the boundary that would enable the State health people to accommodate to this without being too rigidly inclined.

Part of the intent of our proposal is to permit the State health agency at its discretion to reallocate some of this money to another State agency or agencies, including but not limited to the State mental health agency as may be necessary in order to deliver health services to the retarded.

In some States a lot of the responsibility for community services for the retarded is vested in the health agency, and in other States it is

vested in the mental health agency, and in some States the residential program is in the mental health, and the community program is in health, and so forth.

There needs to be some fluidity in deploying funds. But at the same time, we think it should be identified so that the States will be on notice that this is to be included in their program.

In particular, we think that such notice, will have an important influence on the planning, the comprehensive health planning, that the States are undertaking.

We would anticipate that once the field of mental retardation has gotten a foothold and gotten established, as has heart and cancer, that it might be possible not to continue in this particular division.

Now, I might mention in this connection that one of the State plans that has come in, is the New York State plan; I know that one of the Senators on your committee is extremely interested in that. One of their priorities for action is increased emphasis, in health programs and in public social welfare and social work, upon the needed skills and services that they can bring to the mentally retarded and their families under their powers and duties.

Now, this is an example of where we want to identify something within the generic service.

The following New York priority is "Explicit provision is in all Federal and State laws and local programs establishing community-wide medical, health, and social protections and services so that the mentally retarded will not be excluded from such benefits."

Such a statement is necessary because, for example, we have been fighting a 10-year battle in the States to eliminate exclusions of mentally retarded persons from the crippled children's programs. This is an example of where the States take it upon themselves to exclude from the benefits of a Federal program which was not intended to be so exclusionary a group of people simply because they had a handicap of mental retardation. And we have to say that this is close enough to our experience now that we feel that the care, the health, and the health-related services to mentally retarded must be protected some way under this legislation at least for a little while longer. That is why we ask for the 10-percent share in the prepared formula grants.

Now, we have made several additional suggestions for modifications in the language of the bill, and I will not take your time now—we are all getting hungry, I am sure—to refer to these explicitly. They have to do with the possible limitations on the use of private funds, to the relaxation of State responsibility, and so forth.

And I would hope, however, that the members of the committee and the staff might consider these recommendations that we have made, because quite frankly they go beyond the mere issue of mental retardation. We think they are relevant to some of the questions that came up earlier today. For example, there will be a tendency under this bill to place the comprehensive State health plans on a kind of a pedestal. It is important, therefore, that we consider the mechanisms by which something which has been left out can get in.

Now, finally, I would like to come back to the place of the retarded under the general heading of "Project grants."

We are pleased to hear reference to the intent, as I understood it, of the Department to continue under the new language of this bill a number of the project grant programs which are now underway.

With respect to the field of mental retardation, however, we have to stress that the level of support at this moment for the project grant programs is quite small and does not permit support of some rather important demonstrations that should be undertaken.

Now, elsewhere in the New York report—and this would apply equally in Rhode Island and several other reports that have come to our attention already—is the recommendation stated as follows:

There is a serious need for day training-centers for those over 5 years of age whose degree of retardation or lack of self-control is such that they are excluded even from school classes for the trainable.

Now, this area of children who are very severely handicapped and usually multiply handicapped, who are so handicapped that they cannot be involved even in special education programs, are not acceptable there, and concurrently the adults who are so severely handicapped that they do not have potential for employment even in sheltered circumstances—this group of people is not benefiting by rehabilitation money, it is not benefiting by elementary and secondary education money. Here it is one of the gaps, one of the blank spots so far as Federal assistance is concerned.

We have discussed it with people in the Department, they know our feelings, on this. But we feel that the States are ready to move in this area in many instances, and that it would be quite important to have some beginning authority this year which would indicate the intention of the Federal Government to fill out this gap.

But, if that were to be done, it would have to be because the Congress identified its intent, that this be done, because the amounts of money that would have to be involved are larger than those likely to be made available by the present ordinary incremental system.

But, again, we would feel that with respect to this particular thing, the position of the Federal Government and of the Congress should become known soon, its intention should be known soon, and we would think that a token appropriation in 1967 would be desirable. When I say "a token," I mean a small amount that is available to enable the agency responsible to develop its regulations and to try out a few proposals and know what they are in for.

There is nothing like a small amount of money to induce people to show what they want and what they need.

We would like to see something of that sort, followed with authorization for considerably higher appropriations in subsequent years.

We would be delighted to make available to the committee some further comments on this, if you are interested.

I think that that represents the main points that we want to make, Mr. Chairman. I am very happy to elucidate and explore.

The CHAIRMAN. Senator Javits was compelled to leave this committee to go to another committee meeting.

Have you had an opportunity to examine his bill providing certain amendments to the mental retardation legislation?

Mrs. BOGGS. I am very glad that you have brought this subject up, Senator, because we have indeed examined this bill, and your bringing it up gives me a chance to say for the record—and I am sorry he is not here—that we very much appreciate Senator Javits focusing attention on the need. He did it earlier in his questioning. We agree with him, that something should be done this year.

We have had in mind to make some remarks relevant to that bill at the time that S. 3009 might be considered, since it is addressed at least in part to the Construction Act.

We think that section 3 of his bill, which suggests a more liberal interpretation of the word "construction" is very desirable and necessary, and, as a matter of fact, there are some other areas where the provisions covering rehabilitation construction—both the medical and vocational—do not quite match the mental retardation construction and where we think it would be desirable to bring everything up on a par.

We would like to take another opportunity to tell you in more detail what we think on that.

With respect to what is called the staffing problem, we agree with the need that Senator Javits alludes to. We would suggest that there are somewhat better ways of accommodating that need than the particular bill, the mechanisms that he introduced.

I have spoken earlier of the fact that there are various ways, places, in which the retarded get served. The mental retardation facilities as defined under the act is one of these places, but not by any means the only place.

The second thing is that with respect to services for the retarded, which are most likely to be provided in something called a mental retardation facility, there are significant and important costs other than the cost of salaries.

For example, in any situation that we are aware of, anywhere from 10 to 30 percent of the total cost of operating the service and making it available to children arises from the need to transport the children to the facility.

Now, in many cases if you cannot get the children transported, they are not going to get there. In many instances where the local association for retarded children is providing services, which we do from time to time on a demonstration basis, this cost has been such that the people operating the facility have said: "Well, we will just have to leave it to the parents to get the children now." This means the child in the two-car family gets there, but the child whose parents would have to bring him on a bus does not get there, particularly if he is physically handicapped and not adapted to being transported that way.

So, we believe that we are getting into a semantic bind when we talk about the staffing of facilities. What we think we should talk about is the provision of services and the provisions of services in these facilities in particular.

We have alluded earlier—I have alluded earlier—to the need for these daily group care programs for severely handicapped children, and this is one of the type of things that are needed in the facilities.

We have a general philosophy in our organization that is hard to implement sometimes: that, generally speaking, we should get the support for our different kinds of programs that we need through the agencies that have a general responsibility. This is why we are here talking about health today.

We want support from health agencies; we want support from rehabilitation agencies; we want support through the education services—each in accordance with its particular expertise.

Now, this is hard to do. But we would like to try to succeed in this struggle.

Now, we would be the very first ones to agree that the very fact that this support is fragmented by the nature of government and by the nature of people, if you will, makes it likely that there will be interstitial parts that do not get support, and, hence, gaps in the program. I have referred to one that exists now (daily group care), and we would like to see that particular big gap attended to soon.

But, I think, that particularly in this transitional period, there is very considerable merit for a program of special Federal assistance to aid in establishing and maintaining for a time new services which are associated with facilities which we call mental retardation facilities. There are several criteria that should be met in such legislation. One is that it should be formulated with specific reference to the needs in the mental retardation field. We are dealing here with a chronic disability. The people who need this service most need it not just for months but they need it very frequently for years. It is not a kind of service that, generally speaking, gets covered by hospital insurance or what have you. So that there is a need to see this as something that is going forward for a time, and something which, so far as the families are concerned, is a very serious drain and a continuing one. This is not an emergency that you get over and recover from. This is something that is a chronic problem for the family as well as for the child.

So, we would like to see a statutory formulation which takes into account the distinctive aspects of the mental retardation problem. For example, I mentioned transportation. This would be an includable cost.

Another thing that should be taken into account is that the reasons that were given under the community mental health staffing bill for providing a rapid decrement in support are really not equally valid in the case of mental retardation.

We would say, for example, that to specify a given percentage for each of 4 successive years, regardless of where the project is, where the facility is, what the needs are there, and so on, whether this is an extension of something outgoing, or whether it is something brand new—that the decremental formula is not sufficiently flexible for the needs in question.

We also feel that if these grants are to be consistent with any sort of a State plan, it should be the State mental retardation plan. Now, the Javits bill requires that this be consistent with the mental health plan. That would work all right in New York, because the mental retardation plan has been incorporated into the mental health plan, but this is not true in many other States.

We would hope that eventually most things that are done except for "innovation" would be consistent with the rehabilitation plans, the mental health plans, the health plans, and all the rest, but if you are going to have a requirement, the requirement should be with respect to mental retardation in this instance.

Now, those are some of the points that we think should be taken into account if there is to be a bill addressed to what has come to be known as the staffing problem.

We would like to see such legislation, and we would be very glad to discuss with you or some members of the staff language that might be used in this connection.

I would assume that such a piece of legislation would come under the heading of an amendment to 88-164.

The CHAIRMAN. Suppose you submit to us in writing, for the record, your alternatives to the bill.

Mrs. BOGGS. We will be very happy to do that.

The CHAIRMAN. To the Javits bill.

(The alternatives referred to follow:)

COMPARISON OF PROVISIONS OF S. 2836 WITH THOSE RECOMMENDED BY
NATIONAL ASSOCIATION FOR RETARDED CHILDREN

S. 2836—Section 2

NARC preference

PURPOSE

To assist in meeting initial cost of professional and technical personnel for community mental retardation facilities.

To assist in initiating services to the retarded in mentally retarded facilities (including but not limited to meeting personnel costs).

FORMAT

Amends Public Law 88-164, title II, part B (Community Mental Health Centers Act as amended by Public Law 89-105), by inserting "and community mental retardation facility," where appropriate, following the words "community mental health center" in sections 220 and 221 authorizing "staffing" grants; also adds authorization for additional appropriations.

Amend Public Law 88-164, title I (Mental Retardation Facilities Construction Act), by adding a new part (paralleling part B of title II) but structured to meet the apparent diversity of special needs for initiating service to the retarded in both urban and rural facilities, and in service units affiliated with universities.

ADMINISTRATION

Same as for community mental health centers (NIMH).

Left to discretion of Secretary (after reorganization of PHS).

CONFORMITY TO STATE PLAN

Services must be described in State mental health plan under title III of Public Health Act.

Must be consistent with State mental retardation services plan, if any.

DURATION AND EXTENT OF FEDERAL PARTICIPATION IN ANY ONE GRANT

Time limited to 51 months; starting Federal share not more than 75 percent with sharp mandatory decrement to 30 percent after third year.

Time limited to 5 years; Federal share to vary with circumstances but not more than 75 percent.

AUTHORIZED APPROPRIATIONS

(1) Total of \$30 million over 3 fiscal years, 1967-69, for initial grants, plus amounts necessary to complete grants so initiated up to 1973.

(1) Initial amount of \$1 million in 1967; total of \$40 million over 4 fiscal years (1968-71) for initial grants plus amounts to complete grants so initiated up to 1973.

ALLOTMENTS

Appropriations must be allotted among States on formula basis (taking into account need, population, and per capita income).

Project grant basis without allotment (to accommodate the variety of circumstances which will be encountered).

(If allotment is used, should not begin till fiscal 1969.)

S. 2836—Section 2

NARC preference

REQUIREMENTS FOR ELIGIBILITY OF FACILITY OR SERVICE

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| <p>(1) The facility must be public or non-profit.</p> <p>(2) "Mental retardation facility" means a facility especially designed for the diagnosis, treatment, education, training, or custodial care of the mentally retarded * * * " (title IV, sec. 401).</p> <p>(3) Services to be provided must be part of a program (in the facility or in association with other facilities in the community) which has all the "essential elements" of comprehensive mental retardation services as determined by the Secretary.</p> <p>(4) Facility was constructed as part of a mental health center with Public Law 88-164 funds, or type of service to be funded is new in the facility.</p> | <p>(1) Same.</p> <p>(2) Same. (However NARC recommends that "custodial care" be amended to read "day and residential care.")</p> <p>(3) Services to be provided must be of a type or types deemed basic and necessary by the Secretary, but not all other elements need be already present.</p> <p>(4) Eligible facilities include but are not limited to mentally retarded facilities constructed under part B or C of title I; service need not be of a new type, but there must be an existing insufficiency in the community of the type or types of service to be funded.</p> |
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MAINTENANCE OF EFFORT

<p>Secretary must be satisfied funds will supplement and increase level of State, local, and other non-Federal funds, and in no event supplant them.</p>	<p>Same. In addition, after July 1, 1969, preference should be given to facilities supported in part by State or local public funds.</p>
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REGULATIONS

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| <p>(1) Secretary shall issue general regulations concerning eligibility and determination of costs with respect to which grants may be made.</p> <p>(2) Secretary must consult National Advisory Mental Health Council.</p> | <p>(1) Same.</p> <p>(2) No formal consultation requirement. (NOTE.—Mentally retarded facility construction applications are now reviewed by representatives of all relevant HEW agencies, e.g., PHS, VRA, OE, WA.)</p> |
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COMMENTS ON COMPARISON OF S. 2836 AND NARC PROPOSAL

PURPOSE

Basic purposes are similar, but NARC position recognizes significant other costs incurred in cities and rural areas for bus transportation to daily programs. Items other than salaries to be controlled by regulation.

FORMAT

Mental retardation facilities and services reach more broadly into community than do mental health centers; hence requirement for strict affiliation between them is inappropriate, and was omitted in construction act. A consistent approach to operating costs requires different format in statute.

ADMINISTRATION

Mental Retardation Branch of U.S. Public Health Service has been coordinating reviews of program components of mental retardation facilities. Same agency should follow through on program assistance.

CONFORMITY TO STATE PLAN

In some States the State mental health plan includes the mental retardation plan, but in States where this is not true, difficulties would be created by S. 2836.

DURATION AND EXTENT OF FEDERAL PARTICIPATION IN ANY ONE GRANT

The sharply decremental pattern of the mental health staffing was predicated on availability of fees from patients through insurance, medicare, etc., and on increased Federal formula aid to State mental health departments as proposed in S. 3008. Such funds are not necessarily available for staffing mental retardation facilities under an agency other than mental health. Therefore flexibility in the project grant authority is needed, to accommodate different situations. In some States, State matching may already be available at 50 percent and a nondecremental grant at a lower percentage may be more suitable. NARC proposal is compatible with innovation grants in rehabilitation. Also experience with construction shows that even within a "wealthy" State, there are poor communities, where maximum aid may be needed to inaugurate new services.

AUTHORIZED APPROPRIATIONS

Appropriations are comparable in the two proposals except that the NARC recommendations are designed to peak at the time of estimated greatest need in relation to new construction.

ALLOTMENTS

Experience with allotting small appropriations in a largely untested field has shown that this is inefficient and unfair. We already know that different States are at different stages of construction of new facilities and hence at different stages of readiness for help with staffing and related costs.

REQUIREMENTS FOR ELIGIBILITY OF FACILITY OF SERVICE

(2) Both bills limit eligibility to specialized facilities and so not assist special programs in general facilities such as hospitals, public schools, etc.

(3) See comment under Format; also the mental health requirement that all (five) essential services be present has cut out many communities which are trying to make a start with one or two.

(4) Need in mental retardation field is not only for new types of service but for extending services now available on token basis only.

MAINTENANCE OF EFFORT

In mental retardation field even more than in mental health, there continues to be a need for participation by public agencies. We should combat tendency for State to bow out in favor of contributed funds to match the Federal dollars.

REGULATIONS

Regulations affecting mental retardation facilities should be developed in consultation with experts in all the various program areas, e.g., health, education, rehabilitation, child welfare, rehabilitation mental health, etc., since all these elements may be present in program to be aided.

The CHAIRMAN. We want to thank you very much.

Mrs. BOGGS. It has been a great pleasure, as usual, Senator. You are, you know, my favorite chairman.

The CHAIRMAN. Thank you very much.

The subcommittee will now stand in recess until 10 o'clock in the morning.

(Whereupon at 12:55 p.m., a recess was taken until 10 a.m., Thursday, March 17, 1966.)

PUBLIC HEALTH PLANNING AND GRANTS

THURSDAY, MARCH 17, 1966

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, presiding. Present: Senator Hill (presiding).

Committee staff members present: Robert W. Barclay, professional staff member; and Roy H. Millenson, minority clerk.

The CHAIRMAN. The committee will kindly come to order.

We will hear from Dr. Bartholomew Hogan of Maryland, deputy medical director, Maryland Psychiatric Association.

We are glad to have you, Doctor. We will be glad to have you proceed in your own way.

STATEMENT OF DR. BARTHOLOMEW HOGAN, DEPUTY MEDICAL DIRECTOR, ON BEHALF OF AMERICAN PSYCHIATRIC ASSOCIATION

Dr. HOGAN. Thank you, Mr. Chairman. I have a short statement here, if I may have the privilege of presenting it.

I am representing the American Psychiatric Association this morning, Mr. Chairman.

I am extremely grateful for this opportunity to appear before this subcommittee to testify in support of S. 3008—proposed by Senator Hill to amend the Public Health Service Act—for in the opinion of the American Psychiatric Association this amendment would result in very significant improvements in the funding and delivery of community health services.

In the past few years, some of the most imaginative health legislation has originated in this committee and the proposal before you today is certainly one which, if adopted, will serve to promote the general welfare.

The members of this subcommittee, the 89th Congress, and the administration, in considering this bill, indicate that we are no longer concerned merely with public health in its narrow sense but, rather, with the health of the public.

Several things are at issue here. The proposal would result in the extension and improvement of comprehensive health planning and of health services. We would like to suggest, Mr. Chairman, that for the first time we have the opportunity within the provisions of these amendments to provide for more effective use of Federal funds in improving personal health services and environmental health services simultaneously.

This proposal provides for the establishment of a State health planning agency as the single agency for administering, or supervising the administration of State health planning functions. It does so correctly, we believe, Mr. Chairman.

A single agency would be able to plan for personal health services—including preventive services, treatment services, and educational services—relating to the entire range of personal health needs. Such an agency would go far in coordinating treatment and services for illnesses whose causes are primarily physical, with treatment and services for mental illness. At the same time, by assuming administrative responsibility for planning a healthy environment, the single agency could, indeed assume a very significant role in implementing the modern concept of treating the "whole man" in his "total environment."

We should like to speak to the kind of agency this might best be, Mr. Chairman, if it is to become the effective vehicle for both planning and delivery of funds in support of health services that the authors of the bill envisage.

As the members of this committee are well aware, we do not, today, have the degree of coordination and collaboration among the major health agencies—both public and private—that we should have in most States.

The CHAIRMAN. You need better teamwork, do you not, Doctor?

Dr. HOGAN. Yes, sir.

We must immediately secure such coordination in fact, if the States are to receive maximum benefit from the health legislation already adopted by this Congress, while planning ahead to improve future services.

We who have been primarily concerned with the mental health needs of the people have had an opportunity to do this kind of coordinated and comprehensive planning, within the mental health field, in the past two and a half years. This experience leads us to strongly endorse the concept of a single planning agency for the health needs of a State.

In establishing a single State health planning agency it is extremely important, we believe, that each State should provide for adequate representation and involvement within the proposed planning agency of those agencies having major health responsibilities.

This will, in actuality, be a decisionmaking body, Mr. Chairman, for it is certainly to be hoped that grants for community services would be grants for services recommended through and by the proposed new planning agency.

We would suggest that if effective planning is to be achieved, coordinate status in making decisions should be accorded the mental health agencies, the public health agencies, and other health agencies. We know that it is difficult to break with traditions in this matter, but the health of our people can only be improved if the public and private health agencies learn rapidly some new kinds of cooperation as well as some new degrees of cooperation.

The second point to which the American Psychiatric Association would like to speak today is in support of a provision that a minimum 15 percent of the funds authorized in this proposal would be earmarked for mental health services and, of that amount, 70 percent would be available for community mental health services.

This allotment of percentages, in effect, approximates the pattern of section 314c of the Public Health Service Act which these amendments would supersede.

We believe, Mr. Chairman, that this provision is sound, particularly as the health services in most of the States are currently organized in separate health and mental health agencies.

This is the prevailing pattern of public health programing which has evolved over a period of time. In 36 States, the mental health authority is not a part of the health department. In 32 of these, the community mental health program is administered outside the public health program. In these States, there is no single department which has responsibility to allocate funds to or between either the health or mental health departments.

In establishing a 15 percent minimum for mental health services, under the current proposal, the Federal Government makes a decision which allows for flexibility within each State, while assuring allotment of funds necessary to maintain mental health services at their present levels.

Mental health services in the community must and in fact are being correlated with other health services, but mental illness brings with it special problems and considerations. Mental disorders, being disorders of the mind and the behavior of man, require special modes of treatment and special kinds of services.

As more and more persons are treated in community mental health centers, the need for services will increase. We feel, therefore, that it is sound, both administratively and socially, to specify a minimum percentage of funds, under the proposed amendment, for mental health services.

We feel strongly that the establishment of the single State planning agency along the lines suggested here would secure the most equitable and efficient assignment and use of Federal funds, and we respectfully urge that the regulations under which S. 3008 would be administered, specifically state such a composition for each health planning agency.

Thank you, Mr. Chairman, for allowing me to present the APA's thoughts to you and also to thank this committee again for its continuing work toward improving the health of the people of this Nation.

The CHAIRMAN. Doctor, as you know, there is a great variety among the States with respect to the supply of mental health personnel. Do you feel that this legislation would be of particular assistance to States in trying to meet their personnel shortages?

Dr. HOGAN. Well, I think a single coordinating planning agency certainly will help improve all aspects of the mental health field including mental health personnel through the training grant projects.

The CHAIRMAN. This bill earmarks some 15 percent of the formula grants for mental health services. About what percent of our total health expenditures are devoted today to mental health? Could you give us a figure? I realize you might not have the exact figure, but could you give us an estimate on it?

Dr. HOGAN. I think approximately 15 percent of Federal funds for health services has been allotted, outside of the building and construction programs, to the mental health field in most States.

The CHAIRMAN. Of course in 1955, when we set up the Joint Commission on Mental Health Illness and—that is when the Federal

Government really got into this field and recognized the importance of it, is that true?

Dr. HOGAN. Yes, sir.

The CHAIRMAN. We have been making progress since then, but we have considerably more progress to make, is that right?

Dr. HOGAN. A great deal—because mental health facilities, services for mental health, have lagged behind for one reason or other, other medical areas. We have a long way to go to catch up.

The CHAIRMAN. There has been too much disposition to put these mentally ill people in what would be called an asylum in the old days, close the door, and that is the end, is that right?

Dr. HOGAN. Yes, sir.

The CHAIRMAN. I think one of our greatest strides forward is the idea of these community mental health centers. A lot of these people can be treated in their local communities and many of them perhaps restored to useful and productive lives, is that right?

Dr. HOGAN. Yes, sir. It is hoped with the establishment of these community mental health centers, that earlier treatment would be available to the individual, which means that a chronic condition may not develop, and he will be able to be treated at the community level.

The CHAIRMAN. Doctor, you have brought us a mighty good statement. We deeply appreciate your statement. We certainly want to thank you for it.

Dr. HOGAN. Thank you, sir. I am glad to see you again.

The CHAIRMAN. Thank you, Doctor—nice to have you here with us.

Our next witness is Dr. Donald A. Galagan of Iowa, consultant, Council on Dental Health, and dean, University of Iowa Dental College.

STATEMENT OF DR. DONALD A. GALAGAN, DEAN OF THE DENTAL COLLEGE, UNIVERSITY OF IOWA, ACCOMPANIED BY BERNARD J. CONWAY, CHIEF LEGAL OFFICER, AMERICAN DENTAL ASSOCIATION, AND HAL CHRISTENSEN, WASHINGTON COUNSEL

Dr. GALAGAN. Mr. Chairman, I am Dr. Donald J. Galagan of Iowa City, Iowa. I am dean of the Dental College at the University of Iowa. With me is Bernard J. Conway of Chicago, chief legal officer of the American Dental Association and secretary of its council on legislation.

If I may be permitted a personal privilege before starting my testimony, Senator Hill—as you know, I was a member of the Public Health Service for 28 or 29 years, and during that time I had the privilege of appearing before you on various hearings by the Appropriations Committee and the Committee on Labor and Public Welfare.

The CHAIRMAN. I recall your work, Doctor. May I say, you have always been a mighty good witness.

Dr. GALAGAN. Thank you, sir. What I could not say then, because I was an employee of the Federal Government, but what I can say now is that the citizens of the United States and the health professions generally and the members of the Public Health Service in particular are greatly in your debt for the leadership and foresight

you have given to health legislation in this country. And we are very grateful for all you have done over the years.

The CHAIRMAN. Thank you, sir.

Dr. GALAGAN. We have a statement which we would like to file for the record.

The CHAIRMAN. All right, sir. We will have it appear in full in the record, Doctor. You may proceed as you see fit, sir.

Dr. GALAGAN. I would like to amplify the statement in two or three respects.

First of all, you know, the American Dental Association has long worked, for more than 25 years, to upgrade the quality and the scope of dental programs in health departments.

The association has worked diligently to do this, because it felt that the State health departments in the United States, were the keystone of public health programs. And it felt, and I think justifiably so, that State health departments, as the years have gone by, were beginning to miss a great deal of the opportunity for constructive and comprehensive health programs for a variety of reasons, all of which are known to you and to members of the committee.

In the past 25 years, welfare agencies and other agencies have moved into the health field, so today there is a very great fragmentation of health services at the State level.

You will recall, too, Senator Hill, that during these 25 years of effort on the part of the association to get some support for State public health dental programs, that this effort finally culminated 2 years ago in the fiscal 1965 appropriation for the Department of Health, Education, and Welfare in earmarking a small amount of money for the support of State dental health programs—thanks to the graciousness and the consideration of the chairman of this committee.

For this reason, therefore, the American Dental Association endorses the overall intent of S. 3008.

There are two special features of the legislation which the association would like to comment upon.

First of all, the section which provides for the comprehensive planning—that section in the opinion of the association is very badly needed and will add a new dimension to the health activities which are going on at the State level, because it will bring into the consideration of the plans for the health services in the State the welfare departments, the medical schools, the dental schools, the nursing schools, and the other health profession schools. It will bring in voluntary agencies with fresh ideas, with new approaches, and will provide, in fact, a new dimension in the supplying of health services in the States, and this feature of the bill the association wholeheartedly endorses.

The second feature of the bill which the association would like to speak to is the proposed interchange of personnel between levels of government, and this feature, too, should provide an infusion of new blood, new ideas, competent workers in State and local governmental agencies, which will add a new dimension to the health activities at the State level.

The American Dental Association has one reservation about the bill, and that reservation, as I am sure you can imagine, has to do with the fact that the categorization of appropriations will disappear

except for that portion which is earmarked for mental health, to which the previous speaker referred.

I am sure that you, Senator Hill, are aware of the experience we have had with general health grants in the 25 years of their existence. I recall some bitter experience in the administration of the program with which I was connected in the Public Health Service, in trying to convince State health authorities that a larger share of these general health grants should be allocated to the support of dental programs, a share which we think is commensurate with the size of the problem.

The association recognizes that health needs vary, and therefore there is a serious need for the freedom and flexibility which unearmarked appropriations will provide State health agencies.

Venereal disease may be higher in one State than it is in another, and tuberculosis may be higher in one State than another, but the fact is that dental disease does not vary, it is universal. I am sure that over the years that testimony has been presented to this committee which identifies the scope of the problem.

Ninety percent of the people in the country suffer from dental disease in one form or another. Half of the people over 50 have lost all their teeth.

The problem is that dental diseases are not dramatic. While they are universal, because of their low emotional intensity, State health agencies have tended not to put the emphasis on the support of dental programs which the association feels is necessary.

Therefore, the association would respectfully recommend that the committee consider earmarking a certain percentage for the support of dental programs.

The association would suggest as a possible percentage 5 percent of the formula grants.

That concludes my testimony, Senator Hill.

(The prepared statement of Dr. Galagan follows:)

PREPARED STATEMENT OF DR. DONALD J. GALAGAN, AMERICAN DENTAL ASSOCIATION

Mr. Chairman and members of the subcommittee, I am Dr. Donald J. Galagan of Iowa City, Iowa. I am dean of the Dental College at the University of Iowa. With me is Bernard J. Conway of Chicago, chief legal officer of the American Dental Association and secretary of its Council on Legislation. I have served for several years as a consultant to the Council on Dental Health of the American Dental Association and represent that association on S. 3008 today. I have a special dedication to dental public health, having spent 27 years of my professional career in the Public Health Service, the last 5 as Chief of the Dental Division.

The American Dental Association recognizes the importance of many of the major goals of S. 3008. Certainly it is desirable to encourage the States and communities to make comprehensive plans in order to meet in the most efficient manner the health problems in their own areas. And certainly as a general proposition there can be no reasonable disagreement with the objective of giving to the States and communities great flexibility in implementing such plans.

We do believe, however, that the new health services grant program within proposed section 314(d) of the Public Health Service Act could be improved by providing specific authority for dental public health grants to State health authorities. Later in my testimony I shall spell out the reasons for recommending special consideration of dental health needs.

There are several parts of S. 3008 which could contribute greatly to the Nation's health goals; these provisions, of course, are unobjectionable to the association. The new planning grants, for example, could have a wholesome effect on State and local health agencies.

There are imaginative professionals in the community public health field who should now be challenged to design programs to meet today's and tomorrow's

problems. Unquestionably the new source of planning funds in S. 3008 would give these persons the time and opportunity to chart the pattern of disease prevention and control to meet the special needs of their States and communities. Obviously, too, the stimulus for planning will produce ideas for new and more effective methods for bringing care to our citizens, especially the aged, the handicapped, the institutionalized, and the homebound. We are certain that public health dentists will contribute their share to these new designs.

The provisions for project grants in S. 3008 could also stimulate new approaches to prevention and treatment of the many diseases that affect mankind. The emphasis upon teamwork between government and nongovernment agencies as a requirement for both the planning and project grant awards is commendable. There is a great need to blend the activities of such private organizations as heart association chapters and mental health community groups with State and local health departments. Dental schools could join more effectively with public health agencies to expand and improve oral pathology services, including oral cancer screening programs.

The association also sees much merit in the proposed interchange of personnel between the Department of Health, Education, and Welfare and the State health agencies. This expanded personnel interchange program would be especially helpful to States which have not yet developed effective dental public health units.

The association's chief concern with S. 3008, however, is the proposed change in the grant system for State public health services. We are convinced on the basis of many years of unhappy experience with general health grants that Federal support for dental public health activities should be specifically authorized.

The administration is proposing in S. 3008 a single-purpose grant for comprehensive State public health services. This is a significant departure from the special grant programs that have evolved over the past 30 years or more. For almost that long the American Dental Association has urged a separate category for State dental health programs. In 1964, with Senator Hill's leadership, this objective was achieved. It is somewhat disheartening, therefore, to face this new plan which could dissipate dentistry's hard-won gains by weakening the foundation upon which the future of State and local dental health programs must be built.

Let me emphasize that the association is not opposed to the idea of flexibility in using Federal health grants where that is a sound approach to a State's health goals. It is, for example, conceivable that one State may have a significant venereal disease program and little concern with tuberculosis. In another State the problems may be reversed in intensity. Obviously a State should have discretion to use its Federal health allotment to meet its pressing problems. It is a fact, however, that the dental disease problem is a serious one in every State. And the history of State health services illustrates that the dental problem needs special consideration to compete with the more dramatic and killing diseases like cancer and heart disease.

Four years ago this committee agreed with our conviction that dental disease is a serious problem in every State and reported favorably a bill (S. 917, 87th Cong.) introduced by the chairman of this committee, to create a special grant program for the prevention and control of dental disease. The 1962 bill proposed a 5-year program of matching grants with authority to appropriate \$7 million the first year and advancing in steps to \$17 million for the fifth year. The testimony of the American Dental Association and the Department of Health, Education, and Welfare witnesses fully proved the need for a substantial dental health grant in 1962; that same need exists today. To illustrate the seriousness of the dental disease problem I shall quote from the testimony presented by the Department witness, Wilbur J. Cohen, then Assistant Secretary for Legislation.

"Dental diseases are the most prevalent of all the chronic diseases which afflict mankind. Tooth decay and diseases of the gums and supportive tissue are experienced by nearly everyone. Among young people, tooth decay is a particularly serious health problem. By the time the average child reaches his 15th year, 11 of his permanent teeth have been damaged or destroyed by tooth decay. Among adults, periodontal diseases are the major oral health problem, the principal cause of tooth loss.

"Other dental disorders, though less prevalent, hold even more serious consequences for those affected. Cleft lip and palate—which occur once in every 800 live births—are disfiguring and crippling abnormalities. Today there are a quarter of a million individuals with cleft lip and palate, and 65,000 of these are under age 18. Malocclusion, which numbers one-half of all schoolchildren among its victims, often proves a severe handicap to the normal development of the child. The physiological effects of these disorders is obvious. Left untreated,

they often produce psychological problems which may cripple the victims emotionally for life.

"Oral cancer, which attacks 23,000 people a year, causes 1 in every 40 deaths from cancer. Early diagnosis and treatment would prevent many of these deaths.

"Dental disorders are also the most neglected of all health conditions plaguing the American people. Each year, some 60 percent of the population receive no dental care at all, and others receive only the emergency services necessary for the relief of pain. As a result, 3 in every 10 people in the United States past the age of 35—and half of those past 55—are left with no natural teeth.

"The full price that dental diseases exact from the Nation has never been totaled. We do know, however, that the cost is great. It is paid by industry in lost production and absenteeism; by the Armed Forces in meeting the massive backlog of dental needs existing among inductees; and by the public which spends \$2.4 billion a year to maintain a standard of dental health in which only 40 percent of the people visit a dentist even once in the course of a year * * *.

"Dental public health programs are by no means a recent innovation. On the contrary, most State and local public health agencies now conduct some programs in this field, but usually of a very limited character. While the scope and content vary greatly, they may include such activities as public health education in practical preventive measures and the essentials of good dental care maintenance; the provision of dental examinations; and in some cases, of corrective service for schoolchildren; and the establishment of clinical services for segments of the population with special needs or problems.

"Despite the well-established value of such activities, dental public health programs today are grossly underemphasized in most State and local health agencies. In 1961, for example, the Public Health Service made general health grants of \$17 million to State public health departments. Yet these departments allocated to dental activities only \$125,000—just 0.7 percent of the total. Nor has this gulf been bridged by funds from other sources.

"Of the more than half a billion dollars spent in 1961 on all State health programs, only \$6.6 million—about 1 percent—went to dental health. This pattern of allocation of public health funds is in sharp contrast with that of private funds, where \$15 out of every \$100 spent for health care goes for the purchase of dental services.

"So great a disparity cannot be ignored, for the current allocation allows less than 4 cents per person per year for all State and community activities in dental health. And 4 cents per person a year is simply not enough. It does not permit programs which even begin to meet the existing national need."

We look to our public health agencies to solve many of the problems cited by Mr. Cohen in his excellent testimony. But in the majority of States dental public health programs are so seriously undermanned and underfunded that they are forced to operate at substandard levels. States which have the greatest need are forced to conduct their dental programs with only one or two dental health officers. As a result, there are far too few organized programs for bringing dental care to the aged and other homebound, the institutionalized, and the handicapped. Schoolchildren do not receive adequate dental health education, dental examination, diagnosis, and referral for treatment. There is a serious shortage of dentists trained to treat patients with special physical or mental problems.

We know that dentistry is in a very unfavorable position to compete for funds in State health departments. Even though dental diseases, as Mr. Cohen emphasized, are serious and widely prevalent, they do not have the dramatic appeal of other diseases and do not arouse wide and intense public sentiment. But, at the same time, we cannot continue to sacrifice the dental health of the American people because of a lack of dramatic appeal.

By earmarking Federal grants for the prevention and control of dental diseases, S. 3008 would go far to remove the disadvantages which have made dental health services the stepchild of public health. With an appropriate amendment to S. 3008 State health departments could be induced to expand laboratory services to determine susceptibility to dental decay, to detect oral cancer. Dental treatment could be made available to the indigent of all ages from preschool children to adults; to those who are geographically isolated, homebound, or in nursing homes; to others who are institutionalized.

Additionally State health departments could promote and guide programs for teaching dental health in teacher training schools; they could participate in public health courses in nursing schools, in medical schools, in dental schools in schools of dental hygiene.

For the last several years, unsuccessful attempts have been made by State dental associations to induce State and local authorities to allocate the funds needed to do the job that needs to be done. We are convinced, however, that earmarked Federal grants will supply the incentive needed to induce more adequate State appropriations. There is evidence already with the limited dental grant authority in existing law (\$1 million for the 50 States) to indicate that the States and communities are expanding their support of dental services beyond the matching requirements. With a Federal grant of at least \$10 million for State dental health services we could begin to build a prevention and control program to meet the Nation's dental need.

The CHAIRMAN. You would earmark funds for the dental services just as they are now earmarked for the mental health services?

Dr. GALAGAN. That is correct.

The CHAIRMAN. You would make it 5 percent?

Dr. GALAGAN. That is the association's recommendation to the committee, yes, sir.

The CHAIRMAN. Is there anything you would like to add, Mr. Conway?

Mr. CONWAY. No, sir—just that I am glad to be here with Dr. Galagan. We have always been very proud of him as the head of the Dental Division of the Public Health Service, and now we are glad to have him as one of our instrumentalities in private dentistry.

The CHAIRMAN. How long have you been in Public Health Service?

Dr. GALAGAN. Twenty-nine years.

The CHAIRMAN. Anything you would like to add, Mr. Christensen?

Mr. CHRISTENSEN. No, except thanks once more, Senator.

The CHAIRMAN. Well, the American Dental Association through the years has been mighty helpful to this committee. We appreciate it very much. We certainly appreciate your statement and your presence here this morning, all of you. We want to thank you very much.

Now, the Association of State and Territorial Mental Health Officers—Dr. Davis of New Jersey.

Good Morning, Doctor.

STATEMENT OF DR. V. TERRELL DAVIS OF NEW JERSEY, ON BEHALF OF NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Dr. DAVIS. Mr. Chairman, I would like to correct the record—I am representing the National Association of State Mental Health Program Directors. We are comparable in our interest and aims in the mental health field—it is just a technicality that our official organization name is the National Association of State Mental Health Program Directors, and this arises because there is a different pattern occurring State to State in the mental health program, more so than in the health programs.

As Dr. Hogan pointed out, 36 of the States have a separate mental health—a mental health program director outside of the health department, and in some of those the mental health program director is a commissioner of mental health in charge of a department. In other States, such as mine, for instance, I am the director of a division of mental health and hospitals within a State department of institutions and agencies, which also includes welfare, correctional programs, but does not include the health department.

The CHAIRMAN. I see. Well, as you know, my State of Alabama just passed legislation to give us a separate agency representing mental health.

Dr. DAVIS. A number of States have taken similar action in recent years.

I do not have a prepared statement to give you at this time, although I do have prepared remarks and I will have a prepared statement of these remarks to return to the committee later this afternoon.

The CHAIRMAN. We will have that appear in full in the record, and you just proceed now in your own way, Doctor.

Dr. DAVIS. Thank you, Senator.

I am a past president of the National Association of State Mental Health Program Directors, and served as a member of the Surgeon General's task force appointed by former Surgeon General Luther Terry to review the Federal public health grants program, and to make recommendations.

It has been particularly gratifying to me, in reviewing this bill to see that it was possible to incorporate in this legislation practically all of the key issues and problems with which this task force was concerned, and to which it addressed itself.

I am testifying on behalf of the National Association of Mental Health Program Directors, but I would like to tell the committee what I said in 1963 when I appeared here as a representative of the association in behalf of the community mental health centers construction legislation. At that time I said that the association does not speak officially for any of the States—"Our purpose is to attempt to present the facts and to permit each of the States to decide how these can be adapted to local needs within the local setting."

In fact, we have a phrase from the Latin, *res ipsa loquitur*, meaning that the facts speak for themselves.

However, I am speaking on behalf of the members of the association and I am happy to be able to tell you that most of the members of the association have been able to review provisions as the task force was working on these various provisions, and there is a united feeling in support of the purposes of this bill.

I was most pleased when I read S. 3008 and realized the potential that it had for providing a basis for significant improvement in public health administration throughout the country.

I emphasize the improvement of administration, because without administration people just do not get services. There has to be leadership.

Without good administration, we will have neither the manpower nor the money to do the job, because it will be dissipated.

The Government, at present, has a special responsibility to see that the vastly increased expenditures of tax money and other funds for health services are utilized efficiently, and with a minimum of dilution by bureaucratic distractions.

In some aspects this bill may be considered a move for the Federal Government to get its own house in order.

It is time to change some of the principles which have guided the appropriation of Federal funds in this field.

We need a partnership of Federal Government with the States and local resources in providing both the leadership and the financing of the essential services.

Seed money which is granted for a period and then withdrawn may be appropriate for demonstration projects, but not for the development of local leadership of public health services.

The CHAIRMAN. That is a continuing problem, is it not?

Dr. DAVIS. That is a continuing problem.

Categorical grants have helped to focus both moneys and efforts on the several areas of health needs, but the bureaucratic devices needed with such programs have fragmented local services and contributed duplication, to destructive competition, and have tended to have a divisive effect on the local organization of services for the people.

S. 3008 would implement such needed change.

In addition, this bill gives recognition to the fact of the vast increase in the Federal moneys available for the purchase of local services and for the construction of health facilities.

Unless State and local health agencies are adequately organized and staffed to provide leadership, our entire effort could lead to chaos.

An essential part of the local leadership is ongoing planning which establishes clear objectives, assesses the existing resources, charts unmet or anticipated needs, provides the effective coordination of services, and develops popular support for new services which supplement and complement the existing services in a practical and efficient manner.

We have found that it is extremely difficult for anyone outside of the field to realize the amount of work which is involved in accomplishing just that.

Thus, when local governments are hard pressed to find sufficient tax moneys, it is natural that requests for additional staff for planning do not receive the essential top priority.

This bill addresses itself initially, I think, and principally to this very important need.

I believe that the efforts of this committee in connection with the Community Mental Health Center Construction Act of 1963, and also with the amendments of 1965, has contributed significantly to establishing a firm commitment among the professional as well as the public at large to the need for comprehensiveness in any health services. This has been long overdue, but it has been terribly encouraging to me, going around locally in the State, to have witnessed the change in the last 3 years—instead of people talking about their particular vested interests, there is a gratifying interest in how can we provide the comprehensive ranges. If we can improve this particular service without improving this one along with it, are we really doing a proper job?

The CHAIRMAN. In other words, we have got so much more teamwork now than we have had in the past, is that right?

Dr. DAVIS. That is right. I think that the concern and interest about the mentally ill and the Federal approach to this problem, and the public education that has been carried on in connection with the work of this committee, has been a significant factor.

It has been distressing to see so many separate plans develop within the State, each to meet Federal regulations for the allocation of Federal funds. We hope that the Congress will establish, through this legislation, a mechanism which will enable the States to develop a comprehensive plan for all of the health services which can be used

as a blueprint for the people in that State in operating their services as well as by the Federal Government to justify the continuing allocation of moneys to the individual State.

At present it is not possible to fully coordinate our State plans for the utilization of Federal community mental health funds with our State appropriations of local moneys because we do not have a commitment for Federal funds before we have to make decisions in connection with departmental budgets which we must present to the legislature.

What I am saying is that we set up our own State budgets, ask our legislature for State moneys, and then we develop our plan for the Federal moneys.

If the Federal funds for fiscal 1968, for instance, were appropriated by Congress early in fiscal 1967, our request for State appropriation could be effectively coordinated.

The State appropriations and Federal appropriations would then both be parts of a whole program within the State.

The CHAIRMAN. Doctor, in that connection—of course your State is one among 50, but how often does your legislature meet in New Jersey?

Dr. DAVIS. This is a pertinent point. Our State happens to have a legislative session and a budget on an annual basis.

The CHAIRMAN. Your legislature meets every year?

Dr. DAVIS. Right.

The CHAIRMAN. That is rather unusual. That is not true with most of the States, is it?

Dr. DAVIS. No, it is not true with most of the States.

The CHAIRMAN. All right.

Dr. DAVIS. So it makes it even a bigger gap in those States which meet only every 2 years, with no leadtime in the availability of the Federal money, so that they can anticipate this in planning, which presents an additional problem.

Now, we do note there is provision in this legislation to carry over Federal appropriations for planning into the subsequent fiscal year. We hope that Congress may see fit to enable the States, as I said before, to anticipate funds when their local moneys are budgeted.

We are also pleased to note the leadtime which is proposed to enable at least one year of planning on the basis of Federal support prior to the effective date of the project grants and the comprehensive health grants. This will also provide congressional authorization a year in advance of appropriations, and this will thus enable the Federal Government to budget appropriation requests more accurately.

There was, as you are aware, a certain amount of confusion at the local level in connection with the community mental construction legislation in that money was available before we had adequately been able to complete the planning, and there were pressures to move before the program was sound.

The CHAIRMAN. Before the planning had been completed; is that right?

Dr. DAVIS. Right. Now, the impact of 2 years of Federal support for planning for comprehensive mental health services, which ended on last July 1965, as I indicated, has been most gratifying. In many areas, however, there is real danger of losing the momentum gained just at a time when we are beginning to see real gains in terms of

program. Gains in terms of benefits through better coordination of existing service—this is a significant byproduct of our planning. There has been much improvement in the efficiency of existing facilities, even without the addition of new facilities as a result of the planning.

Again, gains in terms of convincing skeptics that this type of planning is essential and must be a sustained action. When we submitted our plans for planning, comprehensive community health service, and the word was reported back to our local press that Federal moneys had been granted for a planning operation based on this "plan for planning," we had some quips from the press. One I remember had something to do with about peeling an onion—"What are these bureaucrats going to think of next—not only do they want to plan, but before they plan, they want to plan to plan to plan."

I think they are older and wiser now, and with our experience behind us, there can be no doubt that you do have to have a plan for planning.

I was not able to be here yesterday when the Association of State and Territorial Health Officers testified—but I did see a copy of their statement. In their statement most of the important points that the task force addressed themselves to, which our association as well as that association has been concerned with, were highlighted and I will not repeat that, other than to say for your benefit that we are in full accord.

The CHAIRMAN. You concur pretty much with that testimony?

Dr. DAVIS. Right.

The CHAIRMAN. The position of the State and territorial health officers.

Dr. DAVIS. Right.

Now, the only place that there has been any particular concern and debate in connection with this is the mechanism for developing the comprehensive planning, and the first provision, stating that the State shall designate a single agency, is going to provide a challenge to State government to establish such a single agency. In our judgment, this is going to have to be a commission. I cannot see a czar, one individual, having this ultimate responsibility, because it is too comprehensive.

The CHAIRMAN. You have too many facets.

Dr. DAVIS. Too many facets. And it seems to us that it is going to have to be an interagency health planning commission, with administrative decisionmaking responsibility made up of those individuals with direct operating responsibilities for health and mental health programs. Rarely do we think members of such a commission would be unable to agree. But in such an instance, there is always the Governor who has the ultimate responsibility for the program in the State, and it would be his responsibility to make these decisions, and it seems to us that there is nobody else in the State government who is this accountable to the people, who could carry the responsibility for making a decision in the event that those individuals directly responsible for these health services were unable to agree.

These are the main points, Mr. Chairman, that I had hoped to get before the subcommittee.

The CHAIRMAN. These are all good points, Doctor. We appreciate your very helpful statement.

Anything you want to add for the record, do not hesitate to do so.

DR. DAVIS. I think I have covered the salient points.

THE CHAIRMAN. I think you have presented the case very well. If there is anything else that occurs to you, do not hesitate to add it. We certainly want to thank you very much for your statement. We appreciate it deeply.

Dr. DAVIS. Thank you, Senator.

(A letter subsequently received from Dr. Davis follows:)

NATIONAL ASSOCIATION OF STATE MENTAL
HEALTH PROGRAM DIRECTORS,
Washington, D.C., March 22, 1966.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
Senate Office Building, Washington, D.C.

DEAR SENATOR HILL: It was an honor to be able to appear before your committee last Thursday to testify on behalf of our association in general support of the objectives of S. 3008, which amends the Public Health Service Act, providing for grants to the States for comprehensive health planning.

You were gracious enough during my testimony to suggest that if we had further matter to add to our testimony your committee would be pleased to receive it.

With your suggestion in mind I have reviewed the proposed legislation with the board of directors of our association and it is their desire that I convey to you the following suggestion, which we think carries out the general intent of an exchange you and I had over the wide range of services to be covered in comprehensive planning and the impossibilities of any one individual having the professional competence to direct the entire program.

It is our recommendation that S. 3008 be amended as follows:

On page 3, line 9, after the word "agency" add a comma and add the following language "which may be an interagency commission."

With this addition to the bill it would be clear to the States that the agency for health planning may be an interagency Health Planning Commission made up of those individuals in State government carrying direct operating responsibility for the several health, mental health, and mental retardation programs, each with coordinate status.

Respectfully yours,

V. TERRELL DAVIS, M.D.,
Director, Division of Mental Health, New Jersey.

THE CHAIRMAN. Our next witness will be Dr. Helen Taussig, president of the American Heart Association and professor emeritus of pediatrics at the Johns Hopkins Hospital.

STATEMENT OF DR. HELEN TAUSSIG, PRESIDENT, AMERICAN HEART ASSOCIATION ACCOMPANIED BY DR. JAMES V. WARREN, PROFESSOR OF MEDICINE, OHIO STATE UNIVERSITY AND ROME A. BETTS, EXECUTIVE DIRECTOR, AMERICAN HEART ASSOCIATION.

Dr. TAUSSIG. Mr. Chairman, I am Dr. Helen Taussig, president of the American Heart Association and professor emeritus of pediatrics at the Johns Hopkins Hospital. I am here to testify in behalf of the American Heart Association, on S. 3008, the Comprehensive Health Planning and Public Health Service Amendments of 1966. This bill is designed to enable the States to bring together the various State and voluntary health projects so that they may work more effectively together and furthermore, the act urges the various States to develop their health programs in conjunction with the nongovernmental agencies to meet their local health needs. The American

Heart Association is firmly convinced that the fight against heart disease requires the cooperation of the Federal Government, the State health departments, and the local voluntary agencies. In order to attain maximal effectiveness it is essential to have strong cooperation between the health departments and the medical societies, the medical schools and the voluntary health agencies; such as is planned for the regional medical programs.

We believe that if the bill is well administered, it will increase the health and well-being of the community and it should also increase the effectiveness of the heart disease control program. We do, however, have a few specific suggestions. First, section 314(a)(1): Authorization gives the Surgeon General the power to make grants to States which have submitted plans. We recommend the establishment of a National Health Planning Council, similar to the National Advisory Council of the regional medical programs, and that said Council will review the programs and make recommendations to the Surgeon General, and that the Surgeon General must consult with, and may not act against the recommendation of said Council.

The CHAIRMAN. You mean such as we have in the National Institutes of Health—each institute, as you know, has an advisory council.

Dr. TAUSSIG. Yes.

The CHAIRMAN. It meets three or four times a year.

Dr. TAUSSIG. Yes.

To repeat, we recommend the establishment of such a National Advisory Council. The said Council will review the programs and make recommendations to the Surgeon General, and the Surgeon General must consult with, and may not act against the recommendations of said Council.

The Council should be composed of representatives of the various State and voluntary agencies concerned in the State planning, that is, the medical societies, the medical schools, the dental schools, and the principle voluntary agencies, such as the American Heart Association, the American Cancer Association, the National Society of Crippled Children and Adults, and Planned Parenthood.

Next, in regard to section 314, section 2, the State plans a comprehensive State health planning, paragraph A reads "designated to provide for the establishment of a single State agency, as the sole agency for the administrating, supervising of the State health planning function under the plan." The bill should clearly state that the single State agency should in most instances be the State agency concerned with the public health of the community and if such is not the case, that such State agency should have strong representation on the planning council, as the program is concerned with State and community health.

Section B calls for the establishment of a Health Planning Council. We believe that it would be wise to state definitely that the Planning Council includes representatives in the State and local agencies, such as the department of the state health commission primarily concerned with the health of the people, the heart disease control program, and the nongovernmental organizations which should have representation from the regional medical advisory council or councils, and the leading medical schools and dental schools, the medical societies, and the various health agencies such as the Heart and Cancer Association, Planned Parenthood, agencies concerned with vocational

training and rehabilitation, and others deeply concerned with the health of the community. Furthermore, we believe that the hospitals that are concerned with the health of the community should have some representation on the Health Planning Council. Finally, in section B, it should be stated that the single State agency, although it need not always accept the recommendations of the Health Planning Council, cannot undertake the programs which are not approved by the Health Planning Council. Were such a provision not inserted, the Health Planning Council might be nothing but a "token" board, with no responsibility, as the health agency would not have to accept any of its recommendations and could act entirely independently from the board. Finally, in this connection on page 5, section H, which concerns the annual review of the program by the State agency, the review should be done in conjunction with the State planning advisory board. This also applies to page 11, line 3.

Our next suggestion is that in order to be certain that these funds are used to supplement and not replace other funds, we recommend that on page 4, paragraph E, the wording be amended so that the funds could not replace either State or private funds. This might be done merely by adding to line 13 "available either from State or private sources."

Our next recommendation concerns the project grants at the bottom of page 13. These project grants for areawide health service developments should be so planned that they are not at cross purposes with the regional medical program or programs, or with the medical practices and services already existing with the States.

The American Heart Association has repeatedly testified concerning the shortage of manpower and the importance of training; therefore, we are in accord with the project grants for training, studies, and demonstration, but we urge that such grants should not only be available to public or private agencies, but also to persons in nonprofit private organizations and/or agencies. (This recommendation applies to page 8 (c), and (d), and also page 26, section 5, line 8.)

The American Heart Association is even more deeply concerned about authorization of grants. In section 9, page 25, lines 18-20, enable the Surgeon General to "make grants under such terms and conditions as may be prescribed by the regulations for provision to public and nonprivate schools of public health, accredited by a body or bodies, recognized by the Surgeon General." We feel very strongly that this should be broadened to not only include schools of public health, but departments of public health within the medical schools, even in schools in which there are no specific departments of public health within the medical schools, the departments within the medical schools which are concerned with the health problems of the community should be permitted to apply and receive grants. Furthermore, in such States that do not have either schools or public health or medical schools, that the community hospitals concerned with the public health of the community should be able to receive grants to improve the health of their community. We believe this change is essential because of the extremely limited number of schools of public health in this country. I believe there are only 12 such schools in the entire United States of America. Those States which do not have schools of public health should be permitted to receive help through their medical schools, and where there are no medical schools, the

States need help through the leading community hospitals. This recommendation also applies to page 26, line 2.

Gentlemen, this concludes our prepared testimony. If there are further questions which I can answer, I shall be glad to do so. Thank you for permitting us to testify.

The CHAIRMAN. Well, Doctor, as you know, we are all very proud of you. You and Dr. Blalock have been great pioneers in the field of cardiac and heart surgery. You were pioneers of the blue baby operation as we know it today.

I notice you are professor emeritus at Johns Hopkins. Are you doing any teaching now?

Dr. TAUSSIG. I am doing some teaching. This year I am working mostly with the American Heart Association. That takes most of my time.

The CHAIRMAN. In other words, you are carrying the message to the people throughout the country, rather than concentrating on just a few classes at Johns Hopkins; is that right?

Dr. TAUSSIG. Yes, sir.

The CHAIRMAN. Well, I think your suggestion is a good one. We must consider the fact that we have only 12 schools of public health and recognize that a lot of education and training in public health is going on within our medical schools—our general medical schools, so to speak; is that correct?

Dr. TAUSSIG. Yes.

The CHAIRMAN. And we should seek to encourage and help that training as well as the training in public health schools; is that right?

Dr. TAUSSIG. Yes.

The CHAIRMAN. Well, I want you to know we are very much honored to have you here today. You are a lady and an American of whom I have been very proud for many years. We are grateful for the tremendous, wonderful work that you have done. We certainly appreciate very much your presence here and the statement which you brought to us. We are honored to have you.

Is there anything you gentlemen would like to add?

Dr. WARREN. I might just comment about two things briefly.

Since I come from a medical school which does not have a school of public health, Ohio State University, our medical schools of our type are very active in the public health field, and I think it would be highly restrictive to exclude such schools from the benefits of this bill. So I strongly concur with what is said about that.

The CHAIRMAN. Do you have a public health school in the State of Ohio?

Dr. WARREN. No.

The CHAIRMAN. Pittsburgh would be about the nearest school to you.

Dr. WARREN. It depends on the original pattern. The University of Cincinnati has very strong interests. I am not sure—I do not believe that it is organized as a separate school. It is a matter of the university organizational pattern. It is a department and a very strong and large one—not technically a separate school.

The Heart Association has been interested for some period of time in the program of the heart disease control branch of the Public Health Service. We felt that there have been some reasons why

this might be more logically transferred to the National Institute of Health. That is an intra Public Health Service decision.

We do feel that this unit is doing an excellent job and would not want to see activities of this bill disrupt that, but rather supplement the activities. They are undertaking a very fine program and we would like to note that.

Finally, with the increased activity almost day by day in the development of regional medical programs under the bill passed last year, those activities should certainly be coordinated with the activities of this bill, and there has been some expression of apprehension that the Council, the group set up in the regions under this bill, and under that bill, might possibly be in conflict. I think steps should be taken so that they would work in cooperation.

The CHAIRMAN. Work together?

Dr. WARREN. Yes. That is all I have to say.

The CHAIRMAN. Anything you would like to add, sir?

Mr. BETTS. Just one item, Senator. In one of my other capacities, voluntary, this year, I am serving as chairman of a committee on continuing education of the National Health Council. Along with you, we are very much concerned with this matter of manpower and training of existing personnel. So that we would strongly endorse the proposal in this bill for providing for training—but underscore what Dr. Taussig has already said—we should very much like to see this broadened to make it possible for employees or personnel, rather, of voluntary organizations and private organizations to receive the benefits of the training programs as they come into being through this kind of planning.

This, I think, is referred to in one or two points in the specific suggestions we have made and in an accompanying memorandum, of which Mr. Barclay has a copy.

The CHAIRMAN. We will have that memorandum appear in full in the record at this point.

(The memorandum referred to follows:)

MEMORANDUM TO ACCOMPANY SUGGESTED ALTERATIONS TO S. 3008, SUBMITTED BY MR. BETTS, AMERICAN HEART ASSOCIATION

The American Heart Association believes that any measure intended to improve health services and to administer more economically the funds that are made available by the Federal Government, is worthwhile legislation.

The objective of far greater cooperation among all organizations and agencies concerned with the health of the people is most desirable. We assume that this may well be one of the principal results of the work that has been done by the National Commission on Community Health Services. Certainly, it is to be hoped that the bill now before the Senate will help to achieve this all-important purpose.

We should at this point, however, like to mention that a year ago the Congress had before it another major piece of health legislation in the form of the regional medical programs bill, which was later enacted into law. We should like to stress the necessity for having the kind of joint or cooperative planning called for in the present bill coordinated at all points with the regional medical programs, in order to make certain to prevent overlapping of function or conflict of interest.

Additionally, and a point which we should like to emphasize strongly, it would be our hope that as a result of this legislation the administrators of the Heart Disease Control Branch will finally gain the authority, which they have not had in the past, to plan and develop project grants. We do not presume to indicate where in the present bill such provision be made, but we do regard it as very important that this authority be conferred.

There are other specific alterations and improvements that we believe should be considered for this legislation in order that it will most effectively achieve its purpose. We take this opportunity to suggest these changes as follows:

1. *Page 2, line 14.*—Strengthening of leadership and capacities should apply to voluntary health organizations as well as to State health agencies.

2. *Page 3, line 2.*—We believe that the Surgeon General should act with the advice and approval of a suitable advisory council. In this respect we recommend the establishment of a National Health Planning Advisory Council similar to that provided for in Public Law 89-239, the Regional Health Planning Act.

3. *Page 3, line 17.*—It appears reasonable that the composition of State health planning councils be more specifically outlined than in the present bill. We would favor an arrangement providing that no less than one-half of the membership of such councils be drawn from nongovernmental sources and that representatives from each regional medical program operating within the State be included. We further believe that the State health planning councils should have the authority to approve as well as to advise upon plans of the State health agency.

4. *Page 3, line 22.*—There should be comprehensive planning for facilities and personnel, as well as for health services, both public and private. The language of the bill should make this entirely clear, because it is our understanding that is not the purpose of the bill to provide for extensive construction projects.

5. *Page 4, line 11.*—The intent of this bill, as we understand it, is not to supplant but to supplement with Federal appropriations funds made available by State government and private sources.

6. *Page 5, line 5.*—We believe that the function of the State health planning council to advise and approve should be extended to all reviews and changes of plan made by the State health agency. This applies to page 5, line 5; page 7, line 18; page 8, line 8; and page 11, line 3.

7. *Page 7, line 22.*—It is to be hoped that nothing in this bill will operate at cross-purposes with medical practices and services existing within the States. Just as was accomplished in the case of the regional health programs law, 89-239, so here it is of utmost importance that all major forces contributing to the people's health have a strong voice in determining the nature and form of the health services to be delivered to the people.

8. *Page 8, line 22 and page 26, line 8.*—In establishing and maintaining adequate public health services, training should be authorized for personnel from nonprofit private agencies, as well as from State and local government. This also would apply to the language on page 26, line 8.

9. *Page 9, line 5.*—It is presumed that "State health authority" as used in this line is synonymous with "State health agency" as previously used in this bill.

10. *Page 25, line 20 and page 26, line 2.*—There being so few independent schools of public health in the country, we suggest that grants also be made available to departments of public health within medical schools.

The CHAIRMAN. Dr. Taussig, I believe you were a member of the DeBaKey Committee on Heart Disease, Cancer, and Stroke.

Dr. TAUSSIG. Yes, sir.

The CHAIRMAN. That was a historic report. On Tuesday evening I had the honor of being at a dinner we had at the Statler Hotel when the James F. Mitchell Foundation honored Dr. DeBaKey for his great work. You must have put in many hours on that report, did you not?

Dr. TAUSSIG. Yes, sir.

The CHAIRMAN. Well, again I want to say how honored we feel in having you here today. We thank you gentlemen, too. We want to thank you and express our deep appreciation to you.

Now, our next witness is Mr. William T. MacCracken, Jr., Washington counsel, American Optometric Association.

Mr. MacCracken, we are very happy to have you back with us again, sir. We would be glad to have you proceed now in your own way.

STATEMENT OF WILLIAM P. MACCRACKEN, JR., WASHINGTON
COUNSEL, AMERICAN OPTOMETRIC ASSOCIATION

Mr. MACCRACKEN. Thank you, Mr. Chairman, for this opportunity. My statement is very brief.

My name is William P. MacCracken, Jr. My office address is 1000 Connecticut Avenue, 20036, Washington, D.C., where I am engaged in the general practice of law. I am a member of the bar of the Supreme Court of the United States and of the courts of the District of Columbia. I was originally admitted to practice law before the Supreme Court of Illinois in 1911. It has been my privilege for more than 20 years to represent the American Optometric Association in the National Capital. The association is composed of optometrists duly licensed to practice their profession in 1 or more of the 50 States and the District of Columbia. There are approximately 17,000 licensed optometrists practicing in the United States, and two-thirds or more are members of the association.

The purpose of the bill is to assist in the extension and the improvement of comprehensive health planning and public health services, as well as to provide for a more effective use of available Federal funds. It will authorize the Surgeon General of the United States to make grants to States which have submitted State plans for comprehensive State health planning approved by the Surgeon General. Section 314(a)(2)(B) requires a State plan to be approved to provide for the establishment of a State health planning council "which shall include representatives of State and local agencies and nongovernmental organizations and groups concerned with health and of consumers of health services to advise such State agencies."

There is no question but that the language of the bill would permit the appointment of duly licensed health personnel to a State planning council, but in order to make certain that Congress intended that representatives of the various health professions be included on these State councils, we recommend that on page 3, line 15, after the word "health" there be inserted "duly licensed personnel in sciences related to health." The term "sciences related to health" has been used in several recent congressional enactments, one passed by the first session of this Congress known as the Medical Library Assistance Act of 1965, Public Law 89-291. The House committee report in referring to the term "sciences related to health" said:

This means that the disciplines which may receive construction assistance under the health research facilities program are the same disciplines as will be included under the reported bill, such as medicine, dentistry, optometry, pharmacy, osteopathy, and other related sciences.

Mr. Chairman, you will recall that when Dr. Henry Hofstetter testified before this committee in support of the amendment to include optometrists in the forgiveness provisions of the student loan fund legislation, the committee acted favorably upon his request and this amendment is now in the law.

On behalf of the optometric profession, I want to express our appreciation for the recognition the committee has accorded them in the past as well as to express my own appreciation of the courtesies extended to me. If there are any questions which you or other members of the committee would like to ask, I will be pleased to endeavor to answer them.

The CHAIRMAN. Well, we want to thank you for your appearance. You may be assured, sir, we will certainly consider carefully the suggested amendment which you have given us.

Mr. MACCRACKEN. Thank you, sir.

The CHAIRMAN. We are always glad to have you here and happy to have you here this morning.

Mr. MACCRACKEN. It is always a pleasure to be here.

The CHAIRMAN. We thank you very much.

At this point we will insert in the record various communications we expect to receive after the close of the hearing.

(The material referred to follows:)

MONTGOMERY, ALA., April 1, 1966.

Senator LISTER HILL,
Senate Office Building,
Washington, D.C.:

We understand that S. 3008 is now before your committee. Nurses of Alabama will appreciate your support of this bill. We have discussed provisions of the bill with representatives of our State health department who also believe that passage will greatly assist in planning health services for Alabama.

Mrs. WALTER BRAGG SMITH,
Executive Director, Alabama State Nurses' Association.

STATE OF ALASKA,
OFFICE OF THE GOVERNOR,
Juneau, April 1, 1966.

Hon. LISTER HILL,
Chairman, Senate Committee on Labor and Public Welfare, New Senate Office
Building, Washington, D.C.

DEAR SENATOR HILL: I understand that S. 3008 is now under consideration, and I would like to tell you that the State of Alaska would urge its passage. I believe this bill will promote and assist in the extension and improvement of public health services, particularly in those States with unique problems.

Of primary importance in the bill is the provision of developing firm and practical health plans—plans which consider the needs, resources, and concurrent plans of the separate States and their components—as well as for furnishing comprehensible health services in accordance with these plans. All too often in the past health services could not be brought to bear on a problem of local significance where ample funds were available for a problem receiving national emphasis.

It is our assumption that this bill will not decrease the Federal allotment to Alaska. I would like to point out to you that present formula for allotments on the basis of population and per capita income results in Alaska's receiving proportionately less health service than those States having lower per capita income and more buying power per dollar. Alaska is in the peculiar position of having a quite high per capita income, yet it has some of the most abject poverty under the American flag, aggravated by a rather high cost of living. It is hoped that consideration might be given to developing a formula for allotments which does not discriminate against States such as Alaska. I much appreciate your interest, and I sincerely hope that S. 3008 will be favorably considered.

Kindest regards.

Sincerely,

WILLIAM A. EGAN, Governor.

DEPARTMENT OF HEALTH AND WELFARE,
OFFICE OF THE COMMISSIONER,
Juneau, Alaska, March 25, 1966.

Hon. E. L. BARTLETT,
U.S. Senate, Washington, D.C.

DEAR SENATOR BARTLETT: Currently under consideration in the Senate is S. 3008, a bill to amend the Public Health Service Act. I believe that this bill will, as its full title implies, promote and assist in the extension and improvement

of public health services, and I therefore urge that you make all appropriate attempts to secure its passage.

Of primary importance in the bill is the provision for developing firm and practical health plans—plans which consider the needs, resources, and concurrent plans of the separate States and their components, as well as for furnishing comprehensive health services in accordance with these plans. All too often in the past, health services were not possible to combat a problem of local significance, while ample funds were available for a problem receiving national emphasis.

It is our assumption that this bill will not decrease the Federal allotment to Alaska. The bill provides for continuation of allotments to the States on the basis of population and per capita income. While this may be the best and simplest formula to use on a national basis, it results in Alaska's receiving proportionately less health service than those States having lower per capita income and more buying power per dollar. It is hoped that studies will continue with the view to developing a formula for allotments which does not discriminate against States such as Alaska.

I much appreciate your interest and shall welcome your assistance in securing passage of S. 3008.

Very sincerely yours,

LEVI M. BROWNING, M.D.,
Commissioner.

DEPARTMENT OF HEALTH AND WELFARE,
OFFICE OF THE COMMISSIONER,
Juneau, Alaska, March 25, 1966.

HON. ERNEST GRUENING,
*U.S. Senate,
Washington, D.C.*

DEAR SENATOR GRUENING: Currently under consideration in the Senate is S. 3008, a bill to amend the Public Health Service Act. I believe that this bill will, as its full title implies, promote and assist in the extension and improvement of public health services, and I therefore urge that you make all appropriate attempts to secure its passage.

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Very sincerely yours,

LEVI M. BROWNING, M.D.,
Commissioner.

ARKANSAS STATE BOARD OF HEALTH,
Little Rock, March 25, 1966.

HON. J. W. FULBRIGHT,
U.S. Senator, Washington, D.C.

DEAR SENATOR FULBRIGHT: You are aware of the fact that hearings are now being conducted on S. 3008 which was introduced by Senator Hill. The principles of this bill deal with the public health briefly to the extent of: (a) establishing planning grants, (b) support grants with categories, (c) provide project grants for special health problems, and (d) to authorize an interchange of health personnel between Federal, State and local agencies.

The association of State and territorial health officers, of which I am a member, strongly recommends the favorable consideration of S. 3008. I personally and officially have strong feelings regarding the following points in the bill:

1. The statutory language should require that the State health officer in each State be a member of the planning agency in his State. (As a matter of fact, it would probably be well to require that the State health agency be the planning agency.)

2. Basic health services are feasible and should be made available in all jurisdictions because health and disease are no respecters of political boundaries.

3. The authorization for an interchange of personnel through all governmental levels and agencies will be of considerable value to all concerned, since this provision would upgrade professional qualifications, experiences and services.

4. All types and levels of health programs and services should be required to perform according to previously prepared and approved plans.

We would reject the philosophy of devoting our time, resources and professional services toward correcting detrimental situations and conditions that were not prevented. We should direct our efforts, plans and resources toward prevention, earlier diagnosis, and the application of modern treatment. The contents and provisions of S. 3008 will enable us to go far in this direction. Your support and favorable consideration is needed.

Sincerely yours,

J. T. HERRON, M.D.,
State Health Officer.

ARKANSAS STATE BOARD OF HEALTH,
Little Rock, March 25, 1966.

Hon. JOHN L. McCLELLAN,
U.S. Senator, Washington, D.C.

DEAR SENATOR McCLELLAN: You are aware of the fact that hearings are now being conducted on S. 3008 which was introduced by Senator Hill. The principles of this bill deal with the public health briefly to the extent of: (a) establishing planning grants, (b) support grants with categories, (c) provide project grants for special health problems, and (d) to authorize an interchange of health personnel between Federal, State, and local agencies.

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1. The statutory language should require that the State health officer in each State be a member of the planning agency in his State. (As a matter of fact, it would probably be well to require that the State health agency be the planning agency.)

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We would reject the philosophy of devoting our time, resources, and professional services towards correcting detrimental situations and conditions that were not prevented. We should direct our efforts, plans, and resources towards prevention, earlier diagnosis, and the application of modern treatment. The contents and provisions of S. 3008 will enable us to go far in this direction. Your support and favorable consideration is needed.

Sincerely yours,

J. T. HERRON, M.D.,
State Health Officer.

PHOENIX, ARIZ., *March, 24, 1966.*

Hon. LISTER HILL,
U.S. Senator, Washington, D.C.:

The provisions of S. 3008 will enable the Arizona State Department of Health and the county health departments in cooperation with public, private, professional and institutional health interests to develop and put in effect a State health plan for more effective and efficient use of manpower, facilities, and financial resources for comprehensive community health services. The department

believes the suggested changes of the association of State and territorial health officers will strengthen the bill. We strongly favor passage of this legislation.

WILLIAM J. MOORE M.D.,
Commissioner.

BERKELEY, CALIF., *March 25, 1966.*

Senator THOMAS H. KUCHEL,
*Senate Office Building,
Washington, D.C.:*

Most urgent for development of Health Services in California and throughout the Nation with most efficient use of resources if passage of S. 3008 for comprehensive health planning.

LESTER BRESLOW, M.D.,
California Department of Public Health.

BERKELEY, CALIF., *March 25, 1966.*

Senator GEORGE MURPHY,
Senate Office Building, Washington, D.C.:

Most urgent for development of health services in California and throughout the Nation with most efficient use of resources if passage of S. 3008 for comprehensive health planning.

LESTER BRESLOW, M.D.,
Director, California Department of Public Health.

DENVER, COLO., *March 25, 1966.*

Senator LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare, Senate Office Building,
Washington, D.C.:*

In concurrence with the members of the Association of State and Territorial Health Officers I urge your strong support of S. 3008.

L. CLEERE, M.D.,
Director, Colorado State Department of Public Health.

FLORIDA STATE BOARD OF HEALTH,
Jacksonville, March 28, 1966.

Senator LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
New Senate Office Building, Washington, D.C.*

DEAR SENATOR HILL: I received a copy of S. 3008 a few days ago and I have carefully reviewed it, and its companion bill, H.R. 13197. Along with other State health officers, I am excited about its possibilities and believe that with the adoption of one slight change in wording it will be the most significant health bill considered by Congress in a long time.

I heartily endorse the statement of the bill of the need for comprehensive planning for health, and the need for strengthening the leadership and capacities of State health agencies. I do not think that any State health department deserves the name unless it includes planning along with its operating program. The bill, however, in its present form provides for the designation, or establishment, of a single State agency for administering or supervising the administration of the State's health planning functions. Undoubtedly in most States the State health department would be designated as the health planning agency. But almost inevitably in some States other agencies would be designated or established. This may or may not be done on the basis of the competence of the State health department.

In the States where agencies other than the health department take over the health planning functions, the health departments will be weakened rather than strengthened, as the bill intends. And an impetus will have been given to further fragmentation and dispersal of responsibility in the health field.

I hope, therefore, that the bill can be changed to recognize that health planning agencies already exist in every State in the form of State health departments.

There is a need to be sure for their planning capacities and staffs to be greatly strengthened. I do not believe that it is sufficient for the State health officer to be a member of the planning agency as has been proposed.

I, therefore, suggest that lines 8 through 11, page 3, read as follows:

"(a) Designate the official State public health authority as the sole agency for administering or supervising the administration of the State's health planning function under the plan;"

I strongly endorse the provision for the establishment of a State health planning council to advise the State health department in carrying out its functions under the plan. Also, I am particularly enthusiastic about the provision for the interchange of personnel between the various levels of government. I have had the privilege of serving at State and local levels on loan from the Public Health Service; and also later serving in the Public Health Service on a leave-of-absence basis from my present position in Florida. I can therefore testify personally as to the benefits of such a program.

Although you may be somewhat familiar with my background I offer for the record the following information.

I have been in the field of public health for about 30 years, and as stated above have served at Federal, State, and local levels of government. I have been the State health officer of Florida since 1945. I have served as president of the Association of State and Territorial Health Officers, as president of the American Association of Public Health Physicians, and for 6 years as a member of the executive board of the American Public Health Association. I was a member of the committee of the State and Territorial Health Officers which with representatives of the State mental health authorities and the Public Health Service studied the problems of grants to States. I am happy to see that so many of the recommendations of this joint task force are incorporated in your bill. I also served last year as a member of the Task Force on Financing of the National Commission on Community Health Services.

However, the views I am expressing are my own, and those of my State board of health, and I am presenting them to you by the direction of that body.

I hope very much Senator Hill that you will carefully consider the single change in S. 3008 that I propose. If this can be done and the bill passed, I believe that a major step forward will have been taken in the field of health.

Sincerely,

WILSON T. SOWDER, M.D.,
State Health Officer.

STATE OF GEORGIA,
DEPARTMENT OF PUBLIC HEALTH,
Atlanta, Ga., March 23, 1966.

HON. HERMAN E. TALMADGE,
U.S. Senate, Washington, D.C.

DEAR SENATOR: I would like to call your attention to S. 3008, Comprehensive Health Planning and Public Health Service Grants, 1966, introduced by Senator Hill.

As you know, new health knowledge has come from the fields and the laboratories so rapidly that there have been many isolated efforts to bring specific benefits to the people of this country. Such fragmentation has also been nurtured by mobility of our population, its almost explosive increase, urbanization, and many other factors.

In Georgia, we have given intensive efforts to the planning process in order to reduce the fragmentation of health services, provide a comprehensive mechanism of delivery, and to shorten the time between discovery and application to the needs of our people. This has been difficult for many reasons including the lack of adequate support for this purpose, and the specific categorical nature of Federal grants without sufficient flexibility in their use. I have personally worked, over the past 3 years, with other State health officers, the Surgeon General, and the Public Health Service in an effort to achieve a rational solution to these problems.

Much of what we have done in this regard has been excellently interpreted by Senator Hill and by important contributions of his own in S. 3008.

While there may be a few relatively unimportant details that we would like to see changed, I believe that the concepts in this bill will make major improvements in our ability to provide comprehensive care and through the provisions for statewide coordinated planning for necessary flexibility in the grant mechanism.

I would appreciate it very much if you can give this legislation your serious attention and find that you are able to support it in the Senate.

With best personal regards, I am

Sincerely yours,

JOHN H. VENABLE, M.D., *Director.*

STATE OF GEORGIA,
DEPARTMENT OF PUBLIC HEALTH,
Atlanta, Ga., March 23, 1966.

HON. RICHARD B. RUSSELL,
U.S. Senate,
Washington, D.C.

DEAR SENATOR: I would like to call your attention to S. 3008, Comprehensive Health Planning and Public Health Service Grants, 1966, introduced by Senator Hill.

As you know, new health knowledge has come from the fields and the laboratories so rapidly that there have been many isolated efforts to bring specific benefits to the people of this country. Such fragmentation has also been nurtured by mobility of our population, its almost explosive increase, urbanization, and many other factors.

In Georgia, we have given intensive efforts to the planning process in order to reduce the fragmentation of health services, provide a comprehensive mechanism of delivery, and to shorten the time between discovery and application to the needs of our people. This has been difficult for many reasons including the lack of adequate support for this purpose, and the specific categorical nature of Federal grants without sufficient flexibility in their use. I have personally worked, over the past 3 years, with other State health officers, the Surgeon General, and the Public Health Service in an effort to achieve a rational solution to these problems.

Much of what we have done in this regard has been excellently interpreted by Senator Hill and by important contributions of his own in S. 3008.

While there may be a few relatively unimportant details that we would like to see changed, I believe that the concepts in this bill will make major improvements in our ability to provide comprehensive care and through the provisions for state-wide coordinated planning for necessary flexibility in the grant mechanism.

I would appreciate it very much if you can give this legislation your serious attention and find that you are able to support it in the Senate.

With best personal regards, I am

Sincerely yours,

JOHN H. VENABLE, M.D., *Director.*

OFFICE OF THE GOVERNOR,
Springfield, Ill., March 17, 1966.

HON. LISTER HILL,
U.S. Senate, Senate Office Building,
Washington, D.C.

DEAR SENATOR HILL: I should like to take this opportunity to express my deep interest in S. 3008. This bill, in my opinion, takes a long step forward in establishing a program for improving health planning at all levels of government and in strengthening the leadership and capacities of State health agencies.

Formula grants for categorical programs dealing with specific diseases have been and are most useful and helpful in our efforts to prevent and control these diseases. The formulas for their use, however, seems to be unnecessarily rigid and limiting. The very real need exists to provide the kinds of financial support that will lead to comprehensive public health services and that will be sufficiently flexible to meet the special health problems of the individual States and the local communities within the States.

It appears that S. 3008 will accomplish these things and will improve substantially the kinds, extent, and effectiveness of health services which can be provided for the people of Illinois. For this reason, I congratulate you for your insight into our problems and want you to be aware of my support for this fine legislation which you have introduced.

Sincerely,

OTTO KERNER, *Governor.*

STATE OF ILLINOIS,
DEPARTMENT OF PUBLIC HEALTH,
Springfield, March 16, 1966.

Re S. 3008 and H.R. 13197.

Hon. EVERETT MCKINLEY DIRKSEN,
U.S. Senate, Washington, D.C.

DEAR SENATOR DIRKSEN: I am writing to you concerning the above legislation which represents a milestone in public health progress. The President's health message provides the basis for this legislation which will make it possible for States to perform comprehensive State health planning. It will also strengthen the leadership and capacity of State health departments. Additionally, it will increase the flexibility and usefulness of Federal health grants, thus enabling State and local health departments to increase the effectiveness of health programs, including environmental health.

It is my hope that you will not judge the importance of this legislation by the brevity of my letter, but rather the substance of the proposed legislation which is important to public health progress in all of the States. There has always been an admirable working relationship between the Federal, State, and local governments in health programs. Passage of this legislation will enhance this relationship. It is my sincere hope that after consideration you will be able to give this legislation full support.

If there is any further information that I can provide, please do not hesitate to call upon me.

Yours sincerely,

FRANKLIN D. YODER, M.D.,
Director of Public Health.

STATE OF ILLINOIS,
DEPARTMENT OF PUBLIC HEALTH,
Springfield, March 16, 1965.

Re S. 3008 and H.R. 13197.

Hon. PAUL H. DOUGLAS,
U.S. Senate, Washington, D.C.

DEAR SENATOR DOUGLAS: I am writing to you concerning the above legislation which represents a milestone in public health progress. The President's health message provides the basis for this legislation which will make it possible for States to perform comprehensive State health planning. It will also strengthen the leadership and capacity of State health departments. Additionally, it will increase the flexibility and usefulness of Federal health grants, thus enabling State and local health departments to increase the effectiveness of health programs, including environmental health.

It is my hope that you will not judge the importance of this legislation by the brevity of my letter, but rather the substance of the proposed legislation which is important to public health progress in all of the States. There has always been an admirable working relationship between the Federal, State, and local governments in health programs. Passage of this legislation will enhance this relationship. It is my sincere hope that after consideration you will be able to give this legislation full support.

If there is any further information that I can provide please do not hesitate to call upon me.

Yours sincerely,

FRANKLIN D. YODER, M.D.,
Director of Public Health.

STATE OF IOWA,
DEPARTMENT OF PUBLIC HEALTH,
March 28, 1966.

Hon. JACK R. MILLER,
*2327 New Senate Office Building,
Washington, D.C.*

DEAR SENATOR MILLER: As commissioner of public health for the State of Iowa, I wish to record my definite endorsement of S. 3008, the bill to amend the Public Health Service Act to promote and assist in the extension and improvement of comprehensive health planning and public health services, to provide for a more effective use of available Federal funds for such planning and services, and

for other purposes. It is believed that this legislation will provide improved coordination among Federal, State, and local authorities and their responsibilities for the provision of necessary health services.

The concept of a more comprehensive approach to public health, looking-toward reduction of fragmentation of activities and responsibilities, is of paramount significance. In a State such as Iowa, which has very inadequate local health services, the proposed legislation should provide some of the mechanisms and capabilities for the planning, development, and operation of such services. The total effect then would be one of updating, improving, and conducting the public health services required for the entire State.

Please accept my sincere recommendation that this legislation be vigorously supported.

Respectfully yours,

ARTHUR P. LONG, M.D., Dr.P.H.,
Commissioner of Public Health.

TOPEKA, KANS., March 25, 1966.

Senator LISTER HILL,
Chairman, Senate Committee on Labor and Public Welfare, New Senate Office Building, Washington, D.C.:

Wish to assure you that in Kansas there is cooperative support for comprehensive statewide planning for health services, both public and private, including facilities, care and treatment, and the personnel required for the provision of health services as now incorporated in S. 3008.

ROBERT H. RIEDEL, M.D.,
State Health Officer.

KANSAS STATE NURSES' ASSOCIATION,
Topeka, Kans., April 1, 1966.

Hon. LISTER HILL,
Chairman, Labor and Public Welfare Committee, U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: Today I am writing to you concerning S. 3008, the bill to amend the Public Health Service Act to promote and assist in the extension and improvement of comprehensive health planning and public health services, and additional benefits.

As the professional staff member of the Kansas State Nurses' Association, I wish to support the position that the American Nurses' Association has taken in regard to this bill.

How to provide adequate health services for our citizens is also a concern here in Kansas. By comprehensive health planning and through public health services these needs undoubtedly can be met. A particular concern of the professional organization is a need for additional nurses prepared in the field of public health nursing.

The publication, "A Study of Nursing Needs and Goals in Kansas Through 1975," by the Kansas Health Facilities Information Service, Inc., August 1965, provides information that there were 371 nurses in public health and schools in 1964; yet the estimated need was 488. The study also estimated the need for a total of 540 public health nurses to meet the needs in Kansas in 1975. This study was done prior to the passage of the Health Insurance Benefits Amendments to the Social Security Act with the provision for paid home health services as a benefit. Certainly on the eve of medicare more nurses are needed to serve in the home care program.

It would seem to me that the provisions in S. 3008 are essential to meet health needs in Kansas. Therefore, I want to share my thoughts about it as you consider this bill.

Respectfully yours,

FLORENCE J. NELSON, R.N.,
Executive Director.

OFFICE OF THE GOVERNOR,
Frankfort, Ky., March 17, 1966.

HON. LISTER HILL,
Chairman, Health Subcommittee, Senate Committee on Labor and Public Health,
New Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: I understand that hearings are being held on S. 3008. I am happy to support this bill, which will provide for assistance to States to help them plan in a more comprehensive manner for the delivery of health services, the provision of required facilities and the most efficient utilization of health manpower. As a State executive, I have become painfully aware of the difficulties encountered in assuring all of the people in the Commonwealth of Kentucky the health benefits which should rightfully be theirs.

This problem is accounted for in no small measure by the completely well-intentioned assistance of the Federal Government, which is most certainly needed and appreciated, but which provides for severe administrative difficulties within the State because of the variety of categorical approaches and differing requirements which are presently used to provide these services.

Let me illustrate by citing below the health programs within Kentucky which are assisted by Federal grants and which provide partial support:

Public Health Service formula grants; general health, chronically ill and aged, radiological health, Federal tuberculosis, Federal cancer control, heart disease, dental health, hospital administration (Hill-Burton), water pollution control, home health services, and community mental health services.

Public Health Service special grants; venereal disease casefinding, Armed Forces medical rejectees project, air pollution control program, Kentucky public health hearing conservation program, migrant worker health project, tuberculosis project, vaccination assistance project, medical self-help training projects, nurses training short-term project, and health insurance benefits.

Two grants from the Office of Economic Opportunity and Appalachia for the eastern Kentucky health resources project.

Three grants from the Children's Bureau for maternal and child health projects, and one grant for crippled children.

Funds for medical care under title XVIII and title XIX of the Social Security Act.

I think it is extremely important that the comprehensive planning feature of S. 3008 be enacted. We have already taken steps along this line here in Kentucky in order to bring some order out of the fragmentation which I have alluded to above. I think it is important to make support grants and the project grants which are applied for through the State health department and department of mental health bear a close relationship to the recommendations of the state planning agency. I think too that it might be advisable to have either through the law or through regulations a provision whereby the commissioner of health will act in the role of secretariat to the State health planning agency.

We are long past the day when a greater share of the responsibility must be assumed by the Federal Government in bolstering basic public health services. The provision of your bill, S. 3008, which would assure that not less than 70 percent of the Federal grant be used for services on a community level is most commendable and I heartily support it. I also believe that the authorizations proposed to provide for interchange of personnel between States and the Federal agency to be truly innovative and a feature of this bill which could provide great advance in understanding of mutual problems and the education of the respective persons to the problems and difficulties of the Federal and State public health programs.

It appears that there is an implication in the sections relative to the State health planning agency that evaluation of programs would be a responsibility of that agency. The bill, however, states only that there will be an annual review; and it seems to me that it might be helpful if provision was made in the law requiring the State planning agency to evaluate the programs which have been either initiated or supported by the grants obtained from the Federal agency.

Again, may I most respectfully urge favorable action by your committee and the Congress on this most needed health proposal.

Sincerely,

EDWARD T. BREATHITT, Governor.

LANSING, MICH., March 25, 1966.

Senator LISTER HILL,
Senate Office Building, Washington, D.C.:

We wholeheartedly support Senate bill 3008 as a means to provide sustaining Federal support for coordinated, comprehensive services to protect the health of our citizens. Current grant structure has led to fragmentation and duplication. Provisions of Senate bill 3008 will stimulate unified effort, improve the use of scarce technical manpower, and squarely confront the emerging health problems and opportunities before us. Letter to follow.

ALBERT E. HEUSTIS, M.D.,
Director, Michigan Department of Public Health.

STATE OF MONTANA,
STATE BOARD OF HEALTH,
Helena, Mont., March 28, 1966.

Senator LISTER HILL,
Senate Office Building,
Washington, D.C.

DEAR SENATOR HILL: We are attaching a copy of a letter written to Senator Mike Mansfield urging his support of S. 3008, the Comprehensive Health Planning and Public Health Services Amendments of 1966.

We have also written Senator Lee Metcalf asking him to support this same bill.

Sincerely yours,

JOHN S. ANDERSON, M.D.,
Executive Officer.

MARCH 23, 1966.

Senator MIKE MANSFIELD,
Office of the Majority Leader,
Senate Office Building,
Washington, D.C.

DEAR SENATOR MANSFIELD: This letter urges your support of S. 3008, the Comprehensive Health Planning and Public Health Services Amendments of 1966, introduced by Senator Lister Hill.

This bill would do away with the individual categorical health grants to States, substituting a single block grant. I believe the only exception to this would be the vaccination assistance program. The States would be required to establish a single State health planning agency and a State health planning advisory committee. This group would annually prepare a State plan for the use of these funds. The States have the opportunity to establish their own priorities.

Montana would, for example, decide to emphasize tuberculosis control rather than heart disease or vice versa. At the present time the grant system is not flexible for the States.

This procedure should also reduce the auditing restrictions, which in the past created ridiculous situations. To the auditors, it was a cardinal sin to be found guilty of using heart money for cancer control. This posed a real hardship on the State agency. For example, we have several public health nurses on our payroll who are assigned certain geographical territories to supervise local public health nurses. One nurse will be paid out of heart funds, another from tuberculosis funds, etc. The nurse is actually supervising all the programs which utilize public health nurses. We simply could not afford to send four or five nurses to Plentywood, all to consult with the single public health nurse there.

Accounting procedures have become more and more rigid, so that we would have to prove that a single public health nurse spent one-eighth of her time in cancer, three-sixteenths on heart, three-sixteenths on tuberculosis, etc. The nurse would have to keep time sheets scoring each program properly. When these programs are applied on a local level, the same considerations were even more meaningless.

The bill does not show the amounts for appropriation except for \$5 million to schools of public health. The bill states that the appropriations would be made on the basis of estimates provided by the Surgeon General. I would prefer that these would be in the bill so that we could all read them. It is my understanding that the recommended appropriations for fiscal year 1967 are \$10 million and are for planning grants only. This would be broken down as follows:

State health planning, \$2.5 million; local health planning, \$5 million; demonstration grants for planning, \$2.5 million.

The following year, fiscal year 1968, the above amounts would be double. In addition, the support block grant would go into effect. This would total \$170,500,000. The present appropriations for programs which this block grant would replace is \$60 million.

The formula for allotments to States would be based on population with an adjustment for per capita income. This seems to be the traditional formula. Montana comes out about average in this respect.

It is interesting to me that States with low per capita income generally tend to have strong public health programs. The States which have the lowest State expenditures for public health are located in the north central and mountain areas. The only common denominator I can find to explain this is that those States all have small populations distributed over large geographical areas.

I wish someone could come up with a formula that would take into consideration the high cost of space. This is about the only part of the bill which I do not like.

The most important part of the bill for Montana is the requirement that at least 70 percent of the State's grant will be applied locally. This would provide the stimulator we need in Montana for organizing more public health services on a local level.

Montana has only two full-time health departments. Half of the counties do not have local sanitarian services and a third do not have public health services. Only \$23,000 is distributed to local departments to subsidize public health services.

This month I am talking to groups in Butte and Billings to see if it would be possible to consolidate their city and county health departments. If S. 3008 were in effect now, there would be no question that these communities would go ahead and form full-time health departments.

This is an important piece of legislation for public health and Montana. We State health officers have wanted this for a long time. We are gratified to see that it has the support of the President and the Surgeon General.

Sincerely yours,

JOHN S. ANDERSON, M.D., *Executive Officer.*

MONTANA NURSES' ASSOCIATION,
Helena, Mont., March 31, 1966.

HON. LISTER HILL,
*Chairman, Labor and Public Welfare Committee,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: This association favors S. 3008 and would like to ask your committee to give it favorable consideration.

There is a great need to find some way to more equitably provide adequate health services to all people in our rural State and the approach suggested in S. 3008 for the development of a State plan with assistance of a planning council seems very logical and necessary.

We would recommend that the State agency responsible for developing such a plan be the State board of health because of its established relationships with communities and all agencies providing health services.

Sincerely,

(Mrs.) MARY D. MUNGER, R.N.,
Executive Director.

NEVADA DEPARTMENT OF HEALTH AND WELFARE,
DIVISION OF HEALTH,
Carson City, Nev., March 25, 1966.

HON. LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
Senate Chambers,
Washington, D.C.*

DEAR SENATOR HILL: The Association of State and Territorial Health Officers and other health organizations have given formal support to the program of health planning and programing proposed in S. 3008. This letter is to add my personal recommendation for this timely proposal.

As you may know, I grew up in the health departments of DeKalb and Marshall Counties. During this time I repeatedly heard from my father of your sponsor-

ship of programs to improve health care throughout the county. Thus, I am confident that you will do your best to see this bill passed and signed into law.

Sincerely yours,

W. T. WEATHINGTON, M.D.,
State Health Officer.

NEW HAMPSHIRE NURSES' ASSOCIATION,
Concord, N.H., March 30, 1966.

HON. LISTER HILL,
*Chairman, Labor and Public Welfare Committee,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: The New Hampshire Nurses' Association wants to go on record in support of S. 3008, to amend the Public Health Service Act to promote and assist in the extension and improvement of comprehensive health planning, to provide more effective use of the available Federal funds for such planning of services, and for other reasons.

We are interested in the best health care for our citizens and feel a unified agency under the guidance of State and local agencies, and others interested in health services can achieve better results than the present fragmentation of services.

We especially like the idea that this bill will provide funds to establish and maintain adequate public health services, also, the provision for training personnel as a step toward improving public health services. A lack of qualified personnel is one of the limiting facts in reaching the highest efficiency in many health programs today.

We request your support of Senate bill 3008, which will meet the health needs of our citizens.

Sincerely,

(MRS.) MARY T. MADDEN,
Executive Director.

STATE OF NEW HAMPSHIRE,
DEPARTMENT OF HEALTH AND WELFARE,
DIVISION OF PUBLIC HEALTH,
Concord, March 28, 1966.

Senator LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
Washington, D.C.*

DEAR SENATOR HILL: It is with the greatest of enthusiasm that I wish to add my endorsement to the proposed legislation contained in S. 3008. It is my belief that through such legislation can optimal organization and administration of health programs in the United States be achieved. It would enable the several States to plan for and achieve the most efficient use of its facilities and its most effective use in the serious problem involved in the shortage of trained health personnel. The concept of a broader representative advisory health planning council is entirely acceptable and is essential if a comprehensive statewide planning device is to develop for health services, including both public and private; including indeed facilities for care and treatment and for personnel required to provide all necessary health services. The much feared fragmentation of existing services and obvious duplicate effort in this important field will be prevented.

I hope that this legislation will receive favorable action.

Sincerely yours,

MARY M. ATCHISON, M.D., *Director.*

STATE OF NEW JERSEY,
DEPARTMENT OF HEALTH,
Trenton, N.J., March 28, 1966.

HON. LISTER HILL,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: Attached is a copy of a letter sent to Senators Case and Williams respectfully requesting their support of Senate bill 3008.

Your constructive interest in public health is commendable. The provisions of the bill introduced by you will allow for most necessary and important advances

in the planning and administrative processes needed to meet modern day public health demands.

Sincerely,

ROSCOE P. KANDLE, M.D.,
State Commissioner of Health.

MARCH 21, 1966.

HON. CLIFFORD P. CASE,
U.S. Senate,
Washington, D.C.

DEAR SENATOR CASE: Your attention is respectfully invited to S. 3008 introduced by the Honorable Mr. Hill, on March 2, 1966, and referred to the Committee on Labor and Public Welfare. It is my understanding that hearings on this bill are currently taking place.

This bill amends the present Public Health Service Act and provides for:

1. Comprehensive statewide health planning to include the coordination and integration of areawide planning.

2. The strengthening and extending of community health services in a manner which would bring about close intergovernmental collaboration and would allow for a real partnership of public and private, individual and organizational, official and voluntary efforts necessary to meet the complexities of modern day public health. Much of this ability is not now possible under the existing detailed categorical grant approach.

3. Since the needs and resources of communities and States vary widely, maximum flexibility in administration is necessary in order properly to provide for public health service of a varied and different scope. Such flexibility is important to insure that local programs are designed to meet local problems. Such flexibility is not now available.

4. The continuance of project or development grants to meet specific health problems of limited geographic scope, or of specialized regional or national significance necessary to stimulate and launch new health programs, and to undertake studies, demonstrations, and training programs.

5. The interchange of personnel with States and political subdivisions of a State so that maximum use of specialized knowledge could be made available in areas where needed without loss of benefits to such interchanged persons.

The measures incorporated in this bill are most important and most necessary if we are effectively to meet the broad demands of public health in this State and if we are effectively to serve the citizens of New Jersey. Public health can no longer be considered a singular, simple, parochial problem.

This bill, if passed without substantive change, would provide the means for an effective partnership and would remove current categorical restrictions to effective planning and operation.

I respectfully request your favorable consideration and support of this bill.

Sincerely,

ROSCOE P. KANDLE M.D.,
State Commissioner of Health.

NORTH CAROLINA STATE BOARD OF HEALTH,
Raleigh, March 24, 1966.

HON. SAM J. ERVIN, Jr.,
U.S. Senate, Washington, D.C.

DEAR SENATOR ERVIN: I am writing to ask your support of S. 3008 introduced by Senator Hill for the purpose of providing funds to assist States in planning for comprehensive health services—prevention, cure, and rehabilitation. Passage of this legislation would serve an important need in knitting together Federal, State, and local health efforts.

It was good to meet you at the Winston-Salem meeting of the United Medical Research Foundation. I enjoyed the opportunity to talk with you and to learn of your strong support for the school milk program.

Sincerely,

JACOB KOOMEN, M.D., M.P.H.,
Acting State Health Director.

NORTH CAROLINA STATE BOARD OF HEALTH,
Raleigh, March 24, 1966.

Hon. B. EVERETT JORDAN,
U.S. Senate, Washington, D.C.

DEAR SENATOR JORDAN: I am writing to ask your support of S. 3008 introduced by Senator Hill for the purpose of providing funds to assist States in planning for comprehensive health services—prevention, cure, and rehabilitation. Passage of this legislation would serve an important need in knitting together Federal, State, and local health efforts.

It was good to meet you at the Winston-Salem meeting of the United Medical Research Foundation. I enjoyed the opportunity to talk with you and to learn of your strong support for the school milk program.

Sincerely,

JACOB KOOMEN, M.D., M.P.H.,
Acting State Health Director.

STATE OF NORTH DAKOTA,
EXECUTIVE OFFICE,
Bismarck, March 25, 1966.

Hon. LISTER HILL,
Chairman of the Senate Committee on Labor and Public Welfare,
New Senate Office Building, Washington, D.C.

DEAR SENATOR HILL: I am taking this opportunity of informing you of my support for S. 3008. I believe that enactment of this legislation would be beneficial in augmenting the public health program in North Dakota.

Specifically, it would assist us in developing a long-range health plan and in implementing this plan. Further, it would enable us to carry out health activities with more assurance that funds available for such services would not be suddenly interrupted.

The North Dakota Department of Health is supporting passage of S. 3008. I add my support in requesting favorable consideration for this legislation.

Sincerely,

WILLIAM L. GUY, Governor.

NORTH DAKOTA STATE DEPARTMENT OF HEALTH,
Bismarck, March 24, 1966.

Hon. QUENTIN N. BURDICK,
U.S. Senate, Washington, D.C.

DEAR SENATOR BURDICK: We respectfully request your support of S. 3008. We believe that the passage of S. 3008 will have an impact upon the preventive aspects of illness and injury comparable to that which Public Law 89-97 will have upon the medical care aspects of illness.

Some of its advantages to North Dakota as well as to the Nation are:

1. It reorganizes the Federal grants-in-health aid, thus increasing the efficiency of health administration on both the State and Federal levels.
2. It provides financial support to the States and local governments for competent health planning and for health services, the latter to be governed by the approved plans.
3. It makes feasible the uninterrupted of health programs. The State health departments will know well in advance that Federal authorization and funds for health services will be forthcoming.
4. It more adequately recognizes the local health needs.
5. Indirectly it acknowledges greater Federal responsibility for financial support in preparing our country for disasters.

Thank you for your consideration of this important piece of health legislation.

Sincerely,

JAMES R. AMOS, M.D., State Health Officer.

NORTH DAKOTA STATE DEPARTMENT OF HEALTH,
Bismarck, March 24, 1966.

Hon. MILTON R. YOUNG,
U.S. Senate, Washington, D.C.

DEAR SENATOR YOUNG: We are very much interested that S. 3008 become a public law. It would be especially advantageous in augmenting the public health of North Dakota. Specially among its merits are:

1. It reorganizes the Federal grants-in-health aid, thus increasing the efficiency of health administration on both the State and Federal levels.
2. It provides for good health planning by each State.
3. It provides for financial support of health services in the States and local governments.
4. It provides for the health services to be based upon, and governed by, the plans.
5. It more adequately recognizes the local or community health interests and needs.
6. It provides for continuation of States' rights in the administration of public health services.

Your support of S. 3008 is respectfully requested.

Sincerely,

JAMES R. AMOS, M.D., *State Health Officer.*

STATE OF OHIO DEPARTMENT OF HEALTH,
Columbus, March 23, 1966.

Hon. FRANK G. LAUSCHE,
U.S. Senate, Washington, D.C.

DEAR SENATOR LAUSCHE: I have had an opportunity to review S. 3008 cited as the "Comprehensive Health Planning and Public Health Services Amendments of 1966," introduced by Senator Lister Hill, and referred for consideration by the Senate Committee on Labor and Welfare. I wish to commend this legislation and its purposes to your attention and to express my hope that it will receive favorable consideration by Congress.

Your particular attention is called to the action taken by the Association of State & Territorial Health Officers in support of S. 3008. A copy of the statement presented to the Subcommittee on Health is enclosed.

In Ohio, as in the other States, we have for many years been faced with an increasing fragmentation of health services, resulting in costly duplication and waste. As research and modern techniques produce the means to further elevate the health levels of our people, this fragmentation and waste can only multiply unless the necessary mechanism is developed to unite our total abilities, resources, and efforts.

I believe that S. 3008 represents, to a high degree, a positive and genuine approach through which National, State, and grassroot purposes can be focused on a common goal toward the fulfillment of our country's rightful health heritage.

Your earnest consideration of S. 3008 will be very much appreciated and I would be happy to give you any further information you may request with respect to this legislation and its possible impact on Ohio's health programs.

Sincerely yours,

E. W. ARNOLD, M.D.,
Director of Health.

STATE OF OHIO DEPARTMENT OF HEALTH,
Columbus, March 23, 1966.

Hon. STEPHEN M. YOUNG,
U.S. Senate, Washington, D.C.

DEAR SENATOR YOUNG: I have had an opportunity to review S. 3008 cited as the "Comprehensive Health Planning and Public Health Services Amendments of 1966" introduced by Senator Lister Hill, and referred for consideration by the Senate Committee on Labor and Welfare. I wish to commend this legislation and its purposes to your attention and to express my hope that it will receive favorable consideration by Congress.

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Your earnest consideration of S. 3008 will be very much appreciated and I would be happy to give you any further information you may request with respect to this legislation and its possible impact on Ohio's health programs.

Sincerely yours,

E. W. ARNOLD, M.D.,
Director of Health.

OHIO STATE NURSES ASSOCIATION,
Columbus, Ohio, March 29, 1966.

HON. LISTER HILL
*Chairman, Labor and Public Welfare Committee,
U.S. Senate,
Washington, D.C.*

DEAR SENATOR HILL: As the official voice for approximately 40,000 nurses in the State of Ohio, the Ohio State Nurses Association wishes to express its support of S. 3008, the proposed amendment to the Public Health Service Act.

Our interest in this legislation stems from our vital concern for the provision of high quality nursing care to patients since this is the main purpose of our organization. We believe that the attainment of this goal depends to a large degree upon the development and improvement of community health services.

Over the years numerous public health programs have emerged and grown independently. In many instances the activities of these individual units have duplicated each other, resulting not only in the needless expenditure of time and money, but also in ineffective action. At the same time, other geographical areas have suffered from a total lack of these very same services.

S. 3008 would assist in alleviating this problem by providing meaningful coordination of comprehensive areawide health facility planning. Therefore, we strongly support the enactment of this legislation.

Sincerely,

DOROTHY A. CORNELIUS, R.N.,
Executive Director.

OKLAHOMA CITY, OKLA., April 2, 1966.

Senator LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
Senate Office Building, Washington, D.C.:*

Your favorable consideration is urged for passage of S. 3008. A progressive measure of this sort is essential for the continued justification of the expanding research investment in the medical field. Major improvement in the delivery mechanism of health services is becoming more crucial each day as the complexities of life and of environment increase. Reenforced State health departments, particularly in their planning capabilities can wait no longer. Strong leadership by State health departments is vital to comprehensive health planning to meet the requirement of coordinating health resources and a coherent delivery of health services. Oklahoma has already made great strides forward as evidenced by action during our last legislative session by initiating a program of regional health and social services centers whereby the resources and services of State agencies can be coordinated and made complementary. This program has the tangible support of \$1½ million to assist in the construction of several facilities throughout the State to implement this concept. Already one center is well along in the planning stage and initial construction is expected to begin the close of the year. Governor Bellmon, by an executive order, has already put into effect the concept of comprehensive health planning which includes provisions for coordination and cooperation of official and voluntary agencies and the general public through continuous, deliberate, and directed planning efforts both at the State and regional levels. In view of the steps taken by Oklahoma, S. 3008

would be a determining influence to this essential and vital movement in the health field.

KIRK T. MOSLEY, M.D.,
Oklahoma State Commissioner of Health.

OREGON STATE BOARD OF HEALTH,
Portland, Oreg., March 31, 1966.

HON. LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: I would like to express my strong support of the position of the State and territorial health officers on Senate bill 3008. As a member of the Association of State and Territorial Health Officers and the health officer representing a State which has a keen interest in the concept of State and Federal partnership in developing health services for the Nation, I thoroughly concur in the principle of adjusting the Federal health grants to the needs of the individual States.

I do believe that the statutory language should require the health officer or his designated representative of each State to be a member of the planning agency within the State. Furthermore, since the health agencies in all of our States have a statutory and moral responsibility for converting health planning concepts into health programs and delivery of services, I sincerely hope that your committee will recognize the necessity of preserving the State health agency's responsibility in the delivery of the planned services to the citizens of its State.

I shall be grateful for your consideration and support.

Sincerely,

RICHARD H. WILCOX, M.D.,
State Health Officer.

COMMONWEALTH OF PENNSYLVANIA,
DEPARTMENT OF HEALTH,
Harrisburg, March 25, 1966.

HON. LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: I believe it would be most helpful for public health practice in the United States to have S. 3008, the "Comprehensive Health Planning and Public Health Service Amendments of 1966," bill enacted. The contents of this bill are the result of several years of prolonged but careful deliberations between the Department of Health, Education, and Welfare and the Association of State & Territorial Health Officers.

The improved method of Federal grants of health funds for local use as stated in S. 3008 should bring about better coordinated health planning and operations than is now possible with the highly categorized, highly restricted and piecemeal type of operation which is necessary under the present wording of the law.

As the State health officer of Pennsylvania and as the next to the last president of the Association of State & Territorial Health Officers, I respectfully urge the passage of S. 3008. A little modification in the bill would be desirable, such as suggested by William J. Peeples, M.D., commissioner of the Maryland State Department of Health, testifying for the Association of State & Territorial Health Officers.

Sincerely,

C. L. WILBAR, Jr., M.D.

STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS,
DEPARTMENT OF HEALTH,
Providence, March 28, 1966.

HON. LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: As director of the Rhode Island Department of Health, I have long been concerned with the current method of Federal financing of health services.

The fragmentation and the lack of adequate support for basic health services presents serious barriers to the development of coordinated programs.

As a member of the advisory group of the Association of State and Territorial Health Officers to the U.S. Public Health Service, I have been actively involved for several years in studying the need for new legislation. Your bill S. 3008 provides the opportunity for correcting many existing deficiencies, and I have written to Senators Pell and Pastore and Congressmen Fogarty and St Germain urging them to vigorously support the Senate and House versions of your bill.

I have also requested Gov. John H. Chafee to give his support to this proposed legislation.

Sincerely yours,

JOSEPH E. CANNON, M.D., M.P.H.,
Director of Health.

STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS,
Providence, March 29, 1966.

Senator LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
New Senate Office Building, Washington, D.C.*

DEAR SENATOR HILL: The Rhode Island director of health, Dr. Joseph E. Cannon, has informed me of the introduction of your bill, S. 3008, and I wish to give this proposed legislation my full support.

For several years now, I have been increasingly concerned with the fragmentation of health services, the lack of realistic Federal financial support for basic public health programs, and the shortages of trained professional personnel.

The provisions of your bill provide for the correction of some of the inherent defects in the current system and represent a beginning for the orderly development of needed public health services.

Sincerely yours,

JOHN H. CHAFEE, *Governor.*

SOUTH DAKOTA STATE DEPARTMENT OF HEALTH,
Pierre, March 25, 1966.

Hon. GEORGE MCGOVERN,
U.S. Senate, Washington, D.C.

DEAR SENATOR MCGOVERN: I would like to add my personal endorsement to the statements submitted by the Association of State & Territorial Health Officers to the Subcommittee on Health of the Senate Committee on Labor and Public Welfare during hearings on S. 3008.

In the every-broadening field of public health it is becoming more and more evident that we must have comprehensive planning involving all agencies concerned in the provision of health services. It is also necessary that we provide for more training, both for those who plan and for those who provide service.

In South Dakota, our greatest difficulty has been the financing of our basic health programs and assistance is needed in this area rather than in the area of control of certain specific diseases. This assistance is especially needed at the local level.

We therefore urge that favorable consideration be given to S. 3008, the provisions of which will make it possible for us to provide more and better health services to the citizens of our State.

Sincerely,

G. J. VAN HEUVELEN, M.D.,
State Health Officer.

SOUTH DAKOTA STATE DEPARTMENT OF HEALTH,
Pierre, March 25, 1966.

Hon. KARL E. MUNDT,
*U.S. Senate,
Washington, D.C.*

DEAR SENATOR MUNDT: I would like to add my personal endorsement to the statements submitted by the Association of State & Territorial Health Officers to the Subcommittee on Health of the Senate Committee on Labor and Public Welfare during hearings on S. 3008.

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In South Dakota our greatest difficulty has been the financing of our basic health programs and assistance is needed in this area rather than in the area of control of certain specific diseases. This assistance is especially needed at the local level.

We therefore urge that favorable consideration be given to S. 3008, the provisions of which will make it possible for us to provide more and better health services to the citizens of our State.

Sincerely,

G. J. VAN HEUVELEN, M.D.,
State Health Officer.

STATE OF TENNESSEE,
DEPARTMENT OF PUBLIC HEALTH,
Nashville, Tenn., March 22, 1966.

HON. ALBERT GORE,
U.S. Senate,
Washington, D.C.

DEAR SENATOR GORE: There has been introduced by Senator Lister Hill S. 3008, and I would like to strongly urge your favorable consideration of this legislation.

This bill proposes a system of planning, programing, and budgeting for health in a manner which, I believe, will bring our Federal public health appropriations and legislation up to date. This reorganization is sorely needed.

The bill as introduced by Mr. Hill needs some minor language change so as to require that the health officer of each State be a member of the planning agency in his State. There is another area of change that personally, I think would help the bill, but you will have to decide whether or not it will be constitutional. This would be a provision for areawide planning not only interstate but intrastate so that regions located in contiguous States could develop plans for an areawide service. (This may run into our constitutional prohibition against States making treaties without specific congressional approval.)

In the bill there is a provision for incorporating the financial resources of non-profit agencies into the general program. I believe that the bill would be materially strengthened if the statutes stipulated that such funds must be turned over to the Public Treasurer for disbursing.

This bill is needed because at the present time we have a hodgepodge of categorical appropriations that make it extremely difficult to administer programs in a most efficient manner. Mr. Hill evidently has given serious thought to consolidation of these services and I hope that you will be able to support him on this bill.

Sincerely yours,

R. H. HUTCHESON, M.D.,
Commissioner.

STATE OF TENNESSEE,
DEPARTMENT OF PUBLIC HEALTH,
Nashville, Tenn., March 22, 1966.

HON. ROSS BASS,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BASS: There has been introduced by Senator Lister Hill S. 3008, and I would like to strongly urge your favorable consideration of this legislation.

This bill proposes a system of planning, programing, and budgeting for health in a manner which, I believe, will bring our Federal public health appropriations and legislation up to date. This reorganization is sorely needed.

The bill as introduced by Mr. Hill needs some minor language change so as to require that the health officer of each State be a member of the planning agency in his State. There is another area of change that personally I think would help the bill, but you will have to decide whether or not it will be constitutional. This would be a provision for areawide planning not only interstate but intrastate so that regions located in contiguous States could develop plans for an areawide service. (This may run into our constitutional prohibition against States making treaties without specific congressional approval.)

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This bill is needed because at the present time we have a hodgepodge of categorical appropriations that make it extremely difficult to administer programs in a most efficient manner. Mr. Hill evidently has given serious thought to consolidation of these services and I hope that you will be able to support him on this bill.

Sincerely yours,

R. H. HUTCHESON, M.D.,
Commissioner.

TENNESSEE NURSES' ASSOCIATION, INC.,
Nashville, Tenn., March 29, 1966.

Hon. LISTER Hill,
*Chairman, Labor and Public Welfare Committee,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: The Tennessee Nurses' Association wishes to record its support of S. 3008, to amend the Public Health Service Act to promote and assist in the extension and improvement of comprehensive health planning and public health service, to provide for a more effective use of available Federal funds for such planning and services, and for other reasons.

We would further like to support the statement relative to S. 3008 presented to you by the American Nurses' Association on March 22, 1966. We believe that the need is urgent to make it possible for communities to plan comprehensive health services and render the same.

Respectfully,

(Mrs.) REBECCA CLARK CULPEPPER, R.N.,
Executive Director.

UTAH STATE DEPARTMENT OF HEALTH,
Salt Lake City, Utah, March 28, 1966.

Hon. LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
Senate Office Building, Washington, D.C.*

DEAR SENATOR HILL: S. 3008 is welcome legislation. While this type of legislation may be considered long overdue by some health officials and in some areas of the country it is most timely in others, particularly so in Utah.

The nature of the work of State health agencies has always required and actually involved planning, especially with the impact of categorized Federal grants. But it is generally recognized that planning has been rarely adequate both as to extent or quality. S. 3008 will give definite stimulus to improving the quantity and quality of health planning in both the State and local activities and should result in coordinated planning rather than of categorical.

S. 3008 is particularly timely for Utah, because of the recent Utah little Hoover commission report on the organization of the executive branch of the government which specifically recommends a division of planning and research be established in the State department of health. The State board of health has already indicated interest in this function with the intention of carrying it out as soon as financially permissible. No criticism of this recommendation has been voiced.

By reporting this latest Utah development, I am happy to be able to add it to my own view and those of the Association of State and Territorial Health Officers for your use in obtaining passage of S. 3008.

Sincerely yours,

G. D. CARLYLE THOMPSON, M.D.,
Director of Public Health.

STATE OF VERMONT,
DEPARTMENT OF HEALTH,
Burlington, March 31, 1966.

Hon. LISTER HILL,
U.S. Senate, Washington, D.C.

DEAR MR. HILL: It is a long time since you have heard from the "north country," but I did want to write to you to express my wholehearted support of S. 3008.

At long last, it looks like we are going to get somewhere in being able to plan and finance health services in the States, in accordance with the needs of the individual States. It is extremely important at this time, because practically every new Federal program seems to have a health factor attached, and the result in the States is utter confusion, overlapping and even head-on collisions in planning. Perhaps this will start health departments back on the road to the role that they should play, of leadership, surveillance, and coordination in the field of health.

I also feel very strongly that a similar move should be taken at the Federal level. I could name a half dozen programs, or even parts of the same program, being initiated independently by several Federal agencies. It is all right to straighten out confusion at the State level, quite a bit of which is due to Federal legislation, but it is also time it was straightened out at the Federal level.

Best personal wishes.

Sincerely,

R. B. AIKEN, M.D.,
Commissioner of Health.

STATE OF WEST VIRGINIA,
March 24, 1966.

Hon. JENNINGS RANDOLPH,
Member, U.S. Senate,
Senate Office Building,
Washington, D.C.

DEAR SENATOR RANDOLPH. I am writing you in behalf of Senate bill 3008, which provides grants for comprehensive health planning beginning in fiscal year 1967, and grants for comprehensive public health services beginning in fiscal year 1968.

West Virginia would be entitled to \$100,000 for use in State and local health departments and for demonstration purposes for instigation of planning activities 1 year prior to activation of the new grant arrangement. Based on \$0.50 per capita, the State would be entitled to \$1,183,102 of the Federal Public Health Service comprehensive grant in fiscal year 1968. This almost doubles the composite 1966 fiscal year Public Health Service formula grants, amounting to \$651,793. It is contemplated that this grant would eventually expand to \$2,957,755 by fiscal year 1971.

It is significant that 70 percent of this grant is earmarked for health services at the local level where the need is extremely great.

We would appreciate your support of this legislation which in my judgment would provide a golden opportunity for the people of West Virginia to receive adequate and deserving public health services.

Sincerely yours,

N. H. DYER, M.D., M.P.H.,
State Director of Health.

STATE OF WEST VIRGINIA,
March 24, 1966.

Hon. ROBERT C. BYRD,
Member, U.S. Senate,
Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: I am writing you in behalf of Senate bill 3008, which provides grants for comprehensive health planning beginning in fiscal year 1967, and grants for comprehensive public health services beginning in fiscal year 1968.

West Virginia would be entitled to \$100,000 for use in State and local health departments and for demonstration purposes for instigation of planning activities 1 year prior to activation of the new grant arrangement. Based on \$0.50 per capita, the State would be entitled to \$1,183,102 of the Federal Public Health

Service comprehensive grant in fiscal year 1968. This almost doubles the composite 1966 fiscal year Public Health Service formula grants, amounting to \$651,793. It is contemplated that this grant would eventually expand to \$2,957,755 by fiscal year 1971.

It is significant that 70 percent of this grant is earmarked for health services at the local level where the need is extremely great.

We would appreciate your support of this legislation which in my judgment would provide a golden opportunity for the people of West Virginia to receive adequate and deserving public health services.

Sincerely yours,

N. H. DYER, M.D., M.P.H.,
State Director of Health.

NATIONAL TUBERCULOSIS ASSOCIATION,
New York, N.Y., March 23, 1966.

HON. LISTER HILL,
Chairman, Senate Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: I am pleased to forward this statement of the National Tuberculosis Association in support of the principles contained in S. 3008 which I am informed you are considering in your committee. It is our belief that the objectives of S. 3008 are consistent with the goals of this organization.

I need not point out to you and the members of your committee that the NTA is particularly interested in the elimination of tuberculosis and control of other respiratory diseases. We are much indebted to you and to the Congress for the support given to tuberculosis control efforts in public health departments, whose responsibility it is to carry on the major efforts in control of this disease. We are also appreciative of your recent recognition of the need to increase the ability of health agencies to control the growing problem of emphysema, chronic bronchitis, and other respiratory diseases.

We have always recognized the value of well-financed health departments staffed by competent and trained personnel. For years our tuberculosis associations have supported official State and local health programs; tuberculosis control programs cannot exist in a vacuum without their basic services, such as generalized public health nursing, nutrition programs, statistics, and laboratories. There can be no question of the fact that the money which the Federal Government has given to State and local health departments has been a vital force in the improvement of health services throughout this country and as such has been of benefit to tuberculosis control.

Although the precise language of your bill was not known at the time of our recent board of directors meeting, the intent of its provisions was available. On February 6, 1966, the board recommended that:

"In relation to any reorganization of the Public Health Service grant program, the NTA board of directors reaffirms its support for continuation of the program and appropriations recommended by the task force on tuberculosis, as well as support of improved general health services."

Having checked the bill, I take this opportunity to comment on it in the context of this action by the board of directors.

We believe the planning provisions which would be authorized would be completely consistent with the objectives of the NTA and we therefore approve this section. The support grants to State and local health departments would be of material assistance in increasing the capacity of those agencies to better carry out their responsibilities, and such expansion would help the tuberculosis and respiratory disease control programs. Certainly, amounts of grant funds should be increased appreciably over what is presently made available for basic services.

However, it is our experience that in some instances in the past it was necessary to use funds appropriated for tuberculosis control to maintain the general health program of the State. Therefore, the support of the association for this new grant arrangement can only be made with the understanding that the support for tuberculosis control activities will in no way be endangered. If a sufficient amount of money is appropriated to have well-staffed health departments, tuberculosis and respiratory disease control programs can be adequately financed through the project grant mechanism which has been found to be an acceptable method of approach. As you know, the Surgeon General's task force on tuberculosis control recommended that sizable project grants be made available for the tuberculosis control program over a period of a decade—8 years of this period are yet to come.

The tuberculosis problem varies tremendously in degree between different geographic areas and between the rural and urban sections of the country, although it is found everywhere. The project grant authority which is proposed in S. 3008 would enable us to be responsive to the need where it does exist.

I am confident that you will be sympathetic to our concern for continued emphasis on tuberculosis control at this particularly critical time of accelerated activities. The increase in amount for project grants is too recent to exert the type of impact anticipated by the task force and it would be extremely shortsighted to cut off the mainstream of Federal support at this time.

I would appreciate it if you would make this statement of position by the NTA a part of the record of your hearings on S. 3008.

Yours truly,

JAMES E. PERKINS, M.D.,
Managing Director.

AMERICAN NURSES' ASSOCIATION, INC.,
New York, N.Y., March 22, 1966.

Hon. LISTER HILL,
*Chairman, Labor and Public Welfare Committee,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HILL: The American Nurses' Association wishes to record its support for S. 3008, to amend the Public Health Service Act to promote and assist in the extension and improvement of comprehensive health planning and public health service, to provide for a more effective use of available Federal funds for such planning and services, and for other reasons.

Our interest and support stems from the members' deep concern for the provision of adequate health services for the American people. The system of public health services has developed piecemeal over the years to meet current problems without an assessment of the changing needs of society for these services. Programs have been built around and on top of each other, creating an unwieldy, inefficient operation. Local programs have developed only to the extent that local pressures will allow. Bold action is indicated if we are to meet the needs of the changing times.

As interest in each disease category was stimulated, programs were established to prevent, and control the particular disease. Each program has grown into a totality and as the programs develop in depth, they have a tendency to become increasingly ingrown. Meaningful coordination of the multiple programs is essential for planning the total health needs of a community.

S. 3008 will provide a focus for an integrated generalized program. Health service needs for any given area may vary widely. Such factors as age and educational level of the population, the economy, and the topography influence the kinds of programs which must be tailored to suit each community. Flexibility in the use of Federal grants will provide a stimulus for imaginative planning and reduce the emphasis on disease-oriented programs.

S. 3008 provides for the development and improvement of home health services. The passage of the Health Insurance Benefits Amendments to the Social Security Act with the provision for paid home health services as a benefit, makes it imperative that community health services be developed, extended and improved.

We believe that there is urgent need to enact S. 3008 so that, as the title of the bill states, planning for comprehensive health services can become a reality.

Respectfully,

JUDITH G. WHITAKER, R.N.,
Executive Director.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., March 21, 1966.

Hon. LISTER HILL,
*Chairman, Senate Labor and Public Welfare Committee,
Senate Office Building, Washington, D.C.*

DEAR SENATOR HILL: This statement is sent to you to express the views of the American Hospital Association in respect to S. 3008, Comprehensive Health Planning and Public Health Services Amendments of 1966. The bill appears to visualize a broadened scope for public health services and suggests various means for the coordination of those matters generally considered to be public health,

and therefore within the sphere of Government health services, and those which are in the area of so-called curative health services, and considered to be within the sphere of the voluntary health services. Thus, the legislation suggests a bringing together of preventive and curative medicine with an expanded interpretation of "public health."

The role of government, and especially the Federal Government, in the Nation's health affairs is growing and it is obvious from the number of Federal programs developed over the past few years that Federal financing is essential if we are to meet the needs of the public. With this degree of governmental involvement, it is well that we develop a philosophy and policy of partnership between the governmental sector and the voluntary sector. Such a partnership is essential if we are to provide health services of high quality in the most economic and effective manner. S. 3008 appears to us to suggest various means for developing such a partnership. The bill used the term comprehensive health services which can be taken to mean anything and everything. It might be well to provide a specific definition for the purpose of this legislation. The bill proposes three major programs following the general recommendations included in the President's domestic health message.

SECTION 314, GRANTS TO STATES FOR COMPREHENSIVE STATE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

It is our understanding of this section of the bill that it proposes one agency responsible for the administration and supervision of health planning throughout the State. To accomplish this end, it is proposed that a variety of health programs now carried on in the States, and which involve planning for such services, will be brought together and coordinated in one planning agency. This should be an effective method for coordinating planning for health services so as to avoid duplication and gaps and to provide the most economic development of health facilities and services for the most efficient use of health personnel.

Whereas in the past, planning has really been limited in scope and pertained largely to the development of facilities, this bill proposes expanding planning so as to encompass all health services and health personnel as well as planning for health facilities. A State health planning agency is provided for, to be made up of representatives of the State government. The planning agency established under the bill appears to be limited in function and authority to the role of planning and does not appear to participate in any way in the carrying out of the plan or in the provision of health services by any agency of government or otherwise. We believe the function of the planning agency as described in the bill is quite obscure as to the carrying out of the State plan once it is agreed upon.

An advisory council made up of government and nongovernment representation also is established. This council is advisory to the single State planning agency. The authority and responsibility of the advisory council appears to be limited to advising on the development of a plan. It has no authority in respect to carrying out the plan.

The bill apparently proposes to encompass the planning of a number of health activities which presently carry on their own planning, such as, the State departments of public health, the mental health program, the Hill-Burton program, the medical school and the nursing school construction programs. For example, the bill is not clear as to whether the heart, cancer, and stroke program or the rehabilitation programs are to be included under the planning activities of this new planning council. Thus, it is questionable whether the bill, at present, does provide for all-inclusive authority over planning.

Each of the health activities mentioned above has its own advisory council and quite likely the planning activities in respect to each of these programs carry a responsibility to the individual advisory council. A basic question arises as to whether this legislation proposes to abolish the individual advisory councils. It raises particular question as to the future role and authority of the State boards of public health which exist in certain States. We believe the bill needs to be much clearer and more specific in respect to the relationship of each of these programs and their advisory councils to the State planning agency proposed under the bill. Otherwise, a great deal of confusion, we feel, will be generated.

Though the bill provides for a State advisory council to the State planning agency, there is no provision for an advisory council at the Federal level. It would appear to us that provision should be made for a Federal advisory council related to planning to guide the decisions of the Surgeon General in evaluating the State plans which are submitted to him.

We wish to make clear that this association is not opposed to coordinated planning. In fact, quite to the contrary. When the Mental Health Act was being considered by the Congress, we urged that the planning phases of that program be coordinated with planning under the already existing Hill-Burton programs, pointing out that it made little sense to attempt to plan for mental health services completely apart from the essential planning for general health services.

We face enormous shortages of essential health personnel. Our ability to carry out various health programs which are needed will be curtailed unless there is a substantial increase in available personnel. The Federal Government has already recognized this fact as it has supported several programs to provide increased numbers of health personnel. It would appear to be essential that planning for facilities and services must be related to planning for essential personnel within the States. This bill suggests a basic approach in this direction. These efforts may well lead to increased controls over the provision of health services. If these controls become excessive, they could become a handicap to efficient administration of health programs.

(b) PROJECT GRANTS FOR AREA-WIDE HEALTH PLANNING

This section of the bill authorizes the Surgeon General to make project grants to public or private nonprofit agencies or organizations to enable them to develop comprehensive regional plans for health services and to provide for the coordination of such planning. It also proposes, just as it has under the State plan, to incorporate not only facilities but services and personnel under the regional coordinated plans.

At the present time, the Federal Government is providing assistance for the development of regional planning agencies. The grants by the Surgeon General at the present time may be made on the approval of the State Hill-Burton agency. S. 3008 provides that the Surgeon General may make project grants which will be approved by the State planning agency. Thus, the activities of regional planning groups may be controlled and influenced by a new planning group and one which is representative of a variety of agencies which has not been the case in the past. This may have certain strengths in relationship to centralized control and does bring about more comprehensive planning by these independent groups. On the other hand, a weakness may be that the State planning group may be less sympathetic to regional planning groups and wish to take much greater authority upon itself. This would weaken the independence of regional planning groups and local initiative and responsibility.

As we have already mentioned, the heart, cancer, and stroke program establishes a planning body for the development of programs for these three diseases; and the Federal Government is providing the financing for such planning efforts. In the law, this planning is not related in any way to the work of any other planning group. It would appear that consideration should be given to amending S. 3008 so as to require that planning for the heart, cancer, and stroke program be coordinated with planning at both the State and regional levels.

(c) PROJECT GRANTS FOR TRAINING, STUDIES, AND DEMONSTRATIONS

This section of the bill is highly desirable, we feel, as it would provide grants to both public and private nonprofit agencies, institutions, and organizations to encourage projects for training, studies, and demonstrations. These are aimed toward the development of improved, or more effective, comprehensive health services throughout the Nation. We feel, however, that this section does not go far enough. We would urge that greater assurance is given that the results of such studies, demonstrations, and research will be made available to the entire health field. The results of much of the research carried on at the present time are not made readily available to the health field. There should be a clearinghouse or an information center provided for, so that duplication of projects may be avoided and so that the results of all such projects may be readily accessible.

(d) (2) STATE PLANS FOR PROVISION OF PUBLIC HEALTH SERVICES

As we understand this section of the bill, it is intended to permit the States to do a much more meaningful job of providing public health services through a system of block grants rather than the existing system of categorical grants. We recognize that this has been a subject of basic concern on the part of the public health officials for a good many years. It has been pointed out repeatedly that, though categorical grants have had certain benefits in terms of obtaining greater support for specific disease areas, they have also been the means of seri-

ously limiting the wise allocation of funds in relationship to major public health problems within the States. Therefore, it is our belief that this section of the bill would provide for a greatly improved administration of public health services by the States.

(f) (1) INTERCHANGE OF PERSONNEL WITH STATES

As we understand this section of the bill, it would facilitate the interchange of health personnel between the States and the Federal Government, between the States themselves, and among areas within the States.

It appears to us that such interchange is limited to various levels of government. Inasmuch as the legislation establishes a basic policy that any barriers which may exist between the governmental sector and the voluntary sector of health services should be reduced, we believe it may be well if this basic policy were extended to provide, also, for the interchange of health personnel between levels of government and the voluntary health institutions.

(g) GENERAL

The bill contains provisions which would preserve the existing authorization which provides for training grants to schools of public health. When this section was added to the public health service law, we had expected that the schools providing for master degree training for administrators of hospitals and other health care institutions would be included in the provision. We believe strongly that a hospital administrator is an administrator of a community health service and, thus, should be assisted with training grants in a manner similar to that now provided to public health trainees. We urge, therefore, that this section of the bill be amended so as specifically make students in university programs of hospital administration eligible to receive training grants irrespective of whether their course is part of the school of public health or of business administration.

We would appreciate your making this statement a part of the record of the hearings on S. 3008.

Sincerely,

KENNETH WILLIAMSON, *Associate Director.*

NATIONAL ASSOCIATION OF COUNTIES,
Washington, D.C., March 29, 1966.

Hon. LISTER HILL,
Chairman, Senate Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR CHAIRMAN HILL: On behalf of the National Association of Counties, I should like to express our support of S. 3008, a bill to amend the Public Health Act to promote and assist in the extension and improvement of comprehensive health planning and public health services, to provide for a more effective use of available Federal funds for such planning and services and for other purposes.

The concepts embodied in this legislation are in keeping with the American county platform, the official policy statement of our association, specially our position on regional cooperation and county planning. I am enclosing a copy of our policy statement and we would appreciate section 2-10 and 2-11, along with this letter, be made a part of the committee record on this legislation.

(The sections referred to above follow:)

"2-10. *Incentives in State and Federal grant programs to encourage joint efforts to resolve common problems.*—Numerous services performed by local government are best provided when undertaken on a territorial basis broader than the individual unit of local government. Experience in such fields as open space land acquisition, public health, urban planning, and airports has shown that grant programs can be designed to achieve more effective local services through joint undertakings by more than one unit of local government. The National Association of Counties believes that State and Federal grant programs, where appropriate, should contain provisions to encourage joint undertakings among local units of government.

"2-11. *State and Federal legislation needed.*—We recommend that in order to strengthen county and regional planning that applications from local governments within a metropolitan area for Federal grants-in-aid for airport construction, waste

treatment works, urban renewal, public housing, hospital construction, and urban highways be reviewed and commented on by a legally constituted planning agency with responsibility for comprehensive planning for the metropolitan area or region and that such planning agencies be composed of or responsible to the elected local government officials of the metropolitan area."

We would urge that program grants for areawide health planning as provided for in section 314(b) include a requirement that where comprehensive planning for the area is being carried out, that planning for health facilities under this section be consistent with any such comprehensive plan.

Very truly yours,

W. W. DUMAS, *President.*

AMERICAN SOCIAL HEALTH ASSOCIATION,
New York, N.Y., March 29, 1966.

HON. LISTER HILL,
*Chairman, Senate Committee on Labor and Public Welfare,
New Senate Office Building, Washington, D.C.*

DEAR SENATOR HILL: Since the board of the American Social Health Association does not meet until April 30, our president, executive committee chairman, and I, as chairman of the board, have read S. 3008, which you introduced, and we wish to express our support for it. We feel sure that the board will confirm our action when it meets.

As we understand the intent and probable consequences of this bill's passage, it would: encourage local and State planning in light of particularized health needs, integrate public health services into a whole man approach, yet provide opportunities to work intensively and flexibly in such hazardous problem areas as control of venereal diseases and of drug abuse.

This seems to us to open up the possibility of planning and appropriations more suited to differing geographic areas and to the changing needs of changing times. We hope that our organization may be helpful to its passage and greatest usefulness.

Sincerely,

PHILIP R. MATHER,
Chairman of the Board.

THE JOHNS HOPKINS UNIVERSITY,
SCHOOL OF HYGIENE AND PUBLIC HEALTH,
OFFICE OF THE DEAN,
Baltimore, Md., March 28, 1966.

HON. LISTER HILL
*Chairman, Senate Committee on Labor and Public Welfare,
New Senate Office Building,
Washington, D.C.*

DEAR MR. CHAIRMAN: In the absence of our president, Dr. Myron Wegman, who is in Vietnam with the Gardner group, I write on behalf of the Association of Schools of Public Health concerning S. 3008 now before your committee. The Association approves the principles of the legislation but would propose a slight change to the effect that the authorization of Hill-Rhodes formula grants be placed in section 306 with the traineeships rather than in section 309 with the project grants as proposed in S. 3008.

There is, as you know, a direct relationship between the number of public health trainees and the teaching costs in the schools of public health. The Hill-Rhodes formula grants are allocated primarily on the basis of numbers of federally sponsored students in the schools of public health and most of these are public health trainees. There is no such relationship between, on the one hand, the project grants which are made for specific training purposes in several kinds of health institutions and, on the other hand, the Hill-Rhodes formula funds which are made exclusively to schools of public health as partial reimbursement for the costs incurred in training federally sponsored students.

We feel that it would be logical and advantageous both to the Congress and to the schools of public health to have the traineeships linked with the formula grants by placement in the same section of the Public Health Service Act. Such an arrangement would avoid any possible confusion in the future as to the exact nature of project grants and formula grants, as each would be considered sepa-

rately. It would tend to eliminate any question of duplication as regards the two distinctly different forms of support for public health training and would facilitate the process of adjusting the level of formula funds to the current volume of teaching costs as determined by the numbers of public health trainees and other federally sponsored students in any given period.

We would be glad to discuss this recommendation with you or members of your staff, if you wish. We trust that the proposed change will be relatively easy to make, if you agree that our suggestion has merit.

As always, we turn to you with confidence that you will decide in the best interests of public health to which you have contributed so much.

As ever, in deep gratitude, I am,

Sincerely yours,

ERNEST L. STEBBINS, M.D.,
Vice President, Association of Schools of Public Health, Inc.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., March 16, 1966.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: We understand that your committee is presently holding hearings on S. 3008, the Comprehensive Health Planning and Public Health Services Amendments of 1966. This bill is now receiving our attention and study.

Because of its interest in health legislation, the American Medical Association appreciates each opportunity to appear before congressional committees on such matters. While it would appear that the deemphasis on categorical health grants to States would be consistent with the policy of the AMA, we regret we cannot, within the time allotted, prepare an evaluation of this bill which would be commensurate with its significance.

We would welcome an opportunity to submit our views to you at a later date when we have a more complete understanding of the legislation.

Sincerely,

F. J. L. BLASINGAME, M.D.

NORTH AMERICAN ASSOCIATION OF ALCOHOLISM PROGRAMS,
April 1, 1966.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: By direction of President David J. Pittman and the executive board of the North American Association of Alcoholism Programs, I should like to bring to your attention some factors concerning alcoholism which we consider to be pertinent with regard to your bill, S. 3008, for comprehensive health planning.

We know that it is your intention that the illness of alcoholism be included in this legislation to share with the other major medical-social problems in the Federal Government's comprehensive health plans. It is, therefore, felt appropriate to bring these matters to your attention.

1. Currently some 42 States and the District of Columbia operate tax-supported alcoholism programs at the State level. Of these existing programs, 10 are organizationally independent commissions; 1 is located within the department of social welfare and the others are listed as divisions or sections within State departments of public health or mental health. These programs vary extensively in terms of financial support, level of activity, and focus of programming.

2. Our experience with the Community Mental Health Centers Act of 1963 has not been entirely satisfactory. Alcoholism and narcotics addiction was listed as one of the concerns in plans for planning. However, only 26 of the 50 States had specific task forces to cope with these significant health and social problems. We are concerned that this not happen in the case of S. 3008.

3. Two very significant decisions have been handed down recently by the courts concerning the disposition of chronic alcoholic offenders. On January 22, 1966, the Fourth U.S. Circuit Court of Appeals ruled in favor of the appellant, Joe B. Driver, of North Carolina. The unanimous opinion written by Judge Albert V. Bryan included the following statement:

"The upshot of our decision is that the State cannot stamp an unpretending chronic alcoholic as a criminal if his drunken public display is involuntary as the result of disease. However, nothing we have said precludes appropriate detention of him for treatment and rehabilitation so long as he is not marked a criminal."

A similar case *DeWitt Easter v. the District of Columbia*, was heard by the District of Columbia Court of Appeals on January 19, 1966. A unanimous decision in favor of the appellant by the eight-judge panel was rendered only yesterday, March 31.

Several other like cases are pending in other courts over the Nation. Similar decisions in favor of the appellants are expected in these cases. These enlightened court decisions will necessitate vigorous action at the Federal, State, and local levels to provide adequate noncriminal facilities and programing for the many thousands of late stage alcoholics so affected. Immediate planning is most necessary.

We were heartened by President Johnson's very significant statement concerning alcoholism in his health and education message to Congress on March 1. The mounting interest shown in this major problem by the 89th Congress is most encouraging. These factors coupled with your own proven dynamic leadership in health matters will inevitably result in a sound program for alcoholism at the Federal level.

Your serious consideration in this matter will be sincerely appreciated.

Respectfully yours,

GUS HEWLETT, *Executive Secretary.*

THE COUNCIL OF STATE GOVERNMENTS,
Washington, D.C., April 1, 1966.

HON. LISTER HILL,
*Chairman, Committee on Labor and Public Welfare,
Senate Office Building, Washington, D.C.*

DEAR MR. CHAIRMAN: Recently hearings were held on S. 3008, introduced by you, to amend the Public Health Service Act to promote and assist in the extension and improvement of comprehensive health planning and public health services, to provide for a more effective use of available Federal funds for such planning and services, and for other purposes. Because of the brief interval between the time the bill was introduced and hearings were held, representatives of certain organizations of State officials were unable to prepare testimony on the legislation. We should appreciate it, therefore, if this letter could be included in the hearing record in lieu of such testimony.

For many years both the national Governors' conference and the National Association of State Budget Officers have been interested in bringing about a greater measure of flexibility in the purposes for which grants-in-aid of various health purposes might be expended. It appears to us that the bill you have introduced serves this purpose admirably. We are also pleased to note that the comprehensive public health services grants are programed over a 5-year period.

Another provision of the proposal which implements recommendations of State officials is that which provides for the interchange of Federal and State public health personnel.

Other provisions of the bill merit favorable comment. All in all, it appears to us that enactment of the proposed legislation would aid materially in achieving better organization and administration of public health programs.

Thank you very much.

Yours very truly,

CHARLES F. SCHWAN, Jr.,
Director, Washington Office.

The CHAIRMAN. The subcommittee will now stand in recess subject to the call of the Chair.

(Whereupon, at 11:10 a.m., the subcommittee was recessed subject to the call of the Chair.)



