KANSAS STATE UNIVERSITY LIBRARIES

DEPARTMENTS OF LABOR, AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1969

KSU LIBRARIES
A11900 458900

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETIETH CONGRESS

SECOND SESSION

SUBCOMMITTEE ON DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE AND RELATED AGENCIES

DANIEL J. FLOOD, Pennsylvania, *Chairman*

WILLIAM H. NATCHER, Kentucky
NEAL SMITH, Iowa
W. R. HULL, JR., Missouri
BOB CASEY, Texas
MELVIN R. LAIRD, Wisconsin
ROBERT H. MICHEL, Illinois
GARNER E. SHRIVER, Kansas

ROBERT M. MOYER, *Staff Assistant to the Subcommittee*

PART 2

STATEMENT OF THE SECRETARY OF HEALTH, EDUCATION AND WELFARE

OVERVIEW OF 1969 BUDGET

Printed for the use of the Committee on Appropriations

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

DEPARTMENTS OF LABOR, AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1969

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETIETH CONGRESS

SECOND SESSION

SUBCOMMITTEE ON DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE AND RELATED AGENCIES

DANIEL J. FLOOD, Pennsylvania, *Chairman*

WILLIAM H. NATCHER, Kentucky
NEAL SMITH, Iowa
W. R. HULL, JR., Missouri
BOB CASEY, Texas
MELVIN R. LAIRD, Wisconsin
ROBERT H. MICHEL, Illinois
GARNER E. SHRIVER, Kansas

ROBERT M. MOYER, *Staff Assistant to the Subcommittee*

PART 2

STATEMENT OF THE SECRETARY OF HEALTH, EDUCATION AND WELFARE

OVERVIEW OF 1969 BUDGET



Printed for the use of the Committee on Appropriations

U.S. GOVERNMENT PRINTING OFFICE

92-594 WASHINGTON : 1968

COMMITTEE ON APPROPRIATIONS

GEORGE H. MAHON, Texas, *Chairman*

MICHAEL J. KIRWAN, Ohio
JAMIE L. WHITTEN, Mississippi
GEORGE W. ANDREWS, Alabama
JOHN J. ROONEY, New York
ROBERT L. F. SIKES, Florida
OTTO E. PASSMAN, Louisiana
JOE L. EVINS, Tennessee
EDWARD P. BOLAND, Massachusetts
WILLIAM H. NATCHER, Kentucky
DANIEL J. FLOOD, Pennsylvania
TOM STEED, Oklahoma
GEORGE E. SHIPLEY, Illinois
JOHN M. SLACK, West Virginia
JOHN J. FLYNT, Jr., Georgia
NEAL SMITH, Iowa
ROBERT N. GIAIMO, Connecticut
JULIA BUTLER HANSEN, Washington
CHARLES S. JOELSON, New Jersey
JOSEPH P. ADDABBO, New York
JOHN J. McFALL, California
W. R. HULL, Jr., Missouri
JEFFERY COHELAN, California
THOMAS G. MORRIS, New Mexico
EDWARD J. PATTEN, New Jersey
CLARENCE D. LONG, Maryland
JOHN O. MARSH, Jr., Virginia
SIDNEY R. YATES, Illinois
BOB CASEY, Texas
DAVID PRYOR, Arkansas

FRANK T. BOW, Ohio
CHARLES R. JONAS, North Carolina
MELVIN R. LAIRD, Wisconsin
ELFORD A. CEDERBERG, Michigan
GLENARD P. LIPSCOMB, California
JOHN J. RHODES, Arizona
WILLIAM E. MINSHALL, Ohio
ROBERT H. MICHEL, Illinois
SILVIO O. CONTE, Massachusetts
ODIN LANGEN, Minnesota
BEN REIFEL, South Dakota
GLENN R. DAVIS, Wisconsin
HOWARD W. ROBISON, New York
GARNER E. SHRIVER, Kansas
JOSEPH M. McDADE, Pennsylvania
MARK ANDREWS, North Dakota
WILLIAM H. HARRISON, Wyoming
LOUIS C. WYMAN, New Hampshire
BURT L. TALCOTT, California
CHARLOTTE T. REID, Illinois
DONALD W. RIEGLE, Jr., Michigan

KENNETH SPRANKLE, *Clerk and Staff Director*
PAUL M. WILSON, *Assistant Clerk and Staff Director*

SUBCOMMITTEE ON DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE AND RELATED AGENCIES

DANIEL J. FLOOD, Pennsylvania, *Chairman*

WILLIAM H. NATCHER, Kentucky
NEAL SMITH, Iowa
W. R. HULL, Jr., Missouri
BOB CASEY, Texas

MELVIN R. LAIRD, Wisconsin
ROBERT H. MICHEL, Illinois
GARNER E. SHRIVER, Kansas

ROBERT M. MOYER, *Staff Assistant to the Subcommittee*

DEPARTMENTS OF LABOR, AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1969

MONDAY, MARCH 4, 1968.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT OF THE ACTING SECRETARY

WITNESSES

WILBUR J. COHEN, ACTING SECRETARY
RALPH K. HUITT, ASSISTANT SECRETARY, LEGISLATION
JAMES F. KELLY, ASSISTANT SECRETARY, COMPTROLLER
JAMES B. CARDWELL, DEPUTY ASSISTANT SECRETARY, BUDGET

Mr. FLOOD. We are now pleased to have with us the Honorable Wilbur J. Cohen. We are especially pleased to see that he is Acting Secretary of the Department of Health, Education, and Welfare.

As far as I am concerned, I would like to see him Secretary of the Department of Health, Education, and Welfare.

BIOGRAPHICAL SKETCH OF ACTING SECRETARY

If there is no objection we will insert your biographical sketch in the record at this point.

(The biographical sketch follows:)

BIOGRAPHICAL INFORMATION—WILBUR J. COHEN

Wilbur J. Cohen was appointed Under Secretary for Health, Education, and Welfare on June 1, 1965, by President Johnson. He was previously Assistant Secretary for Legislation, having been appointed to this post by President Kennedy in January 1961. He was responsible for handling some 65 legislative proposals which became law during the 4½ years he was Assistant Secretary for Legislation He was responsible for coordinating major policy issues between the legislative and executive branches during the 2½ years he served with Secretary John W. Gardner.

He is on leave as professor of public welfare administration from the University of Michigan where he taught from 1956 to 1961. He was Chairman of President Kennedy's Task Force on Health and Social Security in 1960 which recommended medicare and other health and social security proposals.

He was the research assistant to the Executive Director of President Roosevelt's Cabinet Committee on Economic Security from 1934 to 1935 which drafted the original Social Security Act. He has been intimately connected with all of the legislative developments in the social security, public assistance, and child health programs since 1934 and has been closely associated with the recent medicare, medical school, and education legislation.

Mr. Cohen was born in Milwaukee, Wis., in 1913, where he attended elementary and secondary school. He graduated from the University of Wisconsin in economics in 1934 from which he also received the honorary degree of doctor of laws in 1966. He also holds honorary degrees from Adelphi and Yeshiva Universities. He is a fellow of Brandeis University. He was married to Eloise Bittle of Ingram, Tex., in 1938, and is the father of three sons, born in 1942, 1944, and 1946.

He is the author of several books and many articles in the social security, health, welfare and education fields and is a recipient of a number of awards for distinguished service in health, education, and welfare. He is currently a member of the Presidential Commission on Income Maintenance programs.

He is an avid stamp collector and enjoys sawing and chopping wood for exercise and recreation.

Mr. Cohen is a legal resident of Ann Arbor, Mich.

General Statement

Mr. Flood. I see, Mr. Cohen, you have a statement. How do you wish to proceed?

Mr. Cohen. I would suggest, Mr. Chairman, that we put the whole statement in the record. I will go through it making some additional comments, if that is agreeable with you.

Mr. Flood. If there is no objection, that will be done.

(The statement follows:)

Statement of Hon. Wilbur J. Cohen, Acting Secretary, Department of Health, Education, and Welfare

Mr. Chairman and members of the committee, it is a pleasure to appear before you as you consider appropriations for the Department of Health, Education, and Welfare for fiscal year 1969.

I have appeared before this distinguished committee many times, sometimes as a witness on a given program or appropriation, and more recently as a support witness accompanying the Secretary. But this is the first time I have testified on behalf of the entire Department of Health, Education, and Welfare. For me, a man who began his career in a predecessor agency to the Department in 1934, it is an honor and a privilege.

With your permission, Mr. Chairman, I would like to direct my remarks toward some of the major trends and issues facing the Nation and the Department in the fields of health, education, and welfare. I believe this will provide a backdrop for the more detailed discussions of individual items in the budget which will follow when the agency heads and their staff appear before you later during these hearings. I have prepared for the committee a highlight and summary statement of the budget. If the committee wishes, following my presentation, Mr. Kelly and Mr. Cardwell will review for you the major overall aspects of the 1969 budget.

An overall view

A Federal budget represents a proposed allocation of resources to serve national objectives, the allocation of limited resources among competing demands within the public sector as well as between the private and public sectors. It identifies priorities for dealing with unmet needs. Hence, it is important to look at the total national picture of health, education, and welfare expenditures—public and private—in evaluating the Federal role in any year or over a period of time.

Total expenditures for health, education, and welfare—public and private—amounted to $146 billion in the fiscal year 1967 or about 19 percent of the gross national product. In 1950, comparable expenditures amounted to only 12.7 percent of the gross national product; in 1960 they represented 15.6 percent. These comparisons are shown in chart 1.

Of the total expenditures in 1967, approximately $100 billion—or about two-thirds—were public expenditures and about $46 billion—about one-third—were in the private sector. In the public sector, $54 billion were Federal expenditures, and $46 billion State and local.

It is interesting to note that private expenditures and State and local expenditures are approximately equal. As chart 2 shows, the private expenditures are primarily for medical care while the State and local expenditures are concentrated on elementary and secondary education.

Funds from all three sectors have been increasing. The Federal share increased about $8.5 billion from fiscal year 1966 to 1967; the State and local share $7.6 billion; the voluntary sector increased about $1.2 billion even though there was a transfer of over $3 billion in health insurance expenditures for the aged from the private to the public sector due to the inauguration of medicare.

The three-way cooperative approach we have in our country to meeting health, education, and welfare needs is not a simple, clearcut way of handling our problems. It is a constantly evolving partnership which brings with it all the complexities involved in cooperation, competition, and compromise. But, in my opinion, it is an arrangement which brings with it great potentialites for progress, improvement, and widespread participation and innovation by many persons, institutions, and agencies.

The most important observation to be drawn from these figures is that these expenditures have been growing rapidly and seem likely to continue to grow, both in terms of the total amount spent, and as a percentage of the GNP. I personally look upon them as an investment in the future growth and vitality of our Nation.

REASONS FOR GROWING EXPENDITURES

There are a number of reasons for the growth in expenditures for health, education, and welfare. First, the population is steadily increasing. The elderly population and the young population, those groups requiring the most services, have shown the largest increases. These groups have increased by more than 20 percent over the past 10 years and now constitute nearly 46 percent of the population.

Second, America is a Nation on the move. People are moving from East to West, South to North, from city to suburb, from farm to city. During the 6-year period 1960–66, the farm population had an annual average net loss of 804,000, an annual loss rate of 5.9. percent.

The number of people living in urban areas has increased more than 25 percent in the past 10 years and now make up about 70 percent of the population. By the year 2000 all but 20 percent of the population may be living in these concentrated areas. This population trend has had, and will continue to have, a direct bearing on expenditures. New services must be provided in areas where none existed and existing services must be expanded to accommodate growing numbers of persons. Also, the social problems—illegitimacy, alcoholism, mental illness, and broken families—that are generated, at least partially, as a result of this mobility, have come to be recognized as community responsibilities requiring community action.

Prices, too, have increased, pushing up the cost of the services purchased. For example, the cost of medical care in January 1968 went up 0.6 percent over the December 1967 level, bringing the index to 41.2 percent above the 1957–59 level.

Added to the above factors is the rising level of aspirations of people. They want better health care. They want better schools and more education for their children. Within a single generation the proportion of pupils who graduate from high school has risen by nearly 60 percent. For every 1,000 children in the fifth grade in 1959–60, there were an estimated 721 high school graduates in 1967. This may be compared with 621 graduates in 1960 and with 455 graduates in 1940 for each 1,000 pupils in the fifth grade 8 years earlier.

There is no question in my mind that the investment in health and education will and must continue to grow.

THE PARADOX OF PLENTY AND POVERTY

Although both the Nation's GNP and HEW expenditures have been increasing and much social progress has been made, we are all acutely aware of the many needs which are still unmet. An important aspect of our recent history is the growing awareness of these unmet needs and the concern about dealing more effectively and promptly with them.

The paradox of poverty amidst plenty is one which has been receiving considerable attention.

The good life enjoyed today by the average American goes beyond the fondest dreams of our grandfathers. Yet, in the face of all this Nation has accomplished—the highest standard of living in the world—the greatest educational and job opportunity for the most people of any nation on earth—the elimination of dread disease and a greater life expectancy—we are beset by problems associated with poverty—social unrest, rising welfare costs, inadequate education and training of some groups, and inadequate health care for many of our people.

As we have brought the fruits of progress to more and more of our people, the disparity between those who have gained the most and those who have gained the least has grown.

As we have raised our standard of living, so have we widened the gap between the poor and economically secure.

As we have provided an elementary and secondary education to more and more of our people, so have we increased their thirst for greater knowledge and for more education.

As we have broadened medical knowledge, so have we created a demand to extend the miracles of modern medicine to every corner of the land.

Thus, the United States today is faced with the difficult task of eliminating the disparities that exist—

Between the affluent and the poor;

Between those who have the skills and motivations for a job and those who do not;

Between those who have full opportunity for adequate health care and those who do not;

Between those who are receiving an adequate education and those who do not have full educational opportunity;

Between those who live in the ghetto and those who have become free to live where they choose.

Let's take a brief look at some facts about poverty.

The Social Security Administration in the Department of Health, Education, and Welfare makes annual estimates derived from data from the Bureau of the Census on the extent and characteristics of poverty.

The basic income levels used to determine the poverty line for the year 1966 are as follows: for a nonfarm family of four, $3,335; for a single person $1,635. These are adjusted for size of family, age, and for farm and nonfarm residence. The more detailed figures are shown in table 1.

From 1959 to 1967 the number of persons in poverty fell from about 39 million to about 27.4 million, or from 22.1 percent to 14 percent of the population. We estimate that on March 1 the number of persons in poverty declined an additional million by virtue of the increase in social security benefits.

It is highly significant that Federal programs aiding the poor have undergone substantial changes in the past 8 years. During this period the country has greatly increased both the size of this aid and the proportion of it that is provided trhough what I would like to call the human investment programs. Total funding of programs directly aiding the poor has more than doubled, from $9.5 billion in fiscal year 1960 to an estimated $24.6 in fiscal year 1968 and $27.7 billion in 1969. About two-thirds of these total estimated expeditures in aid to the poor for fiscal years 1968 and 1969 are provided through programs administered by the Department of Health, Education, and Welfare.

Significant yet often unnoticed changes have occurred in the nature of the aid provided. In the fiscal year 1960, over 87 percent of this aid to the poor was provided through cash benefit payments. By fiscal year 1968 (and for fiscal year 1969), cash benefit payments are estimated to account for 59 percent of Federal aid to the poor. Human investment programs providing education, work and training, health and other social services were greatly accelerated during this period. (Source: "The Budget for fiscal year 1969," p. 36.)

When President Johnson signed the Social Security Amendments of 1967, he named a presidential commission, under the chairmanship of Mr. Ben W. Heineman, the chairman and executive officer of the Chicago & Northwestern Railway, to review welfare and income maintenance programs. There have been many proposals for improvements in social security, for a guaranteed annual income, the negative income tax, for family allowances, and for governmental work and training programs. I think it is very timely that a top-level commission have an opportunity to review all of these proposals, as well as many other suggestions for innovation and change, and to try to find a wider and more comprehensive income maintenance system which is more adequate and more generally acceptable. The Commission consists of 19 members from varied walks of life. I am a member of the Commission. We plan to have our staff work intensively on these problems and proposals during the coming year.

PUBLIC ASSISTANCE

Although 27 million persons are living in poverty, only about 8 million are receiving public assistance. This fact should be kept in mind when the question is asked why welfare rolls are rising when unemployment is declining and social security and other income maintenance and economic opportunity programs are expanding.

But first let me say that a number of factors such as social security and employment opportunities, decreased mortality rates, safer working conditions, higher wages, homeownership, and life insurance have reduced the need of some groups to rely on public assistance. Largely as the result of the effectiveness of the social security program, the proportion of the aged on public assistance, in spite of a large increase in the total aged population, declined from 22.5 percent in 1950 to 11 percent in 1967. There would be about 2½ million more aged persons on welfare today if the proportion had remained at 22.5 percent. Chart 3 shows the change in the composition of the public assistance caseload which has occurred.

Secondly, the number of children receiving assistance under the AFDC program because of the death of a father has markedly declined. The problems of economic dependency of fatherless children which was one of our major social and economic problems at the beginning of this century has largely disappeared in the past 60 to 70 years. The combination of a number of factors, primarily declining mortality rates and the social security program have virtually eliminated the economic problems of orphanhood. If we had the same mortality rates today as we had in 1910, there would be about 5 million more children without one or more parents than there are today.

However, to answer the original question of why the public assistance rolls continue to increase, estimates suggests, as chart 4 indicates, that for every person receiving public assistance in June 1965, there was another person who was "categorically eligible" under the public assistance titles of the Social Security Act but who was not receiving public assistance. That is, there was a large group who might be called potential public assistance recipients; persons who meet all the categorical eligibility requirements of Federal law and who might become public assistance recipients depending upon such factors as the additional eligibility requirements of the State in which they live, their knowledge of public assistance programs, or their personal desire or lack of desire to apply for public aid. In other words, somewhat less than half of the poor persons who meet all the Federal categorical eligibility requirements were receiving public assistance in June 1965. Up to the present time, such factors as residence requirements, man-in-the-house rules, lack of knowledge, unwillingness to apply for welfare, and lack of financial participation by the States are factors which have kept the welfare rolls from rising even faster than they have.

It is true, however, that the number of AFDC recipients increased more than three times as rapidly in 1967 as it had in most preceding years. There is the possibility that poverty programs under the Economic Opportunity Act may have made more people aware of their eligibility. There are, too, the migration trends of persons from rural areas to the cities where money is an urgent necessity. There is the possibility that the availability of medical assistance under title XIX has increased the number of persons who were referred and found eligible for cash assistance payments.

The complex problems of illegitimacy and family breakup which are reflected in the growing AFDC rolls greatly concern all of us. Illegitimacy has been rising among both white and nonwhite families.

There are over 300,000 births out of wedlock each year. While about 17 percent of the children on the AFDC rolls are there because they were born out of wedlock, it should also be remembered that about 80 percent of all illegitimate children are not on the welfare rolls.

As a result of its concern, the Congress in the Social Security Amendments of 1967 took a number of steps to deal with the problems of illegitimacy, family instability, and to protect children. The amendments provide that—

1. State welfare programs establish and implement both a program of "preventing or reducing the incidence of births out of wedlock and otherwise strengthening family life" and a program of family planning service.

2. Paternity be established and support secured from such parent for children born out of wedlock.

3. A work incentive program be established permiting welfare recipients who work to retain the first $30 a month of earnings and 30 percent of any additional amount without any reduction in assistance payments. All earnings of a full-time student may be retained.

4. Day care services be provided for the children of working mothers with the requirement that such day care services must provide "for the development and implementation of arrangements for the more effective involvement of the parent or parents in the appropriate care of the child and the improvement of the health and development of the child." This new provision is the outgrowth of a great deal of consideration growing out of the Headstart program about the need for building into the programs strong provisions that relate to working with the parents and developing the motivation of the child.

5. Welfare agencies refer to the courts of law enforcement agencies any condition where a home is unsuitable for the child because of neglect, abuse, or exploitation of such child.

6. Cooperative arrangements be made among welfare agencies, courts, and law enforcement officials (including making Federal and State financial arrangements) to effectively carry out the new programs.

7. Emergency assistance can be given for 30 days on a flexible and simplified basis and payments may be made in the form of loans, grants, payments in kind, or in services.

8. Payments for foster care of children and the authorization for child welfare services be increased and protective services for children be expanded.

The net effect of all these provisions is an increase in both the Federal and State cost over the next few years. The congressional committees which acted on this legislation did not wish to see children hurt but rather directed their attention to constructive measures to improve the conditions for children under welfare. But it is clear that the costs of welfare will continue to rise although more of the costs will be for services such as day care for children, work, training, and related activities.

THE AFDC REFERRAL AND FREEZE PROVISIONS

One of the controversial features of the new legislation has been the extent to which mothers would be required to accept employment contrary to their wishes or what they might regard as the best interest of their children. When Secretary Gardner and I appeared before the Senate Committee on Finance we emphasized the Department's conviction that there were more mothers who wanted employment and training than there would be opportunities for under these programs. A recent study made in New York City showed that 70 percent of the mothers on assistance wanted to work. The available evidence indicates that there is and will be in the foreseeable future ample opportunity to fill available work and training positions by mothers who wish such training and work on a voluntary basis.

The President has directed us to work with the States to see that the mandatory referral to work provision is administered compassionately, and we are doing so.

With respect to the AFDC freeze, the law says that for the last half of 1968 no larger proportion of the child population under the age of 18 shall receive Federal aid because of the absence of a parent than the average proportion in the first quarter of the year. By relating the number to the child population under 18 on January 1, of each year, provision is made to permit an annual adjustment to give effect to any changes in the child population. But if present trends continue, most, if not all States, will be faced with financial problems as the result of this provision.

Chairman Mills, when he presented the Ways and Means Committee's bill to the House, stated that the purpose of the freeze was to apply pressures to the States which would assure that they move promptly and vigorously to put the new work programs and other features of the legislation into effect. We certainly cannot expect work programs or family planning services will have much effect on AFDC rolls before July 1. In my judgment, what is needed now is concrete information that will show what the effects will be on the individual States, what will happen to mothers and children as the result of the freeze, and what

specific efforts States are making to achieve the objectives of the Congress. We have asked the States for this information. I met with the State Welfare Administrators recently and with several of the Governors last week on this matter and exchanged ideas on these points.

We have been asked whether States may use waiting lists so as to limit recipients of AFDC to the number for which Federal financial participation is available under the freeze. In our proposed policy statement on the freeze, we have maintained our longstanding position that States may not maintain waiting lists. The Congress did not change the requirement in the Federal law that State plans must provide "that aid to families with dependent children shall be furnished with reasonable promptness to all eligible individuals."

Some of the States have indicated that they disagree with this interpretation and, if necessary, they will seek administrative hearing and court review to test our proposed position. While we are acutely aware of the fiscal problems which the freeze presents for the States, we believe we have no alternative, under the law and in the interest of children, to requiring that aid must be furnished promptly to all eligible individuals, without waiting lists.

MEDICAID AND MEDICARE

I have mentioned some of the factors which lead me to believe welfare costs will continue to rise. One of the reasons for this is the medicaid program and the rising cost of medical care.

It is estimated that 5.2 million persons received care under medicaid in the fiscal year 1967, 7.3 million will receive care in 1968, and that about 8.5 million will be served in 1969.

In 1950, payments for medical services were only an infinitesimal fraction of welfare costs. As shown on chart 5, we estimate that medical care will represent over 40 percent of all welfare costs in 1969.

There is still a wide variation in income limits and scope of medical coverage under the State medicaid programs. This is not desirable. One of our big challenges ahead is whether the States and the interested groups can work together to narrow these variations to provide essential services for medically needy persons and at the same time improve voluntary health insurance coverage.

I believe that the medicaid program meets a basic need in our society because there are many persons with incomes too low to finance adequate health insurance coverage. Our voluntary health insurance system has many gaps. I recently outlined to representatives of nonprofit and commercial insurers a number of improvements needed in voluntary insurance if medicaid costs are to be kept within reasonable limits. However, until medical insurance coverage is more comprehensive—and covers all of the low-income families—there will continue to be a compelling need for more funds under medicaid. For instance, one of the important areas in which voluntary insurance must expand its coverage is in the area of mental illness. Outpatient care, home health services, and nursing home care are other important areas in which voluntary insurance should expand.

One area in which I believe we can extend medicare insurance is to the over I million persons who have been determined to be disabled under the social security program. This proposal was considered by the Congress last year and a speical study was authorized as was the entire question of coverage of prescription drugs under the medicare program. Recommendations from this study are to be submitted to the Congress before the end of this year.

RISING MEDICAL COSTS

Today, there are indications that many Americans are simply not getting the health care they need.

One of the most formidable barriers to high-quality health care is the steady rise in medical costs. A day in the hospital, which cost $14.40 in 1950, now exceeds $55. Other health costs, including drug prices and doctors' bills, have risen during the same period. In the past 12 months alone medical care prices have increased 7 percent.

This rising spiral of costs seriously threatens our ability to make health care more widely accessible and more readily available to the people who need it.

To explore this problem, the Department called a conference on medical costs last summer, in which leading physicians, hospital administrators, and others from all over the Nation participated. The group was in general agreement that one of the reasons for the rapid rise in costs is that we have an antiquated and

inefficient system of health care. As a nation, we are simply not well enough organized today to provide all of our people with the health services they want and need on an economical and efficient basis.

This conference was followed with several more—on private health insurance, on the group practice of medicine, and on hospital architecture and design. In addition, the Secretary established a Committee on Hospital Effectiveness to study the entire system of hospital and related services. And recently President Johnson created a National Advisory Commission on Health Facilities to recommend this year new directions in Hill-Burton and related hospital legislation.

We need intensive experimentation in the years ahead. We need to devise and test new patterns for delivering high-quality health services.

For example, we have to find a mechanism for channeling people away from large and costly institutions when institutional care is not necessary and warranted. We need systematically to employ less expensive facilities. We need to broaden the reach of physicians' services with the use of new communications techniques and computer technology. We need to develop better emergency medical services.

We're also faced with the task of conserving scarce health manpower by making better use of highly trained professional people and by developing new types of health workers.

We need, in brief, to expand our research and development effort in health services. That is the purpose of our new National Center for Health Services Research and Development. It will enable physicians, clinics, and communities around the country to experiment in new ways of providing and delivering health care. It will help us find new patterns, new models, new directions.

Our purpose in this and other new approaches is to insure the best possible health care, provided in the most efficient manner and at the lowest possible costs, for all Americans.

The Congress last year recognized that more must be done to control rising medical prices.

First, they wrote into the medicaid program a new requirement that States must—"provide such methods and procedures relating to the utilization of and the payment for care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."

In addition, Chairman Mills sponsored an amendment applying to medicare, medicaid, and the child health program which authorizes experiments with existing charge or cost reimbursements to include specific incentive payments "to have the effect of increasing the efficiency and economy of health services through the creation of additional incentives to these ends without adversely affecting the quality of such services."

Much more, however, remains to be done if we are to extend the quality of care, restrain costs, and promote efficiency and economy. This will be a continuing and difficult responsibility for some time to come. We are far from knowing all the answers. We must find answers which do not restrict the private practice of medicine or the doctor-patient relationship.

I cannot let this opportunity pass without referring to the constructive and cooperative relationships which have developed between the health professions and our programs in the past 2½ years, expecially in the medicare program. The recent article by Dr. David Jay Scott, entitled, "We Doctors Were Wrong About Medicare," in the Saturday Evening Post issue of February 24, is worth reading. He reports that to his amazement "even the Government forms are less complicated" than those used under other doctor-approved insurance programs. He points out how "medicare is helping to improve the entire standard of health in the United States."

CHILD HEALTH

One area which calls for redoubled effort is child health. Our infant death rate declined some 6 percent last year, but it is a shocking fact that at least 12 other nations have rates lower than ours. The reason is apparent: the extreme disparity between the health services available to the poverty stricken and to the more affluent segment of society. The benefits of modern medical knowledge have barely begun to reach the children of the poor in our inner city and rural slums, and particularly our nonwhite population.

The contrasting death and illness rates of our white and nonwhite populations confirm the inequality of services. The death rate for nonwhite infants is 87 percent higher than that of white infants. A white child who survives infancy can expect to live from 5 to 6 years longer than a nonwhite child of the same age. The poor and nonwhite still suffer from a wide variety of handicapping conditions that could be prevented or corrected by early medical attention.

Often, however, the medical care they get is too little and too late—fragmented, impersonal, inaccessible. The result is sickness that need not happen and death that could be averted.

We need new approaches and new resources for expanded child health services—in neighborhood centers, parent and child centers, and comprehensive maternity and infant care projects in low-income areas. In some areas where such projects have been launched, the infant death rate has dropped by as much as 40 percent. This is an auspicious beginning, but we need to reach many more mothers and children if we are to bring our health standards to the levels of which we are capable in this country.

We made substantial progress last year in expanding and consolidating the child health provisions into the Child Health Act of 1967. The 1969 budget contains an increase of $58 million for these purposes.

In addition, we are proposing additional legislation this year to extend over a 5-year period maternity care to all mothers in low-income families, and medical services to children under the age of 1 year in such families.

FAMILY PLANNING

I believe that one of the most significant legislative achievements of the Congress last year was the statutory recognition of the importance of family planning services. Specific language was added by the Congress to both the child health and dependent children (AFDC) laws incorporating family planning services in these two programs. In the child health program, there is a specific earmarking for family planning services of 6 percent of the total funds. All such services are provided on a voluntary basis with freedom from coercion and freedom in choice of method utilized.

Family planning should be an intrinsic part of medicaid, maternal and child health, and AFDC programs. There is a close association between poverty, illness, and large family size. Studies have shown that most people at all income levels prefer small families, but the poor have less freedom of choice because they lack the knowledge of and availability to family planning services.

I would like to report to the committee one of the conclusions of a study we made last year. This study showed that, of the 8.2 million low-income women in the childbearing age, there were 451,000 unwanted pregnancies. This study may be of interest to your committee and I should be glad to make it available for your review.

Last year, a new position of Deputy Assistant Secretary for Family Planning and Population was established in the Department to coordinate the Department's programs of medical and social services, education and research in this field, and Mrs. Katherine Oettinger was named to this important post.

In a memorandum to the heads of HEW's operating agencies, the Secretary said, "The immediate objective is to extend family planning services to all those desiring such services who would not otherwise have access to them. Family planning is an integral part of our overall health program directed at the reduction of infant and maternal mortality and improving the health of the family."

The policy emphasized freedom from coercion and freedom of choice in method to be used.

The Department also plans to step up its research in human reproduction and fertility, to continue to test the safety and effectiveness of contraceptive devices, and to increase public understanding of family life and sex education.

The budget places greatly increased emphasis on family planning. The $56 million in the budget for 1969 compares with $28 million budgeted in 1968 and $20 million in 1967.

HEALTH RESEARCH

All of our progress in health depends on a sound foundation of biomedical research. Thanks to the interest and support of this committee, our health research effort has grown steadily over the years.

In its report to the President last year, the National Institutes of Health noted that as a result of Federal support of research, 65,000 senior investigators are

now at work in some 2,000 academic and research institutions. In addition, some 30,000 individuals are getting advanced training in scientific and clinical specialties.

This vast effort has revolutionized the range of medical capability; has improved the outlook for people suffering from heart disease, cancer, and a number of other serious ailments; and has opened new insights into the functioning of biological systems, the ways in which we develop and age, and into the nature of life itself.

Within the past year, we witnessed new and dramatic potentialities of medical research, particularly in organ transplantation, in the development of the artificial heart and the artificial kidney, and in new knowledge of the mechanisms of human heredity. Such specific, target-oriented research should be continued and encouraged, and we intend to give this kind of work a high priority. At the same time, we need to pursue new knowledge along a broad and varied front—knowledge that will yield new techniques to prevent diseases, ease suffering, and promote longevity for as many people as possible.

I think this is an appropriate place to mention that we are proceeding with plans for the establishment of the international center for advanced study in the health sciences, which will bear the name of the distinguished former chairman of this committee, the late John E. Fogarty. The initial function of the Fogarty Center will be to create the environment and to provide the means to assemble scholars and scientists for the advanced study of science as it relates to health.

MANPOWER AND WOMANPOWER SHORTAGES

All of our social programs depend on an adequate supply of well-trained professional and supporting manpower. At present, the Nation's manpower shortage is grave, and it is likely to remain so for some time to come.

The recent report of the National Advisory Commission on Health Manpower underscored the great need for health workers of all types. The need is equally serious in the fields of social work, education, and rehabilitation.

We need to increase the output of trained people in all these fields. We need to devise patterns of organization and administration that will make the most efficient use of professional personnel. And we need to develop and train new categories of workers—aides, auxiliaries, technicians—to provide essential services as part of a team effort and to stretch our limited supply of manpower. To do so, we have to reevaluate the skills required for various types of services and tailor these skills to different categories of need.

The manpower problem is a challenge to almost every element of society—business and industry, the education community, professional groups, and government at all levels. We have made a start in various training programs and in our efforts at coordination among governmental agencies. But we need to be both more imaginative and more aggressive if we are to come anywhere near our manpower needs in the decade ahead. Chart No. 6 gives some indication of the manpower problems in the health field.

ENVIRONMENTAL PROBLEMS AND CONSUMER PROTECTION

Americans continue to foul their environment at a phenomenal rate. Each year we dump 125 million tons of pollutants in the air. Our landscape is littered with junk and wastes, part of the 165 million tons of solid waste we produce annually. We are buffeted by crowding, harried by noise, endangered by radiation. We know relatively little about the more than 500,000 synthetic chemicals and other compounds on the market today or about their effect on human beings.

The rising tide of pollution threatens not only our health but the very quality of our lives.

The Air Quality Act of 1967 gave us new tools to help restore the Nation's air to an acceptable quality. It will enable us to expand our research and development efforts in this field. It authorizes the establishment of air quality control regions which should lead in to the development of desirable air quality criteria. It encourages planning and control activities on a regional basis.

As a result, we are accelerating our efforts to clean up the air. But we are not nearly as advanced in other environmental areas. Nor have we as yet begun to develop a total, comprehensive approach toward conserving our environment or refashioning it where necessary.

The increasing complexity of the products and services we live with makes it necessary to take protective measures in common. The individual is simply not up to judging the safety or efficacy of a new drug or plastic or synthetic. He is asked to choose wisely under conditions which baffle the experts. We must devise new safeguards to protect the American consumer from fraudulent or potentially hazardous substances and products.

VOCATIONAL EDUCATION

A useful and rewarding job is the surest road to independent living. But the disadvantaged face almost insurmountable barriers in getting and holding a job. They lack skills, work experience and normal work habits. Seeing no way out for themselves, they often lack motivation and self-respect. They need education to live as well as to learn.

Vocational education and job training are crucial to our efforts at salvaging human beings. Much greater attention must be given to vocational education within the framework of our school system. Too often, vocational education has been outside that system or has occupied an inferior place within it. Children enrolled in vocational education courses sense this second-class status and usually drop out early.

Moreover, vocational education in many States has not been as responsive to the needs of our society as it might be. The emphasis has been on occupations bypassed by our advancing technology.

Vocational education should be part of a total program that prepares the individual to live in society. Our young people and our adults have the right to a total rather than a fragmented education, including preparation for the world of work. Occupational education, planned work experience, and job and career counseling should be offered as part of the general education program in all schools. And to help serve the multiple and changing needs of individuals, the school should link itself to family, employer, and community.

We need new and innovative approaches to vocational education and manpower training. We need to build a sound system that will motivate young people to stay in school, that will be preventive and constructive instead of palliative. And we need to do a much better job of coordinating the various job training programs at the local level.

We recently transmitted to the Congress the report of the Advisory Committee on Vocational Education appointed under the 1963 amendments. The committee headed by Martin Essex made a number of recommendations which should be reviewed by both the substantive legislative committees and the appropriations committees. There will also shortly be transmitted the report of the special committee which was authorized by your subcommittee last year.

We still have a long way to go before we have a satisfactory and adequate program of vocational education in this country.

HIGHER EDUCATION

Our society is committed to the goal that every American receive all the education he is capable of, in whatever variety his abilities and interests dictate. In today's world, this means higher education. For millions of Americans, higher education used to be only a dream. Today, it is a necessity and more and more students are aspiring to an education beyond the high school.

They are doing so in increasing numbers. College and university enrollment last fall was at a record high of nearly 7 million, an increase of 8 percent over the previous fall and 45 percent over 4 years ago. In another 4 years the enrollment total is expected to rise another 25 percent.

At the beginning of this century only 4 percent of Americans from 18 to 21 were enrolled in higher education; by 1960 this proportion had increased to 23 percent. Today it is over 33 percent. For the first time in our history, education beyond the high school is becoming the norm rather than the exception in America. Table 2 is an indication of the remarkable progress made in recent years and the growth expected in the next 7 years.

One of the most significant developments which is occurring is the increase in enrollment in 2-year community colleges. Enrollment has increased from about 850,000 in the fall of 1963 to 1,440,000 in the fall of 1967. This is a most important step in making post-high school education more easily accessible to additional students.

Yet millions of youngsters still do not share in this opportunity. The cost of higher education has soared in recent years. For too many high school graduates going on to college still depends far more upon the ability to pay than the ability to learn. We have to strike down all the barriers—financial, racial, social, and geographical—to a college education. We also have to make sure that our colleges and universities have the teachers, facilities, and resources they need to accommodate the flood of new students. Finally, we have to maintain and improve the quality of higher education and to strengthen its services to our communities and States.

The growth in expenditures for higher education is shown in table 3. We can except these expenditures to grow in both amount and relative to the GNP.

A major issue will be how to organize and finance student financial aid so that all students from low-income families who have the ability and interest in attending college can do so.

Chart No. 7 indicates that in 1967, 48 percent of all undergraduates came from the 25 percent of families with the highest incomes, while only 7 percent came from the 25 percent of the families with the lowest incomes.

I believe we must begin to develop a plan by which we make it possible for every boy or girl with ability and purpose to attend college.

ELEMENTARY AND SECONDARY EDUCATION

Any adequate discussion of the needs in elementary and secondary education would require an entire volume by itself.

The Elementary and Secondary Education Act of 1965 has enabled the Nation to make important progress, but it is still premature to know in substantial detail exactly what the results will be until we have had a longer period of experience.

I am glad that the Congress extended the ESEA for 2 years last year and I hope that advance funding for title I will be enacted this year. School districts need this kind of longer-range provisions to enable them to plan wisely and well for the use of the Federal funds.

There are many unsolved problems in elementary and secondary education which will take us a number of years to deal with properly. As chart No. 8 shows, while the average annual current expenditure per pupil in 1967 was $569 for the Nation, State annual per pupil expenditures ranged from $912 in New York to $335 in Mississippi. Fifteen States expended over $600 and five States expended under $400 per pupil.

The relative difference between the State with the highest per pupil expenditure (New York) and the State with the lowest per pupil expenditure (Mississippi) has decreased somewhat in recent years. In school year 1963–64, for example, New York's per pupil expenditure ($744) was triple that of Mississippi ($249). By the 1966–67 school year, New York's per pupil expenditure ($912) was 2.7 times as large as Mississippi's ($335). But the gap is increasing in terms of absolute dollar differences ($495 difference in 1963–64, as compared to $577 in 1966–67).

There are still many localities in which children cannot attend kindergarten. In the year 1966, about 25 percent of all 5-year-old children did not attend kindergarten or school; 80 percent of all 4-year-olds were not enrolled in any kindergarten or nursery school.

The major responsibility for financing elementary and secondary education falls on the localities, and financial problems today plague practically every city school system. No one would question that elementary and secondary education in the inner city must be strengthened greatly in financial resources and in quality of teachers if the children in these areas are to have high quality education. Yet a study of the Advisory Commission on Intergovernmental Relations, covering 37 largest standard metropolitan statistical areas in the country, showed that State financial aid to local schools tended to favor suburban schools over central city schools. The Commission's studies show that the schools serving low-income, central city children are receiving less per pupil as well as per capita than those serving the more affluent suburbs. Another study of 35 cities showed that cities averaged $124.92 per pupil in State aid in 1964–65, while suburban districts got an average of $165.54 per student—$40.62 more. We need to reconsider local and State methods of financing elementary and secondary education and the role of Federal financial help in the three-way partnership if these imbalances are to be corrected.

The need for effective, competent teachers grows each day. Allowing for enrollment increases, teacher turnover and some replacement of teachers with sub-

standard certificates we foresee a need for well over 900,000 new teachers in the next 5 years. Teachers salaries in 1967–68 range from an average of $4,611 in Mississippi to $8,900 in California, with a national average of $7,296. An increase in the salaries of elementary and secondary school teachers is mandatory to attract and hold capable, imaginative and enthusiastic individuals as teachers. The success of our educational programs will depend on the quality of our teachers. More effort must be made to provide adequate numbers of trained educational manpower. Teacher training and retraining and the use of teacher aides should be emphasized and additional measures taken to attract qualified people into teaching and to strengthen teacher education.

THE URBAN CRISIS

Many of the problems I have been discussing converge with special severity in our cities. The cities are in deep crisis, a crisis that is both physical and social. The physical crisis is visible in the terrible overcrowding, contaminated air, choked streets and highways, and deteriorating neighborhoods. But the social crisis—the rising welfare loads, high unemployment among the young and untrained, high rates of crime and delinquency, and unrest and alienation in the inner city ghettos—is even more corrosive.

The reasons for the crisis are familiar. The concentration within the cities of racial minorities has created ghettos which reflect not only poverty but also the multiple ills of economic and racial segregation. The flight of the upper and middle income groups to the suburbs has eroded the local tax base, while the costs of public services—police and fire protection, education, sanitation, welfare, health—have soared in the inner city.

Within the last few years we have begun to face the urban problem realistically and with a renewed sense of dedication. Recent legislation has given us a variety of new tools and resources. But we are still groping for solutions. We have a long way to go before we apply ourselves to the total problems of the city in a coordinated way.

The overriding challenge of our time is to rebuild our cities so that they are not only more livable but so that they are once more the centers for jobs, education, culture, and leadership in today's world.

RESPONDING TO THE PROBLEMS

Many other problems are also before us—mental illness and mental retardation, alcoholism, drug addiction, and juvenile delinquency, to name but a few. In my presentation, I have limited myself to but some of the issues as we view them today.

We are, I believe, responding to all of these problems. We certainly don't have all the solutions. And the pace of progress has been understandably uneven. We are confronted with matters of incredible complexity, involving institutional change as well as the reordering of human resources.

Nonetheless, we can report encouraging progress on a broad series of fronts.

Before doing so, however, I should like to describe some of the organization and management improvements we have made in HEW. These actions have two important purposes: (1) to discharge our own responsibilities, our share in the national effort, in a more efficient manner; and (2) to improve our relationships with the agencies and institutions, both public and private, with which we work.

Organization and management

We have given considerable attention to modernizing the Department's administrative machinery and revitalizing its organizational structure. Since we last reported to this committee, we have made two major organizational realinements.

The first occurred last August when three major agencies—the Welfare Administration, the Vocational Rehabilitation Administration, and the Administration on Aging—were combined in a new Social and Rehabilitation Service. This reorganization was designed to—

Bring together the various HEW services that deal with special groups, such as the aged, the handicapped, and children;

Encourage the concept of preventive and rehabilitative social services for all the disadvantaged, including the poverty stricken;

Separate cash payments for welfare recipients from programs of service, thus making better use of scarce, highly skilled personnel; and

Help improve the delivery of services by establishing simplified and cleaner channels at the regional level to the States and communities.

This move is already helping to encourage a combination of services—counseling, medical diagnosis and treatment, income support, day care, homemaker services, adult basic education—delivered in a coordinated way and tailored to the specific needs of disadvantaged individuals and families.

The second major change is still under discussion. Its purpose is to strengthen and improve the coordination of the Department's scattered health programs by giving the Assistant Secretary for Health overall direction and policy responsibility for health programs.

The new alinement would group our health activities under three major subdivisions: research, health services, an environmental health and consumer protection.

This arrangement would give us greater flexibility in dealing with States and communities, hospitals and universities, and the health professions. We hope, too, that it would serve to improve the delivery of health services to the people who are most in need of health care.

In another reorganization last year, St. Elizabeths Hospital, heretofore a separate agency within HEW, was transferred to the National Institute of Mental Health. The purpose is to transform it, under NIMH tutelage, into a modern, community-based mental health center for the District of Columbia.

As you know, our Department has important responsibilities in bringing about compliance with title VI of the Civil Right Act of 1964. Here, too, we moved to strengthen our organizational capabilities. All the civil rights functions heretofore scattered in several agencies were transferred to a newly created Office of Civil Rights, headed by the Secretary's Special Assistant for Civil Rights.

In addition to these organizational steps, a number of improvements were made in management systems. To cite just one result, the Food and Drug Administration was able to eliminate a 2-year backlog in processing new drug applications.

One of the most significant management reforms had to do with HEW assistance to State and local agencies. As you know, more than 90 percent of the funds appropriated to this Department are allocated to these agencies in the forms of grants. The improvements included delegating more decisionmaking authority to regional offices; eliminating duplicative requirements, and streamlining the technical review procedure. These reforms are expected to cut the time devoted to the processing of grants by 50 percent, and should enable the Department to respond much more quickly to State and local needs.

Working with others

All of these administrative and organizational measures are part of the De partment's continuing effort to strengthen State and local agencies and to improve our relationships with them.

This effort has taken two forms: (1) legislation to encourage greater initiative and flexibility on the part of State and local agencies and institutions; and (2) the creation of mechanisms to foster closer ties between the Federal and non-Federal partners.

A major legislative breakthrough was the Partnership for Health Act which freed the States and communities from categorical restraints. It enabled them to approach their own health needs more rationally, to plan comprehensively, and to set their own priorities.

Another step in this direction was the Educational Professions Development Act which provided greater flexibility in Federal support for the training of faculty and staff members.

The late funding of Federal programs in support of education has been a continuing source of frustration to the school community. School officials had to hire teachers and plan their activities before they knew how Federal authorizations would affect these activities. After studying this problem, we proposed a system of advance funding and the Congress enacted an amendment to this effect last year. Advance funding should remove many of the uncertainties faced by the Nation's school officials and enable them to plan their programs more realistically.

We are looking into the matter of grants from several angles—financial arrangements, procedures, and relationships. We are giving intensive study to the difficult and controversial question of block versus categorical grants. We are exploring new ideas and alternatives that might help us arrive to more flexible arrangements.

Finally, we are focusing resources throughout the Department on urban problems. We established a new base for this effort in the Center for Community Planning, which was set up within the Office of the Secretary last year. The Center enables HEW to address itself directly to the problems of the central cities. It serves as a resource for city officials and a primary point of contact with the Department of Housing and Urban Development on model cities plans and programs. It works closely with HUD and other Federal agencies to coordinate multipurpose projects involving education, land use, recreation, housing, health care, and social services.

ACCOMPLISHMENTS

Now let me highlight just a sampling of accomplishments under some major HEW programs which you have made possible:

On March 1 more than 23.5 million people—one out of every nine Americans—received an increased monthly social security check. In 1967, social security benefits helped keep 5.7 million people out of poverty. As I pointed out before, a million more people are expected to escape poverty as a result of the 1967 Amendments to the Social Security Act. An additional million would have been taken out of poverty if the benefits had been increased to a $70 minimum as the administration recommended.

In its first 18 months, medicare has helped pay over 28 million medical bills, totaling almost $1.3 billion. Virtually all older people are now protected against hospital costs and some 93 percent are signed up for voluntary medical insurance, a tremendous response for a voluntary program.

About 9 million disadvantaged children—in over 18,000 school districts in all the States—were helped last year by special projects under the Elementary and Secondary Education Act of 1965.

Nearly one and a quarter million young Americans are continuing their education beyond high school with the help of Federal financial aid programs.

Some 10 million adults have participated in federally assisted vocational education programs since 1965.

More than 200,000 mothers and their infants have received special medical care in 54 low-income areas over the past 4 years. In some of these areas, infant mortality has dropped by as much as 40 percent.

This year more than 200,000 disabled people will be rehabilitated for useful work, almost 50 percent more than 3 years ago. More than one out of every 10 of these people were on public welfare.

Close to 300 community mental health centers are being built or staffed with Federal help. They are located in areas where 47 million American live.

The foregoing are merely illustrative of the vast effort you are supporting in every field related to human well-being. It is a shared effort, which depends on participation and leadership among a variety of groups and at all levels of government. We appreciate the support you have given to making it possible to make continued progress in these important programs.

This completes my opening statement, Mr. Chairman. If I may, I would like to have Mr. Kelly and Mr. Cardwell give you a summary of our 1968 and 1969 budget proposals. Mr. Huitt is also here to give you a summary of our legislative program for this session of Congress. We stand ready to give you any information you want and to answer any questions you may have.

Mr. FLOOD. Mr. Cohen, will you proceed?

Mr. COHEN. Thank you, Mr. Chairman and members of the committee. It is a pleasure to appear before you as you consider appropriations for the Department of Health, Education, and Welfare for fiscal year 1969. I have appeared before this distinguished committee many times, sometimes as a witness on a given program or appropriation, and more recently as a support witness accompanying the Secretary. But this is the first time I have testified on behalf of the entire Department of Health, Education, and Welfare.

For me, a man who began his career in a predecessor agency of the Department in 1934, I might add at a salary of $1,580, it is an honor and a privilege. With your permission, Mr. Chairman, I would like to direct my remarks toward some of the major trends and issues

facing the Nation and the Department in the fields of health, education, and welfare.

I believe this will provide a backdrop for the more detailed discussions of individual items in the budget which will follow when the agency heads and their staffs appear before you later during these hearings.

I have prepared for the committee a highlight and summary statement of the budget. If the committee wishes, following my presentation, Mr. Kelly and Mr. Cardwell will review for you the major overall aspects of the 1969 budget. First, I am going to present an overall view.

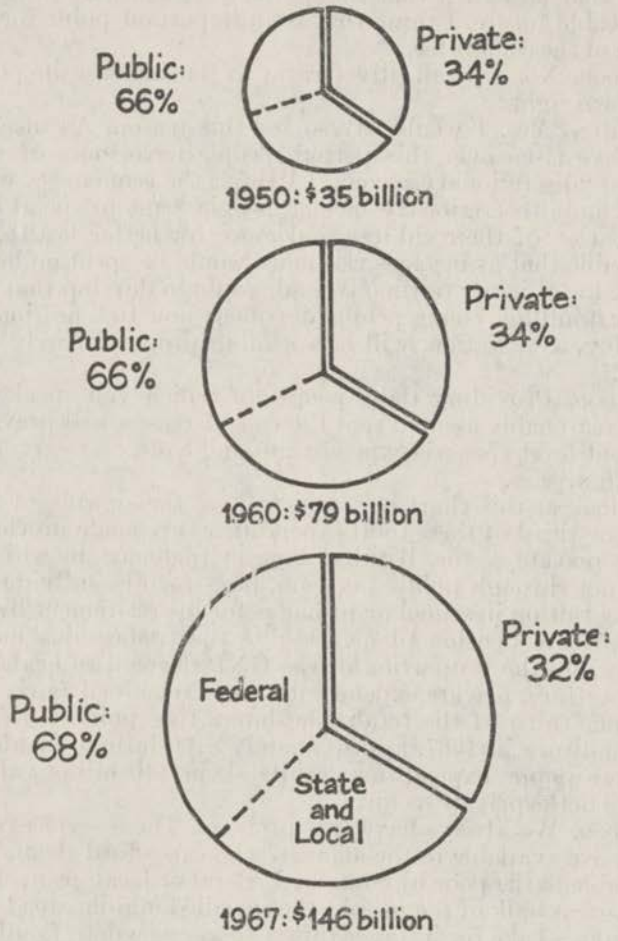
A Federal budget represents a proposed allocation of resources to serve national objectives, the allocation of limited resources among competing demands within the public sectors as well as between the private and public sectors. It identifies priorities for dealing with unmet needs. Hence, it is important to look at the total national picture of health, education, and welfare expenditures, public and private, in evaluating the Federal role in any year or over a period of time.

TOTAL EXPENDITURE FOR HEALTH AND SOCIAL WELFARE

I would like you to look first at chart 1.

(Chart on this subject follow:)

Total Expenditures for Health, Education and Social Welfare



Mr. COHEN. Gentlemen, if you take the total expenditures for health, education and welfare, in the Nation, public and private,—that is, what society as a whole is investing in this area—the amount is $146 billion in the fiscal year 1967. I have presented here how this expenditure has grown since 1950 when it was $35 billion, to 1960 when it was $79 billion, to 1967 when it was $146 billion.

The important point, Mr. Chairman, about these is that this $146 billion represents about 19 percent of the gross national product. Looked at in another way, you might say, 19 percent of everything our economy produces is directed toward these three areas of health, education, and welfare. In 1950, comparable expenditures amounted to only 12.7 percent of the GNP. In 1960 they represented 15.6 percent. In other words, as you can see from the chart, they not only increased in amount, they also increased in their proportion of the GNP.

Mr. FLOOD. I think we could very well use here the overused term "dramatic," couldn't we, as far as the increase is concerned.

Mr. COHEN. Yes, as I will show, this has not only been increasing steadily but I am going to make the prediction on the basis of the programs that now exist that this is likely to continue to increase in the foreseeable future. I think that is an important point for the consideration of the committee.

Mr. FLOOD. Not only in direct ratio to the increase in population but in its own right?

Mr. COHEN. Yes. I would say so for this reason. As incomes rise, as they have risen over this period, people have more of what has been called "discretionary income." I think the economists would say that with more discretionary income people want to spend more for their education of their children and more for better health. So it is very probable that as incomes rise more would be spent on health and education. Later in my testimony I am going to develop that as we go from over 6 million young people in college now to 9 million in 1975, we probably, as a Nation, will be spending proportionately more for education.

Mr. FLOOD. Providing these people of which you speak are convinced or reasonably assured that the rule of reason will prevail at the Government level vis-a-vis expenditures and costs.

Mr. COHEN. Yes.

If you look at this chart here you will see the significant fact that roughly one-third of these total expenditures are made in what I have called the private sector. By that I mean that part in which an individual, not through public taxation, pays for his individual doctor or pays the tuition in school or provides for his retirement by contributing to private pension plans. Despite the tremendous increase in the dollars and the proportion of the GNP devoted to health, education, and welfare, private expenditures have remained fairly constant at about one-third of the total. The interesting point is that of the total expenditure in 1967, approximately $100 billion, or about two-thirds, were public expenditures while about $46 billion, about one-third, were in the private sector.

Mr. FLOOD. We always have this problem. These services of which you speak are available to the affluent, who can afford them. They are also available to the poor by State or Federal or local grant. But what about the great bulk of the people, the so-called middle area?

Mr. COHEN. Take for instance this year when median family income is about $7,500 a year.

I would say for people with incomes between $5,000 and $10,000, in that median area, in the health field a large proportion of them have Blue Cross or Blue Shield insurance and they are paying a very substantial part of their own way. That family may have great difficulty if they have two or three children and wish to send them to college. It is important that there is some public subsidy available to them.

Mr. FLOOD. And this contributes to the decrease in birth rate. If you have three or four children that are going to school at once you decide you cannot afford to have seven children.

Mr. COHEN. It does appear from the studies made that there is a tendency toward a smaller size family than in the past because people now have greater aspirations for their children to go to college. They are aware of the fact that 4 years of college might cost anywhere from $6,000 to $15,000.

COMPARISON OF PUBLIC AND PRIVATE EXPENDITURES

Mr. COHEN. I think the significant factor here, if you look at chart 2 for a moment now, is the difference between the areas of education and social welfare. If you take chart 2 you will see that in the health field, where the total expenditures for 1967 are estimated to be about $47 billion, private expenditures are the largest factor constituting 66 percent. That is because individuals are paying through Blue Cross or Blue Shield or paying doctor bills out of their own pocket.

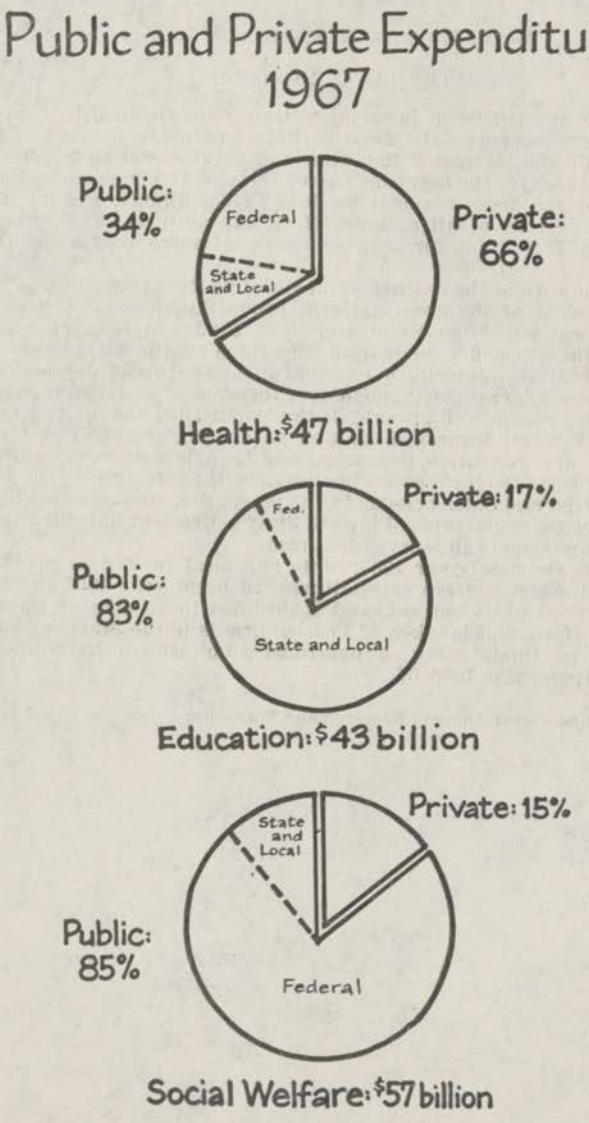


CHART 2

Mr. FLOOD. Are you in a position at this point, and if not, would you have the record show, what was the situation just 10 years ago?

Mr. COHEN. I have an analysis, which I can put into the record.

Mr. FLOOD. Suppose you do that.

Mr. COHEN. This article analyzes these expenditures back to 1929.

Mr. FLOOD. I think we should have it.

(The information follows:)

SOCIAL WELFARE EXPENDITURES, 1929–67

(By Ida C. Merriam*)

The long-time upward trend in social welfare expenditures, both in absolute amounts and as a percent of the gross national product, continued in the fiscal year 1967. So did the increasing importance of the Federal sector. Total social welfare expenditures for the first time passed the $100 billion mark and amounted to 13 percent of the gross national product ($763 billion). Federal funds accounted for 54 percent of all social welfare expenditures. The largest single increase was the $3.3 billion for health insurance for the aged under the Social Security Act (medicare).

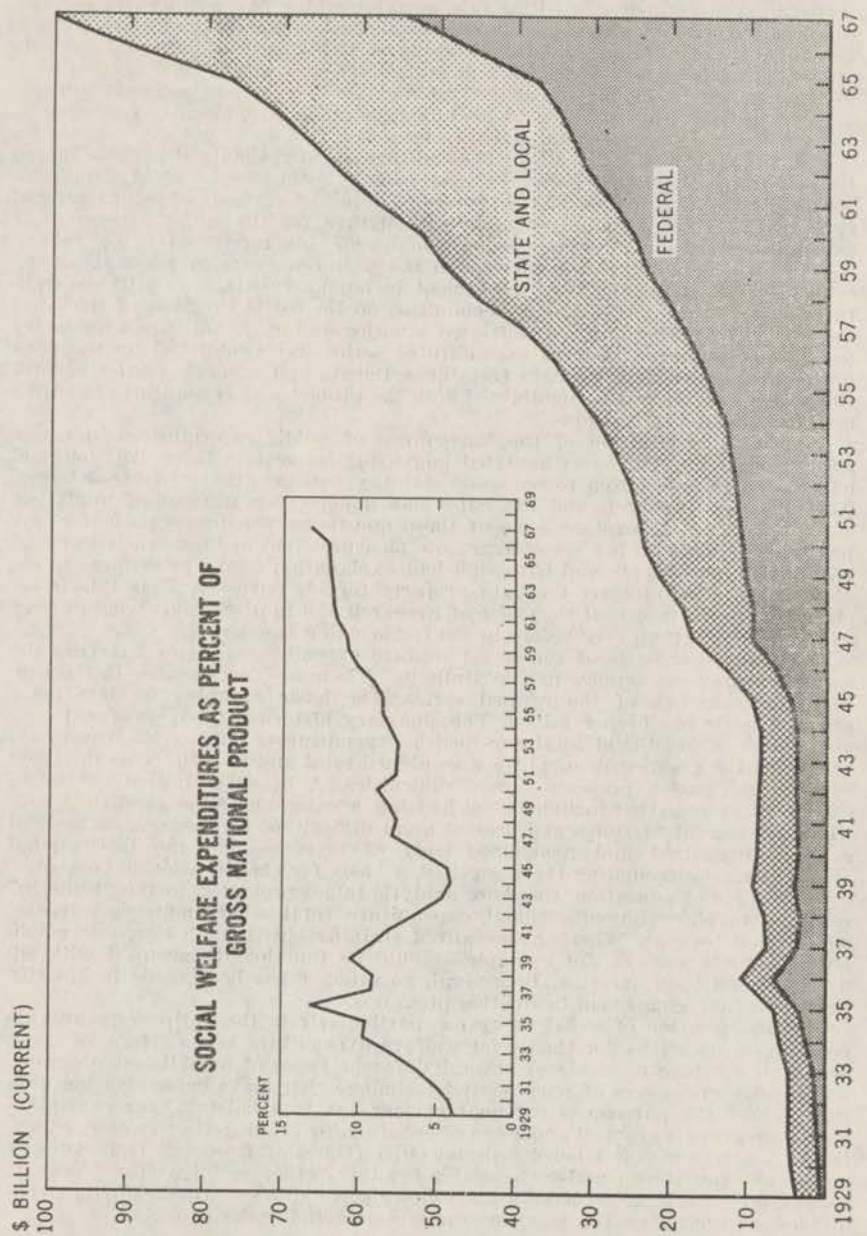
Just before the turn of the century, total social welfare expenditures amounted to about 2.4 percent of the gross national product with expenditures for education—almost entirely from State and local funds—making up almost half the total. Veterans' benefits, more than one-third of the total, were the only significant Federal social welfare expenditures. The great depression of the 1930's brought the Federal Government into the area of social welfare activities in a major way. Significant growth in the population and in the number of risks covered by social insurance, as well as an accelerating Federal involvement in health and education programs, has been largely responsible for the rising trends in social welfare expenditures since the late 1950's. The increasing number of children and older persons in the population, accompanied by the prolonging of school years and a trend toward early retirement have had their effect on both transfer payments and service programs.

As recently as the fiscal year 1965, State and local funds had provided more than half of all social welfare expenditures. In fiscal year 1966 the State and local share dropped to 48 percent, and it declined to 46 percent the following year (chart 1). If account is taken of Federal grants to the States and localities, the proportion of funds going to programs administered by State or local agencies was 56 percent in 1966–67.

---

*Assistant Commissioner, Office of Research and Statistics.

CHART 1.—Social welfare expenditures, by source of funds and as a percent of gross national product, 1929–67



THE REVISED SERIES

For the past several years, the Office of Research and Statistics has been reviewing the estimates used in this social welfare expenditure series. The concepts and classifications have been reexamined in the light of new program developments and of questions raised by users. The sources of data and methods of estimating have been extended and refined. The series has been carried back to 1929, and revisions, which earlier had been made only for the 5-year interval data presented in the "Bulletin," have now been made in the year-to-year figures, along with other changes dictated by this review.

A monograph, "Social Welfare Expenditures Under Public Programs in the United States, 1929–66," presenting the revised estimates in great detail, together with an explanation of the sources of data and methods of estimates, will be issued in 1968. A summary table with figures for the major categories of expenditures for each year from 1929 through 1967 is included here (table 1a.)

There has been increasing interest in the past few years in a system of accounts related to the Nation's investment in human resources and its expenditures on social programs. The Subcommittee on Economic Progress of the Joint Economic Committee last year initiated a major inquiry in this area. Summary data from the social welfare expenditures series were published by the committee along with detailed data from departments and agencies of the Federal Government.[1] This report highlighted both the problems of classification and the need for more analytic studies.

A growing recognition of the importance of public expenditures in major areas of consumption has stimulated increasing interest in their distributional effects and their relation to economic stability and growth and related issues. The Office of Research and Statistics has underway a number of analytical studies designed to explore some of these questions. The prerequisite for any major study in depth is a set of aggregate measures that are constructed around meaningful components and with sufficient explanation of the procedures to enable the user to interpret the data properly for his purposes. It is this latter obligation to the user that the Office of Research and Statistics has tried to meet more effectively than ever before in the forthcoming monograph.

The conceptual basis of the social welfare expenditures series has been described in previous articles in the "Bulletin." There are few changes in the conceptual framework of the revised series. The basic grouping of data on a program basis has been retained. The summary historical table presented here also shows a functional total for health expenditures. This is the functional area with the greatest demand for a combined total and also the area in which such categorization presents fewest difficulties. A broad definition of health expenditures—one that included good housing, adequate nutrition, and the like—would have great fuzziness and present great difficulties. By focusing on medical care—an organized and recognized body of services—and the institutional arrangements surrounding these services, a basis for classification is created.

In the field of education, the more analytic tables presented in the "Bulletin" continue to show an educational expenditure total what includes veterans' educational benefits. Whether specialized training—in the Job Corps or neighborhood youth centers, for example—should be functionally grouped with education is an open question. In general, no attempt has been made to identify the "education" component in all other programs.

The proliferation of social programs, particularly in the antipoverty area, is posing new questions for the social welfare expenditure series. Many of these programs combine elements of several different types of established programs and involve crossovers of purpose and technique that make categorization difficult. Where the purpose is reasonably clear—as in Headstart, for example—the subprogram is grouped under the relevant major heading (in this case, education). A category now labeled "special OEO (Office of Economic Opportunity) programs" and shown under the major heading "other social welfare" may at some later time come to have a more descriptive title or may be further subdivided, depending on the way these programs actually develop.

---

[1] "Federal Programs for the Development of Human Resources" (joint committee print), 89th Cong., second sess., December 1966.

TABLE 1.—SOCIAL WELFARE EXPENDITURES UNDER PUBLIC PROGRAMS, SELECTED FISCAL YEARS, 1928–29 THROUGH 1966–67 [1]

[In millions; revised estimates as of October 1967]

Program	1928–29	1934–35	1939–40	1944–45	1949–50	1954–55	1959–60	1964–65	1965–66	1966–67 [2]
	Total expenditures									
Total	$3,921.2	$6,548.3	$8,795.1	$9,205.3	$23,508.4	$32,639.9	$52,293.3	$77,261.5	$87,973.3	$100,238.5
Social insurance	342.4	406.3	1,271.8	1,409.4	4,946.6	9,834.9	19,305.7	28,090.0	31,905.0	37,377.1
Old-age, survivors, disability, and heal h insurance [3]			40.4	266.8	784.1	4,436.3	11,032.3	16,997.5	20,295.3	24,579.3
Health insurance for the aged									63.6	3,393.1
Railroad retirement			116.8	145.0	306.4	556.0	934.7	1,128.1	1,211.6	1,272.3
Public employee retirement [5]	113.1	208.8	283.4	355.0	817.9	1,388.5	2,569.9	4,520.5	5,145.4	6,021.0
Unemployment insurance and employment service [6]		9.2	553.0	216.7	2,190.1	2,030.6	2,829.6	3,002.6	2,662.3	2,752.1
Railroad unemployment insurance			18.9	4.3	119.6	158.7	215.2	76.7	52.4	38.7
Railroad temporary disability insurance					31.1	54.2	68.5	46.5	42.6	38.7
State temporary disability insurance [7]				5.1	72.1	217.5	347.9	483.3	507.3	520.0
Hospital and medical benefits [8]					2.2	20.0	40.2	50.9	54.3	56.0
Workmen's compensation [9]	229.3	188.4	259.2	416.6	625.1	943.0	1,308.5	1,834.8	1,988.2	2,155.0
Hospital and medical benefits [8]	75.0	65.0	90.0	122.0	193.0	315.0	420.0	580.0	630.0	685.0
Public aid	60.0	2,997.6	3,597.0	1,030.6	2,496.2	3,003.0	4,101.1	6,283.4	7,301.4	8,901.6
Public assistance [10]	59.9	623.9	1,124.3	1,028.8	2,490.2	2,941.1	4,041.7	5,874.9	6,497.5	7,780.4
Vendor medical payments [8]					51.3	211.9	492.7	1,367.1	1,709.9	2,318.3
Other [11]	.1	2,373.7	2,472.7	1.7	6.0	61.9	59.4	408.5	803.9	1,121.2
Health and medical programs [12]	351.1	427.2	615.5	2,354.2	2,063.5	3,103.1	4,463.8	6,418.5	7,161.0	8,113.3
Hospital and medical care	146.3	253.1	343.0	1,995.9	1,222.3	2,042.4	2,853.3	3,629.9	4,069.9	4,513.4
Civilian programs	117.1	225.3	297.6	364.8	886.1	1,297.6	1,973.2	2,514.8	2,720.3	2,790.8
Defense Department [13]	29.2	27.7	45.4	1,631.1	336.2	744.8	880.1	1,115.1	1,349.5	1,722.6
Maternal and child health programs [14]	6.2	6.9	13.8	62.1	29.8	92.9	141.3	227.5	281.5	312.8
Medical research [8]						.2	.6	4.3	5.3	6.0
Medical research [15]		.3	2.6	2.5	69.2	132.8	448.9	1,165.6	1,305.9	1,456.5
School health (educational agencies)	9.4	10.0	16.4	23.3	30.6	65.9	101.0	132.0	135.0	140.0
Other public health activities [16]	88.8	112.2	154.5	178.0	350.8	383.7	401.2	671.5	723.8	900.9
Medical-facilities construction	100.4	44.8	85.2	92.4	360.8	385.4	518.1	592.0	645.0	789.6
Defense Department				38.9	1.1	33.0	40.0	34.8	28.6	58.5
Other	100.4	44.8	85.2	53.5	359.8	352.4	478.1	557.2	616.4	731.2
Veterans' programs	657.9	597.5	629.0	1,125.8	6,865.7	4,833.5	5,479.2	6,038.8	6,360.3	7,011.7
Pensions and compensation [18]	434.7	386.5	443.3	766.6	2,092.1	2,689.7	3,402.7	4,156.0	4,423.8	4,554.8
Health and medical programs	50.9	50.8	75.8	101.8	748.0	761.1	954.0	1,239.0	1,301.9	1,369.2
Hospital and medical care	46.7	47.8	61.5	85.5	582.8	721.5	879.4	1,120.9	1,175.2	1,271.3
Hospital construction	4.2	3.0	14.3	16.3	161.5	34.1	59.6	81.2	86.0	51.0
Medical and prosthetic research					3.7	5.6	15.1	36.9	40.7	46.9
Education				9.8	2,691.6	706.1	409.6	43.4	36.9	378.3
Life insurance [17]	136.4	122.8	77.0	201.2	475.7	490.2	494.1	446.9	455.4	557.9
Welfare and other [15]	35.8	37.5	32.9	46.4	853.3	186.5	218.8	153.6	142.3	151.5

See footnotes at end of table, p. 27.

TABLE 1.—SOCIAL WELFARE EXPENDITURES UNDER PUBLIC PROGRAMS, SELECTED FISCAL YEARS, 1928-29 THROUGH 1966-67 [1]—Continued

[In millions; revised estimates as of October 1967]

Program	1928-29	1934-35	1939-40	1944-45	1949-50	1954-55	1959-60	1964-65	1965-66	1966-67 [2]
Education [13] [18]	$2,433.7	$2,007.5	$2,561.2	$3,076.3	$6,674.1	$11,157.2	$17,626.2	$28,050.2	$32,566.9	$35,632.7
Elementary and secondary	2,216.2	1,820.1	2,267.4	2,620.6	5,596.2	9,734.3	15,109.0	22,353.9	25,054.9	27,427.1
Construction [5] [19]	377.0	123.3	258.0	82.5	1,019.4	2,231.9	2,661.8	3,267.0	3,449.9	3,600.6
Higher	182.1	147.9	217.6	314.4	914.7	1,214.4	2,190.7	4,784.6	6,319.6	6,943.4
Construction [5]	.2	([20])	20.6	42.3	310.3	198.6	357.9	1,229.0	1,814.3	1,813.0
Vocational and adult [19]	34.9	39.1	75.4	139.2	160.8	204.9	298.0	852.4	1,067.1	1,121.7
Housing [15]		13.2	4.2	11.1	14.6	89.3	176.8	318.1	334.8	374.6
Public housing		13.2	4.2	11.1	14.5	74.7	143.5	234.5	249.2	277.7
Other					.1	14.6	33.2	83.6	85.6	96.8
Other social welfare	76.2	99.0	116.4	197.9	447.7	619.0	1,139.4	2,062.4	2,343.8	2,827.5
Vocational rehabilitation	1.6	2.3	4.2	10.2	30.0	42.4	96.3	210.5	298.6	411.3
Medical services [5]	.1	.2	.3	1.4	7.4	9.1	17.7	34.2	48.0	80.5
Medical research [9]						.3	6.6	22.4	27.9	31.0
Institutional care [21]	74.7	70.7	62.4	82.9	145.5	195.3	420.5	784.4	766.7	840.1
School meals [22]			4.0	47.4	160.2	239.6	398.7	617.4	537.4	582.6
Child welfare [23]		26.0	45.0	55.5	104.9	135.1	211.5	356.1	399.5	445.8
Special OEO programs [24]								51.7	287.3	464.5
Social welfare, not elsewhere classified [25]			.9	2.0	7.1	6.5	12.4	42.3	54.2	83.1
	From Federal funds									
Total	$798.4	$3,207.2	$3,443.1	$4,339.4	$10,541.1	$14,622.9	$24,956.7	$37,881.0	$45,623.1	$54,141.7
Social insurance	55.9	118.9	393.8	734.9	2,103.0	6,385.0	14,307.2	21,806.6	25,663.5	30,686.6
Old-age, survivors, disability, and health insurance [3]			40.4	266.8	784.1	4,436.3	11,032.3	16,997.5	20,295.3	24,579.3
Health insurance for the aged [4]									63.6	3,393.1
Railroad retirement [3]			116.8	145.0	306.4	556.0	934.7	1,128.1	1,211.6	1,272.3
Public employee retirement [3]	51.9	102.6	136.3	158.7	507.9	808.5	1,519.9	2,780.5	3,220.4	3,885.8
Unemployment insurance and employment service [6]		7.4	67.1	145.5	328.6	320.8	473.5	699.8	761.8	789.6
Railroad unemployment insurance			18.9	4.3	119.6	158.7	215.2	76.7	52.4	38.7
Railroad temporary disability insurance					31.1	54.2	68.5	46.5	42.6	38.7
Workmen's compensation [9]	4.0	8.9	14.2	14.7	25.1	50.5	63.1	77.6	79.5	82.0
Hospital and medical benefits [8]	.6	3.0	5.2	4.7	5.2	6.9	9.0	11.3	11.8	12.0
Public aid		2,373.7	2,243.1	420.1	1,103.2	1,504.2	2,116.9	3,593.9	4,366.3	5,399.1
Public assistance [10]			280.1	418.4	1,097.2	1,442.3	2,057.5	3,185.4	3,562.4	4,277.9
Vendor medical payments [8]						23.3	199.8	555.0	758.0	1,134.7
Other [11]		2,373.7	1,963.1	1.7	6.0	61.9	59.4	408.5	803.9	1,121.2
Health and medical programs [12]	46.7	49.5	96.6	1,801.4	603.5	1,150.3	1,737.1	2,963.7	3,391.9	4,163.8
Hospital and medical care	37.7	39.4	60.9	1,660.8	382.6	811.5	983.5	1,253.1	1,495.8	1,880.9
Civilian programs	8.5	11.6	15.5	29.7	46.4	66.7	103.4	138.0	146.2	158.3

Defense Department [13]	29.2	27.7	45.4	1,631.1	336.2	744.8	880.1	1,115.1	1,349.5	1,722.6
Maternal and child health programs [14]	1.2		7.8	55.2	20.1	23.7	35.3	74.1	113.4	134.6
Medical research [6]						.2	.6	4.3	5.3	6.0
Medical research [15]		.3	2.6	2.5	69.2	132.8	425.9	1,110.6	1,244.9	1,391.5
Other public health activities [15]	6.9	6.6	22.7	44.0	63.8	65.0	57.3	222.9	228.8	342.1
Medical-facilities construction	.9	3.3	2.7	38.9	67.8	117.4	235.1	303.0	309.0	414.6
Defense Department				38.9	1.1	33.0	40.0	34.8	28.6	58.5
Other	.9	3.3	2.7	([26])	66.8	84.4	195.1	268.2	280.4	356.2
Veterans' programs	657.9	597.5	619.8	1,118.5	6,386.2	4,771.9	5,367.3	6,018.4	6,339.0	6,989.5
Pensions and compensations [16]	434.7	386.5	443.3	766.6	2,092.1	2,689.7	3,402.7	4,156.0	4,423.8	4,554.8
Health and medical programs	50.9	50.8	75.8	101.8	748.0	761.1	954.0	1,239.0	1,301.9	1,369.2
Hospital and medical care	46.7	47.8	61.5	85.5	582.8	721.5	879.4	1,120.9	1,175.2	1,271.3
Hospital construction	4.2	3.0	14.3	16.3	161.5	34.1	59.6	81.2	86.0	51.0
Medical and prosthetic research					3.7	5.6	15.1	36.9	40.7	46.9
Education				9.8	2,691.6	706.1	409.6	43.4	36.9	378.3
Life insurance [17]	136.4	122.8	77.0	201.2	475.7	490.2	494.1	446.9	455.4	557.9
Welfare and other [15]	35.8	37.5	23.7	39.1	378.8	124.9	106.9	133.2	121.0	129.3
Education [15 18]	36.5	52.7	74.7	187.3	156.7	485.1	867.9	2,446.3	4,571.9	5,232.9
Elementary and secondary	9.6	21.2	14.7	48.5	47.1	309.2	441.9	761.3	2,025.4	2,457.8
Construction [5 19]	([20])	8.0	([20])	14.5	5.2	139.9	70.6	77.0	46.5	54.6
Higher	12.1	11.9	18.9	43.2	48.5	101.8	293.1	1,219.6	1,876.6	2,113.7
Construction [5]	.2	([20])	([20])	([20])	5.7	5.1	1.2	324.0	664.3	721.3
Vocational and adult [19]	14.3	19.1	40.4	93.5	58.7	70.5	104.5	406.2	544.6	520.8
Housing [15]		13.2	4.2	11.1	14.6	74.7	143.5	238.2	250.8	284.6
Public housing		13.2	4.2	11.1	14.5	74.7	143.5	234.5	249.2	277.7
Other					.1			3.6	1.6	6.8
Other social welfare	1.4	1.7	10.9	66.1	174.0	251.7	416.7	813.7	1,039.7	1,385.3
Vocational rehabilitation	.7	1.1	2.1	7.5	21.0	27.1	64.3	143.3	218.0	320.5
Medical services [5]	.1	.1	.1	1.0	5.1	5.7	11.2	21.2	32.4	60.4
Medical research [5]						.3	6.6	22.4	27.9	31.0
Institutional care [21]	.7	.7	2.4	7.9	20.5	40.3	20.5	34.4	21.7	20.1
School meals [22]			4.0	47.4	121.2	170.7	306.1	503.7	415.4	447.6
Child welfare [2]			1.6	1.4	4.2	7.1	13.4	38.3	43.0	49.4
Special OEO programs [24]								51.7	287.3	464.5
Social welfare, not elsewhere classified [25]			.9	2.0	7.1	6.5	12.4	42.3	54.2	83.1
	From State and local funds [27]									
Total	$3,122.8	$3,341.1	$5,351.0	$4,865.9	$12,967.3	$18,017.1	$27,336.6	$39,380.6	$42,350.1	$46,096.8
Social insurance	286.5	287.4	878.0	674.5	2,843.6	3,449.9	4,999.4	6,283.4	6,241.5	6,690.5
Public employee retirement [5]	61.2	106.2	14.71	196.3	310.0	580.0	1,050.0	1,740.0	1,925.0	2,135.0
Unemployment insurance and employment service [6]		1.7	485.9	71.2	1,861.5	1,759.9	2,356.1	2,302.8	1,900.5	1,962.5
State temporary disability insurance [7]				5.1	72.1	217.5	347.9	483.3	507.3	520.0
Hospital and medical benefits [8]					2.2	20.0	40.2	50.9	54.3	56.0
Workmen's compensation [9]	225.3	179.5	245.0	401.9	600.0	892.5	1,245.4	1,757.3	1,908.7	2,073.9
Hospital and medical benefits [8]	74.4	62.0	84.8	117.3	187.8	308.1	411.0	568.7	618.2	673.0
Public aid	60.0	623.9	1,352.8	610.4	1,393.0	1,498.8	1,984.2	2,689.5	2,935.1	3,502.5
Public assistance [10]	59.9	623.9	843.2	610.4	1,393.0	1,498.8	1,984.2	2,689.5	2,935.1	3,502.5
Vendor medical payments [8]					51.3	188.6	292.9	812.1	951.9	1,183.6
Other [11]	.1		509.6							

See footnotes at end of table, p. 27.

TABLE 1.—SOCIAL WELFARE EXPENDITURES UNDER PUBLIC PROGRAMS, SELECTED FISCAL YEARS, 1928-29 THROUGH 1966-67 [1]—Continued

[In millions; revised estimates as of October 1967]

From state and local funds—Continued

Program	1928-29	1934-35	1939-40	1944-45	1949-40	1954-55	1959-60	1964-65	1965-66	1966-67 [2]
Health and medical programs [12]	$304.4	$377.7	$518.9	$552.8	$1,460.0	$1,952.8	$2,726.8	$3,454.8	$3,769.1	$3,949.5
Hospital and medical care	108.6	213.7	282.1	335.1	839.7	1,230.9	1,869.8	2,376.8	2,574.1	2,632.5
Maternal and child health programs	5.0	6.9	6.0	6.8	9.7	69.2	106.1	153.4	168.1	178.2
Medical research [13]							23.0	55.0	61.0	65.0
School health (educational agencies)	9.4	10.0	16.4	23.3	30.6	65.9	101.0	132.0	135.0	140.0
Other public health activities [13]	81.9	105.6	131.9	134.0	287.0	318.8	343.9	448.6	494.9	558.8
Medical-facilities construction	99.5	41.5	82.5	53.5	293.0	268.0	283.0	289.0	336.0	375.0
Veterans' programs			9.2	7.4	479.5	61.6	111.9	20.4	21.3	22.2
Education [15]	2,397.2	1,954.8	2,486.6	2,889.0	6,517.5	10,672.1	16,758.3	25,603.9	27,995.0	30,399.9
Elementary and secondary	2,206.6	1,798.9	2,252.8	2,572.2	5,549.1	9,425.1	14,667.1	21,592.6	23,029.5	24,969.3
Construction [8 15]	377.0	115.3	258.0	68.0	1,014.2	2,091.9	2,591.2	3,190.0	3,403.4	3,546.1
Higher	170.0	136.0	198.7	271.2	866.3	1,112.6	1,897.7	3,565.0	4,443.0	4,829.7
Construction [8]	(20)	(20)	20.6	42.3	304.6	193.4	356.7	905.0	1,150.0	1,091.7
Vocational and adult [19]	20.6	19.9	35.1	45.6	102.1	134.4	193.5	446.2	522.5	600.9
Housing [15]						14.6	33.2	80.0	84.1	90.0
Other social welfare	74.8	97.2	105.5	131.8	273.7	367.3	722.8	1,248.6	1,304.1	1,442.2
Vocational rehabilitation	.8	1.2	2.1	2.7	9.0	15.3	32.1	67.1	80.5	90.8
Medical services [8]	.1	.1	.1	.4	2.3	3.5	6.6	13.0	15.5	20.1
Institutional care	74.0	70.0	60.0	75.0	125.0	155.0	400.0	750.0	745.0	820.0
School meals [22]					39.0	69.0	92.6	113.7	122.0	135.0
Child welfare [23]		26.0	43.4	54.1	100.7	128.0	198.1	317.8	356.5	396.4

[1] Expenditures from Federal, State, and local revenues (general and special) and trust funds and other expenditures under public law; includes capital outlay and administrative expenditures unless otherwise noted. Includes some expenditures and payments outside the United States. Fiscal years ended June 30 for Federal Government, most States, and some localities.

[2] Preliminary estimates.

[3] Excludes financial interchange transactions between OASDHI and railroad retirement.

[4] Hospital insurance and supplementary medical insurance included in total shown directly above. Benefit payments began July 1, 1966; 1965-66 data represent administrative expenses only.

[5] Excludes refunds of employee contributions; includes payments to retired military personnel and survivors. Data for administrative expenses not available for Federal noncontributory retirement.

[6] Includes unemployment compensation under State programs, programs for Federal employees and ex-servicemen, and cash training allowances.

[7] Cash and medical benefits in the 4 States with programs. Includes private plans where applicable and State costs of administering State plans and supervising private plans. Data for administrative expenses of private plans not available.

[8] Included in total shown directly above; excludes administrative expenditures, not available separately but included for entire program in preceding line.

[9] Cash and medical benefits paid under Federal laws and under State laws, by private insurance carriers, State funds and self-insurers. Includes Alaska and Hawaii, beginning 1959-60; excludes administrative costs of private carriers and self-insurers.

[10] Represents payments under the Social Security Act and, from State and local funds, general assistance. Data for 1939-40 include $1 million in administrative costs for which distribution by source of funds is not available.

[11] Work relief, other emergency aid, surplus food for the needy, food stamps, and Job Corps, Neighborhood Youth Corps, and work-experience programs under the Economic Oppportunity Act.

[12] Excludes expenditures for domiciliary care in institutions other than mental or tuberculosis, and services in connection with OASDHI, State temporary disabiiity insurance, workmen's compensation, public assistance, vocational rehabilitation, and veterans' and antipoverty programs. (Included in total expenditures for these programs.)

[13] Includes cost of medical care for military dependent families.

[14] Includes services for crippled children.

[15] For detailed description of this item and its components, see forthcoming monograph "Social Welfare Expenditures Under Public Programs in the United States, 1929-66."

[16] Includes burial awards.

[17] Excludes servicemen's group life insurance.

[18] Federal expenditures for administrative costs (Office of Education) and research not shown separately but included in total.

[19] Construction costs of vocational and adult education programs included under elementary-secondary construction expenditures.

[20] Not available.

[21] Includes surplus food for institutions.

[22] Cash and commodities under the National School Lunch Act; special milk, pilot school breakfasts, and nonfood cash assistance under the Child Nutrition Act of 1966; and surplus food for schools. State and local funds represent direct appropriations only.

[23] Represents primarily child welfare services under title V of the Social Security Act.

[24] Includes community action, migrant workers, and VISTA programs and all administrative expenses of the Office of Economic Opportunity. Other OEO programs listed in appropriate subsections under public aid and education.

[25] Includes administrative expenses of the Commissioner of Welfare and the Secretary of Health, Education, and welfare; Indian welfare and guidance; aging activities; certain manpower activities; and other items.

[26] Less than $50,000.

[27] Except as otherwise noted (see footnotes 7 and 9).

Source: Data taken or estimated from Treasury reports, Federal budgets, and available reports of Federal, State, and local administrative agencies. For detailed description of sources, see forthcoming monograph, "Social Welfare Expenditures Under Public Programs in the United States, 1929-66."

Ten years from today programs now omitted from the social welfare series may appear to be obviously an aspect of social welfare policy that should be included. For the present, the general boundary line of programs designed specifically to deal with individual welfare has been retained, and the series continues to exclude such community services as urban transportation, city planning and urban renewal, water and sewer works, preservation of law and order, and parks and recreation. Admittedly, the dividing line is arbitrary. Some legal aid services are included with the special OEO programs and some juvenile delinquency services with child welfare. But the maintenance of courts, police departments, reform schools, and prisons seem better treated as a general function of government and omitted from this series. Similarly, one can recognize the importance of urban transportation in assuring access to jobs and steady earnings without classifying it as a social welfare program. Recreational facilities, or at least organized recreational services, and library services may be regarded as closer to the borderline. They continue to be omitted, however, except where they may be hidden in expenditures for schools or other activities. Unless such distinctions were retained, the series would become almost a listing of government expenditures for nondefense purposes and lose much of its intended character and usefulness.

The series continues to relate to direct expenditures and to exclude such indirect types of subsidy or support as loans, loan guarantees, or income tax exemptions. The basic series relates to public programs. Related private expenditures for health, education, and income maintenance and welfare services are brought together in the regular bulletin series, as heretofore. The forthcoming monograph covers only the public program data. Some consideration is being given to the desirability of a companion volume that would describe the concepts, data sources, and methods of estimating that underlies the private expenditure figures. These items have, of course, been summarized in successive bulletin articles in this or other series prepared by the Social Security Administration. There is some question, however, whether the considerable amount of staff time necessary to elaborate the explanations in the same detail as was thought essential for the public expenditures can be devoted to the project.

TABLE 1-A.—SOCIAL WELFARE EXPENDITURES UNDER PUBLIC PROGRAMS, BY MAJOR CATEGORY: TOTAL AND FEDERAL AS PERCENT OF TOTAL, FISCAL YEARS, 1928–29 THROUGH 1966–67

[Amounts in millions]

Fiscal year	Total	Social insurance	Public aid	Health and medical programs	Veterans' programs	Education	Housing	Other social welfare	All health and medical care [1]
	Total expenditures								
1928–29	$3,921.2	$342.4	$60.0	$351.1	$657.9	$2,433.7	.....	$76.2	$477.1
1929–30	4,084.9	360.9	77.8	378.1	667.8	2,522.8	.....	77.5	512.6
1930–31	4,200.8	368.3	164.0	405.8	744.3	2,439.6	.....	78.8	549.2
1931–32	4,303.4	355.3	255.9	434.5	825.0	2,351.8	.....	80.9	580.6
1932–33	4,462.2	343.9	689.1	417.6	818.8	2,104.0	.....	88.8	545.7
1933–34	5,832.0	361.8	2,530.5	400.3	529.5	1,913.8	$0.4	95.8	497.7
1934–35	6,548.3	406.3	2,997.6	427.2	597.5	2,007.5	13.2	99.0	543.2
1935–36	10,184.2	455.6	3,079.4	453.9	3,825.5	2,227.6	41.7	100.5	582.3
1936–37	7,858.2	545.2	3,436.0	500.1	892.7	2,375.7	3.1	105.4	637.6
1937–38	7,923.5	848.6	3,232.9	539.5	627.3	2,563.0	3.9	108.2	684.5
1938–39	9,212.9	1,181.2	4,229.6	575.2	606.1	2,503.7	3.4	113.8	724.2
1939–40	8,795.1	1,271.8	3,597.0	615.5	629.0	2,561.2	4.2	116.4	781.6
1940–41	8,953.4	1,330.0	3,523.7	724.4	612.9	2,617.2	8.9	136.4	892.6
1941–42	8,609.2	1,375.6	2,777.1	948.7	645.4	2,694.2	14.3	153.9	1,125.5
1942–43	8,283.1	1,258.7	1,549.7	1,885.8	623.3	2,793.3	13.6	158.6	2,071.5
1943–44	8,227.6	1,255.7	1,031.5	2,225.1	720.0	2,800.4	13.3	181.6	2,428.9
1944–45	9,205.3	1,409.4	1,030.6	2,354.2	1,125.8	3,076.3	11.1	197.9	2,579.5
1945–46	12,797.9	3,652.1	1,150.6	1,904.1	2,402.9	3,296.8	158.7	232.7	2,282.0
1946–47	17,337.0	4,160.0	1,441.8	1,367.0	5,682.5	4,089.0	280.9	315.6	2,098.6
1947–48	18,652.3	3,602.8	1,702.0	1,416.0	6,638.2	4,897.3	27.3	368.8	2,152.7
1948–49	21,164.9	4,185.8	2,089.1	1,753.1	6,926.7	5,805.6	7.7	395.9	2,657.4
1949–50	23,508.4	4,946.6	2,496.2	2,063.5	6,865.7	6,674.1	14.6	447.7	3,065.3
1950–51	24,054.7	4,772.2	2,591.7	2,782.8	5,996.0	7,415.1	35.0	461.9	3,812.8
1951–52	25,576.4	5,671.0	2,584.7	3,331.3	5,255.6	8,245.7	37.1	451.0	4,483.0
1952–53	27,044.9	6,607.3	2,727.9	3,190.4	4,734.7	9,230.9	50.6	503.0	4,377.8
1953–54	29,546.8	8,264.7	2,788.2	3,099.1	4,630.9	10,084.4	67.4	612.1	4,335.9
1954–55	32,639.9	9,834.9	3,003.0	3,103.1	4,833.5	11,157.2	89.3	619.0	4,420.6
1955–56	35,130.6	10,646.1	3,114.7	3,307.1	5,061.2	12,154.4	111.7	735.4	4,689.3
1956–57	39,350.4	12,471.8	3,308.5	3,775.8	5,118.8	13,732.3	120.2	823.0	5,246.4
1957–58	45,456.9	15,956.7	3,615.4	4,090.9	5,426.7	15,312.6	134.2	920.4	5,675.5

See footnotes at end of table.

TABLE 1-A.—SOCIAL WELFARE EXPENDITURES UNDER PUBLIC PROGRAMS, BY MAJOR CATEGORY: TOTAL AND FEDERAL AS PERCENT OF TOTAL, FISCAL YEARS, 1928-29 THROUGH 1966-67—Continued

[Amounts in millions]

Fiscal year	Total	Social insurance	Public aid	Health and medical programs	Veterans' programs	Education	Housing	Other social welfare	All health and medical care [1]
1958-59	$49,821.4	$18,286.5	$3,997.9	$4,400.6	$5,472.3	$16,498.3	$156.2	$1,009.6	$6,164.8
1959-60	52,293.3	19,306.7	4,101.1	4,463.8	5,479.2	17,626.2	176.8	1,139.4	6,395.2
1960-61	58,236.0	22,364.9	4,444.3	4,927.0	5,623.7	19,337.2	196.1	1,342.8	7,058.7
1961-62	62,658.7	24,193.8	4,945.3	5,229.8	5,654.0	21,004.6	216.6	1,414.5	7,637.5
1962-63	66,767.2	25,613.5	5,295.9	5,594.5	5,751.2	22,670.7	243.1	1,593.4	8,305.3
1963-64	71,491.1	26,971.3	5,642.1	6,003.5	5,861.5	24,989.0	277.7	1,746.0	8,970.9
1964-65	77,261.5	28,090.0	6,283.4	6,418.5	6,038.8	28,050.2	318.1	2,062.4	9,717.8
1965-66	87,973.3	31,905.0	7,301.4	7,161.0	6,360.3	32,566.9	334.8	2,343.8	11,044.7
1966-67 [2]	100,238.5	37,377.1	8,901.6	8,113.3	7,011.7	35,632.7	374.6	2,827.5	16,166.6
	Federal funds as percent of total expenditures								
1928-29	20.4	16.3	----------	13.3	100.0	1.5	---------	1.8	20.6
1929-30	20.0	16.7	----------	12.5	100.0	1.6	---------	1.9	21.0
1930-31	21.7	18.7	----------	12.5	100.0	1.9	---------	2.2	21.8
1931-32	23.8	21.0	----------	12.7	100.0	2.0	---------	2.1	23.0
1932-33	30.0	23.6	50.0	12.4	100.0	1.9	---------	1.9	22.4
1933-34	47.5	26.1	79.2	12.0	100.0	4.9	100.0	1.7	18.3
1934-35	49.0	29.3	79.2	11.6	100.0	2.6	100.0	1.7	19.0
1935-36	63.9	29.2	75.0	12.0	100.0	6.2	100.0	3.2	19.2
1936-37	48.2	35.5	72.6	13.9	98.6	6.0	100.0	3.9	21.4
1937-38	41.1	34.8	64.2	13.5	98.1	7.3	100.0	4.6	20.5
1938-39	43.3	30.3	67.9	13.7	98.4	2.9	100.0	6.1	21.1
1939-40	39.1	31.0	62.4	15.7	98.5	2.9	100.0	9.4	22.7
1940-41	40.9	35.3	62.1	32.0	98.6	5.2	100.0	16.1	34.3
1941-42	41.9	38.7	61.1	49.6	98.7	8.1	100.0	23.3	48.5
1942-43	44.5	44.9	52.8	73.3	99.0	9.0	100.0	22.8	70.5
1943-44	45.7	50.2	41.4	77.5	99.1	6.9	100.0	30.6	74.8
1944-45	47.1	52.1	40.8	76.5	99.3	6.1	100.0	33.4	74.0
1945-46	49.6	52.4	39.0	66.9	97.7	3.8	100.0	32.0	66.7
1946-47	56.5	62.6	42.8	40.6	96.9	3.2	100.0	32.5	54.2
1947-48	50.8	56.6	42.5	29.7	90.4	2.9	100.0	34.6	46.0
1948-49	48.4	50.2	45.1	29.8	92.4	2.4	100.0	35.3	46.9
1949-50	44.8	42.5	44.2	29.2	93.0	2.3	100.0	38.9	44.4
1950-51	46.3	57.1	46.2	42.0	94.4	2.4	61.7	37.4	49.3
1951-52	45.9	58.9	46.9	47.6	97.3	3.7	67.7	32.1	53.0
1952-53	45.3	63.9	49.9	43.3	97.6	4.7	74.9	38.0	49.1
1953-54	44.0	61.6	50.9	39.0	97.8	4.2	79.8	43.6	45.7
1954-55	44.8	64.9	50.1	37.1	98.7	4.3	83.7	40.7	44.1
1955-56	46.1	70.8	49.9	38.0	98.2	3.9	82.4	44.4	43.9
1956-57	46.1	71.6	51.1	37.4	99.2	3.9	84.2	46.3	42.9
1957-58	45.4	68.0	50.8	38.3	97.8	4.0	82.4	37.9	44.2
1958-59	47.3	71.4	52.1	39.0	98.9	4.6	81.8	38.8	45.3
1959-60	47.7	74.1	51.6	38.9	98.0	4.9	81.2	36.6	45.6
1960-61	47.1	71.4	52.6	39.6	98.5	5.2	81.2	33.6	46.1
1961-62	48.9	75.6	55.4	42.9	98.3	5.2	80.1	37.5	48.6
1962-63	48.9	75.8	56.6	43.7	99.7	5.8	77.6	35.8	49.4
1963-64	48.9	76.5	56.9	45.8	99.7	6.5	76.4	37.3	49.7
1964-65	49.0	77.6	57.2	46.2	99.7	8.7	74.9	39.5	49.6
1965-66	51.9	80.4	59.7	47.4	99.7	14.0	74.9	44.4	51.0
1966-67 [2]	54.0	82.1	60.7	51.3	99.7	14.7	76.0	49.0	63.6

[1] Combines "health and medical programs" with medical services provided in connection with social insurance, public aid, veterans, and antipoverty programs.
[2] Preliminary estimates.

Although many detailed refinements and revisions of estimates have been introduced, the revised figures for the major categories and for the total differ little from those previously published. The following tabulation shows the totals for selected years, by 5-year intervals, as revised and as published in the Bulletin for December 1966.

[In millions]

Fiscal year	December 1966 series	Revised series
1934-35	$6,417	$6,548
1939-40	8,762	8,795
1944-45	8,859	9,205
1949-50	22,973	23,508
1954-55	32,243	32,640
1959-60	52,154	52,293
1964-65	77,505	77,262

Most of the changes result from a cleaning-up process as duplications in data from several different sources were identified and eliminated or estimates for programs only recently of any significant size were carried back to earlier years. Other changes are the result of new estimating techniques for those expenditures for which data are not available through normal sources. One example is the new methodology developed for estimating State and local expenditures for institutional care—an item that has shown fluctuating estimates in earlier years as different techniques were applied. Another example is the development of comprehensive estimates of expenditures under public employee retirement systems.

For recent years, the major changes dollarwise have occurred within the education category. Federal expenditures for higher education were adjusted downward to exclude certain basic research, research facilities, and development expenditures that are not education-oriented—military and space research, for example. State and local expenditures were adjusted upward to incorporate new Office of Education estimates of higher education expenditures, especially for construction. Because these two adjustments were offsetting to a large degree, however, the net effect was not great.

The tables presented here and in the monograph contain several new lines. One is veterans' life insurance, which had been excluded heretofore partly because of the voluntary nature of the coverage. This program, along with the voluntary program of supplementary medical insurance under OASDHI, is included in the series in accordance with a new conceptual framework adopted for social security and related programs. This framework calls for inclusion not only of expenditures under programs that require compulsory participation but also of those under programs authorized by public law that provide for voluntary participation in which the program or risk is underwritten or insured exclusively by the government.

Further changes include: (1) the addition of an item, "other" housing programs, that encompasses programs other than those meeting the definition of public housing, such as rent supplements, housing rehabilitation grants, rural housing, and low-income demonstration grants; (2) the establishment of a separate subsection "vocational and adult education" under education; and (3) the addition of a new subsection "social welfare, not otherwise classified" under a renamed category "other social welfare." The new subsection includes such items as Indian welfare and guidance, activities in the field of aging, certain manpower activities, and the administrative expenses of such coordinating bodies as the Office of the Secretary in the Department of Health, Education, and Welfare.

Users of the series will probably note that expenditures reported for several other lines have undergone what seem to be extensive revisions. Some of these changes, however, are merely the reshuffling of data between catagories. For example, the transfer of expenditures for Job Corps and neighborhood youth centers from "special OEO programs" to "other public aid" accounts largely for the changes in these two lines. The establishment of a separate subsection on vocational and adult education had its effects on the other components of the education series, especially on data for elementary and secondary education expenditures.

Detailed description of the changes in the series are provided in the monograph, which also summarizes the factors responsible for the differences between the earlier and the revised figures and explains the current estimating techniques.

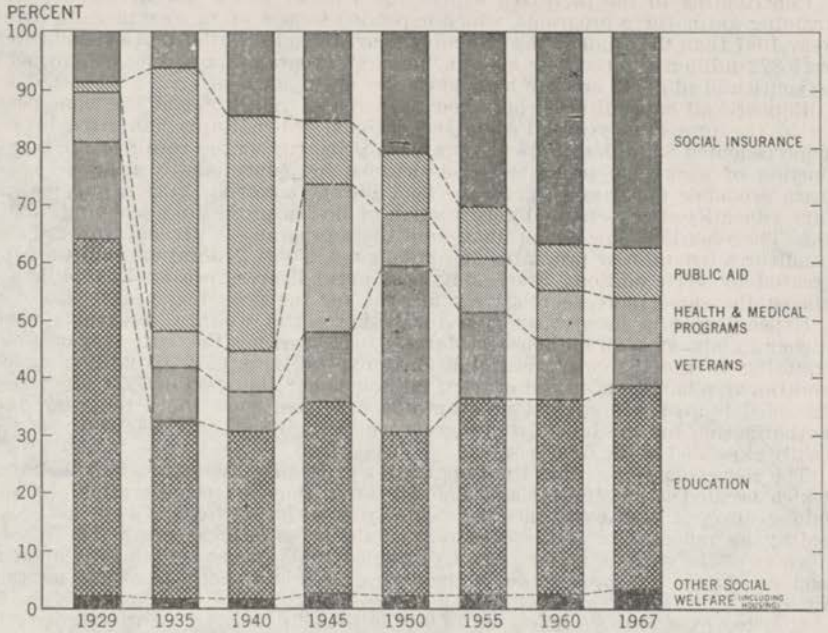


CHART 2.—Social welfare expenditures, by type of program, 1929–67

EXPENDITURES IN FISCAL YEAR 1967

The $12 billion increase in total social welfare expenditures in the fiscal year 1967 was the largest absolute year-to-year increase in the entire period covered. The relative increase of 13.9 percent has not been exceeded since 1958 (tables 1 and 1a).

As in the preceding year, a major share of the increase was attributable to the OASDHI program. Benefits and cost of administration under the new program of health insurance for the aged amounted to $3.4 billion. Cash benefit payments under OASDHI increased about $1 billion.

The first full year of medicaid (the new medical assistance program under title XIX of the Social Security Act) brought a net increase of $608 million in vendor payments for medical care under public assistance.

Health and medical programs listed under this major category showed a rise in expenditures of almost $1 billion that resulted from a variety of developments Expansion of medical benefits to dependents of military personnel and the increased tempo of the Vietnam conflict were responsible for $375 million of the rise; medical research accounted for another $150 million; construction for $145 million; and other pulbic health activities for $175 million. The latter figure includes additional Federal expenditures of more than $100 million in the areas of community and environmental health services, chronic disease programs, and food and drug conrtol. Also included are the new comprehensive health planning and services program ($4.5 million) and the new regional medical programs ($7.5 million).

When all health expenditures are totaled (including those under such programs as OASDHI, public assistance, and the antipoverty group), the increase from fiscal year 1966 is more than $5 billion—the largest absolute and relative increase in the history of the series, except for 1 year during World War II when expenditures almost doubled because of military medical expenditures.

Expenditures for veterans' programs rose $650 million, the largest absolute increase since the years immediately following World War II. Mainly responsible for this increase is the new educational benefits program for veterans serving after the Korean conflict. Expenditures under the latter program amounted to more than $325 million in the first full year of operation.

Contributing to the increased expenditures under public aid were the work-training antipoverty programs, which expended some $300 million more in fiscal year 1967 than they had in the preceding year. Included in the 1967 expenditures was $72 million for the new special "impact" programs providing employment to youth and adults in areas of high, hard-core unemployment.

Educational expenditures continued to increase, though not at the same pace as in the preceding years. Federal educational expenditures had risen by an unprecedented $2 billion in fiscal year 1966, primarily as the result of the introduction of such new programs as assistance for educationally deprived children, economic opportunity grants, school library materials grants, supplementary educational centers, and construction of health professions teaching facilities. The year 1967 saw a continuation of these programs, with some upward expenditures but no new programs of consequence. Total Federal expenditures increased by $600 million; State and local expenditures rose by $2.4 billion—almost the same increase relatively as that for the preceding year.

Expenditures in fiscal year 1967 for "other social welfare" programs were higher by almost $500 million—the largest increase since the series began. Contributing to the increase were additional expenditures of $110 million under vocational rehabilitation and of $180 million under the special OEO programs. Included is a pilot breakfast program added to the school lunch program; the authorization for the breakfast program was $2 million (only $600,000 was actually expended in the first year).

The reorganization within the Department of Health, Education, and Welfare, which created a new Social and Rehabilitation Service and separated the administration of cash assistance payments from social services, will in all probability be reflected in some regroupings data in subsequent years. The consequences of the reorganization (effective August 1967) are as yet not fully known, and no change has been made in the series on this account as of the present time.

Housing expenditures increased by $40 million in 1967, an above average advance. Included in the 1967 figure are expenditures of about $5.3 million for the two relatively new Federal programs of rent supplements and housing rehabilitation grants. The latter program makes grants to low-income owner-occupants for necessary repairs and improvements to bring their homes up to standards under local codes or urban renewal plans.

TRENDS IN EXPENDITURES

The growth in social welfare expenditures in the past few decades has resulted partly from the growth in population, partly from higher prices, and partly from an expansion of programs and services. Since 1929, the total population of the United States has increased 63 percent and the proportion who are aged 65 and over or under age 18 has risen from 40 percent to 45 percent of the total. Prices, as measured by the implicit price deflator for personal consumption expenditures, have more than doubled during the same period.

Though actual dollar expenditures for social welfare were 25 times higher than they had been in 1929, total expenditures in fiscal year 1967, when adjusted for population growth and price change, were only 7½ times as great as the 1929 total (table 3). This is a measure of the real increase in the level of publicly financed social welfare cash and service benefits.

The per capita growth in social welfare expenditures differs considerably among the various categories in the series. Per capita expenditures for health rose 593 percent (in constant dollars) during the period under review and that of education rose 339 percent, but the growth in social insurance and public aid was several thousandfold. Since fiscal year 1950, the increase in real (price adjusted) per capita expenditures for social insurance has been 315 percent, compared with a 135-percent rise for all social welfare expenditures.

TABLE 3.—PER CAPITA SOCIAL WELFARE EXPENDITURES UNDER PUBLIC PROGRAMS IN THE UNITED STATES, TERRITORIES AND POSSESSIONS, IN ACTUAL AND 1966–67 PRICES, SELECTED FISCAL YEARS, 1928–29 THROUGH 1966–67

Fiscal year	Per capital social welfare expenditures in actual prices [1]							Constant 1966–67 prices		
	Total [2]	Social insurance	Public aid	Health and medical programs	Veterans' programs	Education	Other social welfare	Total social welfare exdenditures [1]		Implicit price deflators 66-67 =100)
								Amount (in millions)	Per capita	
1928–29	$31.80	$2.78	$0.49	$2.85	$5.31	$19.75	$0.62	$7,995.3	$64.89	49.0
1934–35	50.62	3.15	23.21	3.31	4.54	15.55	.77	16,761.5	129.80	39.0
1939–40	65.56	9.49	26.84	4.59	4.61	19.11	.87	21,851.7	163.08	40.2
1944–45	64.75	9.93	7.26	16.59	7.83	21.67	1.39	16,124.0	113.59	57.0
1949–50	152.59	32.20	16.26	13.44	44.20	43.47	2.92	32,445.0	211.34	72.2
1954–55	194.50	58.72	17.98	18.58	28.29	66.68	3.71	39,616.5	237.19	82.0
1959–60	286.46	105.74	22.54	24.54	29.64	96.76	6.26	57,522.0	316.18	90.6
1964–65	392.33	142.42	32.00	32.69	30.40	142.69	10.50	80,484.8	409.95	95.7
1965–66	441.20	159.74	36.73	36.03	31.64	163.59	11.79	90,132.5	453.44	97.3
1966–67 [3]	497.14	185.07	44.28	40.36	34.47	177.03	14.07	99,934.2	497.14	100.0
Percentage change for 1966–67 expenditures [3] (1966–67 prices) from:										
1928–29	+666	+3,164	+4,373	+593	+218	+339	+1,017	+1,149	+666	----------
1934–35	+283	+2,193	−26	+376	+196	+344	+614	+496	+283	----------
1949–50	+135	+315	+97	+117	−44	+194	+248	+208	+135	----------
1959–60	+57	+59	+78	+49	+5	+66	+104	+74	+57	----------
1964–65	+21	+24	+32	+18	+8	+19	+28	+24	+21	----------
1965–66	+10	+13	+17	+19	+6	+5	+16	+11	+10	----------

[1] Excludes expenditures within foreign countries for education, veterans' payments, and OASDHI benefits; see table 1 for data including such expenditures.
[2] Includes housing, not shown separately.
[3] Preliminary estimates.

Sources: Per capita figures based on January 1 data from the Bureau of the Census for total U.S. population, including Armed Forces Forces overseas and the civilian population of Territories and possessions. Deflators based on implicit price deflators for personal consumption expenditures prepared by National Income Division, Office of Business Economics, Department of Commerce.

TABLE 2.—SOCIAL WELFARE EXPENDITURES UNDER PUBLIC PROGRAMS AS PERCENT OF GROSS NATIONAL PRODUCT, SELECTED FISCAL YEARS, 1889–90 THROUGH 1966–67

Fiscal year	Gross national product (in billions)	Social welfare expenditures as percent of gross national product							Total health and medical expenditures as percent of GNP [2]
		Total [1]	Social insurance	Public aid	Health and medical programs	Veterans' programs	Education	Other social welfare	
1889–90	$13.0	2.4	(3)	[4] 0.3	0.1	0.9	1.1	(4)	(4)
1912–13	39.9	2.5	(3)	[4] .3	.4	.5	1.3	(4)	(4)
1928–29	101.0	3.9	0.3	.1	.3	.7	2.4	0.1	0.5
1929–30	96.7	4.2	.4	.1	.4	.7	2.6	.1	.5
1930–31	83.1	5.1	.4	.2	.5	.9	2.9	.1	.7
1931–32	66.9	6.4	.5	.4	.6	1.2	3.5	.1	.9
1932–33	56.8	7.9	.6	1.2	.7	1.4	3.7	.2	1.0
1933–34	60.3	9.7	.6	4.2	.7	.9	3.2	.2	.8
1934–35	68.7	9.5	.6	4.4	.6	.9	2.9	.1	.8
1935–36	77.4	13.2	.6	4.0	.6	4.9	2.9	.1	.8
1936–37	86.5	9.1	.6	4.0	.6	1.0	2.7	.1	.7
1937–38	87.6	9.0	1.0	3.7	.6	.7	2.9	.1	.8
1938–39	87.6	10.5	1.3	4.8	.7	.7	2.9	.1	.8
1939–40	95.1	9.2	1.3	3.8	.6	.7	2.7	.1	.8
1940–41	112.1	8.0	1.2	3.1	.6	.5	2.3	.1	.8
1941–42	141.2	6.1	1.0	2.0	.7	.5	1.9	.1	.8
1942–43	174.8	4.7	.7	.9	1.1	.4	1.6	.1	1.2
1943–44	200.8	4.1	.6	.5	1.1	.4	1.4	.1	1.2
1944–45	211.1	4.4	.7	.5	1.1	.5	1.5	.1	1.2
1945–46	210.3	6.1	1.7	.5	.9	1.1	1.6	.1	1.1
1946–47	221.2	7.8	1.9	.7	.6	2.6	1.8	.1	.9
1947–48	244.4	7.6	1.5	.7	.6	2.7	2.0	.2	.9
1948–49	260.0	8.1	1.6	.8	.7	2.7	2.2	.2	1.0
1949–50	263.4	8.9	1.9	.9	.8	2.6	2.5	.2	1.2
1950–51	310.4	7.7	1.5	.8	.9	1.9	2.4	.1	1.2
1951–52	337.1	7.6	1.7	.8	1.0	1.6	2.4	.1	1.3
1952–53	358.8	7.5	1.8	.8	.9	1.3	2.6	.1	1.2
1953–54	361.9	8.2	2.3	.8	.9	1.3	2.8	.2	1.2
1954–55	379.7	8.6	2.6	.8	.8	1.3	2.9	.2	1.2
1955–56	409.5	8.6	2.6	.8	.8	1.2	3.0	.2	1.1
1956–57	431.7	9.1	2.9	.8	.9	1.2	3.2	.2	1.2
1957–58	440.2	10.3	3.6	.8	.9	1.2	3.5	.2	1.3
1958–59	469.2	10.6	3.9	.9	.9	1.2	3.5	.2	1.3
1959–60	495.6	10.6	3.9	.8	.9	1.1	3.6	.2	1.3
1960–61	506.5	11.5	4.4	.9	1.0	1.1	3.8	.3	1.4
1961–62	541.7	11.6	4.5	.9	1.0	1.0	3.9	.3	1.4
1962–63	574.5	11.6	4.5	.9	1.0	1.0	3.9	.3	1.4
1963–64	611.6	11.7	4.4	.9	1.0	1.0	4.1	.3	1.5
1964–65	655.5	11.8	4.3	1.0	1.0	.9	4.3	.3	1.5
1965–66	715.2	12.3	4.5	1.0	1.0	.9	4.6	.3	1.5
1966–67 [5]	763.1	13.1	4.9	1.2	1.1	.9	4.7	.4	2.1

[1] Includes housing, not show separately.
[2] Combines "health and medical programs" with medical services provided in connection with social insurance, public aid, veterans', and antipoverty programs.
[3] Less than 0.05 percent.
[4] "Other social welfare" included with "public aid."
Not available.
[5] Preliminary estimates.

This variation in growth patterns is reflected in chart 2, which shows the distribution of social welfare expenditures by major category for selected years since 1929. In that year, education was the single largest category, responsible for more than three-fifths of all expenditures. Social insurance and public assistance together accounted for 10 percent of the total spent. With the onset of the depression in the 1930's, public aid became the largest category. It was not until World War II that expenditures for education again represented the largest share of social welfare expenditures, a situation that was not changed until the late 1950's. At that time a rapidly growing social insurance sector supplanted education as the chief category. In fiscal year 1966 education expenditures again exceeded social insurance payments, but with the inauguration of medicare benefits the following year, social insurance once more became the dominant category, accounting for 37 percent of total expenditures.

In terms of the national output of goods and services, the growth in social insurance and education expenditures has been most significant. In fiscal year 1967, expenditures for each of these two categories, as a percent of the gross

national product, were more than 2½ times what they had been 20 years earlier (table 2). In the past 2 years alone, stimulated by 1965 Federal legislation expanding the OASDHI program and providing additional aid in support of public education, social insurance expenditures rose from 4.3 percent of the gross national product to 4.9 percent and education expenditures rose from 4.3 percent to 4.7 percent. Also rising in 1967, after years of relatively little change, were the proportions of the national output used for public aid and health and medical programs.

Although social welfare expenditures have increased tremendously since 1929, they have been almost matched by mounting expenditures for other functions of government, especially for war, defense, and international affairs. In fiscal year 1967, social welfare expenditures from public funds represented 43 percent of all government expenditures (Federal, State, and local)—a ratio not much higher than the 37 percent recorded in 1929 (table 4). In fact, expenditures for social welfare in 1967 still represented a smaller proportion of all government spending than they had in the 1930's. In the State and local sector alone, the proportion going for social welfare purposes has remained fairly stable since 1950.

PRIVATE AND PUBLIC EXPENDITURES

In sharp contrast to the $4 billion rise in the preceding year, private expenditures for health, education, and organized income-maintenance and welfare programs in the fiscal year 1967 increased only $1 billion to a total of $47 billion. This slow-down was due to developments in the health field, where private expenditures were estimated to have declined by more than $600 million during the year. Combined public and private expenditures for health, education, and welfare amounted to an estimated $146 billion, after account is taken of the overlap that exists because small parts of private expenditures for health and education represent the spending of benefits received under public programs and, to a lesser extent, under private employee-benefit plans.

Health

The decline in private spending for health is attributable to the new Federal programs of medicare and medicaid, which reduced direct payments by consumers to providers of services and increased the amount of health expenditures in the public sector. As a result the proportion of all health and medical care expenditures from public funds increased from 26 percent in fiscal year 1966 to 34 percent in 1967 (table 5).

TABLE 4.—SOCIAL WELFARE EXPENDITURES [1] IN RELATION TO GOVERNMENT EXPENDITURES FOR ALL PURPOSES, SELECTED FISCAL YEARS, 1928–29 THROUGH 1966–67

Item	1929	1935	1940	1945	1950	1955	1960	1965	1966	1967 [2]
All social welfare expenditures from public funds:										
Total, as percent of total government expenditures	37.4	49.6	47.5	8.6	37.3	32.2	37.6	41.5	42.6	42.5
Federal, as percent of total Federal Government expenditures	27.5	50.9	37.8	4.6	25.5	21.3	27.1	31.6	33.6	34.0
State and local, as percent of total State and local government expenditures [3]	41.2	48.3	57.4	56.6	61.0	60.4	59.2	60.6	60.9	61.2
Social welfare expenditures from general revenue:										
Total, as percent of total government expenditures from general revenue	37.6	49.0	44.7	8.0	33.0	26.0	29.2	33.0	33.9	33.4
Federal, as percent of total Federal Government expenditures from general revenue:										
All programs	27.7	50.6	36.0	4.1	22.7	13.9	15.3	18.5	20.1	20.2
Veterans programs	22.7	9.5	6.9	1.2	15.9	7.6	6.7	5.9	5.6	5.3
State and local, as percent of total State and local government expenditures from general revenue: [3]										
All programs	41.0	47.4	53.9	56.0	55.1	56.6	56.1	57.9	58.5	58.5
Education	31.7	29.6	29.3	37.4	34.8	38.2	40.9	43.4	43.9	43.7

[1] Expenditures from general revenues and from social insurance trust funds; that part of workmen's compensation and temporary disability insurance payments made through private carriers and self-insurance was omitted in computing percentages.
[2] Preliminary estimates.
[3] Excludes Federal grants-in-aid

The 1967 estimates for the private sector are provisional and are subject to revision when complete data for the fiscal year become available. At this writing, the only relatively firm figures are those for hospital care, published monthly by the American Hospital Association. Estimates for other components are based on trends in medical care prices and utilization.

When expenditures for programs specifically concerned with health are combined with expenditures for medical care under social insurance, public assistance, and veterans' and other programs, the total amount expended in fiscal year 1967 for health and medical care from public funds reaches $16 billion. This amount represents an increase of $5 billion from the total of $11 billion spent in the preceding year. In relation to the gross national product, the total spent for this purpose rose from 1.5 percent in 1966 to 2.1 percent in 1967.

Despite a drop from the amount spent in 1966, the estimated total of $31.1 billion spent in the private health sector in 1967 was still almost twice as great as that spent in the public sector. It is estimated that higher amounts were expended during the year for all items in the private sector except direct consumer payments (private health insurance benefits and the costs of providing them, industrial in-plant medical services, philanthropic expenditures for health purposes and medical facilities construction).

When public and private expenditures for health and medical care are combined, the 1967 fiscal year total of $47.3 billion is some $4.5 billion higher than the 1966 total. This is the largest increase in the history of the series. Total health expenditures continued to rise as a percent of the gross national product—from 6 percent in 1966 to 6.2 percent in 1967. Between 1966 and 1967 the medical care index rose 7.3 percent, a much larger increase than any in recent years.

If expenditures for medical facilities construction, medical research, general public health activities, and administration of health programs (both private and public) and of philanthropic agencies are excluded, the remaining amount ($40 billion in 1967) represents essentially expenditures of personal health care. Public funds accounted for 31.6 percent of the total, a spurt of 9.7 percentage points from the estimate for the preceding year. Because of Government's growing role in providing personal health care, the proportion of such costs met through direct payments from consumers dropped from 51.3 percent in 1966 to 45 percent in 1967. Similarly, the proportion covered by private health insurance benefits dipped from 24.1 to 22.5 percent during the year.

It may be worth calling attention to one addition to table 5—a special category of OEO expenditures for health and medical care. These are expenditures for health and medical care primarily through the community action program but also in connection with Job Corps, Headstart, VISTA, and other antipoverty programs. The amounts are included in the appropriate categories in table 1 but are not shown separately there because they were so small. This special category will probably grow in importance. It should be noted that expenditures under other programs—such as medicaid, medicare, or various health programs—for services provided in OEO community health centers or clinics are included in the total expenditures for the specific program.

TABLE 5.—HEALTH AND MEDICAL CARE: PRIVATE EXPENDITURES AND EXPENDITURES UNDER PUBLIC PROGRAMS, SELECTED FISCAL YEARS, 1928–29 THROUGH 1966–67

[Amounts in millions]

Type of expenditure	1928–29	1934–35	1939–40	1944–45	1949–50	1954–55	1959–60	1964–65	1965–66	1966–67[1]
Total	$3,589.1	$3,123.2	$3,804.6	$7,914.4	$12,129.5	$17,923.6	$26,391.1	$39,989.8	$42,813.9	$47,266.6
Private expenditures	3,112.0	2,580.0	3,023.0	5,335.0	9,064.0	13,503.0	19,996.0	29,272.0	31,769.2	31,100.0
Health and medical services	3,010.0	2,570.0	2,992.0	5,305.0	8,849.0	13,178.0	19,518.0	28,038.5	30,458.8	29,730.0
Direct payments	[2]2,900.0	[2]2,500.0	[2]2,900.0	[2]4,875.0	7,146.0	9,448.0	13,087.0	17,386.0	18,981.0	18,000.0
Insurance benefits					879.0	2,344.0	4,674.0	8,280.5	8,935.4	9,000.0
Expenses for prepayment					274.0	596.0	792.0	1,212.0	1,347.4	1,500.0
Industrial in-plant services	30.0	30.0	40.0	90.0	150.0	210.0	265.0	330.0	345.0	360.0
Philanthropy	80.0	40.0	52.0	340.0	400.0	580.0	700.0	830.0	850.0	870.0
Medical-facilities construction	102.0	10.0	31.0	30.0	215.0	325.0	478.0	1,233.5	1,310.4	1,370.0
Public expenditures	477.1	543.2	781.6	2,579.5	3,065.3	4,420.6	6,395.2	9,717.8	11,044.7	16,166.6
Health and medical services	372.5	495.1	679.5	2,468.2	2,470.2	3,862.3	5,346.3	7,815.3	8,933.9	13,785.4
OASDHI (health insurance for the aged)									63.6	3,393.1
Temporary disability insurance (medical benefits)[3]					2.2	20.0	40.2	50.9	54.3	56.0
Workmen's compensation (medical benefits)[3]	75.0	65.0	90.0	122.0	193.0	315.0	420.0	580.0	630.0	685.0
Public assistance (vendor medical payments)					51.3	211.9	492.7	1,367.1	1,709.9	2,318.3
General hospital and medical care	117.1	225.3	297.6	364.8	886.1	1,297.6	1,973.2	2,514.8	2,720.3	2,790.8
Defense Department hospital and medical care	29.2	27.7	45.4	1,631.1	336.2	744.8	820.1	1,036.8	1,273.4	1,571.8
Military dependents' medical care							60.1	78.3	76.2	150.8
Material and child health services	6.2	6.9	13.8	62.1	29.8	92.7	140.7	223.2	276.2	306.8
School health (educational agencies)	9.4	10.0	16.4	23.3	30.6	65.9	101.0	132.0	135.0	140.0
Other public health activities	88.8	112.2	154.5	178.0	350.8	383.7	401.2	671.5	723.8	900.9
Veterans' hospital and medical care	46.7	47.8	61.5	85.5	582.8	721.5	879.4	1,120.9	1,175.2	1,271.3
Medical vocational rehabilitation	.1	.2	.3	1.4	7.4	9.1	17.7	34.2	48.0	80.5
OEO health and medical care								5.6	48.2	120.2
Medical research		.3	2.6	2.5	72.9	138.9	471.2	1,229.2	1,379.7	1,540.5
Medical-facilities construction	104.7	47.8	99.6	108.7	522.3	419.4	577.7	673.2	731.0	840.6
Defense Department	([4])	([4])	([4])	38.9	1.1	33.0	40.0	34.8	28.6	58.5
Veterans' Administration	4.2	3.0	14.3	16.3	161.5	34.1	59.6	81.2	86.0	51.0
Other	100.4	44.8	85.2	53.5	359.8	352.4	478.1	557.2	616.4	731.2

TABLE 5.—HEALTH AND MEDICAL CARE: PRIVATE EXPENDITURES AND EXPENDITURES UNDER PUBLIC PROGRAMS, SELECTED FISCAL YEARS, 1928–29 THROUGH 1966–67—Continued

[Amounts in millions]

Type of expenditure	1928–29	1934–35	1939–40	1944–45	1949–50	1954–55	1959–60	1964–65	1965–66	1966–67[1]
Total expenditures as a percent of gross national product	3.6	4.5	4.0	3.7	4.6	4.7	5.3	5.9	6.0	6.2
Public expenditures as a percent of total expenditures	13.3	17.4	20.5	32.6	25.3	24.7	24.2	24.9	25.8	34.2
Personal care expenditures[3]	3,272.2	2,941.5	3,502.1	7,506.1	10,578.2	15,906.7	23,481.7	33,742.4	37,025.0	40,000.3
Private expenditures	2,990.0	2,560.0	2,979.0	5,220.0	8,475.0	12,437.0	18,551.0	26,619.0	28,898.9	27,360.0
Public expenditures	282.2	381.5	523.1	2,286.1	2,103.2	3,469.7	4,930.7	7,123.4	8,126.1	12,640.3
Percent from:										
Private expenditures	91.4	87.0	85.1	69.5	80.1	78.2	79.0	78.9	78.1	68.4
Direct payments	88.6	85.0	82.9	64.9	67.6	59.4	55.7	51.5	51.3	45.0
Insurance benefits					8.3	14.7	19.9	24.5	24.1	22.5
Public expenditures	8.6	13.0	14.9	30.5	19.9	21.8	21.0	21.1	21.9	31.6

[1] Preliminary estimates.

[2] Includes any insurance benefits and expenses for prepayment (insurance premiums less insurance benefits).

[3] Includes medical benefits paid under public law by private insurance carriers and self-insurers.

[4] Data not available.

[5] Includes all items shown under "health and medical services" except (1) "expenses for prepayment" and one-fourth of "philanthropy" under private expenditures and (2) "other public health activities" and administrative expenses for "health insurance for the aged" and "veterans' hospital and medical care" under public expenditures.

Education

Total public and private expenditures for education reached $43.4 billion in fiscal year 1967. The increase of $4.1 billion did not match the increase of the previous year but otherwise was the largest during the period under review.

Public expenditures for education continued to account for 83 percent of public and private educational expenditures combined, a ratio that has hardly changed since the mid-1950's. Public expenditures for higher and other education as a proportion of total higher and other education expenditures again increased slightly. The 1967 increase was, however, entirely the result of public expenditures for veterans' educational benefits (table 6).

TABLE 6.—EXPENDITURES FOR EDUCATION, SELECTED FISCAL YEARS, 1949-50 THROUGH 1966-67

[Amount in millions]

Program	1949-50	1954-55	1959-60	1964-65	1965-66	1966-67 [1]
Total amount	$10,914	$14,202	$21,706	$33,965	$39,234	$43,397
Public expenditures for education	9,366	11,863	18,036	28,094	32,604	36,011
Current operations [2]	8,036	9,433	15,016	23,598	27,340	30,597
Elementary and secondary	4,577	7,502	12,447	19,087	21,605	23,826
Higher	604	1,016	1,833	3,556	4,505	5,130
Veterans	2,692	706	410	43	37	378
Vocational and adult	161	205	298	852	1,067	1,122
Construction	1,330	2,431	3,020	4,496	5,264	5,414
Elementary and secondary	1,019	2,232	2,662	3,267	3,450	3,601
Higher	310	199	358	1,229	1,814	1,813
Private expenditures [3] for education	1,548	2,339	3,670	5,871	6,630	7,386
Current operations	1,266	1,829	3,126	5,155	5,788	6,519
Elementary and secondary	436	719	1,232	1,882	1,974	2,175
Higher	830	1,110	1,894	3,273	3,814	4,344
Construction	282	510	544	716	842	867
Public expenditures for education as percent of—						
Total	85.8	83.5	83.1	82.7	83.1	83.0
Current operations	86.4	83.8	82.8	82.1	82.5	82.4
Elementary and secondary	91.3	91.3	91.0	91.0	91.6	91.5
Other	80.6	63.5	57.3	57.6	59.5	60.4
Higher	42.1	47.8	49.2	52.1	54.2	54.1
Construction	82.5	82.7	84.7	86.3	86.2	86.2

[1] Preliminary estimates.
[2] Includes expenditures for administration (U.S. Office of Education) and research, not shown separately below.
[3] Includes expenditures by privately controlled schools, and private expenditures in publicly controlled schools for current educational purposes, in the form of students' tuition and fees and private gifts.

Income-Maintenance Programs

The grouping of public and private programs for income maintenance and welfare services has always presented problems. As noted in earlier articles, it is not possible to aggregate expenditures for income security in the same way that total private and public expenditures for health or education are measured. In previous years, the article has presented a table showing the total expenditures under organized income-maintenance and welfare service programs. For public expenditures, this was essentially a residual figure after health and education were subtracted from the total. With the growth of public welfare service expenditures and the lack of any really comparable private component, this grouping appears less and less meaningful.

A more useful comparison is that between public and private cash transfer payments. Table 7 groups cash benefits under social insurance, veterans' cash benefits, and cash payments under public assistance and compares these expenditures with those under private employee benefit plans (excluding health benefits).

TABLE 7.—EXPENDITURES FROM PUBLIC AND PRIVATE FUNDS FOR CASH TRANSFER PAYMENTS (EXCLUDING ADMINISTRATION), SELECTED FISCAL YEARS, 1949–50 THROUGH 1966–67

[Amounts in millions]

Source of funds	1949–50	1954–55	1959–60	1964–65	1965–66	1966–67 [1]
Total cash transfer payments	$10,112	$16,609	$28,718	$40,526	$45,219	$48,830
Public	9,147	14,714	25,173	34,861	38,884	41,695
Social insurance [2]	4,447	9,118	18,151	26,426	30,007	32,043
Veterans' programs [3]	2,423	3,094	3,810	4,518	4,790	5,025
Public assistance	2,277	2,502	3,212	3,918	4,087	4,627
Private employee benefits [4]	965	1,895	3,545	5,665	6,335	7,135
Public as percent of total	90.5	88.6	87.7	86.0	8.60	85.4

[1] Preliminary estimates.
[2] Includes cash benefits paid under workmen's compensation and temporary disability insurance laws by private insurance carriers and self-insurers.
[3] Veterans' pension and compensation, burial awards, and life insurance.
[4] Under private pension plans; group life (including government employee programs), accidental death and dismemberment, and voluntary sickness insurance; paid sick leave; and supplemental unemployment benefit plans. Temporary disability insurance benefits under State legislation excluded here and included under social insurance above.

Despite the rapid growth of OASDHI and other social insurance programs, public funds accounted for a smaller proportion of all cash transfer payments in fiscal year 1967 than in 1950. The expansion of benefits under employee benefit plans, and especially under private pension plans, has more than matched percentagewise the growth of social insurance benefits. In addition, the dollar amounts expended by the Government for veterans and for the needy have been increasing at less than half the pace of that for other income-maintenance programs. Veterans' and public assistance programs, which accounted for more than half the cash transfer payments under public programs in the fiscal year 1950, paid out less than a fourth in 1967.

Some small part of philanthropic expenditures for welfare purposes, estimated at about $1.6 million in fiscal year 1967, goes for cash payments to needy persons. The estimate itself is so rough that a breakout of an amount for cash transfers has not been attempted. The major part of philanthropic welfare expenditures in recent years has gone for institutional care, family counseling, day care, and other social services.

Nevertheless, it is evident that public programs are the major source of organized income maintenance for the nonearning groups in the population and account for 85 percent of total expenditures.

Mr. COHEN. It shows you the tremendous change that has been taking place over the years in these areas.

For this analysis I did not want to go back too far so I started with 1950, but there is no question if you look at this whole analysis that an upward trend in all of these three areas is taking place. I might add before we go on that when I deal with health, education, and welfare, in this analysis, I do not necessarily include absolutely everything that a person might possibly attribute to these fields. We do not include under social welfare individual life insurance premiums although we include group life insurance.

In other words, these totals are minimal. Instead of $146 billion, if you really took in everything that you could possibly include, the total could be substantially more.

Mr. FLOOD. We are aware of about what your yardstick is.

Mr. LAIRD. You have the private pension plans.

Mr. COHEN. Yes, sir.

Mr. FLOOD. But you do not include individual insurance plans.

Mr. COHEN. Wherever there is any kind of group activity, employer-employee arrangement, we include it. But naturally there are lots of

other elements such as home ownership, life insurance, and a number of other factors that contribute to individual security but which we do not include in this.

Mr. FLOOD. As I say, I think we know your yardstick.

DIVISION BETWEEN PUBLIC AND PRIVATE EXPENDITURES FOR HEALTH, EDUCATION, AND WELFARE

Mr. COHEN. Funds from all three sectors, are increasing. The Federal share increased about $8½ billion from fiscal year 1966 to 1967. The State and local share increased about $3.6 billion. The voluntary sector increased about $1.2 billion, even though there was a transfer of over $3 billion in health insurance expenditures for the aged from the private to the public sector due to the inauguration of medicare.

Mr. FLOOD. Why wouldn't you say medicare and medicaid?

Mr. COHEN. Medicaid was largely in the public sector before. There was not much direct transfer from that. It was rather an increase. There was a small decrease but I think largely most of those people now receiving benefits from medicaid were previously getting the service largely free or at a lesser cost.

You notice when you turn to education, the second circle, that because of the great amount of public funds in elementary and secondary education, public funds are 83 percent of the total and private are only 17. You have a completely different relationship here. In social welfare, public again is about 85 percent, private is 15, made up of private pension plans and private philanthropy. But when you take all three together and add them up, they roughly represent about equal thirds.

The Federal Government is approximately a third, the State and local governments are approximately a third, and the private is approximately a third of the total that you would be concerned about in your committee.

Mr. FLOOD. With health, education, and welfare?

Mr. COHEN. All together.

Mr. LAIRD. That is calendar year 1967?

Mr. COHEN. No; this is fiscal 1967. This particular series is fiscal.

SOCIAL WELFARE

Mr. FLOOD. We understand pretty generally what health is. We understand pretty generally what education is. Would you for a minute tell us what is social welfare? Social welfare as a phrase is a little vague for the average person.

Mr. COHEN. The social welfare orbit includes first all of the social insurance programs, old age survivors and disability insurance, railroad retirement, unemployment insurance, railroad unemployment insurance, railroad temporary disability. State temporary disability laws, and State workmen's compensation laws. Then there are all of the public assistance or welfare programs, vocational rehabilitation, child welfare, those aspects of the OEO programs that relate to social welfare in this area, and certain types of veterans pensions and group life insurance.

So this makes up the total.

Mr. FLOOD. You were speaking entirely in reply to my question obviously, about the public sector. With reference to the 15 percent of the private sector, what is social welfare?

Mr. COHEN. In the private sector this is made up, for instance, of private employee pension plans.

First, the retirement plans, then employer temporary disability plans, supplemental unemployment benefits negotiated by collective bargaining between employers and unions, life insurance. We also include that part of private philanthropy, private foundations, and private welfare agencies that is directed to these programs.

Mr. FLOOD. This will include the so-called United Funds and Community Chests.

Mr. COHEN. Yes. This is an attempt to bring everything together in some focus so you can see what our total society is doing in health, education, and welfare. This analysis and these details that I just read to you are contained in this article that I have put in the record. (See pp. 20–40.)

Now, Mr. Chairman, the three-way cooperative approach that I have been talking about, that is, the Federal Government, State and local governments, and the private sector, this approach that we have in our country to meeting health, education, and welfare needs is not a very simple or clear-cut way of handling our complex problems.

It is a constantly evolving partnership which brings with it all of the complexities involved in cooperation and competition and compromise. But in my opinion it is an arrangement which brings with it great potentialities for progress, improvement, and widespread participation and innovation by many persons, institutions, and agencies. The most important observation, it seems to me, to be drawn from these figures is that these expenditures have been growing rapidly, and I think they seem likely to continue to grow both in terms of the total amount spent, and as a percentage of the gross national product. I personally look upon them as an investment in the future growth and the vitality of our Nation.

REASONS FOR GROWTH IN NATIONAL EXPENDITURES FOR HEALTH, EDUCATION, AND WELFARE

Now I would like to go into the reasons why these expenditures have been growing and are likely to continue to grow. There are a number of reasons for this growth. First, the population is steadily increasing. The elderly population and the young population, those groups requiring the most services, have shown the largest increases. These groups have increased by more than 20 percent over the past 10 years, and now constittue nearly 46 percent of the population. Second, America is a nation on the move. People are moving from East to West, South to North, from city to suburb and from farm to city. During the 6-year period 1960 to 1966 the farm population had an annual average net loss of 804,000, an annual loss rate of 5.9 percent.

The number of people living in urban areas, as you know, has increased more than 25 percent in the past 10 years and now makes up about 70 percent of the population. By the year 2000 all but 20 per-

cent of the population may be living in these concentrated areas. This population trend has had and will continue to have a direct bearing on expenditures in health, education and welfare. New services must be provided in areas where none existed, and existing services must be expanded to accommodate growing numbers of persons. Also, the social problems—illegitimacy, alcoholism, mental illness, broken families—that are generated at least partially as a result of this mobility have come to be recognized as community responsibilities requiring community action.

ORGANIZATION FOR DELIVERING SERVICES

Mr. FLOOD. I think you also have in mind, I would hope, that if the montain won't come to Mohammed, Mohammed will go to the mountain. You are getting away from these great big offices, these Taj Mahals in the center of town. You will bring these services into the neighborhoods where they are needed.

Mr. COHEN. I think that is one of the most important factors that we are going to have to concentrate on immediately. As you look at these problems of the congested urban areas, you have to have things like neighborhood health centers. In a major downtown urban area many people do not have a private physician. The physicians or hospitals may be long distances from them. I would think that if we could decentralize those services more to people close where they live, we would have better quality of service.

Mr. FLOOD. It is also a matter of transportation.

Mr. COHEN. Yes.

Mr. FLOOD. These people who most need the services, if they can get downtown, they approach this tremendous place, these great big halls with marble and bronze and glass and potted palms and meet functionaries, the traditional bureaucrat. I have gone into those places and stood with my hat in hand in absolute awe.

Mr. COHEN. I think you have to do a number of things. I think you have to organize your services much more efficiently. There is a great deal of waste and inefficiency in our present health system. Many of the units are not located where they should be.

Mr. FLOOD. The same applies to the welfare system.

Mr. COHEN. And not located satisfactorily to the needs of the people. I would think that we have to reexamine where they are located in order to give the individual the best service. One of the problems, for instance, 15 or 20 years ago when we did not organize the health services as well as we do now, was that a doctor was spending a major part of his time driving his car around. That is not the most efficient use of the doctor's time. A much better way is to have a little clinic in Marshfield or Wilkes-Barre where the doctors are all together.

It has always seemed to me that when the medical care services are so limited you have to find methods by which you maximize the use of these professional people's time. So we have to find ways for them to serve at a point where they can best contribute their professional services.

Mr. FLOOD. We are talking about the same thing, then.

Mr. COHEN. Yes. The point I am now going to make is one that you are all aware of, that prices have increased, pushing up the cost of the medical services purchased. For example, the cost of medical care in January 1968 went up six-tenths of a percent over the December 1967 level, as it had been doing for quite some time, bringing the index to 41.2 percent above the 1957–59 level. I might add, Mr. Chairman, studying that medical care price index, I must say I see no way at the present time that it will be reduced. It seems to me from studying it very carefully it is going to continue to go up. So in talking about our budget, in talking about this whole area, one of the most difficult problems is this constantly increasing price of medical care.

Mr. FLOOD. I see newspaper reports periodically about the increase in the cost of living and there are always five or six particular items mentioned. It might be services, it might be home appliances, rental, but always hospital and medical care.

Mr. COHEN. The hospital index has been the most rapidly rising part of costs in the price index. Hospital costs, as reflected in hospital expenses per person-day, increased about 7 percent a year for the 20 years between 1946 at the end of World War II to approximately 1966. Gentlemen, 7 percent per year cumulative means 100 percent every 10 years. That is, in effect, a doubling every decade. In the last year hospital cost increases were double the 7-percent annual increases over the last two decades.

It now appears that hospital costs may average this year and maybe next year something in the neighborhood of 14-percent increase per year. You can see what the implications of that are for the Federal budgets, State and local budgets, Blue Cross, Blue Shield, and for what you pay out of your own pocket. That is really one of the most important cost increases that we have, both nationally and in terms of the area that you are concerned about.

Mr. FLOOD. And it will get worse before it gets better.

Mr. COHEN. I am going to make a few suggestions later on how we might hopefully—what is the correct word—keep the rise in that from being less than it would be otherwise. I do not think anybody can see a way to stop the progression, but we might dampen the rate of increase. If we could do that, I think we would make a very great contribution.

Added to the above factors is the rising level of aspirations of people. They want better health care. They want better schools and more education for their children. Within a single generation the proportion of pupils who graduate from high school has risen by nearly 60 percent. For every 1,000 children in the fifth grade in 1959–60, there were an estimated 721 high school graduates in 1967. That is roughly 72 percent. This may be compared with 621 graduates in 1960, and with 455 graduates in 1940, for each 1,000 pupils in the fifth grade 8 years earlier. We all understand how costs and expenditures in elementary and secondary education have risen as more people have completed high schools.

TIMING OF REQUEST FOR 1968 SUPPLEMENTAL APPROPRIATIONS

Mr. LAIRD. Mr. Chairman, may I ask a question at this point?

Mr. FLOOD. Surely.

Mr. LAIRD. You bring up the subject of elementary and secondary education in your statement. In this budget for 1969 you are dealing with a 1970 figure, is that correct? The 1969 budget includes the request for the elementary and secondary 1970 appropriation. And you intend to finance 1969 in a 1968 supplemental.

Mr. COHEN. Yes.

Mr. LAIRD. Last year you and the Secretary talked to us about advancing the funding for this program 1 year.

Mr. COHEN. Yes.

Mr. LAIRD. I was a little disturbed that a 1970 estimate is the matter before the committee now and you have not even gotten the 1969 budget request before the Congress.

What seems to be the trouble? Why did you send 1970 before you sent 1969?

Mr. COHEN. As I understand that is coming very shortly.

Mr. LAIRD. Very shortly? It seems to me you have this all out of gear. We should be having hearings on 1969 before we have hearings on 1970.

Mr. CARDWELL. The 1969 budget submitted by the President in January contained in effect two proposals; one was an advance funding arrangement.

Mr. LAIRD. Last year this proposal looked reasonable. But it looks to me like the 1969 request is not even before us, Mr. Chairman. And the 1970 request is.

Mr. CARDWELL. The President in a message he is going to send to Congress, hopefully by the end of this week, will make reference to that. The Bureau of the Budget takes the position that the language that is carried in the 1969 budget is adequate. There are two pieces of language; one piece refers to 1969, the other to 1970. They both provide an equal level of $1.2 billion. The Congress has been asked to authorize the appropriation of $1.2 billion for 1969 prior to next June 30 and also to approve an appropriation of $1.2 billion for 1970.

Mr. LAIRD. Maybe the Bureau of the Budget is in error here. The President said he was sending up a supplemental.

Mr. CARDWELL. That is correct.

Mr. FLOOD. The President's budget message indicated——

Mr. LAIRD. He said definitely he would send up a supplemental. There were no if's, and's or but's.

Mr. FLOOD. This is a matter of opinion, since there is this other language for 1969 in the budget.

Mr. LAIRD. He put it in plain language. The President said he would send up a request for a supplemental.

Mr. FLOOD. If it is included in the next supplemental, then it might pass later than the regular bill.

Mr. LAIRD. It will, or at best it will be ahead of the regular bill by a very short period of time.

Mr. CARDWELL. Our understanding is that a group of HEW supplementals will be sent up by the end of this week to the House of Representatives. That is the understanding I had as of last Friday.

Mr. LAIRD. And the education money will be in it?

Mr. CARDWELL. A specific request will be referred to in the President's message. He is not going to propose a supplemental per se.

Mr. LAIRD. If he is not going to propose a supplemental then we will have the 1969 money in the regular bill and the 1970 money will go out the window so far as action this year is concerned.

Mr. CARDWELL. He is going to ask the Congress to make an appropriation in advance for 1969 prior to June 30, 1968. That will be in the message.

Mr. LAIRD. If we really had wanted to do something to get this program funded well in advance, it would seem to me this should have been a priority item in the supplemental the committee just worked on.

Mr. CARDWELL. They only sent two items for HEW. In fact, three items for the Government as a whole.

Mr. KELLY. They were only items that were running out of money immediately. We share your concern and we hope you will bear with us. In getting on to the new funding arrangement we have to make a transition. Once the transition has been made, we would be requesting the funds a year in advance. This is in the nature of a request that you act on a 1969 item in a bill which precedes the 1969 fiscal year. There will be such a bill considered by the Congress in the form of a supplemental. We are asking that you include this 1969 appropriation in it and therefore after that we will be on the basis of advanced funding for elementary and secondary education. I think, myself, it is one of the most important steps that you can take to make these funds more useful to each of the 19,500 participating districts.

Mr. LAIRD. Mr. Chairman, I am sorry to have interrupted you, but it seems to me the language of the President's budget message was very clear. On page 156 of the printed budget this was spelled out about as clearly as it possibly could be. Now I understand from what you say there will not be a specific supplemental request for the 1969 funding; is that correct?

Mr. CARDWELL. It depends on what you mean by request. The President in his message to Congress will request that you give this consideration as a part of the supplemental he is going to send forward.

Mr. LAIRD. But he is not going to be asking for any money?

Mr. CARDWELL. It is a matter of how you look at it. He is asking the Congress to appropriate money to be available beginning July 1, 1968. He will ask the Congress to do this in the next supplemental.

Mr. LAIRD. But he is not going to ask for any dollars and cents in new obligational authority?

Mr. CARDWELL. That is correct.

Mr. LAIRD. I cannot understand that. He wants us on the Appropriations Committee to write in obligational authority in a supplemental without his asking for it?

Mr. CARDWELL. It is specified in the budget which he sent in January. It shows up in the language in the 1969 budget for 2 years, for 1969 and for 1970.

Mr. LAIRD. It shows up in the language as a part of the regular bill, however.

Mr. CARDWELL. That is correct, but I think in all fairness the President is asking you for the same obligational authority he identified in the regular budget for the same period.

I think what you are saying is because he is not sending you a routine regular document that you would normally receive for a regular supplemental, you are not receiving one. But in effect he is sending you one. He is sending a request in writing to Congress and it will arrive, I hope, by the end of this week.

Mr. LAIRD. I would like you to explain to me why it is being handled that way.

Mr. KELLY. We are in the unusual situation of rather than asking for obligational authority to become immediately available, of asking for obligational authority to become available for the next fiscal year. We had to devise a mechanism of doing this.

Mr. LAIRD. We agreed when these discussions went on that it would be a direct appropriation. There would be no back door financing, there would be no contract authority. You would come up in clean fashion and ask for obligational authority in the supplemental.

Now you are not doing that. I would like to know why.

Mr. KELLY. I feel we are. I think the only difference is that we are not asking for 1968 obligational authority. We are asking for 1969 obligational authority. In this transition, an attempt is being made to distinguish between a request for obligational authority that becomes available for the next fiscal year from obligational authority that becomes immediately available for this fiscal year. I would hope that we could work out any confusion that occurs on this point. It is true that with respect to the funding of airports, urban mass transportation, that when funds were appropriated in one fiscal year to be available in the following fiscal year, that the Congress and the executive branch bookkeeping of how much obligational authority is requested and being made available will be treated with respect to the fiscal year for which it is available rather than the fiscal year in which it is appropriated. That is all that is being done here. It is exactly the same technique.

Mr. LAIRD. It does not seem to me you are very much in a hurry to get the 1969 funds.

Mr. KELLY. I would like to get them at the earliest possible time. I think it really advances the cause of Federal assistance to elementary and secondary education.

Mr. LAIRD. The Secretary's statement that you presented to our committee today confuses the issue to a further extent than it was confused before. I do not think you are helping to promote the best planning of educational funds.

Mr. COHEN. I would certainly have to agree, Mr. Laird, that it is very urgent that it come up very promptly. We have tried to make that view known.

Mr. LAIRD. I understand it is not coming up.

Mr. CARDWELL. The language that is being proposed appears on page 394 of the budget that was submitted in January.

Mr. LAIRD. But that is submitted in the form of a part of the 1969 appropriation bill.

Mr. CARDWELL. But it does specify a 1969 appropriation to become available beginning July 1, 1968. We will call your concern to the attention of the Bureau of the Budget when we finish here this afternoon.

Mr. FLOOD. Very well.

Mr. COHEN. I would like to turn now, Mr. Chairman, to a discussion of the paradox of plenty and poverty.

THE PARADOX OF PLENTY AND POVERTY

Although both the Nation's GNP and HEW expenditures have been increasing and much social progress has been made, we are all acutely aware of the many needs which are still unmet. An important aspect of our recent history is the growing awareness of these unmet needs and the concern about dealing more effectively and promptly with them.

The paradox of poverty amidst plenty is one which has been receiving considerable attention.

The good life enjoyed today by the average American goes beyond the fondest dreams of our grandfathers. Yet, in the face of all this Nation has accomplished—the highest standard of living in the world—the greatest educational and job opportunity for the most people of any nation on earth—the elimination of dread disease and a greater life expectancy—we are beset by problems associated with poverty—social unrest, rising welfare costs, inadequate education and training of some groups, and inadequate health care for many of our people.

As we have brought the fruits of progress to more and more of our people, the disparity between those who have gained the most and those who have gained the least has grown.

As we have raised our standard of living, so have we widened the gap between the poor and economically secure.

As we have provided an elementary and secondary education to more and more of our people, so have we increased their thirst for greater knowledge and for more education.

As we have broadened medical knowledge, so have we created a demand to extend the miracles of modern medicine to every corner of the land.

TABLE 1.—WEIGHTED AVERAGE OF POVERTY AND LOW-INCOME CRITERIA [1] FOR FAMILIES OF DIFFERENT COMPOSITION BY HOUSEHOLD SIZE, SEX OF HEAD, AND FARM OR NONFARM RESIDENCE

Number of family members	Weighted average of incomes at poverty level						Weighted average of incomes at low-income level					
	Nonfarm			Farm			Nonfarm			Farm		
	Total	Male head	Female head	Total	Male head	Female head	Total	Male head	Female head	Total	Male head	Female head
1 member	$1,635	$1,710	$1,595	$1,145	$1,180	$1,110	$1,985	$2,080	$1,930	$1,390	$1,440	$1,340
Head under age 65	1,685	1,760	1,625	1,195	1,230	1,140	2,045	2,140	1,975	1,450	1,495	1,380
Head aged 65 and over	1,565	1,580	1,560	1,095	1,105	1,090	1,890	1,925	1,880	1,330	1,350	1,315
2 members	2,115	2,130	2,055	1,475	1,480	1,400	2,855	2,875	2,735	1,990	2,000	1,870
Head under age 65	2,185	2,200	2,105	1,535	1,540	1,465	2,945	2,970	2,790	2,075	2,080	1,945
Head aged 65 or over	1,970	1,975	1,955	1,380	1,380	1,370	2,665	2,675	2,615	1,870	1,875	1,835
3 members	2,600	2,610	2,515	1,815	1,820	1,725	3,425	3,440	3,330	2,400	2,400	2,325
4 members	3,335	3,335	3,320	2,345	2,345	2,320	4,345	4,355	4,255	3,060	3,060	3,000
5 members	3,930	3,930	3,895	2,755	2,755	2,775	5,080	5,085	4,970	3,565	3,565	3,560
6 members	4,410	4,410	4,395	3,090	3,090	3,075	5,700	5,710	5,600	3,995	4,000	3,920
7 or more members	5,430	5,440	5,310	3,790	3,795	3,760	6,945	6,960	6,780	4,850	4,850	4,815

[1] Required income in 1966 according to Social Security Administration poverty or low-income index for a family of a given size and composition. Family income criteria weighted together in accordance with percentage distribution of total units by number of related children and sex of head, as of current population survey, March 1967.

For detailed description of the Social Security Administration measures of poverty and low income and their rationale, see the Social Security Bulletin for January 1965 (pp. 5–11) and July 1965 (pp. 3–10).

Thus, the United States today is faced with the difficult task of eliminating the disparities that exist—

Between the affluent and the poor;

Between those who have the skills and motivations for a job and those who do not;

Between those who have full opportunity for adequate health care and those who do not;

Between those who are receiving an adequate education and those who do not have full educational opportunity;

Between those who live in the ghetto and those who have become free to live where they choose.

Let's take a brief look at some facts about poverty.

The Social Security Administration in the Department of Health, Education, and Welfare makes annual estimates derived from data from the Bureau of the Census on the extent and characteristics of poverty.

The basic income levels used to determine the poverty line for the year 1966 are as follows: for a nonfarm family of four, $3,335; for a single person $1,635. These are adjusted for size of family, age, and for farm and nonfarm residence. The more detailed figures are shown in table 1, p. 49.

From 1959 to 1967 the number of persons in poverty fell from about 30 million to about 27.4 million, or from 22.1 to 14 percent of the population. We estimate that on March 1 the number of persons in poverty declined an additional million by virtue of the increase in social security benefits.

It is highly significant that Federal programs aiding the poor have undergone substantial changes in the past 8 years. During this period the country has greatly increased both the size of this aid and the proportion of it that is provided through what I would like to call the human investment programs. Total funding of programs directly aiding the poor has more than doubled, from $9.5 billion in fiscal year 1960 to an estimated $24.6 in fiscal year 1968 and $27.7 billion in 1969. About two-thirds of these total estimated expenditures in aid to the poor for fiscal years 1968 and 1969 are provided through programs administered by the Department of Health, Education, and Welfare.

Significant yet often unnoticed changes have occurred in the nature of the aid provided. In the fiscal year 1960, over 87 percent of this aid to the poor was provided through cash benefit payments. By fiscal year 1968 (and for fiscal year 1969), cash benefit payments are estimated to account for 59 percent of Federal aid to the poor. Human

investment programs providing education, work and training, health, and other social services were greatly accelerated during this period. (Source: The Budget for fiscal year 1969, p. 36.)

When President Johnson signed the Social Security Amendments of 1967, he named a Presidential Commission, under the chairmanship of Mr. Ben W. Heineman, the chairman and executive officer of the Chicago & North Western Railway, to review welfare and income maintenance programs. There have been many proposals for improvements in social security, for a guaranteed annual income, the negative income tax, for family allowances, and for governmental work and training programs. I think it is very timely that a top-level commission have an opportunity to review all of these proposals, as well as many other suggestions for innovation and change, and to try to find a wider and more comprehensive income maintenance system which is more adequate and more generally acceptable. The Commission consists of 24 members from varied walks of life. I am a member of the Commission. We plan to have our staff work intensively on these problems and proposals during the coming year.

PUBLIC ASSISTANCE

Although 27 million persons are living in poverty, only about 8 million are receiving public assistance. This fact should be kept in mind when the question is asked why welfare rolls are rising when unemployment is declining and social security and other income maintenance and economic opportunity programs are expanding.

But first let me say that a number of factors such as social security and employment opportunities, decreased mortality rates, safer working conditions, higher wages, home ownership, and life insurance have reduced the need of some groups to rely on public assistance. Largely as the result of the effectiveness of the social security program, the proportion of the aged on public assistance, in spite of a large increase in the total aged population, declined from 22.5 percent in 1950 to 11 percent in 1967. There would be about 2½ more aged persons on welfare today if the proportion had remained at 22.5 percent. Chart 3 shows the change in the composition of the public assistance caseload which has occurred.

CHANGE IN COMPOSITION OF THE PUBLIC ASSISTANCE CASELOAD

If you take a look at that chart, you will see that in 1950 roughly 3.3 percent of the population was receiving public assistance. Then

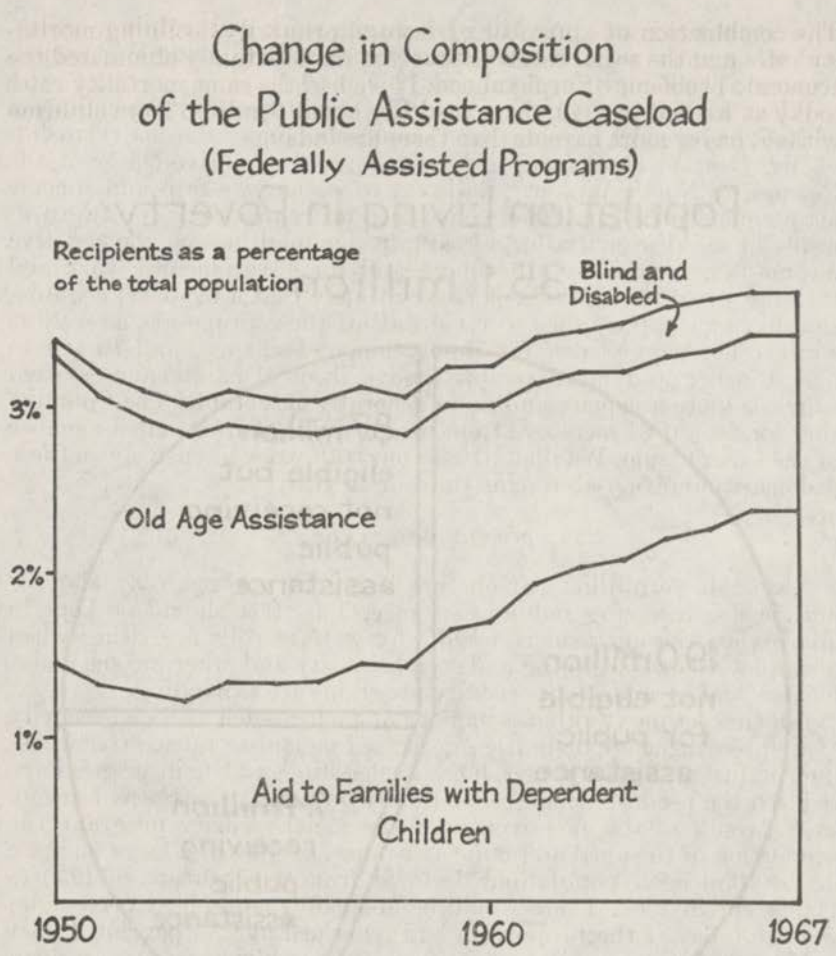


CHART 3

what happened is the old age assistance rolls began to decline as social security had a large impact. But the big factor has been that aid to families with dependent families has increased. So today over 3¾ percent of the population is receiving welfare, a little bit more than there was in 1950, but with a larger total population there are a couple million more people, and the difference in the caseload shows that there are fewer aged and more mothers with dependent children. This is one of the very big problems.

Mr. FLOOD. And more mothers with more dependent children.

Mr. COHEN. I think there are more children per family than there were at that time. There are more mothers on the rolls and the children per AFDC family have increased from about two and a half in 1950 to about three today. That has remained about the same.

Secondly, the number of children receiving assistance under the AFDC program because of the death of a father has markedly declined. The problems of economic dependency of fatherless children which was one of our major social and economic problems at the beginning of this century has largely disappeared in the past 60 to 70 years.

The combination of a number of factors, primarily declining mortality rates and the social security program have virtually eliminated the economic problems of orphanhood. If we had the same mortality rates today as we had in 1910, there would be about 5 million more children without one or more parents than there are today.

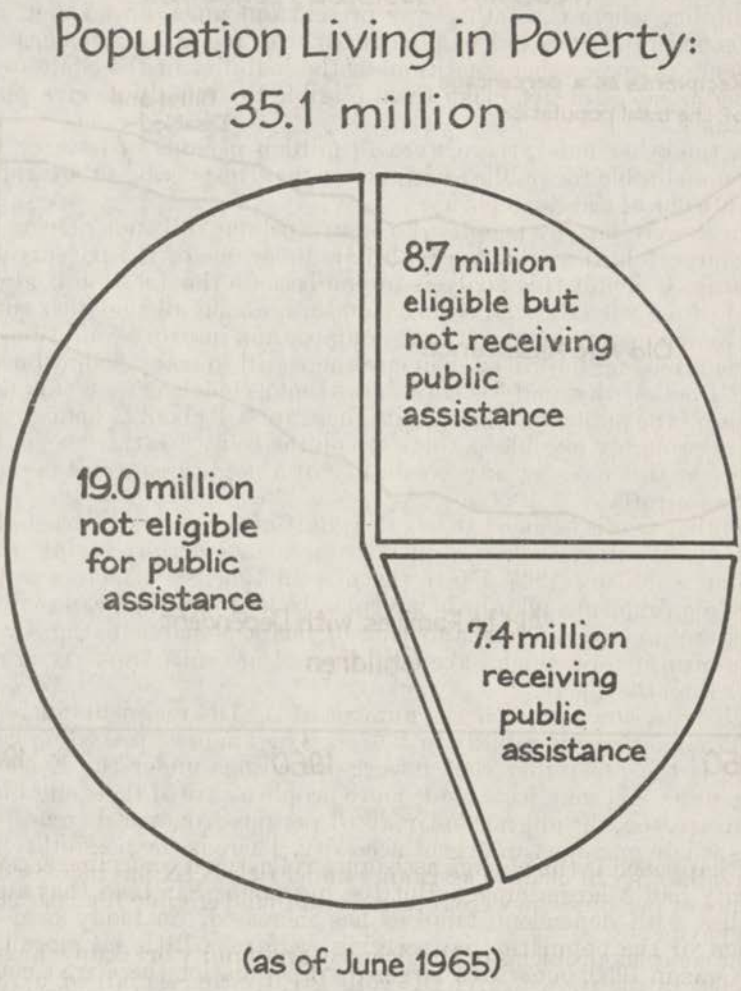


CHART 4

POPULATION LIVING IN POVERTY

However, to answer the original question of why the public assistance rolls continue to increase, estimates suggest, as chart 4 indicates, that for every person receiving public assistance in June 1965, there was another who was categorically eligible under the public assistance titles of the Social Security Act but who was not receiving public assistance.

For this analysis I have had to go back to 1965 figures which showed 35.1 million people in poverty at that time. As you will see, according to that chart, there were 7.4 million receiving public assistance. There were another 8.7 million people who were not receiving public assistance but who were "categorically eligible." They were people who were over 65 or blind or disabled, or in some States dependent children in families where the father was present but unemployed, but some provision in the State law or plan either with regard to income, assets, residence or some other condition, or the inability of the State to put up the money, did not make them eligible to actually receive public assistance.

On the other hand, there were 19 million persons in poverty who were not eligible for public assistance at that time because they did not fall into one of those categories.

Those were largely people who were working full time or who had very large families in which both parents or one of the parents were working. I submit this analysis to you because the question is always asked of me why if social security and wages and all the other things that we have been doing to raise standards and improve conditions for people are being improved, why are there still so many people on welfare? I believe my analysis here shows that as much as we do in taking people off the public assistance rolls, there are still about as many people who are roughly eligible as there are on the rolls. For this reason I do not see at this moment any possibility of a net decrease in the public assistance rolls.

In other words, somewhat less than half of the poor who meet all of the Federal categorical eligibility requirements were receiving public assistance in June 1965. Up to the present time, such factors as residence requirements, man-in-house rules, lack of knowledge, unwillingness to apply for welfare, and lack of financial participation by the States are factors which have kept the welfare rolls from rising even faster than they have.

It is true, however, that the number of AFDC recipients increased more than 3 times as rapidly in 1967 as it had in most preceding years. There is the possibility that poverty programs under the Economic Oportunity Act may have made more people aware of their eligibility. There are, too, the migration trends of persons from rural areas to the cities where money is an urgent necessity. There is the possibility that the availability of medical assistance under title XIX has increased the number of persons who were referred and found eligible for cash assistance payments.

The complex problems of illegitimacy and family breakup which are reflected in the growing AFDC rolls greatly concern all of us. Illegitimacy has been rising among both white and nonwite families.

At the present time there are 3½ to 4 million births each year, but 300,000 of those are out of wedlock.

While about 17 percent of the children on the AFDC rolls are there because they were born out of wedlock, it should also be remembered that about 80 percent of all illegitimate children are not on the welfare rolls.

PROVISIONS REGARDING ILLEGITIMACY IN THE 1967 SOCIAL SECURITY ACT AMENDMENTS

As a result of its concern, the Congress in the Social Security Amendments of 1967, took a number of steps to deal with the problems of illegitimacy, family instability, and to protect children. The amendments provide that:

1. State welfare programs establish and implement both a program of "preventing or reducing the incidence of births out of wedlock and otherwise strengthening family life" and a program of family planning service.

2. Paternity be established and support secured from such parent for children born out of wedlock.

Mr. FLOOD. On point No. 2, the establishment of paternity—does this include giving the proper officials access to social security rolls to trace deserting fathers across State lines?

Mr. COHEN. Yes. There already is an existing policy in this area, a matter of cooperation between welfare departments and the Social Security Administration. But in this legislation Congress went one step further and provided that you may also use the Internal Revenue Service in locating these parents.

Section 410 of the amendments provided that upon receiving the report from the State agency, the Secretary of Health, Education, and Welfare shall furnish to the Secretary of the Treasury the names and social security account numbers of the parents contained in any such report.

Mr. FLOOD. You are reading from the act?

Mr. COHEN. I am reading from the act now. This is a new provision.

The Secretary of the Treasury or his delegate shall endeavor to ascertain the address of each such parent from the master files of the Internal Revenue Service, and shall furnish any address so ascertained to the State agency which submitted such report.

In addition to using the social security records, the master files of the Internal Revenue Service may be used to locate the parent whether he has crossed State lines, or is within the same State.

USE OF SOCIAL SECURITY RECORDS TO TRACE MINOR CHILDREN

Mr. MICHEL. Mr. Chairman, may I ask at this point why Social Security wouldn't permit parents of a minor child to utilize the social security system to trace their minor child who might in the end, having run away from home, become a public charge some place?

Mr. COHEN. I am not aware of this particular case, Mr. Michel.

The general principle is that the social security records are confidential except for certain specific purposes that are authorized. We don't use the social security records to track down people who don't pay their bills, for example.

Mr. FLOOD. I have been reading recently about what Mr. Michel has in mind. Advertisements are being placed in certain types of magazines and periodicals that are purchased by the so-called "hippy" set to establish contact with members of the family. Most of these prob-

lems are with juveniles, children who have become flower children in apparently astounding numbers, to the great distress of their families. There, sometimes, is total inability to contact them except through these strange magazines. Did you have something like that in mind?

Mr. MICHEL. Yes.

Mr. COHEN. Without going to the fundamental policy question, the social security records are not very helpful for locating a child that has just run away. We don't get the name of an employer, a name and social security number, for quite some months after the period of employment. If a child ran away today and you called up tomorrow or next week or next month——

Mr. MICHEL. I am talking about cases where a good period of time has elapsed, and he would have had to get a job or he would have become a public charge, and there is nothing to go on. You can't get Social Security, even through intercession of a Member of Congress, to help these parents. That is completely ridiculous. If some social welfare worker can get some information for one reason or another for whatever you outlined here, I think it is just ridiculous that we then set up a bar where a Member of Congress can't help parents get their kids through these numbers.

We are all operating under a number now, through Internal Revenue and Social Security. The main thing is the social security number. If we can't use that number to track down kids, I think we are dead.

THE DENTON AMENDMENT

Mr. FLOOD. Of course, Congress saw fit to amend the act, as you have just read, in connection with the deserting parent. It would occur to me Congress might see fit to meet Mr. Michel's request.

Mr. LAIRD. This amendment, has been talked about at great length in this committee. We knew it as the "runaway pappy" amendment because of Congressman Denton of Indiana, who used to sit on this committee. He used to speak for that "runaway pappy" amendment at some length each year.

Mr. COHEN. I recall it very well.

Mr. FLOOD. Along with "runaway pappy," we now have "runaway Tommy" or "Mary."

Mr. LAIRD. I have always referred to it as the Denton amendment. Internal Revenue has always had the authority with Social Security.

Mr. KELLY. As relates to public assistance.

Mr. FLOOD. That is right.

Mr. COHEN. This amendment was discussed very extensively in both the Ways and Means Committee and the Senate Finance Committee. They did not adopt Mr. Denton's amendment. Mr. Denton's amendment was, in effect, to make it a Federal offense for a parent to desert his family across State lines. Such a parent could then be tried in the Federal district court. The committee discussed that quite a number of times and didn't do that because they felt that would really clog up the Federal district court. The provision I read was really their substitute for the consideration of the Denton amendment.

Mr. FLOOD. I would hope there would be a Michel amendment which would be an extension of the existing amendment.

Mr. MICHEL. There may very well be.

Mr. COHEN. I do think, though, that when you consider that question we ought to be very careful not to use the social security number system as a system to track down everybody in the United States.

We get lots of requests from people to use the social security number system and track down people for all sorts of reasons. The reasons may seem good on the face of them, but I would say this: I would be very hesitant if we would either go to the extreme of actually processing all of them or making judgments as to which ones are valid requests and which ones are not. I am not commenting on your specific proposal, but I would be very hesitant about using the social security number system as a way to locate everybody.

Now, the problem is that if it did become such a system, then people might start changing their names. It is not a violation of the social security law for a person to walk in tomorrow morning and say his name is John Jones and get a different social security number.

Mr. FLOOD. There is ample evidence of this in the public assistance area, where the fellow has changed his name from place to place, State to State, and job to job. There are quite a number of these. What people don't understand is that legally you do not have to go into court to have your name changed. Most people do. Most people think you must, but it is my understanding that unless you so want to do, you can change your name to Murphy tomorrow if you so see fit.

Mr. CASEY. Mr. Secretary, I know you have sent a letter and the social security number and they will forward it on. You will never know where it went, but they will forward it on, so if the recipient wants to answer it, he can.

Mr. HULL. I still can't see what is wrong with it.

Mr. COHEN. We have done that in a number of cases. That doesn't really track the person down because, as you say, the letter might get to the girl and the girl will say, "I don't want to go back home," and just tear it up. We have done that.

That retains the confidentiality of it, but still makes it possible to make an effort to track them down.

Mr. FLOOD. Proceed.

1967 SOCIAL SECURITY AMENDMENTS

Mr. COHEN. I was describing the third step the Congress took in the Social Security Amendments of 1967 to deal with the problems of illegitimacy, family instability, and to protect children. These amendments provide that:

3. A work incentive program be established permitting welfare recipients who work to retain the first $30 a month of earnings and 30 percent of any additional amount without any reduction in assistance payments. All earnings of a full-time student may be retained.

4. Day care services be provided for the children of working mothers with the requirement that such day care services must provide "for the development and implementation of arrangements for the more effective involvement of the parent or parents in the appropriate care of the child and the improvement of the health and development of the child." This new provision is the outgrowth of a great deal of consideration growing out of the Headstart program about the need for building into the programs strong provisions that relate to working with the parents and developing the motivation of the child.

5. Welfare agencies refer to the courts or law enforcement agencies any condition where a home is unsuitable for the child because of negect, abuse, or exploitation of such child.

6. Cooperative arrangements be made among welfare agencies, courts, and law enforcement officials (including making Federal and State financial arrangements) to effectively carry out the new programs.

7. Emergency assistance can be given for 30 days on a flexible and simplified basis and payments may be made in the form of loans, grants, payments in kind, or in services.

8. Payments for foster care of children and the authorization for child welfare services be increased and protective services for children be expanded.

The net effect of all these provisions is an increase in both the Federal and State cost over the next few years. The congressional committees which acted on this legislation did not wish to see children hurt, but rather directed their attention to constructive measures to improve the conditions for children under welfare. But it is clear that the costs of welfare will continue to rise, although more of the costs will be for services such as day care for children, work, training, and related activities.

SURVEY ON ATTITUDES TOWARD WORK

Mr. FLOOD. Some time ago, within the last month or so, I saw a newspaper account of a survey and report made by some organization in the private sector, in the New York area. They interviewed mothers who would be affected by this new amendment to the act with very startling results. They found that these mothers would be glad to be trained for jobs providing there would be care for the children. Are you aware of that?

Mr. COHEN. I have an excerpt from the report right here.

THE AFDC REFERRAL AND FREEZE PROVISIONS

One of the controversial features of the new legislation has been the extent to which mothers would be required to accept employment contrary to their wishes or what they might regard as the best interest of their children. When Secretary Gardner and I appeared before the Senate Committee on Finance we emphasized the Department's conviction that there were more mothers who wanted employment and training than there would be opportunities for under these programs.

A recent study made in New York City showed that 70 percent of the mothers on assistance wanted to work. The available evidence indicates that there is and will be in the foreseeable future ample opportunity to fill available work and training positions by mothers who wish such training and work on a voluntary basis.

Mr. FLOOD. As I recall the newspaper article, it indicated that of the mothers who were Negro, a much larger percentage indicated that desire than the whites and the Puerto Ricans.

Mr. COHEN. Yes; I will give you the exact figures if you like, Mr. Chairman.

When broken down by white, Negro, and Puerto Rican, 55 percent of the white mothers said they would prefer to work; 81 percent of

the Negro mothers said they would prefer to work; and 60 percent of the Puerto Rican mothers said they would prefer to work. This was a study just completed in December of 1967.

I will put the findings in the record.

Mr. FLOOD. Is the agency which made the study of any standing or repute?

Mr. COHEN. It is an independent social research agency called the Center for Social Research in the Graduate Center of the University of the City of New York, and my review of it would indicate it is completely independent and reliable and I think it represents a very good contribution to the thinking on this subject.

(The document referred to follows:)

FAMILIES ON WELFARE IN NEW YORK CITY*

PRELIMINARY REPORT NO. 3 "MOTHERS' EDUCATION AND EMPLOYMENT"

Major Findings

1. Most of the mothers on welfare attended high school. About one in six were graduated. However, another one in six never went beyond the fourth grade. In general, the respondents with less education were those who were older, who immigrated as adults, and who were reared in rural communities.

2. Most of the mothers on welfare felt that they did not get a chance to acquire as much education as they wanted. The less schooling the respondent had, the more likely she felt educationally deprived.

3. Eight in ten publicly-assisted mothers had some employment experience. Usually this was prior to the birth of their first child, but nearly half worked afterwards.

(a) Fifteen percent of the mothers on welfare had never been employed. Teen-age pregnancy was a factor in having never worked.

(b) While three out of ten of the mothers who worked had relatively brief work histories of three years or less, another three out of ten were employed for over ten years.

4. Seven in 10 mothers on welfare preferred to work for pay rather than stay at home. The major reason for the former choice was financial and for the latter, child care.

(a) Assuming the availability of appropriate day care facilities, six out of 10 mothers with pre-school children preferred to work rather than stay at home.

(b) Two-thirds of the publicly-assisted mothers planned to work in the future. The more schooling, the more likely the respondent expected to become employed.

PREFERENCE FOR WORKING OR HOMEMAKING, BY ETHNICITY, IN PERCENTAGES

	White	Negro	Puerto Rican
Prefer to work	55	81	60
Prefer to stay home	45	19	40
No answer	1	(1)	(1)
Total	100	100	100
Number	(208)	(1,017)	(954)
Major reasons of those who prefer to work:			
Financial	62	52	67
Independence	30	42	37
Personal satisfaction	52	42	33
Number	(114)	(820)	(571)
Major reasons of those who prefer to stay home:			
Child care	86	78	75
Health	12	16	23
House care	17	7	10
Number	(93)	(196)	(381)

[1] Less than 1 percent.

*Extract from Lawrence Podell, Ph. D., *Families on Welfare in New York City: Preliminary Report No. 3—"Mothers' Education and Employment."* New York: Center for Social Research, Graduate Center, City University of New York (33 West 42d St., New York, N.Y. 10036), Dec. 20, 1967, 36 pages.

Mr. COHEN. The President has directed us to work with the States to see that the mandatory referral to work provision is administered compassionately, and we are doing so.

AFDC FREEZE

With respect to the AFDC freeze, the law says that for the last half of 1968 no larger proportion of the child population under the age of 18 shall receive Federal aid because of the absence of a parent than the average proportion in the first quarter of the year. By relating the number to the child population under 18 on January 1, of each year, provision is made to permit an annual adjustment to give effect to any changes in the child population. But if present trends continue, most, if not all States, will be faced with financial problems as the result of this provision.

Chairman Mills, when he presented the Ways and Means Committee's bill to the House, stated that the purpose of the freeze was to apply pressure to the States which would assure that they move promptly and vigorously to put the new work programs and other features of the legislation into effect. We certainly cannot expect work programs or family planning services will have much effect on AFDC rolls before July 1. In my judgment, what is needed now is concrete information that will show what the effects will be on the individual States, what will happen to mothers and children as the result of the freeze, and what specific efforts States are making to achieve the objectives of the Congress. We have asked the States for this information. I met with the State welfare administrators recently and with several of the Governors last week on this matter and exchanged ideas on these points.

Mr. FLOOD. What was the reaction of both groups?

Mr. COHEN. Both groups came to the same general conclusion that the impact of the freeze so quickly on July 1, 1968, when they didn't have adequate notice or time, and when the work programs and family planning had not yet come into effect, is going to make it very, very difficult for them to comply with it.

In other words, the AFDC freeze assumes that the States will put up any money themselves largely, if they go over the limit. As you can well expect, most of the Governors said that their budgets have been completed, that they haven't planned on this provision, and that they felt they wouldn't be able to comply with it that quickly.

We have been asked whether States may use waiting lists so as to limit recipients of AFDC to the number for which Federal financial participation is available under the freeze. In our proposed policy statement on the freeze, we have maintained our longstanding position that States may not maintain waiting lists. The Congress did not change the requirement in the Federal law that State plans must provide "that aid to families with dependent children shall be furnished with reasonable promptness to all eligible individuals."

Some of the States have indicated that they disagree with this interpretation and, if necessary, they will seek administrative hearing and court review to test our proposed position. While we are acutely aware of the fiscal problems which the freeze presents for the States, we believe we have no alternative, under the law and in the interest of

children, to requiring that aid must be furnished promptly to all eligible individuals, without waiting lists.

I believe that the State of Georgia will take us to court on this question, Mr. Chairman. Before they can take us to court, they must, of course, exhaust their administrative remedies which provide for a hearing.

Mr. FLOOD. Is this an agreement for declaratory judgment or what?

Mr. COHEN. We haven't gotten to that point yet. I don't know what kind of case they will use to take us into court, but I have made every arrangement to expedite the administrative hearings so they could take us to court.

Mr. FLOOD. And for the purpose of appeal, if necessary?

Mr. COHEN. Yes.

Mr. SMITH. This is one of the gimmicks that has been in that act for years.

I was on a welfare board before I came to Congress and time and time and time again a women in need would walk into the office and was put on ADC the first day she walks in because the Federal Government would pay 50 percent of that cost. It is then much more difficult to get her over onto a job and off of ADC, but the States follow this procedure because they don't want to carry them even temporarily with their own tax money exclusively. They want the Federal Government to pay half of it.

Mr. COHEN. And in some cases more than half.

Mr. SMITH. In a lot of these cases, if the States were required to carry them on their own money for the full amount of need for a couple of months or so, before they could transfer cost to the Federal Government they would try harder to get them a job or rehabilitate them.

EFFECT OF THE 1967 SOCIAL SECURITY AMENDMENTS ON THE STATES

Mr. COHEN. Or course, Mr. Smith, when the 1967 amendments become effective they will really change the situation because under the new amendments if a woman comes on the rolls and she has work potential or training potential, she must be referred to the work program within 30 days.

Now, that all depends on the extent to which work and training programs are available. I will not be so bold as to say in the next year or two every woman who has work potential is going to be referred, but the new law sets up this work incentive and training program and the welfare departments refer those women to these training programs, make arrangements for her children to go into day care and then the Labor Department conducts the training.

Mr. SMITH. The local government administering the program just doesn't have the incentive it would have if the local government had to carry them with their own money for a couple of months before they could use Federal funds.

Mr. KELLY. The estimates are that unless you can refer a large number of people to a training program and a work experience program, that will get them off the rolls, that the States will have to bear a greater proportion of the total caseload than they now do because they will exceed the limits imposed by the freeze.

Mr. SMITH. Doesn't that depend upon your population trends and everything within that State?

Mr. KELLY. All of the evidence indicates that, unless you can reverse the current trend, this will develop. Our budget estimates for 1969 assume that 475,000 of the recipients of aid to dependent children will be fully borne by the State because they will exceed the maximum that can be supported by the Federal Government.

Mr. SMITH. Will every State be in this situation?

Mr. COHEN. From the reports so far, I think nearly every State will be affected. The AFDC rolls this last year have gone up tremendously in practically every part of the country, particularly in the large urban areas. I tried to give you the reasons previously why I thought this has occurred, although I don't know all of the reasons. But I suspect that the migration from the rural communities to the urban ones and from South to North and into the large cities is going on so fast that unless the work programs and the training programs can be put into operation promptly and effectively, public assistance rolls will continue to increase in the next year or two.

It is a very discouraging situation from that standpoint, and the Ways and Means Committee, as you know, spent weeks and weeks just trying to tackle this problem and see what they could do in these amendments that I have outlined. I am very hopeful that the combination of the family planning requirements, the provisions to prevent illegitimacy, and the work and training program with the $30 and 30-percent work incentive, will encourage some of them to go to work because they will now be able to keep some of the money they earn. If a woman gets a job, she can keep the first $30 she earns each month plus 30 percent of any amount on top of that.

Now, whether all of these things together will produce some change, nobody knows, but we think we ought to tackle it and see what we can do.

SHORT-RUN COSTS OF THE 1967 AMENDMENTS

But, as I pointed out to you, for the short run it is going to cost us more money to do that because you have to put these children in day care arrangements, you have to train the mother and you have to pay for her assistance while she is still in that training.

MEDICAID AND MEDICARE

Now, I would like to turn to medicaid and medicare, Mr. Chairman.

I have mentioned some of the factors which lead me to believe welfare costs will continue to rise. One of the reasons for this is the medicaid program and the rising cost of medical care.

It is estimated that 5.2 million persons received care under medicaid in the fiscal year 1967, 7.3 million will receive care in 1968, and that about 8.5 million will be served in 1969.

Now, Mr. Chairman, the most important observation I can make in this area is that in 1950, for the total welfare program, payments for medical services were only an infinitesimal part of welfare costs. If you will look at chart 5, you can see that in 1950 the medical care payments were not even big enough to put on the chart.

Change in Distribution of Public Assistance Costs

(Federal, State, and Local Funds)

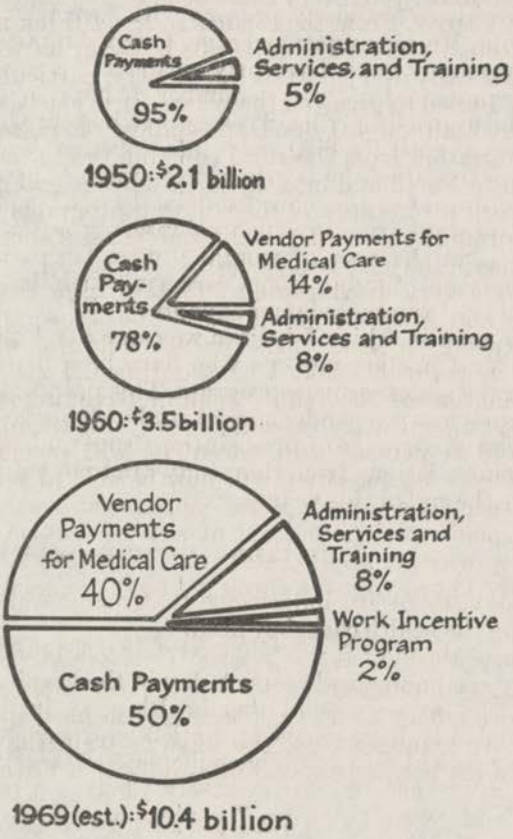


CHART 5

By 1960, with a larger amount of money, medical care payments had become 14 percent. Now look at our 1969 estimate. Forty percent of this bigger $10.4 billion budget for public assistance is estimated to be the total costs for vendor payments for medical care. The whole character of the welfare expenditures that you and the States are being asked to finance have changed over this period of time. As you reduce the amount of cash payments or get people off the rolls, and as you provide more services and training and work-incentive programs, it is likely the vendor payments for medical care within the next 2 or 3 years may represent 45 or 50 percent of your total Federal, State, and local budgets.

92-594—68—pt. 2——5

There is still a wide variation in income limits and scope of medical coverage under the State medicaid programs. This is not desirable. One of our big challenges ahead is whether the States and the interested groups can work together to narrow these variations to provide essential services for medically needy persons and at the same time improve voluntary health insurance coverage.

I believe that the medicaid program meets a basic need in our society because there are many persons with incomes too low to finance adequate health insurance coverage. Our voluntary health insurance system has many gaps. I recently outlined to representatives of nonprofit and commercial insurers a number of improvements needed in voluntary insurance if medicaid costs are to be kept within reasonable limits. However, until medical insurance coverage is more comprehensive—and covers all of the low-income families—there will continue to be a compelling need for more funds under medicaid. For instance, one of the important areas in which voluntary insurance must expand its coverage is in the area of mental illness. Outpatient care, home health services, and nursing home care are other important areas in which voluntary insurance should expand.

One area in which I believe we can extend medicare insurance is to the over 1 million persons who have been determined to be disabled under the social security program. This proposal was considered by the Congress last year and a special study was authorized as was the entire question of coverage of prescription drugs under the medicare program. Recommendations from this study are to be submitted to the Congress before the end of this year.

RISING MEDICAL COSTS

Today, there are indications that many Americans are simply not getting the health care they need.

One of the most formidable barriers to high-quality health care is the steady rise in medical costs. A day in the hospital, which cost $14.40 in 1950, now exceeds $55. Other health costs, including drug prices and doctors' bills, have risen during the same period. In the past 12 months alone, medical care prices have increased 7 percent.

I don't want to frighten you, Mr. Chairman, but, as I told you, if hospital costs were to go up 7 percent a year for 10 years, the present charge of $55 a day would become over a hundred dollars a day in 10 years, and hospital costs are now increasing about twice as fast as 7 percent per year.

This rising spiral of costs seriously threatens our ability to make health care more widely accessible and more readily available to the people who need it.

To explore this problem, the Department called a conference on medical costs last summer, in which leading physicians, hospital administrators, and others from all over the Nation participated. The group was in general agreement that one of the reasons for the rapid rise in costs is that we have an antiquated and inefficient system of health care. As a nation, we are simply not well enough organized today to provide all of our people with the health services they want and need on an economical and efficient basis.

This conference was followed with several more—on private health insurance, on the group practice of medicine, and on hospital architecture and design. In addition, the Secretary established a Committee on Hospital Effectiveness to study the entire system of hospital and related services. And recently, President Johnson created a National Advisory Commission on Health Facilities to recommend this year new directions in Hill-Burton and related hospital legislation.

This Commission was created because the Hill-Burton Act expires next year and it was our thought that before we have a renewal of the Hill-Burton Act, we ought to completely reexamine the questions of whether we are building hospitals as economically or efficiently as possible and whether we are organizing them in the fashion most conducive to providing high-quality service. The head of that Commission is Mr. Boisfevillet Jones from Georgia, and he is scheduled to make a report later this year.

Mr. FLOOD. This includes the number of people who are admitted to hosiptals for unnecessary lengths of time, keeping the beds from persons who should have them. I presume outpatient treatment and nursing care facilities are increasing so as to take the caseload off of hospital beds.

Mr. COHEN. Yes, sir. Some of our medical men who have been studying this say that if we had a different method of providing medical care, as many as a quarter to a half of the people in hospitals today would not have to be in a $55-a-day hospital room.

Mr. FLOOD. I have heard this many times and I also hear administrators and medical people that I have talked to say, without batting an eye, that they can foresee $100 a day.

METHODS OF HIGH-QUALITY HEALTH SERVICE

Mr. COHEN. Now, I think in order to avoid that, you need some very intensive experimentation with new patterns of delivering high-quality health services. For example, we have to find a mechanism for channeling people away from large and costly institutions when institutional care is not necessary or medically warranted. We need systematically to employ less expensive facilities. We need to broaden the reach of physicans' services with the use of new communications techniques and computer technology and we need to develop better emergency medical services.

We're also faced with the task of conserving scarce health manpower by making better use of highly trained professional people and by developing new types of health workers.

We need, in brief, to expand our research and development effort in health services. That is the purpose of our new National Center for Health Services Research and Development. It will enable physicians, clinics, and communities around the country to experiment in new ways of providing and delivering health care. It will help us find new patterns, new models, new directions.

Our purpose in this and other new approaches is to insure the best possible health care, provided in the most efficient manner and at the lowest possible costs, for all Americans.

Mr. FLOOD. Of course, this program we have been referring to now for a few years, the regional medical centers, is part of this concept I am sure.

Mr. COHEN. It is, definitely, and I would hope that when the regional medical program is fully implemented it will result in higher quality medical care that is more immediately available to those who need it.

And I would say this: We talk about $100-a-day hospital care, but we all know that with the heart transplants, with the transplantation of organs generally, with the new kidney machines, all of them which have very high unit costs at the present time, if any of that were to be made more generally available, the cost estimates of doing that, whether they are met out of tax funds or nontax funds, is simply a tremendous financial responsibility. I would think as you look ahead during the next 10 or 20 years, you can see that these high-cost operations, even if they are reduced in half of where they are now, by the economies and efficiencies of mass production of the equipment——

Mr. FLOOD. Do you mean the hardware itself?

Mr. COHEN. Just the hardware and the personnel that is required to manage some of those for 24 hours a day. And I must say, that is why I talked about the economy and efficiency.

If you want those kinds of miracles of modern medicine to be made more generally available, we are going to have to find some more efficient way of making them available to people. I don't know the answer to it. All I can say is that we feel that this is something that we ought to explore very carefully.

CAUSES OF RISING MEDICAL COSTS

Mr. SMITH. Is the cost of the building, depreciation, repairs, heat and so forth, an important share of hospital costs?

Mr. COHEN. Wages generally, wages and salaries, are about 60 percent to 70 percent of hospital costs. If I might take a moment I'd direct your attention to nurses' salaries, because the changing nature of nurses' salaries, illustrates what has been happening. If you go back to 1930, nurses were probably working 60 hours a week and I would say their salary was maybe about 30 or 40 percent of the salary rate for industrial workers in the community.

What has happened in this last 40 years is that the hours of work for people in hospitals has dropped, as it has for most people. They are now working 40 hours a week. They now have pension plans and fringe benefits and the relative wages are now competitive with what girls are getting in other occupations. It may well be that—I haven't looked recently—but I know there may still be communities where a girl will make more money becoming a secretary, with much less education and training and at much less cost, than she would becoming a nurse. As a result, we have been losing a lot of girls who might go into nursing. With a smaller supply and a greater demand, just by economics alone, the price for nurses in terms of wages has gone up.

This has been the largest single factor, Mr. Smith, in hospital costs.

Mr. SMITH. $32 per day would be less than a fourth of it.

Mr. FLOOD. What we call the bricks and mortar.

Mr. KELLY. It is the one-third that is other than salaries. It includes the whole cost of therapeutic drugs and equipment. The repair and maintenance and depreciation of the building—my guess is, and I don't have a precise figure in mind—is that it would be below 10 percent of the total cost.

EFFICIENT USE OF NURSES' TIME

Mr. FLOOD. There is also the development of the so-called floor manager. These nurses are being choked to death with mere paperwork. The idea now is to provide aides or technicians. Assistants of various kinds could perform duties that take as much as 35 percent of the average floor nurse's time, time which is now consumed with documents and paper and not with the patients at all. There is an effort to get the nurses to the bedsides where they ought to be.

Mr. COHEN. There are several factors. First, up until recently the architecture of hospitals has not been designed with the idea in mind of the most economical use of the nurses' time. If you analyze it, you will find that nurses walk back and forth over large areas for a long period of time.

In the newer hospitals they try to provide a nurse station which is either in the center, with radio equipment to the rooms so nurses don't have to walk so far, or where nurses can see more appropriately.

One of the areas of improvement in nurses' workloads is related to the hospital floor plan. The second area has to do with reducing paperwork. The third area has to do with the introduction of nurses' aides and others who will do the nonnursing duties that nurses used to do.

You don't have to have a nurse to bring you the bedpan or to bring you the food or to rub your back. There are a whole host of things that people with less skills can perform.

Mr. FLOOD. I certainly agree. It has always offended me to see these highly trained, skilled, professional nurses acting as mere body servants to a lot of patients. This just doesn't seem correct. Somebody pushes a bell or a button and a nurse has to run down as though she were a handmaiden.

Mr. COHEN. That is right.

My son was in the hospital recently for a month with a brain concussion and I sat there for many evenings and watched what was happening. There is no question in my mind that a substantial part of a nurse's time is spent doing nonnursing duties.

Mr. FLOOD. There is no doubt about it. There is no question about it.

Mr. COHEN. She is doing things that an unskilled person can do. The biggest shortage we have right now is in nurses. If we look over the whole area of medical care—while we have a shortage of doctors, while we have a shortage of dentists, while we have shortages of many health personnel, the biggest shortage is nurses.

COST OF DRUGS

Mr. FLOOD. What do you have to say with regard to the high cost of drugs?

Mr. COHEN. The fact is, while drugs are very costly, drug prices overall have not tended to rise, Mr. Chairman. Drug costs are a peculiar phenomenon.

Mr. FLOOD. They were so high in the first place they wouldn't have to rise.

Mr. COHEN. That may well be, but as a matter of fact, if you will look at the price index, they have tended to decline. They have not risen.

Mr. FLOOD. I am thinking of the case where a physician prescribes for me vitamin X and I go to the drugstore to get vitamin X. Now, this is not the fault of the druggist. The little bottle a couple of inches high with just a few of these pills in it costs $4.68. I have the $4.68, but think of these people you have been talking about all day. What are they going to do about that? The physician says, "Go and get this." What do they do?

Mr. COHEN. I think the burden falls very largely on a small group of people. Our analysis shows that the problem is most severe for older people in particular. Many older persons use a great deal of a certain drug, and they not only have a large cost, but also have a fixed income. This is where the problem is serious.

Mr. FLOOD. Many people on both sides of the Capitol and others in the medical profession are examining this very closely.

Mr. COHEN. The President sent to Congress today his health message which has some recommendations in it attempting to reduce the cost of drugs by authorizing legislation to establish a reasonable price range for drugs used under medicaid and medicare. I think you may want to look at that.

Mr. FLOOD. I feel sure that the proper legislative committees, with your help, will pursue it and are pursuing it.

Mr. COHEN. They have authorized us specifically to make a study on the matter of how to deal with prescription drugs and to report back before the end of this year. We are now involved in that study. I was reading the new requirement in the law which states that States must: "provide such methods and procedures relating to the utilization of and the payment for care and services available under the plan as may be necessary to safeguard against unncessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."

In addition, Chairman Mills sponsored an amendment applying to medicare, medicaid, and the child health program which authorizes experiments with existing charge or cost reimbursements to include specific incentive payments "to have the effect of increasing the efficiency and economy of health services through the creation of additional incentives to these ends without adversely affecting the quality of such services."

Much more, however, remains to be done if we are to extend the quality of care, restrain costs, and provide efficiency and economy. This will be a continuing and difficult responsibility for some time to come. We are far from knowing all the answers. We must find answers which do not restrict the private practice of medicine or the doctor-patient relationship.

HEALTH PROFESSIONS' RELATIONSHIPS WITH HEW

I cannot let this opportunity pass without referring to the constructive and cooperative relationships which have developed between the health professions and our programs in the past 2½ years, especially in the medicare program. The recent article by Dr. David Jay Scott, entitled, "We Doctors Were Wrong About Medicare," in the Saturday Evening Post issue of February 24, is worth reading.

He reports that to his amazement "even the Government forms are less complicated" than those used under other doctor-approved insurance programs. He points out how "medicare is helping to improve the entire standard of health in the United States."

Mr. COHEN. Mr. Chairman, may I have permission to include the Saturday Evening Post article in the record?

Mr. FLOOD. Without objection, it will be included.

(The article referred to follows:)

WE DOCTORS WERE WRONG ABOUT MEDICARE

(By David Jay Scott, M.D.)

Not long ago I received a letter from a physicians' group exhorting me to join their organization against "evil schemes such as medicare." Letters like this still arrive frequently, and they never fail to puzzle and upset me. I can't understand how anyone in his right mind can refer to medicare today as "evil." To me, it has turned out to be about as evil as the Flying Nun.

Like most doctors, I was against medicare when it was proposed, and I still have reservations about it. Before the measure was passed by Congress in 1965, I resisted it, I agreed with the great mass of literature published by the American Medical Association and other doctors' groups, all of which insisted that medicare would mean socialized medicine and a fundamental loss of freedom not only for the doctors of America but also for the millions of citizens over the age of 65.

I anticipated Government fee-fixing and interference with free enterprise medicine, a mountain of red tape and long delays in getting paid for my services, and a stampede of elderly patients demanding unnecessary treatment. I believed that medicare would mean the end of effective medical teaching, because of the loss of elderly ward patients, and that postgraduate education would also suffer.

I still feel there are built-in hazards in medicare, but I must say that after a year and a half of the program, my eyes have been opened, and I view the results with both pleasure and surprise. From what I can see in my private practice, there is considerably more good than bad in medicare. Few, if any, of the dire predictions have come to pass. I don't feel socialized, mechanized or victimized, and as far as I can tell, neither do any of my fellow physicians.

Most doctors, in fact, are happy as clams over medicare, even though they won't admit it—or don't dare to admit it. Their incomes have increased because medicare partially pays them for what used to be charity work. For practically all patients, too, it has been a boon. The average elderly person is now getting a level of care that previously was available only to the rich.

But most important of all, there are definite signs that medicare is helping to improve the entire standard of health in the United States. Currently, for example, there are an estimated 2 million diabetics in this country, one half of them undiagnosed. With 20 million elderly citizens now able to avail themselves of regular medical attention, more and more diabetics are being discovered by routine tests and are being treated before the disease takes its toll. It's safe to predict that because of medicare the number of undiagnosed diabetic people in the United States will soon be significantly reduced.

It's the same with the treatment of stroke. Previously, the average patient paralyzed by a cerebral hemorrhage or thrombosis was sent home to be cared for by his family after his initial treatment in a hospital. He could not normally afford the expensive special nursing care, physiotherapy and speech therapy necessary to restore crippled arms and legs and vocal cords to full use. The doctor lost track of the patient's day-to-day progress and had to rely on family reports for information.

A frequent result of this lack of special medical attention was a dreadful condition known popularly as "claw hand." The muscles of an affected arm would contract the arm permanently into a grotesque hook-like position. The condition was irreparable, and it scarred the patient both physically and psychologically, for the rest of his life.

Today, because of medicare, we're seeing less and less of "claw hand." When a stroke victim leaves the hospital, he gets months of care and physiotherapy in a Government-approved convalescent center.

This sort of improved care for the elderly is yielding unexpected benefits, one of which is a boom in the study of geriatrics. Treating the aged has never been a

popular specialty, but now, with medicare, more doctors are being forced to become geriatricians, and scholarship in this once-limited field is bound to expand. And as doctors learn more about the long-term aspects of diseases—by studying the elderly—they are better able to treat these diseases when they strike the young.

Many doctors still refuse to acknowledge these benefits. Others now grudgingly admit that the program has been satisfactory medically, but they are still diehards about the economics of it. At a party recently, I listened to a physician proclaim that as long as he lived he would never involve himself in medicare's "morass of red tape and delays." Instead, like most physicians, he continues to insist that his patients pay him directly and then collect from the Government on their own.

I must admit I had the same misgivings when medicare went into effect on July 1, 1966, but with my comparatively new practice, in an area of New Jersey where there are many elderly people retired on small incomes, I soon found it more practical to bill the Government myself.

To my amazement I discovered that I get paid faster by medicare (14 days) than I do by doctor-approved insurance programs (3-5 weeks). Even the forms are less complicated. I can fill out a medicare form in half the time it takes me to struggle through that Blue Shield form. If someone asked me to devise a simpler form than medicare's, just so doctors would stop bitching, I couldn't do it. The present form asks just seven essential questions.

The private insurance plans, particularly the Blue Cross-Blue Shield plans, seem to involve endless correspondence over "incorrect claim forms." Months go by with forms being returned, resubmitted, refiled, etc., because of some silly oversight in form filling. I thought that similar confusions would occur with medicare, but I have never had a form returned by them.

When I report this to the diehards, they refuse to believe me or even to look at the form, which they consider to be an instrument of socialism. They also refuse to believe that a physician can benefit financially from the program. At a medical meeting, one doctor told me that he hasn't made a cent out of medicare and doesn't intend to. Since he has what we call a "cream-puff practice," with only rich patients, I'm sure this is true.

To me, as a young doctor, however, medicare has meant the difference between years of struggling and paid-up bills. In the past, physicians beginning practice all had to scrape out a living by taking other doctors' castoff patients (which usually included nonpaying deadbeats, hypochondriacs and pests), by working the emergency room or other part-time jobs in a hospital, by doing physical examinations for insurance companies and by running their butts off on house calls. My colleagues have told me they were in the red for years. Some say they couldn't take a day off for 2 years, and it was unheard of for a young doctor to be able to afford a vacation.

With medicare all that struggle is history (except perhaps for the pediatrician). The young doctor almost immediately gets his share of patients formerly treated as charity cases, and his fees are partially guaranteed by the Government. In my first year medicare patients made up more than 50 percent of my total practice. And my older colleagues are still shaking their heads in bewilderment over the fact that my wife and I were able to take a 2-week vacation in the first year.

Most puzzling of all is the diehards' conviction that medicare is also bad for the finances of their patients.

Part A of medicare gives free hospital care (after the first $40) to all Americans over the age of 65. Part B pays 80 percent of doctors' bills (after the first $50) for all Americans over 65 who pay a $3-a-month premium to the Government. True, even these small payments required of the patient have worked occasional hardship in some instances, but generally the law has been a financial lifesaver not only for the patients but also for their families.

One case of mine, for example, involved a woman who had a severe abdominal illness. She and her husband were living on social security and on the small nest egg they had saved up for emergencies. When she became ill, she quickly ran up the following medical bills: hospital, $4,000; surgeon, $700; anesthetists, $200; internist, $500—for a total of $5,400. Were it not for medicare (plus another small insurance policy that paid the 20 percent doctors' fees and the deductibles not covered by medicare), their life savings would have been severely depleted. As it turned out, their entire expense for the illness was exactly $4—for renting a television set during the wife's last days in the hospital.

My most touching medicare case was a 65-year-old woman who had lived in poverty and has been a clinic patient all her life. Recently, when she came to the Jersey Shore Medical Center and was admitted to my service, she entered a new world. Because she was now covered by medicare, she was entitled to a semi-private room, which she shared with the wife of a millionaire. She enjoyed the other woman's flowers, and she chatted happily with her roommate's visitors. She was tended by four top specialists and consultants whom I requested to assist me. When we first examined her, she did not recognize us as physicians because we were wearing business suits. A doctor to her meant an intern or a resident. "If you're really doctors," she said, "where are your white coats?"

One of the most widespread objections to medicare before it was enacted was that the program would eliminate poor patients from the wards and thus reduce the teaching capabilities of hospitals, which use ward cases in the training of interns and medical students. The diehards still hammer at this point, and of all their arguments, I think it is the most fallacious.

For one thing, taking the elderly out of the wards has merely freed those beds for nonmedicare patients. The wards continue to be filled to capacity. But more important, rather than reducing medical teaching, medicare actually has extended it—into doctors' offices and the smaller hospitals.

When I took my residency training at Metropolitan Hospital in New York City and at the Bronx Veterans' Administration Hospital, I was aware that the highest quality of medicine is practiced in academic institutions. We had the most expensive diagnostic equipment—and we were learning all the time. But I was told that the outside world was different—that the patients' finances would inhibit both the quality of the medicine I would practice and my continuing education.

But it hasn't worked out that way. With assured income from medicare patients, smaller hospitals can now afford extended-care facilities and will soon be able to afford, for the first time, some of the same expensive equipment that only the big academic institutions could buy.

With the cost barrier removed by medicare, we've already made new discoveries in our continued-learning process. Because we're no longer inhibited about ordering tests, we've found out, for example, that there's a considerable amount of thyroid heart disease among elderly people. They don't have the obvious thyroid symptoms. They just report that they're a little nervous and draggy. Doctors used to tell them, "It's just age," and then the patient would go away and slip into heart failure. Now, because medicare has promoted more widespread use of what we call the PBI test, we know that the textbooks, which say that thyroid heart disease is rare, are wrong. So we give the patient iodine and the symptoms clear up. Who knows how many heart problems we've averted?

These, then, are the major benefits of medicare. What are its deficiencies? First, there is the distinct threat of Government control—laymen making judgments on medical issues, price fixing, an unbending bureaucracy—which would inevitably lead to the decay of American medicine.

Secondly, Government's foot in the door can destroy a cherished tradition; the doctor-patient relationship. It is not generally appreciated, but when a patient signs a medicare form, he is authorizing release of all information to those persons who will act on it. Many things are between doctor and patient and are not for public scrutiny. The patient loses this right of privacy with medicare.

The third deficiency is the possibility of overuse of medicare by the patient. The hypochondriac threat hasn't developed yet, but if it does, there is nothing in the law that can curb it. A patient, for example, can go to 50 different doctors for the same inconsequential complaint.

So medicare dangles somewhere between heaven and hell (hell meaning socialization, to the medical profession). My own feeling is that we'll never be consigned to the demons. After all, we've survived many such crises before. In 1933, a medical society president labeled another Government program "a major step toward communization and collectivization of American medicine." What he was talking about was the Veterans' Administration.

Mr. FLOOD. Could you have your people give us a brief biography of the gentleman who wrote the article?

Mr. COHEN. We will be happy to.

(The information requested follows:)

DAVID JAY SCOTT, M.D.

Dr. Scott was born in 1937 in Bronx, N.Y. He grew up in New York City where he attended New York public schools. In 1958 he graduated from Bethany College, West Virginia, where he had majored in chemistry with minors in physics, biology, and mathematics. He then attended New York Medical College for 4 years, graduating in 1962. He had 1 year of rotating internship at the Jersey Shore Medical Center in Neptune, N.J., a year of residency in internal medicine at the Metropolitan Hospital in New York City, and a year of residency in internal medicine at the Bronx Veterans' Administration, Hospital, New York. He was then a resident in internal medicine, and chief resident in cardiology at the Bronx Veterans' Administration Hospital in New York.

Dr. Scott now conducts a private specialty practice in internal medicine and cardiovascular disease in Neptune, N.J. He is also the attending physician, Jersey Shore Medical Center in Neptune, N.J., and consultant in internal medicine at Point Pleasant Hospital, Point Pleasant, N.J. He is a member of the Monmouth County Medical Society and a member of Alpha Omega Alpha (AOA), an honorary medical society. Dr. Scott is married and lives in Neptune, N.J.

Mr. COHEN. I was impressed by this article, I have received quite a number of unsolicited letters from doctors saying they had changed their minds in the last couple of years about medicare.

Mr. FLOOD. I have talked to many, many doctors who have told me this, not merely because of my recently acquired position with this committee, but for some time.

Mr. COHEN. I like to mention it because I think Mr. Ball and the members of our staff who conducted all of the staff negotiations with the doctors really did a magnificent job. I think most doctors felt when the law was enacted that the Federal Government was going to regiment them, was going to practice medicine, was going to invade the practice of medicine.

Mr. FLOOD. First, they used to whisper it to me, feeling that they were traitors to their cause or something like that, but that seems to be no longer the case.

Mr. COHEN. They were consulted. We set a deliberate policy of consulting them on every major matter of policy, regulation, and forms, and they had every opportunity to make constructive suggestions. We have three doctors on our Advisory Committee. I think it really is a very amazing episode in two and a half years, of changing——

Mr. FLOOD. Now, this is by no means unanimous?

Mr. COHEN. Oh, no. I think it is like in elections where if you do 51 percent you are still doing pretty good.

ADMINISTRATION OF CLAIMS PAYMENT

Mr. SMITH. Have the private carriers that are administering the payments speeded up payments yet? There was a great deal of complaint that the private carriers administering the program had so much redtape that was unnecessary as far as the Government was concerned that payment to hospitals was very slow.

Mr. COHEN. It is very, very much better than it has been, but I would say we still have maybe three States where I consider it below what I would like to see as a standard, Mr. Smith. But there was a time, maybe last year, when there were five or seven States, but we have tried very much to push them along.

Mr. SMITH. Is the problem all with one insurance company or are there several different carriers involved?

Mr. COHEN. Different carriers.

Mr. FLOOD. For quite some time the Pennsylvania situation was certainly not very good. Were you aware of that, or are you aware of that? Has that cleared up?

Mr. COHEN. I think the Pennsylvania situation, as far as I know, is much better today. Fortunately, it was not one of the worst situations we had to start with.

Mr. FLOOD. It certainly wasn't one of the best.

Mr. COHEN. No, it wasn't.

We had in two or three States an absolutely impossible situation where we had used a certain carrier that had had just a small number of claims and they didn't have the trained personnel, didn't have the computers, and didn't have the experience. They were just flooded with claims that they were not able to handle properly. But, looking at the claims load now, and last December was the highest claims load we have had in history, we are doing much better.

Mr. SMITH. Do you determine the forms that they use or is this something they work out themselves?

Mr. COHEN. We determine the forms with regard to the doctors in the hospitals.

As Dr. Scott said in this article, as far as the doctor's form is concerned, it is much more simple than the commercial insurance company's form. I have talked with a lot of the doctors and if our form were used by every insurance company, I think it would make it much easier for them. Doctors agree it would make it much easier for the nurse or the girl in the office to fill out the same form, whether it was for XYZ company, medicare or something else.

Mr. SMITH. Do some carriers require them to fill out some other forms too for their own purposes?

Mr. COHEN. I can't say, Mr. Smith, whether that is true.

There was a complaint at one time. We were asking for some statistical information and there was a complaint at one time that we were asking for more statistical information than was thought necessary. I don't know whether that has been worked out, but that may be what you have reference to. I think now that they have had more experience, most of those problems—though not all of them—have been eliminated.

I have talked with our own people. They feel that in four or five of the States they could have done it better than these carriers. However, at the time the legislation was in the Ways and Means Committee I made a commitment to the entire membership of the Ways and Means Committee that we would allow the private carriers to act as intermediaries in every State. John Watts got me to make that commitment.

Mr. NATCHER. He drives a hard bargain, that fellow.

Mr. COHEN. And I carried out my commitment, even though in a couple of States I must say I had reservations—I thought we could have done it better. But there was a major matter of policy involved in using the private carriers rather than Government people and on the whole I think it was a wise overall decision.

ALLEGED ABUSES OF MEDICAL PROGRAMS BY PHYSICIANS

Mr. FLOOD. To what extent are you aware of abuses of these medical programs on the part of physicians? Is this widespread, or is this something that happens very seldom but gets the headlines when it does?

Mr. COHEN. There have been a number of allegations made. They are being investigated. I wouldn't want to make an overall statement because I don't have the facts. A typical kind of allegation concerns a doctor who goes into a nursing home—I will be just hypothetical about this—and he is there for an hour and then he sends in a bill for an injection or something for every one of 50 people in the institution.

Then we have had cases of bills being submitted in which the evidence suggests that the volume of services that he is requesting to be paid for is beyond the ability of a particular person to handle. Well, he comes back to that allegation and says, "I have a nurse and I have an assistant" and so on. So we have to look into each one of them on their merits. We are doing that now.

The popular criticism usually has to do with the individual fee. I really don't think that is the major issue. The real issue is not so much the fee or the price per unit, but the number of units that the person is saying he delivered.

Mr. FLOOD. But this is not widespread?

Mr. COHEN. I don't think it is.

Mr. FLOOD. My grandfather used to say that the good Lord always permitted one rotten apple in the barrel so you could see how many good ones there were.

Mr. COHEN. I would say this: We have enough to be very much concerned about it.

Mr. FLOOD. Oh, you do?

Mr. COHEN. Yes, I think we do. We are now making a very intensive survey of this. Where we have these kinds of allegations—I don't want to say that where a man has submitted these bills they are improper—we feel we ought to look into it very carefully.

Mr. FLOOD. There is a problem and you are examining it?

Mr. COHEN. Yes, sir.

CHILD HEALTH

One area which calls for redoubled effort is child health. Our infant death rate declined some 6 percent last year, but it is a shocking fact that at least 12 other nations have rates lower than ours. The reason is apparent: the extreme disparity between the health services available to the poverty stricken and to the more affluent segment of society. The benefits of modern medical knowledge have barely begun to reach the children of the poor in our inner city and rural slums, and particularly our nonwhite population.

The contrasting death and illness rates of our white and nonwhite populations confirm the inequality of services. The death rate for nonwhite infants is 87 percent higher than that of white infants. A white child who survives infancy can expect to live from 5 to 6 years longer than a nonwhite child of the same age. The poor and nonwhite still suffer from a wide variety of handicapping conditions that could be prevented or corrected by early medical attention.

Often, however, the medical care they get is too little and too late—fragmented, impersonal, inaccessible. The result is sickness that need not happen and death that could be averted.

We need new approaches and new resources for expanded child health services—in neighborhood centers, parent and child centers, and comprehensive maternity and infant care projects in low-income areas. In some areas where such projects have been launched, the infant death rate has dropped by as much as 40 percent. This is an auspicious beginning, but we need to reach many more mothers and children if we are to bring our health standards to the levels of which we are capable in this country.

We made substantial progress last year in expanding and consolidating the child health provisions into the Child Health Act of 1967. The 1969 budget contains an increase of $58 million for these purposes.

In addition, we are proposing additional legislation this year to extend over a 5-year period maternity care to all mothers in low-income families, and medical services to children under the age of 1 year in such families.

CHILD HEALTH ACT OF 1967

Mr. FLOOD. At this point in the record, will you put a synopsis of the salient features of the Child Health Act of 1967?

Mr. COHEN. I will be glad to do so, Mr. Chairman. We have a very fine little summary of it that we distributed to the States. I will be glad to put that in the record.

(The document referred to follows:)

WHAT THE CHILD HEALTH ACT OF 1967 DOES

1. It increases the authorizations for child health under title V of the Social Security Act as follows:

$250 million in fiscal 1969
$275 million in fiscal 1970
$300 million in fiscal 1971
$325 million in fiscal 1972
$350 million in fiscal 1973 and for each year thereafter.

2. It specifically calls for services for reducing infant mortality and otherwise promoting the health of mothers and children. These services must be increased and expanded where our infant mortality rate is highest.

3. For the first time, it spells out family planning services as a regular part of health services to our Nation. Of the amounts appropriated for child health each year, 6 percent shall be available for family planning.

4. It continues the program of maternity and infant care project grants and of comprehensive grants for the health of preschool and school age children until June 30, 1972, after which they become a special part of each State health services plan.

5. It authorizes support of up to 75 percent of the cost of projects to provide comprehensive dental health services for children from low-income families. These projects will study ways of organizing community dental health programs, including ways to increase the efficiency of dentists by using assistants and auxiliary personnel.

6. It combines the maternal and child health program and crippled children's services into one program and requires that the States assume responsibility for project grants in 1972. It requires the States to make more vigorous efforts to screen and treat children with disabling conditions through intensified casefinding and periodic screening of children in schools.

7. It specifies that 10 percent of the authorization for child health programs for each year shall be allocated for research and training. Special emphasis will be given to projects which can increase the effectiveness of health care programs by making maximum use of health personnel with varying levels of training. In 1969, this will be $25 million, in 1970, $27.5 million, in 1971, $30 million, in 1972, $32.5 million, and in 1973, $35 million.

FAMILY PLANNING

Mr. COHEN. Now, I would like to talk about family planning.

I believe that one of the most significant legislative achievements of the Congress last year was the statutory recognition of the importance of family planning services. Specific language was added by the Congress to both the child health and dependent children (AFDC) laws incorporating family planning services in these two programs. In the child health program, there is a specific earmarking for family planning services of 6 percent of the total funds. All such services are provided on a voluntary basis with freedom from coercion and freedom in choice of method utilized.

Family planning should be an intrinsic part of medicaid, maternal and child health and AFDC programs. There is a close association between poverty, illness, and large family size. Studies have shown that most people at all income levels prefer small families, but the poor have less freedom of choice because they lack the knowledge of and availability to family planning services.

Mr. FLOOD. You say studies have shown that most people of all income levels prefer small families?

Mr. COHEN. The studies that have been made of various families suggest that most parents prefer to have two or three children.

Mr. FLOOD. As the standard of living goes up, I suppose this is a problem?

Mr. COHEN. As I mentioned earlier, I think the major reason people prefer to have a smaller sized family is that their aspirations for education have risen.

Mr. FLOOD. I think that is certainly one, perhaps major, but there are others.

Mr. COHEN. Yes. Of course, there are other factors. When I was a boy I could work in my father's business. I think it was a privilege. I enjoyed it very much and it was very important to me to work in my father's business. Other children worked on the farm and in other places and got experience.

My three children grew up and never had that kind of opportunity to work except in the summertime. It has occurred to me that there is really less opportunity now for children to be of financial help on the farm, ranch, or in the store. They cost more, require more health care and more education, so they both bring in less income and cost cost more to raise.

Mr. FLOOD. So it is contrary to the situation in certain sections of the world where children are an insurance against poverty in old age?

Mr. COHEN. Yes, sir. There has been a very marked change in attitude. In the old Chinese community they had lots of children so that the children would support the parents in old age. Today, with private pension plans and social security, a large number of children is no longer considered to be a primary way for parents to find support in old age. There has been a change in psychology as well as economics. I think all of these factors working together tend to result in a smaller size family.

I would like to report to the committee one of the conclusions of a study we made last year. This study showed that, of the 8.2 million low-income women in the childbearing age, there were 451,000 un-

wanted pregnancies. This study may be of interest to your committee and I should be glad to make it available for your review.

Last year, a new position of Deputy Assistant Secretary for Family Planning and Population was established in the Department to coordinate the Department's programs of medical and social services, education, and research in this field, and Mrs. Katherine Oettinger was named to this important post.

In a memorandum to the heads of HEW's operating agencies, the Secretary said, "The immediate objective is to extend family planning services to all those desiring such services who would not otherwise have access to them. Family planning is an integral part of our overall health program directed at the reduction of infant and maternal mortality and improving the health of the family."

The policy emphasized freedom from coercion and freedom of choice in method to be used.

The Department also plans to step up its research in human reproduction and fertility, to continue to test the safety and effectiveness of contraceptive devices, and to increase public understanding of family life and sex education.

The budget places greatly increased emphasis on family planning. The $56 million in the budget for 1969 compares with $28 million budgeted in 1968 and $20 million in 1967.

HEALTH RESEARCH

All of our progress in health depends on a sound foundation of biomedical research. Thanks to the interest and support of this committee, our health research effort has grown steadily over the years.

In its report to the President last year, the National Institutes of Health noted that as a result of Federal support of research, 65,000 senior investigators are now at work in some 2,000 academic and research institutions. In addition, some 30,000 individuals are getting advanced training in scientific and clincal specialties.

I think this is a very important fact, Mr. Chairman.

Mr. FLOOD. Except, of course, numbers in themselves are not conclusive. They are interesting. It is not a question of the more the merrier.

Mr. COHEN. I would not say the more the merrier. But at the end of all medical research is the ability and inventiveness of an individual investigator.

Mr. FLOOD. This could not be intelligently debated. But you are aware that there is a feeling in the Congress vis-a-vis a research and development program of some $16 billion that it bears some examination now and then.

Mr. COHEN. There is no question about that. Yet if you look at the National Institutes of Health you see the outstanding ability of the researchers. When you are all through you really are putting your money on the quality and inventiveness of the people.

Mr. FLOOD. I am not speaking of the National Institutes of Health, but the whole broad spectrum of research. I never fail to mention the fact that I have been sitting on defense appropriations for many years. We are not unacquainted in that subcommittee with the question of scientific research, if you know what I mean.

Mr. COHEN. Yes.

This vast effort has revolutionized the range of medical capability; has improved the outlook for people suffering from heart disease, cancer, and a number of other serious ailments; and has opened new insights into the functioning of biological systems, the ways in which we develop and age, and into the nature of life itself.

Within the past year, we witnessed new and dramatic potentialities of medical research, particularly in organ transplantation, in the development of the artificial heart and the artificial kidney, and in new knowledge of the mechanisms of human heredity. Such specific, target oriented research should be continued and encouraged, and we intend to give this kind of work a high priority. At the same time, we need to pursue new knowledge along a broad and varied front—knowledge that will yield new techniques to prevent diseases, ease suffering, and promote longevity for as many people as possible.

I think this is an appropriate place to mention that we are proceeding with plans for the establishment of the International Center for Advanced Study in the Health Sciences, which will bear the name of the distinguished former chairman of this committee, the late John E. Fogarty. The initial function of the Fogarty Center will be to create the environment and to provide the means to assemble scholars and scientists for the advanced study of science as it relates to health.

ORGAN TRANSPLANTATION

Mr. FLOOD. I would like to interrupt you and go to where you refer to organ transplantation. I have before me a newspaper article of recent date, which is entitled, "Three Heart Specialists Ask Moratorium on Transplants."

I merely mention that to indicate that even in an area of most vital concern there is a problem of going too far too fast. Under certain circumstances an abundance of caution is indicated.

Mr. COHEN. Yes. I would not be able to express a competent viewpoint on that, but I did attend several sessions where some of the leading doctors discussed the question of whether they are going too fast or taking undue risks.

I guess like most questions, there are different points of view on this matter.

Mr. FLOOD. That is good.

Mr. COHEN. I think it ought to be very carefully discussed by the professional people.

Mr. FLOOD. I am sure it will be.

Mr. COHEN. I am sure it will be. As you know, in addition to that issue there are a whole host of what you might call ethical questions.

Mr. FLOOD. And legal.

Mr. COHEN. And legal questions that are very complex in this whole matter of organ transplantation. I think a lot more thought has to be given to it.

Mr. FLOOD. Speaking as a lawyer, it is just a question of time until an action at law is going to be brought against somebody in connection with this kind of thing.

Mr. SHRIVER. Was this all as a result of studies and research at the National Institutes of Health?

Mr. COHEN. Dr. Barnard was largely financed when he was at University of Minnesota Medical School from NIH money. I think a great deal of the hardware work in organ transplants came from NIH. I would not say it all has, but I would say it is a very large factor. Certainly one of the big problems in this area is once something becomes available personnel must be trained to use it. The fellowship program gives them an opportunity to gain experience with new techniques, and new equipment.

MANPOWER AND WOMANPOWER SHORTAGES

All of our social programs depend on an adequate supply of well-trained professional and supporting manpower. At present, the Nation's manpower shortage is grave, and it is likely to remain so for some time to come.

The recent report of the National Advisory Commission on Health Manpower underscored the great need for health workers of all types. The need is equally serious in the fields of social work, education, and rehabilitation.

We need to increase the output of trained people in all these fields. We need to devise patterns of organization and administration that will make the most efficient use of professional personnel. And we need to develop and train new categories of workers—aides, auxiliaries, technicians—to provide essential services as part of a team effort and to stretch our limited supply of manpower. To do so, we have to re-evaluate the skills required for various types of services and tailor these skills to different categories of need.

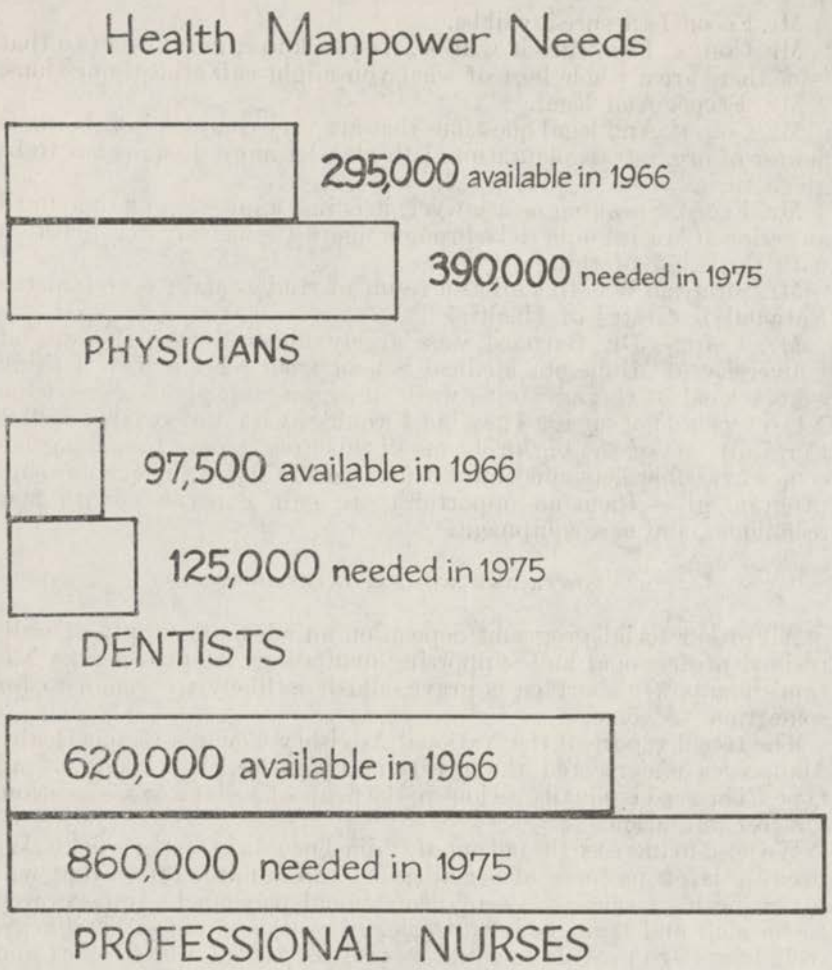


CHART 6

The manpower problem is a challenge to almost every element of society—business and industry, the education community, professional groups, and government at all levels. We have made a start in various training programs and in our efforts at coordination among governmental agencies. But we need to be both more imaginative and more aggressive if we are to come anywhere near our manpower needs in the decade ahead. Chart No. 6 gives some indication of the manpower problems in the health field.

There were 295,000 physicians available in 1966, but with the population increase and the new types of medical care needed, it is estimated 390,000 will be needed in 1975.

Mr. FLOOD. I have heard it said that in Soviet Russia, 70 percent of the so-called general practitioners are female.

Mr. COHEN. That is correct, sir.

Mr. FLOOD. An equally large percentage of medical technicians with 2-year certificates, from what we could call technical institutes are likewise females.

Mr. COHEN. Yes. I think particularly in the field of pediatrics and obstetrics we could well use more women.

Mr. FLOOD. Why don't we get them?

Mr. COHEN. I think there are two reasons. As I recall, I think that about 9 percent of the students in medical schools are women. I think there are two reasons for this.

Mr. FLOOD. Is that because the medical schools have a traditional built-in quota system against female applicants?

Mr. COHEN. I think that is part of it. They do it for this reason. They feel that with the limited number of slots they are going to get more years of service out of a man than out of a woman, because a large number of women will take some period of time off from providing medical service to have their family. When the situation is very tight as far as new openings in the medical schools are concerned, they tend to choose the male entrant.

Mr. FLOOD. What about this appalling shortage that we experience now, and certainly face directly ahead, of so-called medical technicians of all types and kinds? It would be a 2-year course with a certificate. There is a shocking need, I am advised.

Mr. COHEN. There is no question about that.

Mr. FLOOD. Why don't we invite the female into that?

Mr. COHEN. We are.

Mr. FLOOD. The wage scales are comparatively good.

Mr. COHEN. The development of the so-called junior college is important in this respect. In the fall of 1963, there were 850,000 people enrolled in 2-year institutions. In 1964 it was 990,000. In 1965 it went to 1,200,000. In the fall of 1966, it went up to 1,330,000. In the fall of 1967 it went up to a little less than a million and a half.

Mr. FLOOD. Is there a recruiting program in existence? When the Army wants Wacs or the Navy wants Waves they beat the bushes. They go out into the high schools and prep schools and colleges. Are we engaged in any such widespread effort to meet a very obvious and immediate need?

Mr. COHEN. Yes. Congress passed a law called the Allied Health Professions Law which attempts to stimulate and recruit people in these areas that you and I were just talking about. In addition to a law relating to doctors, we have one relating to nurses.

Mr. FLOOD. I am speaking particularly about the female.

Mr. COHEN. The medical specialist and the allied technical groups are predominantly women. I believe we are not going to satisfactorily overcome this problem unless these junior college programs continue to expand. Many of the medical technologists can be trained and educated in 2 years.

Mr. FLOOD. In the United States because of our type of society and our way of life, is there a built-in resistance in the young female against this kind of thing, vis-a-vis the German and the Russian?

Mr. COHEN. No, I do not think so. I think it is just because we failed to organize our educational system to make it possible. The reason why the junior college among other factors is important is that the girl can live at home and go to that junior college. As soon as you send a person away from home, you probably have an additional expense of $1,000 to $1,500 a year. But if the girl can stay at home, and there is an adequate junior college with all of these types of programs, then I think you are going to educate more girls. Here is part of the problem. If a parent has three children, two boys and one girl, that family may send the boy away to college to be a lawyer or a doctor. The girl, if she can go to a junior college in her hometown, will probably be trained. If there is not a junior college, she will probably not go to college.

Mr. FLOOD. That is historical and traditional in most countries.

Mr. COHEN. Yes. My answer to your question really is that if we expand the junior and the community college, so that the tuition is low, there is no room and board, and we have a good recruiting program, we could then develop the supply of these allied medical health people.

Mr. FLOOD. I am sure you are right.

ENVIRONMENTAL PROBLEMS AND CONSUMER PROTECTION

Mr. COHEN. I now turn to environmental problems and consumer protection.

Americans continue to foul their environment at a phenomenal rate. Each year we dump 125 million tons of pollutants in the air. Our landscape is littered with junk and wastes, part of the 165 million tons of solid waste we produce annually. We are buffeted by crowding, harried by noises, endangered by radiation. We know relatively little about the more than 500,000 synthetic chemicals and other compounds on the market today or about their effect on human beings.

The rising tide of pollution threatens not only our health but the very quality of our lives.

The Air Quality Act of 1967 gave us new tools to help restore the Nation's air to an acceptable quality. It will enable us to expand our research and development efforts in this field. It authorizes the establishment of air quality control regions which should lead to the development of desirable air quality criteria. It encourages planning and control activities on a regional basis.

As a result, we are accelerating our efforts to clean up the air. But we are not nearly as advanced in other environmental areas. Nor have we as yet begun to develop a total, comprehensive approach toward conserving our environment or refashioning it where necessary.

The increasing complexity of the products and services we live with makes it necessary to take protective measures in common. The individual is simply not up to judging the safety or efficacy of a new drug or plastic or synthetic. He is asked to choose wisely under conditions which baffle the experts. We must devise new safeguards to protect the American consumer from fraudulent or potentially hazardous substances and products.

VOCATIONAL EDUCATION

A useful and rewarding job is the surest road to independent living. But the disadvantaged face almost insurmountable barriers in getting and holding a job. They lack skills, work experience, and normal work habits, Seeing no way out for themselves, they often lack motivation and self-respect. They need education to live as well as to learn.

Vocational education and job training are crucial to our efforts at salvaging human beings. Much greater attention must be given to vocational education within the framework of our school system. Too often, vocational education has been outside that system or has occupied an inferior place within it. Children enrolled in vocational education courses sense this second-class status and usually drop out early.

Mr. FLOOD. Children enrolled in vocational education courses sense this second-class status and usually drop out earlier? They sense they are in a second-class status? I do not believe that.

Mr. COHEN. Here is what I mean by that. If you have a situation in school which sets up this kind of psychology that you are a very good student if you go through the regular educational curriculum but, if you are not a good student, you have to be sent to vocational school. That is what I mean.

Mr. FLOOD. I understand that. If that is the result.

Mr. COHEN. Yes.

Mr. Flood, we have to give people the feeling that craftsmanship and work is desirable and is a commendable thing.

Mr. FLOOD. They are not being penalized because of an IQ.

Mr. COHEN. The feeling that they are not being penalized because they can do a good job.

Mr. FLOOD. This is also true with this great number of people going to college. An awful lot of boys and girls are in college not because they want to be but because their parents want them to be, because Mrs. Jones' son and daughter are in college. There are many of these young men, and I presume young women, too, but especially young men, who would prefer to go to a scientific or technical training school for 2 years and go to work, instead of spending 4 years on a country club campus for no apparent reason that he can think of at the time.

Mr. COHEN. Many of those are the ones that drop out. They drop out of college, they drop out of these various places. So much of what we have done for them is wasted.

Mr. FLOOD. That is the old story of keeping up with the Joneses.

Mr. COHEN. Yes. It is important, I think, to get over this psychology to young people that working and working well and doing a job well, whatever it is, is important. That is not a lesser value in the scheme of things. I feel that this is rather important. I think many of our educators have put a little too much emphasis on certain elements of the educational system and too little emphasis on certain other elements. This could be very discouraging to some young people.

Mr. FLOOD. I am sure this is so from what I have heard. I am not an educator, but I have big ears. I am sure you are right.

Mr. COHEN. I believe we have made some good progress in vocational education since 1963, but vocational education should be part of a total program that prepares the individual to live in society.

Our young people and our adults have the right to a total rather than a fragmented education, including preparation for the world of work. Occupational education, planned work experience, and job and career counseling should be offered as part of the general education program in all schools. And to help serve the multiple and changing needs of individuals, the school should link itself to family, employer, and community.

COUNSELING

On that point I want to say I think the big deficiency is not having counselors in school at the earliest possible age. I would put more money and more emphasis into having counselors in every school while the kids were still young. At the present time our counseling is often offered when the kid is ready to be a dropout. You can save some of those. I am not saying it is wrong. But I feel very strongly that you should have counseling programs right in the elementary school. I think this would help us a great deal with dropouts. More important, as you indicated, counselors could help get the child in the right school and the right program. I believe as you do that there are a lot of people that go into the wrong program.

Mr. FLOOD. I am sure of that.

Mr. COHEN. I had a most interesting experience one time. I was selling my house and had a conversation with the real estate broker. He told me he was a Ph. D. in chemistry. I said to him, "How did you get to be a Ph. D. in chemistry?" He said, "My father was a chemist. I came to be a chemist. I got my bachelor's, master's, and Ph. D., and I worked for 10 years as a chemist." He said, "I was constantly dissatisfied. So I went down to the employment service one day and took a job aptitude examination and when I took the job aptitude examination it showed that being a chemist was my lowest performance. The test showed that being a person who sells things was most adaptable. I took a course in real estate and I have never been happier in my life." This always had a great impression on me.

Mr. FLOOD. This is an old, old story in law school. Many of those men who are in law school are there because their fathers and grandfathers were lawyers, or the fellow across the street was a lawyer. They had no intention of practicing law and would tell you that for 3 years, and they don't practice law.

Mr. COHEN. I think there are a lot of young people who just do not get the help that they need at the earliest possible stage when they are thinking of their vocational interests.

Mr. FLOOD. There is no doubt about it.

Mr. COHEN. I think that would save a lot of waste in our educational system. We need new and innovative approaches to vocational education and manpower training. We need to build a sound system that will motivate young people to stay in school, that will be preventive and constructive instead of palliative. And we need to do a much better job of coordinating the various job-training programs at the local level.

TABLE 2.—*Dates when degree credit enrollments in institutions of higher education first exceeded significant levels*

Enrollment exceeded—	
100,000	1880
500,000	1920
1,000,000	1928
2,000,000	1946
3,000,000	1957
4,000,000	1962
5,000,000	1965
6,000,000	1967
7,000,000 [1]	1969
8,000,000 [1]	1972
9,000,000 [1]	1975

[1] Projected.

HIGHER EDUCATION

Mr. COHEN. I now turn to higher education. The most important point is that we now are at a stage where there are 6 million young people in college. As you will see from table 2, there will be 9 million by 1975. That is our big problem in higher education, how to finance this tremendously increased program in higher education.

Our society is committed to the goal that every American receive all the education he is capable of, in whatever variety his abilities and interests dictate. In today's world, this means higher education. For millions of Americans, higher education used to be only a dream. Today, it is a necessity and more and more students are aspiring to an education beyond the high school.

They are doing so in increasing numbers. College and university enrollment last fall was at a record high of nearly 7 million, an increase of 8 percent over the previous fall, and 45 percent over 4 years ago. In another 4 years the enrollment total is expected to rise another 25 percent.

At the beginning of this century only 4 percent of Americans from 18 to 21 were enrolled in higher education; by 1960 this proportion had increased to 23 percent. Today it is over 33 percent. For the first time in our history, education beyond the high school is becoming the norm rather than the exception in America. I refer again to table 2. It gives an indication of the remarkable progress made in recent years and the growth expected in the next 7 years.

As I mentioned before, one of the most significant developments which is occurring is the increase in enrollment in 2-year community colleges. Enrollment has increased from about 850,000 in the fall of 1963 to 1,440,000 in the fall of 1967. This is a most important step in making post high school education more easily accessible to additional students.

Yet millions of youngsters still do not share in this opportunity. The cost of higher education has soared in recent years. For too many high school graduates going on to college still depends far more upon the ability to pay than the ability to learn. We have to strike down all

the barriers—financial, racial, social, and geographical—to a college education. We also have to make sure that our colleges and universities have the teachers, facilities, and resources they need to accommodate the flood of new students. Finally, we have to maintain and improve the quality of higher education and to strengthen its services to our communities and States.

GROWTH IN EXPENDITURES FOR HIGHER EDUCATION

TABLE 3.—EXPENDITURES BY INSTITUTIONS OF HIGHER EDUCATION RELATED TO GROSS NATIONAL PRODUCT UNITED STATES, 1957–58 TO 1967–68

[Dollar amounts in billions]

Calendar year	Gross national product	School year	Expenditures by institutions of higher education	
			Total	As a percent of gross national product
1957	$441.1	1957–58	$6.5	1.5
1958	447.3	1958–59	7.1	1.6
1959	483.7	1959–60	7.7	1.6
1960	503.7	1960–61	8.7	1.7
1961	520.1	1961–62	9.5	1.8
1962	560.3	1962–63	11.3	2.0
1963	590.5	1963–64	12.2	2.1
1964	632.4	1964–65	13.8	2.2
1965	683.9	1965–66	15.5	2.3
1966	743.3	1966–67	16.6	2.2
1967	785.0	1967–68	17.9	2.3

The growth in expenditures for higher education is shown in table 3. We can expect these expenditures to grow in both amount and relative to the GNP.

UNDERGRADUATE ENROLLMENT AND FAMILY INCOME

A major issue will be how to organize and finance student financial aid so that all students from low-income families who have the ability and interest in attending college can do so.

Chart No. 7 indicates that in 1967, 48 percent of all undergraduates came from the 25 percent of families with the highest incomes, while only 7 percent came from the 25 percent of the families with the lowest incomes.

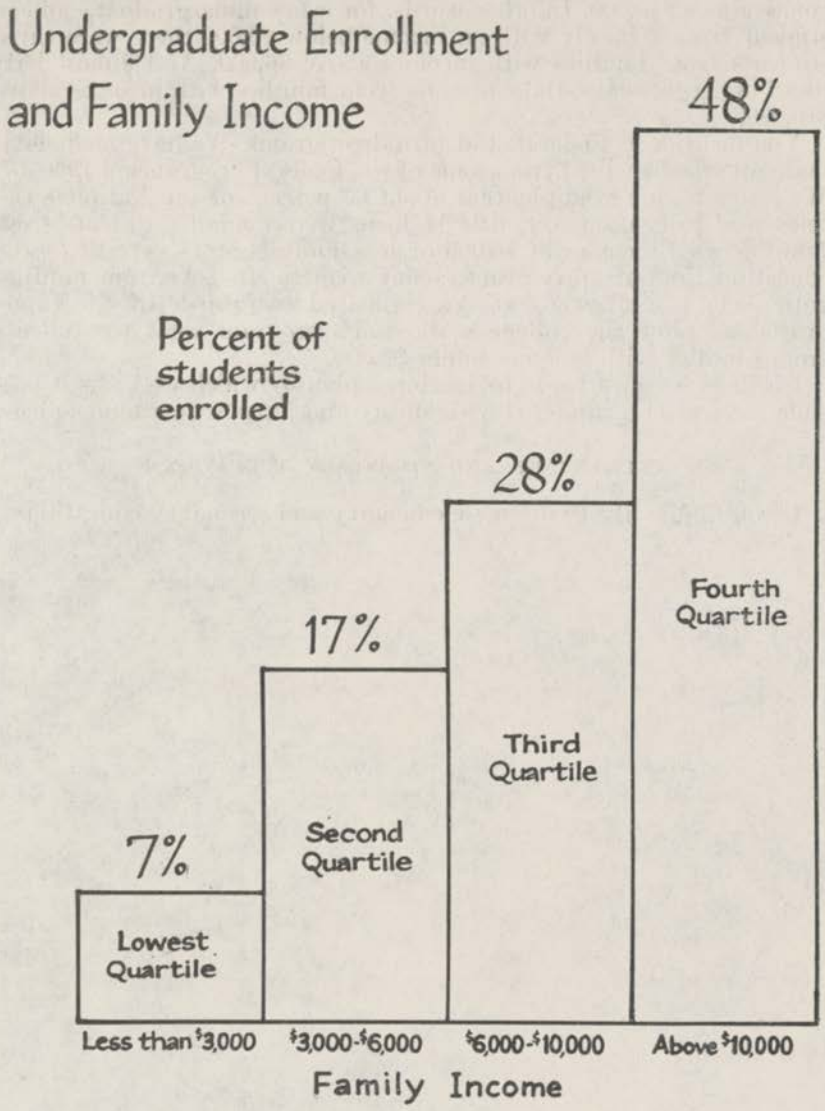


CHART 7

Mr. COHEN. This chart contains our best estimates of the financial or economic composition of the undergraduate student body. As the chart indicates, in 1967 only about 7 percent of the students came from families with incomes below $3,000, 17 percent from families with incomes from $3,000 to $6,000, 28 percent from families with incomes from $6,000 to $10,000, while 48 percent came from families with in-

comes above $10,000. In other words, for every undergraduate college student from a family with an income below $6,000 there were three students from families with incomes above $6,000. And almost half of all undergraduate students came from families with incomes above $10,000.

You mentioned Federal student aid programs. We have made estimates of who benefited from some of the Federal programs in 1966–67. We estimate, for example, that about 65 percent of the National Defense and Education Act, title II loans were made to students from families with incomes of $6,000 or less, and about 88 percent of the educational opportunity grant money went to students from families with incomes under $6,000. An estimated two-thirds of the funds available under the college work-study program went to students from families with incomes under $3,000.

I believe we must begin to develop a plan by which we make it possible for every boy and girl with ability and purpose to attend college.

ELEMENTARY AND SECONDARY EDUCATION

I would now like to discuss elementary and secondary education.

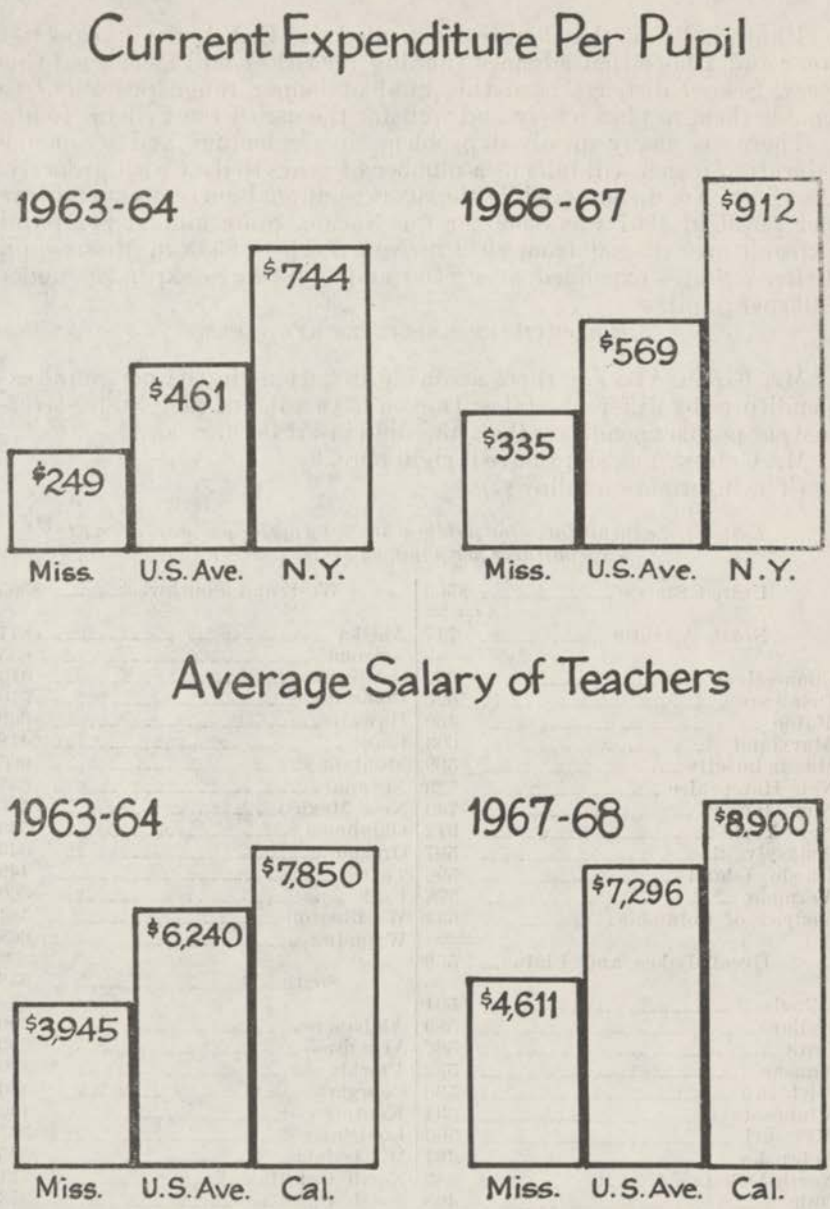


CHART 8

Any adequate discussion of the needs in elementary and secondary education would require an entire volume by itself.

The Elementary and Secondary Education Act of 1965 has enabled the Nation to make important progress, but it is still premature to know in substantial detail exactly what the results will be until we have had a longer period of experience.

I am glad that the Congress extended the ESEA for 2 years last year and I hope that advance funding for title I will be enacted this year. School districts need this kind of longer range provisions to enable them to plan wisely and well for the use of the Federal funds.

There are many unsolved problems in elementary and secondary education which will take us a number of years to deal with properly. As Chart No. 8 shows, while the average annual current expenditure per pupil in 1967 was $569 for the Nation, State annual per pupil expenditures ranged from $912 in New York to $335 in Mississippi. Fifteen States expended over $600 and five States expended under $400 per pupil.

PER PUPIL EXPENDITURES BY STATES

Mr. FLOOD. You say there are wide variations in the per pupil expenditures by different States. Do you have a list of each State's average per pupil expenditure that you could insert in the record?

Mr. COHEN. Yes, sir; I have it right here.

(The information follows:)

Estimated expenditures for public schools, by major purpose, current expenditures per pupil, by State, 1966–67

United States	$569
North Atlantic	717
Connecticut	657
Delaware	626
Maine	430
Maryland	603
Massachusetts	599
New Hampshire	523
New Jersey	740
New York	912
Pennsylvania	597
Rhode Island	596
Vermont	578
District of Columbia	693
Great Lakes and Plains	556
Illinois	591
Indiana	580
Iowa	567
Kansas	552
Michigan	596
Minnesota	634
Missouri	506
Nebraska	464
North Dakota	485
Ohio	468
South Dakota	521
Wisconsin	608
West and Southwest	$565
Alaska	877
Arizona	635
California	613
Colorado	570
Hawaii	669
Idaho	418
Montana	665
Nevada	635
New Mexico	586
Oklahoma	533
Oregon	645
Texas	449
Utah	500
Washington	581
Wyoming	668
Southeast	438
Alabama	390
Arkansas	393
Florida	479
Georgia	430
Kentucky	400
Louisiana	567
Mississippi	335
North Carolina	411
South Carolina	373
Tennessee	404
Virginia	556
West Virginia	411

Mr. COHEN. The relative difference between the State with the higher per pupil expenditure, New York, and the State with the lowest per pupil expenditure, Mississippi, has decreased somewhat in recent years. In school year 1963–64, for example, New York's per pupil expenditure, $744, was triple that of Mississippi, $249. By the 1966–67 school year, New York's per pupil expenditure, $912, was 2.7 times

as large as Mississippi's, $335. But the gap is increasing in terms of absolute dollar differences, $495 difference in 1963–64, as compared to $577 in 1966–67.

There are still many localities in which children cannot attend kindergarten. In the year 1966, about 25 percent of all 5-year-old children did not attend kindergarten or school, 80 percent of all 4-year-olds were not enrolled in any kindergarten or nursery school.

The major responsibility for financing elementary and secondary education falls on the localities, and financial problems today plague practically every city school system. No one would question that elementary and secondary education in the inner city must be strengthened greatly in financial resources and in quality of teachers if the children in these areas are to have high quality education. Yet a study of the Advisory Commission on Intergovernmental Relations, covering 37 largest standard metropolitan statistical areas in the country, showed that State financial aid to local schools tended to favor suburban schools over central city schools. The Commission's studies show that the schools serving low-income central city children are receiving less per pupil as well as per capita than those serving the more affluent suburbs. Another study of 35 cities showed that cities averaged $124.92 per pupil in State aid in 1964–65, while suburban districts got an average of $165.54 per student—$40.62 more. We need to reconsider local and State methods of financing elementary and secondary education and the role of Federal financial help in the three-way partnership if these imbalances are to be corrected.

The need for effective, competent teachers grows each day. Allowing for enrollment increases, teacher turnover and some replacement of teachers with substandard certificates we foresee a need for well over 900,000 new teachers in the next 5 years. Teachers salaries in 1967–68 range from an average of $4,611 in Mississippi to $8,900 in California, with a national average of $7,296. An increase in the salaries of elementary and secondary school teachers is mandatory to attract and hold capable, imaginative and enthusiastic individuals as teachers. The success of our educational programs will depend on the quality of our teachers. More effort must be made to provide adequate numbers of trained educational manpower. Teacher training and retraining and the use of teacher aides should be emphasized and additional measures taken to attract qualified people into teaching and to strengthen teacher education. This wide range in average salary of teachers represents one of the major problems in our elementary education.

Mr. Flood. Yes; I read the newspapers.

And I married a schoolteacher, so I get it both ways.

Mr. Cohen. I think the financial problems which plague every city school system, particularly where local schools have been financed by real estate taxes is one of the real difficult problems we have. We need to change the method of financing, or to organize larger metropolitan areas than the present school districts, or to have more Federal financing or some combination of these if we are going to finance elementary and secondary education more adequately in the future.

This is one of the real serious problems and we ought to devote more attention to it.

URBAN PROBLEMS

I now want to touch upon the urban crisis.

Many of the problems I have been discussing converge with special severity in our cities. The cities are in deep crisis, a crisis that is both physical and social. The physical crisis is visible in the terrible overcrowding, contaminated air, choked streets and highways, and deteriorating neighborhoods. But the social crisis—the rising welfare loads, high unemployment among the young and untrained, high rates of crime and delinquency, and unrest and alienation in the inner city ghettos—is even more corrosive.

The reasons for the crisis are familiar. The concentration within the cities of racial minorities has created ghettos which reflect not only poverty but also the multiple ills of economic and racial segregation. The flight of the upper- an middle-income groups to the suburbs has eroded the local tax base, while the costs of public services—police and fire protection, education, sanitation, welfare, health—have soared in the inner city.

In the report of the National Advisory Commission on Civil Disorders there is much more detail on these problems. I do believe we are faced with tremendous problems here.

Mr. FLOOD. I am going to ask you about that when I get to you in the examination.

Mr. COHEN. Within the last few years we have begun to face the urban problem realistically and with a renewed sense of dedication. Recent legislation has given us a variety of new tools and resources. But we are still groping for solutions. We have a long way to go before we apply ourselves to the total problems of the city in a coordinated way.

The overriding challenge of our time is to rebuild our cities so that they are ont only more livable but so that they are once more the centers for jobs, education, culture, and leadership in today's world.

Many other problems are also before us—mental illness and mental retardation, alcoholism, drug addiction, and juvenile delinquency, to name but a few. In my presentation, I have limited myself to but some of the issues as we view them today.

We are, I believe, responding to all of these problems. We certainly don't have all the solutions. And the pace of progress has been understandably uneven. We are confronted with matters of incredible complexity, involving institutional change as well as the reordering of human resources.

Nonetheless, we can report encouraging progress on a broad series of fronts.

Before doing so, however, I should like to describe some of the organization and management improvements we have made in HEW. These actions have two important purposes: first, to discharge our own responsibilities, our share in the national effort, in a more efficient manner; and second, to improve our relationships with the agencies and institutions, both public and private, with which we work.

ORGANIZATION AND MANAGEMENT

Mr. Chairman, I would like to describe our efforts in the field of organization and management.

We have given considerable attention to modernizing the Department's administrative machinery and revitalizing its organizational structure. Since we last reported to this committee, we have made two major organizational realinements.

The first occurred last August when three major agencies—the Welfare Administration, the Vocational Rehabilitation Administration, and the Administration on Aging—were combined in a new Social Rehabilitation Service. This reorganization was designed to:

Bring together the various HEW services that deal with special groups, such as the aged, the handicapped and children;

Encourage the concept of preventive and rehabilitative social services for all the disadvantaged, including the poverty stricken;

Separate cash payments for welfare recipients from programs of service, thus making better use of scarce, highly skilled personnel; and

Help improve the delivery of services by establishing simplified and clearer channels at the regional level to the States and communities.

This move is already helping to encourage a combination of services—counseling, medical diagnosis and treatment, income support, day care, homemaker services, adult basic education—delivered in a coordinated way and tailored to the specific needs of disadvantaged individuals and families.

The second major change is still under discussion. Its purpose is to strengthen and improve the coordination of the Department's scattered health programs by giving the Assistant Secretary for Health overall direction and policy responsibility for health programs.

The new alinement would group our health activities under three major subdivisions: research, health services, and environmental health and consumer protection.

This arrangement would give us greater flexibility in dealing with States and communities, hospitals and universities, and the health professions. We hope, too, that it would serve to improve the delivery of health services to the people who are most in need of health care.

In another reorganization last year, St. Elizabeths Hospital, heretofore a separate agency within HEW, was transferred to the National Institute of Mental Health. The purpose is to transform it, under NIMH tutelage, into a modern, community-based mental health center for the District of Columbia.

As you know, our Department has important responsibilities in bringing about compliance with title VI of the Civil Rights Act of 1964. Here, too, we moved to strengthen our organization capabilities. All the civil rights functions heretofore scattered in several agencies were transferred to a newly created Office of Civil Rights, headed by the Secretary's Special Assistant for Civil Rights.

In addition to these organizational steps, a number of improvements were made in management systems. To cite just one result, the Food and Drug Administration was able to eliminate a 2-year backlog in processing new drug applications.

Mr. FLOOD. Please explain what this backlog was.

Mr. COHEN. Let me give you an example. In July 1966 there were 98 new drug applications that were in review status in excess of the 180-day limit that exists. By July 1967, there were no new drug applications in review status in excess of this limit. The Food and Drug Administration had become current in its review of new drug applications and it has remained current.

One of the most significant management reforms had to do with HEW assistance to State and local agencies. As you know, more than 90 percent of the funds appropriated to this Department are allocated to these agencies in the form of grants. The improvements included delegating more decisionmaking authority to regional offices; eliminating duplicative requirements, and streamlining the technical review procedure. These reforms are expected to cut the time devoted to the processing of grants by 50 percent, and should enable the Department to respond much more quickly to State and local needs.

HEW RELATIONSHIPS WITH STATE AND LOCAL AGENCIES

All of these administrative and organizational measures are part of the Department's continuing effort to strengthen State and local agencies and to improve our relationships with them.

This effort has taken two forms: (1) legislation to encourage greater initiative and flexibility on the part of State and local agencies and institutions; and (2) the creation of mechanisms to foster closer ties between the Federal and non-Federal partners.

A major legislative breakthrough was the Partnership for Health Act which freed the States and communities from categorical restraints. It enabled them to approach their own health needs more rationally, to plan comprehensively, and to set their own priorities.

Another step in this direction was the Educational Professions Development Act which provided greater flexibility in Federal support for the training of faculty and staff members.

The late funding of Federal programs in support of education has been a continuing source of frustration to the school community. School officials had to hire teachers and plan their activities before they knew how Federal authorizations would affect these activities. After studying this problem, we proposed a system of advance funding and the Congress enacted an amendment to this effect last year. Advance funding should remove many of the uncertainties faced by the Nation's school officials and enable them to plan their programs more realistically.

We are looking into the matter of grants from several angles—financial arrangements, procedures, and relationships. We are giving intensive study to the difficult and controversial question of block versus categorical grants. We are exploring new ideas and alternatives that might help us arrive at more flexible arrangements.

Finally, we are focusing resources throughout the Department on urban problems. We established a new base for this effort in the

Center for Community Planning, which was set up within the Office of the Secretary last year. The Center enables HEW to address itself directly to the problems of the central cities. It serves as a resource for city officials and a primary point of contact with the Department of Housing and Urban Development on model cities plans and programs. It works closely with HUD and other Federal agencies to coordinate multipurpose projects involving education, land use, recreation, housing, health care, and social services.

Now let me highlight just a sampling of accomplishments under some major HEW programs which you have made possible.

On March 1 more than 23.5 million people—one out of every nine Americans—received an increased monthly social security check. In 1967, social security benefits helped keep 5.7 million aged persons out of poverty. As I pointed out before, a million more people are expected to escape poverty as a result of the 1967 amendments to the Social Security Act. An additional million would have been taken out of poverty if the benefits had been increased to a $70 minimum as the administration recommended.

In its first 18 months, medicare has helped pay over 28 million medical bills, totaling almost $1.3 billion. Virtually all older people are now protected against hospital costs and some 93 percent are signed up for voluntary medical insurance—a tremendous response for a voluntary program.

Mr. Flood. Do you mean to say that medicare has provided only $1.3 billion in benefits in a year and a half? That sounds low to me.

Mr. Cohen. You are correct, Mr. Chairman, the figures I have given, 28 million medical bills and $1.3 billion, refer only to part B of medicare, the voluntary supplementary medical insurance program. When part A of medicare, the hospital insurance program, is included total benefits provided by medicare in its first 18 months amount to $5.5 billion.

About 9 million disadvantaged children—in over 18,000 school districts in all the States—were helped last year by special projects under the Elementary and Secondary Education Act of 1965.

Nearly one and a quarter million young Americans are continuing their education beyond high school with the help of Federal financial aid programs.

Some 10 million adults have participated in federally assisted vocational education programs since 1965.

More than 200,000 mothers and their infants have received special medical care in 54 low-income areas over the past 4 years. In some of these areas, infant mortality has dropped by as much as 40 percent.

This year more than 200,000 disabled people will be rehabilitated for useful work, almost 50 percent more than 3 years ago. More than one out of every 10 of these people were on public welfare.

Close to 300 community mental health centers are being built or staffed with Federal help. They are located in areas where 47 million Americans live.

The foregoing that I have listed in my paper are merely illustrative of the vast effort that you and this subcommittee are supporting in every field related to human well-being. It is a shared effort which depends upon participation and leadership among a variety of groups

and at all levels of government. We appreciate the support you have given in making it possible to make continued progress in these important programs.

This completes my opening statement, Mr. Chairman. We would like to have Mr. Kelly and Mr. Cardwell subsequently give you a summary of our 1968 and 1969 budget proposals. Assistant Secretary Huitt is here to give you any summary you want on our legislative program for this session of Congress and, of course, we stand ready to give you any and all information you want, and to try to answer any questions you may have.

Mr. FLOOD. Let me say, Mr. Cohen, that I have heard many presentations by many Government officials made to various subcommittees of the Appropriations Committee upon which I have had the honor of serving. I want to say to you that I don't think I have ever heard a better or more comprehensive presentation made. I can't think of any public official in my experience who impresses me as having a better command of the subject.

Mr. COHEN. Thank you very much, Mr. Chairman. I appreciate that.

TUESDAY, MARCH 5, 1968.

EFFECT OF HOUSE JOINT RESOLUTION 888 (PUBLIC LAW 90–218)

Mr. FLOOD. We are now prepared to hear Mr. Kelly as the second witness in support of the 1969 budget for the Department of Health, Education, and Welfare.

First, tell us what you were required to do this year by House Joint Resolution 888 which became Public Law 90–218.

Mr. KELLY. It requires that controllable obligations in the President's budget, as submitted, be reduced by 2 percent in funds proposed for personal services and 10 percent in all other controllable obligations.

Mr. FLOOD. A so-called across-the-board cut?

Mr. KELLY. That is correct, and it is important that (1) we report to the committee what we have done as a result of that, and (2) it is important that the committee understand the cutback because it influences the entire 1969 budget.

Mr. FLOOD. As I recall the Congress suggested, and I believe the President supplemented the idea, that the 2-percent cut in personnel, wherever possible, be done through absorption.

Mr. KELLY. That is correct. We did not in any event cause a reduction in force.

The President's budget, as submitted in 1968, called for HEW obligations in the amount of $13,706 million. The joint resolution and the legislative history identified $5.7 billion of that as uncontrollable. This included public assistance and vocational rehabilitation programs.

Mr. FLOOD. What do you mean by "uncontrollable?"

Mr. KELLY. That the executive branch does not exercise administrative control. The payment is made pursuant to law. For example, in public assistance the law authorizes the States to provide assistance to needy people.

Mr. FLOOD. There is no executive discretion?

Mr. KELLY. That is right, and the executive branch matches the amount of the States. With $5.7 billion identified as uncontrollable that left us with $7,986 million that constituted controllable expenses under the resolution.

Mr. FLOOD. By "us" you mean the Department of Health, Education, and Welfare?

Mr. KELLY. That is correct, sir.

Now, the 2 percent—10 percent formula required that we reduce this level of obligations by $759 million. The Congress, reviewing our appropriations, effected reductions amounting to $170,165,000; therefore this amount of the reduction had already been achieved.

Mr. FLOOD. We helped you to that extent.

Mr. KELLY. That is correct. At least there you made the decisions. You left the rest of them up to us, so that we had to develop a plan for reducing the amount of the budget by an additional $588 million.

Now, we elected to eliminate from consideration $133,931,000 in proposed supplementals that had been anticipated in the budget, and took the remaining $460 million out of the funds that you had already appropriated in the 1968 act.

Mr. FLOOD. Then you actually did comply with House Joint Resolution 888.

Mr. KELLY. We did, indeed, yes, sir.

These charts will identify where we took it out. The requirement was $588 million. We have actually taken out $594 million.

PRINCIPAL ACTIONS TAKEN TO REDUCE HEW OBLIGATIONS

PRINCIPAL ACTIONS TAKEN BY DHEW TO ACHIEVE REDUCTION IN FISCAL YEAR 1968 OBLIGATIONS

Obligation reductions:

	Millions
1. Formula grants to States and localities	$69
2. Construction and loans and grants for construction	337
3. Personnel costs and related administrative expenses	19
4. Research and demonstration projects	15
5. Eliminate student loan reallocation	6
6. Regional medical program	26
7. Elimination or reduction of proposed 1968 requests for supplemental appropriations	134
8. Adjustment for carryover from 1967	−12
Total, Department of Health, Education, and Welfare reductions	594

FORMULA GRANTS

Mr. KELLY. You will note of the $594 million adjustment in the budget that $69 mililon was taken out of formula grants to States and localities. I will have a chart that identifies the individual programs.

Mr. FLOOD. What do you mean by formula grants?

Mr. KELLY. These are the areas where the funds appropriated are distributed on the basis of an already determined formula, usually based on population and per capita income. We decreased the amount of funds which we would have distributed to the States and localities and which they otherwise would have received under the Appropriation Act.

Mr. FLOOD. You, of course, could not disturb the ratio of formula?

Mr. KELLY. We did not disturb the ratio of formula, and we only applied it in those areas where we had discretion, but the joint resolution gave a much broader degree of discretion to the Secretary than would have been the case without the resolution.

CONSTRUCTION

Now, the largest single decrease that we made was in the area of construction and loans and grants for construction. Here we eliminated $337 million worth of obligations. I will have a chart which depicts this.

Mr. FLOOD. Tell us at this point, construction of what? This is what we call bricks and mortar?

Mr. KELLY. School construction, hospital construction, mental health, mental retardation, the direct facilities of the Department, the food and drug labs.

Mr. FLOOD. These are all bricks and mortar?

Mr. KELLY. Yes, sir.

PERSONAL SERVICES

Mr. KELLY. Now, for the third item of the cutback: We took $19 million out for personal services and related costs. Here we had to meet the requirements of the 2-percent reduction for personnel and we did take out 2 percent in personnel. However, we exempted from the reduction the areas involving direct patient care, the operation of the Public Health Service hospitals, the Indian Health hospitals, and St. Elizabeths Hospital. We felt an across-the-board cut should not be applied. Ths caused us then to make a 3-percent reduction in all other portions of the Department where the staffing is paid for by appropriated funds. We did not apply this to the Social Security Administration because the joint resolution did not apply to trust funds.

EXEMPTIONS UNDER H.J. RES. 888

Mr. FLOOD. House Joint Resolution 888, as a matter of fact, had a series of exemptions.

Mr. KELLY. That is right, and trust fund expenditures were one of those. Social security was exempted in the law itself and then we exempted only in the area of direct medical care. We required everybody else to absorb 3 percent.

Then, with respect to the direct operations of the Department, we required that all agencies make an absorption of 10 percent in their expenditures for travel, supplies, equipment, printing and binding, and related expenses, excepting those items of direct operations related to direct patient care activities. That accounts for this $19 million.

RESEARCH AND DEMONSTRATION PROJECTS

Now, we decreased research and demonstration projects by $15 million, which is a small amount. We actually took out of the research and demonstration projects only the funds associated with overestimates of the cost of continuation projects. Wherever the budget had an estimate for the cost of continuation projects which was greater than our most current estimates, we impounded those funds.

Mr. FLOOD. Would this prevent new starts?

Mr. KELLY. It does not. We have as many new starts as were in the budget for research and demonstration. We decreased only where we had a bad estimate of the cost of continuation and we absorbed the overestimate. Customarily we spend about 8 percent for continuation projects in the form of supplementations when there have been pay raises or changes in the direction of the projects. Supplementations are requested in the form of an additional grant. This normally amounts to 8 percent of the total continuation projects. We cut this in half. We said that the institutions receiving the supplementation grant will have to absorb half of the increased costs and half of the redirected costs.

Mr. FLOOD. All of the institutions affected—and I would presume those interested in the specific programs of the institutions affected, know or should have known, why this was brought about.

Mr. KELLY. I believe so, yes.

STUDENT LOAN PROGRAM

In connection with the student loan program, we took $6 million out, which still allowed every institution in every State to receive the initial allocation under the law, that is, the amount that they were entitled to on the basis of their application, and the amount of the funds appropriated.

Mr. FLOOD. You are speaking now of the allocation of appropriated Federal funds to the several States?

Mr. KELLY. That is correct.

Mr. FLOOD. And then the States having those funds allocated must distribute them to the best of their discretion?

Mr. KELLY. Well now, there is a formula that distributes them within the States to the individual educational institutions.

Mr. FLOOD. Based upon the allocation?

Mr. KELLY. Yes, sir.

When one State does not utilize all of the funds available, we have the discretion to reallocate them to another State. What we did, in fact, was to impound them. We did not reallocate them and played them against the setback.

REGIONAL MEDICAL PROGRAM

In the regional medical program, we took out $26 million. This in no sense represented low-priority treatment of this program. Rather, we recognized it was a new and developing program and at this stage of its development it would be impaired less than if we were to take an equivalent amount of money out of an already established program. Thus, this reduction really represents a deferment and stretchout of the program to the next fiscal year.

Mr. FLOOD. How many of the so-called regional medical programs as of this morning are actually in existence?

Mr. CARDWELL. Fifty-four have planning grants. I don't have the exact number in operation.

Mr. FLOOD. But none of them are any further advanced?

Mr. CARDWELL. By 1969 they will all have some phase of operation under way, by 1969.

Mr. FLOOD. We have your statement that 54 of the regional medical program applicants have already received planning grants and of those 54 there are five that are actually operational?

Mr. CARDWELL. I think there are eight.

Mr. FLOOD. Now, will you state for the record the areas that are covered by those eight operational regional medical programs?

Mr. KELLY. We will indeed, sir.

Mr. CARDWELL. We can give you the eight at this point, if you would like, Mr. Chairman.

Mr. FLOOD. Let's hear them.

Mr. CARDWELL. The States of Kansas, Missouri, and Wisconsin. The two-State area of Washington and Alaksa; the area surrounding

Albany, N.Y., and Rochester, N.Y.; the Tennesee-mid-South region and the intermountain region.

Mr. FLOOD. What is the Tennessee-mid-South region?

Mr. CARDWELL. I am not really sure of the locale covered.

Mr. FLOOD. Supply that for the record.

(The information requested is as follows:)

The Tennessee-mid-South regional medical program is made up of eastern and central Tennessee, southern Kentucky, and northern Alabama.

Mr. FLOOD. The Albany area is the intra-New York State region?

Mr. CARDWELL. Yes, sir. There is the intermountain region, including Utah and portions of five other Western States.

Mr. FLOOD. You will supply the information on what other States besides Utah?

Mr. CARDWELL. Yes.

(The information requested is as follows:)

The intermountain regional medical program includes the entire State of Utah and parts of Colorado, Idaho, Montana, Nevada, and Wyoming.

Mr. FLOOD. Is that calendar or fiscal 1969?

Mr. CARDWELL. Fiscal 1969. The budget proposes that each of the 54 regions reach some phase of operation and receive by the end of fiscal year 1969 some operational grants.

ANTICIPATED SUPPLEMENTALS NOT REQUESTED

Mr. KELLY. The President's budget for 1968 had anticipated that, on the enactment of new legislation, $151 million in supplemental appropriations would be requested of Congress. In light of the joint resolution calling for the cutbacks, the decision was made not to request $134 million of those supplementals and to apply that against the cost reduction.

CARRYOVER FUNDS

Then there was an adjustment for carry over that was unanticipated. Together, all these reductions add up to the $594 million figure.

Mr. FLOOD. What do you mean by "carry over?"

Mr. KELLY. Well, for the first time the Congress, in acting on an appropriation, did not deal in either of the two terms that it normally deals: New obligational authority, the authority to incur commitments; or expenditures, the amount of money which will be disbursed during a given period.

In the joint resolution calling for the across-the-board cutback, Congress applied the cutback to obligations to be incurred during the year. This is the first time, to my knowledge, that this has been done. Thus, where we had anticipated that funds available to us would be obligated in 1967, they were not obligated and were carried forward, available for obligation in 1968. We had to take this into consideration in working out the cutback.

OBLIGATION REDUCTIONS BY AGENCY

Now, this chart merely identifies for you how the $594 million breaks down by operating agency.

(The information follows:)

Obligation reductions in fiscal year 1968 budget by agency

	Millions
Food and Drug Administration	$11
Office of Education	347
Public Health Service	171
Social and Rehabilitation Service	42
Social Security Administration	-----
Special Institutions	6
Office of the Secretary	17
Total	594

Mr. KELLY. There is $11 million in Food and Drug and $347 million in the Office of Education. This is primarily because of the impact of the cutback in construction where you made a one-third cutback in all cases except hospital construction, where we made a 5-percent cutback.

In the Public Health Service, $171 million; Social and Rehabilitation Service, $42 million. The latter figure is small because the preponderance of their funds fall into the uncontrollable area.

The Social Security Administration was not affected, the Special Institutions, by $6 million, and the Office of the Secretary by $17 million.

Mr. FLOOD. What is a special institution?

Mr. KELLY. Howard University, Gallaudet College, American Printing House, the Institute for the Deaf, and the Model School for the Deaf.

FORMULA GRANTS TO STATES AND LOCALITIES

FORMULA GRANTS TO STATES AND LOCALITIES—REDUCTION IN FISCAL YEAR 1968 OBLIGATIONS

[In millions of dollars]

Appropriation/program	1968 obligation in 1968 budget	1968 obligation in 1969 budget	Reduction
Office of education:			
Supplementary educational centers and services (ESEA, title III)	$209	$188	$21
Equipment and minor remodeling (NDEA, title III)	80	77	3
Library resources (ESEA, title II)	104	99	5
School assistance in federally affected areas (Public Law 815 and Public Law 874)	439	420	19
Educational opportunity grants (HEA, title IV-A)	141	133	8
Work-study programs (HEA, title IV-C)	140	134	6
Vocational Education Act of 1963	199	198	1
Library services	6	6	(1)
Adult basic education	32	31	1
Preschool and school programs (ESEA, title VI)	15	14	1
Public Health Service:			
Comprehensive State health planning	5	5	(1)
Health professions educational improvement	52	49	3
Social and Rehabilitation Service:			
Innovation of rehabilitation services	3	3	(1)
Community planning, services and training for the aging	11	10	1
Total, HEW	1,436	1,367	69

[1] Reduction less than $500,000.

Mr. KELLY. I have already indicated to you there was a $69 million reduction applied to formulas and grants. $65 million of that was in the Office of Education.

Twenty-one million dollars relates to the supplemental educational centers under title III of the Elementary and Secondary Education Act. The $3 million relates to equipment and minor remodeling under title II of the National Defense Education Act; $5 million to library resources——

Mr. FLOOD. $3 million is equipment under the National Defense Education Act?

Mr. KELLY. Yes.

Mr. FLOOD. What would be an example of that?

Mr. KELLY. Title III of the National Defense Education Act authorized grants to States for the purchase of equipment in mathematics, foreign languages, and science. The appropriation, as I recall, was $2 million and we made a reduction of approximately 5 percent. There was $80 million appropriated and we allowed $77 million to be appropriated. We reduced it by $3 million.

Mr. LAIRD. You only asked for $47 million in the budget request and we raised that to $80 million. That is the 50–50 matching program.

Mr. KELLY. That is right.

The school assistance in federally affected areas, 815 and 874, were reduced by 5 percent, from $439 million to $420, or $19 million.

Mr. FLOOD. This is what we call the impacted areas.

Mr. KELLY. Yes.

The educational opportunity grants were reduced by $8 million; the work-study program by $6 million; the Vocational Education Act by $1 million; adult basic education by $1 million, and the preschool and school programs by $1 million.

The decrease of $3 million in the Public Health Service all relates to the Health Professions Education Improvement Act.

Finally the Social and Rehabilitation Service's reduction of $1 million relates to community planning and training services. This accounts for the total of $69 million.

The basic policy was a reduction of 5 percent in the areas of controllable grants to States. The Elementary and Secondary Education Act was exempted from this; that is, title I was exempted.

Mr. FLOOD. The caption of the chart is "Formula Grants to States and Localities."

Now, you have made it very clear that by law there are such things known as formula grants to States, but you have not indicated what you mean by "formula grants to localities."

Mr. KELLY. The funds for the so-called impact program, under Public Law 874, go directly from the Federal Government to a school district. The program is based on a formula built into the law.

Mr. SHRIVER. Congress cut some 10 percent from entitlement, but you cut another 5 percent?

Mr. KELLY. On the basis of Public Law 874.

Mr. SHRIVER. Yes.

Mr. KELLY. Congress decided to appropriate the full amount of the budget estimate, but the budget estimate only provided for about 90 percent of the entitlements.

Mr. SHRIVER. This fiscal year they will be receiving a 15 percent reduction under the formula.

Mr. KELLY. It works out now to be about 80 percent of entitlement.

Mr. SHRIVER. They will be receiving 80 percent?

Mr. KELLY. That is correct.

Yesterday, as you may have noticed, the Senate Appropriations Committee, on their own initiative, put in funds for full entitlement. There was no budget request from the administration for it.

HEW SUPPORTED CONSTRUCTION

HEW SUPPORTED CONSTRUCTION (GRANTS, LOANS AND DIRECT)
REDUCTIONS IN FISCAL YEAR 1968 OBLIGATIONS (DOLLARS IN MILLIONS)

Agency	1968 obligations in 1968 budget	1968 obligations in 1969 budget	Reduction
OFFICE OF EDUCATION			
Higher education facilities:			
Grants	$450	$307	$143
Loans	203	154	49
Education research facilities	25	1	24
Total, Office of Education	678	462	216
PUBLIC HEALTH SERVICE			
Hill-Burton (hospital and medical facilities)	274	263	11
Health teaching facilities	203	136	67
Health research facilities	50	38	12
Medical library facilities	11	10	1
Direct construction	20	10	10
Total, Public Health Service	558	457	101
other	49	29	20
Total, HEW Construction	1,285	948	337

Mr. KELLY. This chart shows that the largest reduction was made in the obligation for construction. The budget provided $1,285 million in obligations for constructions.

Mr. FLOOD. It says "HEW-Supported Construction." Then in parentheses you have "Grants, Loans, and Direct."

It is pretty clear to us what "grants and loans" means, but what do you mean by "direct?"

Mr. KELLY. You provide some funds for us to modernize the Public Health Service hospitals, to construct facilities in Indian health programs, to build food and drug laboratories, Social Security Administration district offices, and similar construction activities for our own direct operations. These are small in comparison with the grant and loan assistance programs.

The budget contemplated an obligation of $1,285 million in 1968 for these construction programs. We have constrained this to $948 million to comply with the joint resolution.

I should call your attention, Mr. Chairman, to the fact that——

Mr. FLOOD. Now you are talking about dollars?

Mr. KELLY. Yes, sir.

I should like to point out that the actual obligations, in 1968, if you had not effected this cutback, would really have exceeded $1,285 million, because we did not obligate as much money in the fiscal year 1967 as we had contemplated. We initiated the projects. The design got started, but they did not reach the construction stage as quickly as we had anticipated in the budget. Therefore, if we had not had any constraint, we would really have exceeded this figure, so that we not only made a $337 million reduction below the budget level, but we had to cut the unobligated balances that carried forward in excess of those that were anticipated, into 1969.

Mr. FLOOD. Wasn't there a prohibition against carry-forward?

Mr. LAIRD. Not for construction.

Mr. FLOOD. Not specifically for construction?

Mr. KELLY. That is right.

The nature of the limitation placed on us is that we cannot, in the aggregate, exceed the figures which I originally gave you; that is, out of $7,986 million in obligations, $759 million of that must be removed; the remainder is a ceiling.

Therefore, we established $948 million as the ceiling for obligations for construction.

Now, to achieve this level of decrease, we applied a basic formula of saving that one-third of the funds available for construction would be deferred until a subsequent period. We made one exception to this. In the case of hospital construction, we made this only a 5-percent reduction because of the urgency of need for hospital beds.

The largest decrease in construction occurs in education because this is where the largest programs now exist. It amounts to $216 million. Grants for higher education decreased by $143 million and the loans by $49 million. Construction starts of educational research facilities are deferred by $24 million.

In the Public Health Service there is a decrease of $101 million. The $11 million is in the Hill-Burton hospital construction program; $67 million in teaching facilities for the health act; and $12 million in the health research facilities.

Mr. FLOOD. Do you have any idea what percentage of the health-teaching facilities would be identified with hospitals?

Mr. KELLY. The preponderance of these funds would be for the construction at universities of either additions to medical and dental schools or the creation of new medical and dental schools, and the new ones, of course, very frequently, have a teaching hospital built along with them.

Direct construction programs of the Public Health Service involve a decrease of $10 million. Then, "all other" decreases in construction in HEW amount to $20 million and consist of a reduction in rehabilitation work jobs, in the mental retardation community facilities, and a deferment of Howard University construction of about $6 million.

PERSONNEL COSTS AND RELATED ADMINISTRATIVE EXPENSES

Mr. KELLY. I indicated to you how we made the reduction of the 2 percent in personnel and the related expenses. This chart merely identifies the reductions by operating agencies; the Public Health Service, being the largest of the Department's activities financed from appropriated funds, takes the largest share.

(The information follows:)

Personnel costs and related administrative expenses, reductions in fiscal year 1968 obligations (thousands)

Agency and bureau:	
Food and Drug Administration	$2,417
Office of Education	899
Public Health Service	13,640
Social and Rehabilitation Service	1,019
Office of the Secretary	909
Total, DHEW	18,884

Mr. FLOOD. Was this 2-percent reduction done totally by absorption?

Mr. KELLY. Yes, totally by absorption, and it results in the elimination of about 1,020 positions that had been included in the 1968 budget. They do not now appear in the 1968 budget, nor the 1969 budget.

RESEARCH AND DEMONSTRATION GRANTS

Research and demonstration grants, reductions in fiscal year 1968 obligations
(thousands)

Agency:	
Public Health Service:	
Health Manpower	$379
Disease Prevention and Environmental Control	1,535
Health services	211
National Institutes of Health	10,942
National Institute of Mental Health	1,108
Total, Public Health Service	14,175
Social and Rehabilitation Service:	
Administration on Aging	13
Rehabilitation Services Administration	650
Children's Bureau	300
Total, Social and Rehabilitation Service	963
Total, Department of Health, Education, and Welfare	15,138

Mr. KELLY. I have already indicated to you the $15 million reduction in the research and demonstration program and the way in which we accomplished it. This chart gives you a breakdown of how those funds are applied. The largest share, almost $11 million, is in the National Institutes of Health because this is where a preponderance of the program is. All of the programs in the Department were treated in the same way. We held back on the supplementation of continuation grants and we corrected the estimate wherever there was an overestimate of the cost of continuation, rather than making those funds available for new proects. Thus we did it in such a way as not to decrease the congressionally approved level of research projects.

Mr. FLOOD. Is it your experience that overestimating is a chronic disease?

Mr. KELLY. In some ways I think the answer is, "Yes." It turns out to be a very difficult area in which to estimate. So, if you were to take 15 appropriations and add them together, the estimate for continuation cost would be very close to accurate, but out of the 15, seven of them will be too low and eight of them will be too high. If their estimate is too low, nothing can be done. It decreases new projects.

Mr. FLOOD. From your experience, are there any of these agencies or bureaus or departments who seem to be habitual villains in this business of overestimating? Do they make a practice of it?

Mr. KELLY. I wouldn't call it a practice, but I would say estimates were not made in past years as carefully as they might have been. We have computerized this program and so we can project trends in these estimates from what is in our records.

Mr. FLOOD. And you have a flag up when they come by, do you?

Mr. KELLY. Yes, sir; we do.

This accounts for the method in which we applied the congressional cutback. I think the cutback is important because it not only affects the 1968 program, but it has a very significant effect on the 1969 budget. One effect, as I have already indicated, is that we eliminated 1,020 positions in 1968 which we did not carry forward into 1969. But the most important effect of this cost reduction program, particularly as it relates to construction, is that it does not terminate the appropriations that were made for those services, but it does have the effect of saying, "We will not use them during the fiscal year 1968. Therefore, there will be a very large carryover of unobligated balances of construction funds into 1969." The 1969 budget was put together with the knowledge of that carryover, and therefore we asked for considerably less money than required for the level of program that we planned to carry out. Let me give you an example. In higher education construction, we are proposing a program level——

Mr. FLOOD. In the 1969 budget?

Mr. KELLY. In the 1969 budget. We are proposing a program level of $226 million of new construction obligations, but we are only asking for $75 million in new appropriations because we have such large balances carried forward.

To my mind, the Congress will find it easier this year in reviewing our budget to compare the level of obligations in 1968 with that proposed in 1969, to get the full effect of what the programs are and to understand what we expect to do, because there is a distortion in comparing the amounts appropriated in 1968 with the amounts requested for appropriation in 1969.

Mr. FLOOD. I suppose you don't want Congress to take for granted that you are establishing a precedent by this low 1969 request?

Mr. KELLY. Absolutely. Absolutely. And Mr. Cardwell, who is going to give you a briefing on what is in the 1969 budget, will show you both appropriations and obligations, but he will focus on the obligational figure because it more nearly reflects the program level to be carried out in 1969 if the budget is approved.

OVERVIEW OF 1969 BUDGET

Mr. CARDWELL. My purpose is to give you a very quick overview of the HEW budget.

HEW BUDGET IN BRIEF

HEW BUDGET IN BRIEF

[Dollars in billions]

	1968	1969	Change
Federal funds:			
Appropriations	$14.5	$15.4	+$0.9
Obligations	14.3	16.0	+1.7
Expenditures	13.3	14.5	+1.2
Trust fund expenditures	29.0	33.0	+4.0
Interfund adjustment	−1.4	−1.7	−0.3
Total expenditures for the department	40.9	45.8	+4.9

Mr. CARDWELL. The purpose of this chart is to summarize the budget as a whole for the Department of Health, Education, and Welfare. In terms of appropriations, the budget for HEW, as a whole, proposes an increase of slightly more than $900 million—a net increase. Now, to back up Mr. Kelly's point——

Mr. FLOOD. What point?

Mr. CARDWELL. His point about the effect of a cutback in obligations on program level. A net increase of $900 million for HEW in appropriations, actions by the Congress, will provide us a program level that can be achieved through obligation of a net increase of $1.7 billion.

Now, with total appropriations standing at $15.4 billion for the Department, and obligations at $16 million——

Mr. FLOOD. Total requests of $15.4 billion?

Mr. CARDWELL. That is correct.

Mr. FLOOD. For 1969?

Mr. CARDWELL. And proposed obligation levels of $16 billion, this is still a sizeable budget.

GENERAL FUND EXPENDITURES

In term of outlays from the Treasury, the budget would also go up from $13.3 billion in 1968—now, these are general fund expenditures——

Mr. FLOOD. What do you mean by "general fund expenditures"?

Mr. CARDWELL. These are expenditures out of the Treasury to finance HEW grants and direct operations. They exclude payments made to beneficiaries of the social security trust fund system.

The trust fund expenditures predicted for 1969 would be an increase of $4 million or $33 billion.

INTER-FUND ADJUSTMENT

The chart shows a technicality of inter-fund adjustment——

Mr. FLOOD. The chart shows what?

Mr. CARDWELL. A technical adjustment of $1.7 billion, an inter-fund adjustment.

What this reflects, simply stated, are payments made from the Treasury into the trust fund under law for the Federal share of health insurance for persons over 65, who are not covered under the social security system, for certain payments for military personnel who benefit under the system but who do not participate, do not pay in——

Mr. FLOOD. This $1,700 million refers only and solely to the social security matter?

Mr. CARDWELL. Yes, it does. It involves moneys paid out of the Treasury to put up the Federal share, and payments also paid out of the trust fund to the individuals. So as not to show the expenditure twice and charge it twice, there is this minor adjustment of $300 million in 1969 in terms of change.

Total expenditures for the department would stand at $45.8 billion, an increase of $4.9 billion, for both general fund and trust fund expenditures.

INCREASE IN UNCONTROLLABLE PROGRAMS

Now, before we go to the next chart, I would like to give you two views of this budget. If you look at the appropriation line, you find this increase of $900 million. It is made up of three parts: $966 million is in uncontrollable appropriations, appropriations for public assistance, for payments into the trust fund required by law, and for the basic vocational rehabilitation grants.

Mr. FLOOD. You have just added $66 million to the $900 million?

Mr. CARDWELL. That is right. There is another gross addition and that is $83 million worth of new legislation that will be proposed by the President to the Congress and which is identified in the budget. Offset against those are a net——

Mr. FLOOD. Offset against those last two?

DECREASE IN CONTROLLABLE PROGRAMS

Mr. CARDWELL. Offset against those two increases is a net decrease in controllable programs, a net decrease in appropriations requested of the Congress, of $42 million. In other words, if you break the budget in half and you look at the controllable programs compared to the uncontrollable programs, you find that appropriations requested for the controllable programs actually go down for the department as a whole in 1969.

In terms of obligations, it doesn't work quite that way.

Total obligations would increase by about $800 million for controllable programs, $820 million to be exact. It would increase by about $700 million for the so-called uncontrollable programs. So it is about a 50–50 split.

SUPPLEMENTALS FOR 1968

1968 supplementals (millions)

Public assistance grants	$1,135
Work incentives	40
General fund payment to the health insurance trust funds	373
Social security program administration	85
Rat control	20
Air pollution	16
National Center for Health Services research and development	6
Mental retardation	7
State-wide vocational rehabilitation planning	2
Public broadcasting	4
Other supplementals	2
Total	1,690

Mr. CARDWELL. Now, the 1969 budget indicates to the Congress that the President will come forward this year with supplemental appropriation requests for 1968.

Mr. FLOOD. You are going to talk about things on this chart that didn't happen?

Mr. CARDWELL. They have not yet happened, but they are about to happen—I hope.

The budget indicated there would be a supplemental request aggregating $1,690 million.

Mr. FLOOD. What budget message?

Mr. CARDWELL. The President's budget message sent to the Congress in January 1968, discussing the 1969 budget.

Mr. FLOOD. In which there was discussed what you are now describing from the chart as 1968 supplementals?

Mr. CARDWELL. That is correct.

Mr. FLOOD. And which have not as of this moment happened?

Mr. CARDWELL. Two of the supplementals have. The first item, the $1,135 million, and the statewide rehabilitation planning item, which is $1.9 million, have been sent to the Congress. They have been reviewed by this committee; the House has passed a bill and the Senate committee acted on the bill yesterday.

Now, the remaining items, either in whole or in part, are scheduled to be sent to the Congress this week. The President has reviewed this list of items; and I am fairly certain that, when the list does come to you later this week, you will find that there has been some paring down, that there have been some reductions, and that there probably has been some elimination of items. But we will know more about that as the week proceeds.

Mr. FLOOD. Would we have any reason to believe the suggested or prophesized reductions would be material? Of course, you indicated in some instances there may be elimination of line items, but overall would the program be for material reductions?

Mr. CARDWELL. My guess would be it would be reduced by about $30 million. Below the $1,690 million.

Mr. FLOOD. Of course, you have already taken public assistance and vocational rehabilitation from the $1,690 million total? They are now included in H.R. 15399, the urgent supplemental bill.

Mr. CARDWELL. The President will take another cut of about $30 million. It would leave you a net of about $470 million.

Mr. LAIRD. Where will that $30 million come from, from what you have posted there in your chart?

Mr. CARDWELL. I don't know. We have had almost daily discussions with the Bureau of the Budget. The President has personally reviewed these items.

I don't want to be in the position of second-guessing the President, but in our conversations with the Bureau of the Budget they do indicate that there will be some reductions in this list by the time it reaches you.

PROPOSED LEGISLATION

FUNDS IN 1969 BUDGET FOR PROPOSED LEGISLATION (IN MILLIONS)

Student assistance	$23
Vocational education	15
Juvenile delinquency	25
Public broadcasting	20
Total	83

Mr. CARDWELL. Another aspect of the budget we want to call to your attention—we understand your policy of not dealing with new legislation in your bill, but, as submitted to the Congress in January, the President did identify in the HEW budget $893 million worth——

Mr. FLOOD. The President identified this in his January 1968 message?

Mr. CARDWELL. That is right. It adds up to $83 million. This is not the whole list of legislation for HEW that he would ask the Congress to consider this session, but it does indicate those items that would have a significant cost, as he sees it, in 1969. We are listing these as $83 million. Assistant Secretary Huitt will talk more about them if you like later on. He is here for that purpose.

HEW BUDGET BY OPERATING AGENCY

[In millions of dollars]

	1968		1969	
	Appropriations	Obligations	Appropriations	Obligations
Federal funds:				
Food and Drug Administration	67	72	70	85
Office of Education	4,019	3,887	3,791	4,119
Public Health Service	2,891	2,797	2,914	3,186
Social and Rehabilitation Service	6,051	6,047	6,823	6,836
Social Security Administration	1,385	1,385	1,691	1,691
Special institutions	36	37	37	47
Office of the Secretary	26	26	73	73
Total, Federal funds	14,474	14,251	15,399	16,037
Trust funds:				
Social Security Administration	32,595	28,987	37,670	33,184
Adjustment for interfund transactions	−1,395	−1,395	−1,699	−1,699
Grand total, HEW	45,673	41,842	51,370	47,522

HEW BUDGET BY OPERATING AGENCY

Mr. CARDWELL. This is an overview of the budget by operating agency of the Department. The chart shows both appropriations and obligations for both 1968 and 1969. You can take a quick look at it. It shows increases in obligations for every agency of the Department. It shows some decrease in appropriations for the Office of Education. This is the only major decrease in terms of appropriations; in terms of obligations, which we believe is a good measure of program level, each operating agency would, under the budget, receive some increases.

Mr. SMITH. Is there a new function in the Office of the Secretary, or what is the big increase there?

Mr. CARDWELL. Included in the Office of the Secretary budget is a request, which was turned down last year by Congress, for the International Education Act. That is identified in the Office of Education. About $11 million of the appropriation request increase——

Mr. FLOOD. Off the record.

(Discussion off the record.)

Mr. MICHEL. In your trust fund, social security, why would you have in 1969 that difference of $4 billion from appropriations to obligations? What does that really mean?

Mr. CARDWELL. In the case of the trust funds, the appropriation represents an estimate of income into the trust funds. It isn't truly an appropriation, but under the new budget concept these are called appropriations. It is really a technicality.

Mr. MICHEL. Does that properly reflect income over outgo in the social security trust fund in the year 1969?

Mr. CARDWELL. Yes, sir.

Mr. MICHEL. It will be $4 billion plus.

Mr. CARDWELL. Yes, sir.

NEW BUDGET CONCEPTS

Mr. FLOOD. What do you mean by the new budget concept?

Mr. CARDWELL. The President appointed a commission about a year ago to study the budget and to consider the question of how it should be presented to the Congress and the public. There was the question of the so-called administrative budget, and they came to this concept of including trust funds, both the income and the outgo of trust funds, as a part of the budget. It is being presented this way to the Congress and to the public for the first time.

MAJOR CHANGES IN THE 1969 BUDGET FOR THE OFFICE OF EDUCATION

[In millions of dollars]

	1968		1969	
	Appropriations	Obligations	Appropriations	Obligations
Elementary and secondary	2,080	2,031	1,972	2,004
(Title I, ESEA)	(1,191)	(1,191)	(1,200)	(1,200)
Higher education	1,143	1,045	839	1,094
(Construction grants)	(450)	(307)	(75)	(226)
(Student assistance)	(518)	(503)	(575)	(622)
Teacher training	177	177	247	247
Vocational education	256	265	272	272
Libraries and community services	157	161	149	158
Programs for the handicapped	53	53	85	85
Research	89	90	146	176
Other education programs	63	64	80	82
Total	4,019	3,887	3,791	4,119

MAJOR CHANGES IN 1969 BUDGET FOR OFFICE OF EDUCATION

Mr. CARDWELL. From this point on we would like to highlight some of the major changes that show up in the budgets of the several operating agencies. The elementary and secondary education program is declining in terms of appropriations. That decline reflects the cutback that Mr. Kelly, in some measure, has set out, and the continuation of the cutback as applied in title III of the National Defense Education Act. We are treating that as a lower priority item and will continue to cut it back in 1969.

Mr. FLOOD. What is title III?

Mr. CARDWELL. It authorizes grants to States and school districts to finance equipment purchases and minor remodeling. It is included in that item as a reduction in library resources.

The title I program would be held at the 1968 level roughly. It has a net increase of $9 million, from $1,191 million to $1,200 million.

I would like to call the committee's attention——

Mr. FLOOD. What is title I?

Mr. CARDWELL. Title I is grants to school districts for special project support for underprivileged children. It is the largest single elemen-

tary and secondary education program as authorized by the Elementary and Secondary Education Act of 1965.

I would call the committee's attention to the fact that this portion of the budget does propose the so-called advanced funding of title I of the Elementary and Secondary Education Act. The way that works is as follows: If we ask the Congress to authorize in a supplemental appropriation bill this session an appropriation level for fiscal year 1969 of $1.2 billion, we are also asking the Congress in the regular 1969 bill to include language which would authorize the same level, $1.2 billion, for title I, to become available for allotment to the school districts in fiscal year 1970. This is to allow the school districts advance notice as to how much Federal support they will receive from this program.

Mr. FLOOD. This is to meet that widespread objection on the part of school officials that they could not plan and do their budgeting properly in view of the fact that they didn't know what they would get or when they would get it.

Mr. CARDWELL. That is correct.

Now, going on through the major changes in the Office of Education, the higher education facilities construction program continues to show a significant cutback in terms of appropriations. This is the one Mr. Kelly referred to a moment ago, the appropriation request, a net request of $75 million. However, by use of carryover balances that would continue to be available for 1968, the program can be carried on at an obligation or program level of $226 million. That is still a reduction, however, below the program level of the prior year. Here again we are treating construction, under the concept of a tight budget, as being of lower priorities. Our belief is that construction tends to have a greater short-term inflationary impact and, further, we think we can probably slow down construction for a short period with a minimum long-range impact.

Mr. FLOOD. The reduction will be from $370 million in 1968 as an obligation to $226 million in 1969 as an obligation?

Mr. CARDWELL. Yes, sir.

Now, you will learn more about this when the Commissioner of Education appears. We give very high priority and provide increases in the area of teacher training, implementation of the Educational Professional Development Act of last year, and educational research. Both are items of very high priority in the Department's educational program, and because of the way these increases have in part been financed by the holddown in construction.

There is a minor reduction in libraries and community services. Included in that activity also is the adult basic education program which is actually increasing. The net decrease occurs because of a reduction in community library construction grants.

CHANGES IN 1969 BUDGET FOR PUBLIC HEALTH SERVICE AND FOOD AND DRUG ADMINISTRATION

MAJOR CHANGES IN THE 1969 BUDGET FOR THE PUBLIC HEALTH SERVICE AND FOOD AND DRUG ADMINISTRATION

[Dollar amounts in millions]

	1968		1969	
	Appropriations	Obligations	Appropriations	Obligations
Partnership for health	$156	$150	$195	$200
Health manpower	383	309	282	369
Construction grants	(203)	(135)	(85)	(152)
Disease prevention, consumer protection and environmental control (air pollution)	303	297	336	362
	(80)	(71)	(107)	(118)
Health services (National Center for Health Services R. & D.)	505	504	504	557
	(21)	(21)	(30)	(30)
National Institutes of Health	1,175	1,164	1,197	1,240
Regional medical programs	(59)	(54)	(69)	(100)
Construction grants	(35)	(38)	(8)	(21)
National Institute of Mental Health (construction grants)	358	360	377	426
	(45)	(45)	(15)	(60)
Other PHS programs	78	83	95	117
Total	2,958	2,869	2,984	3,271

Mr. CARDWELL. This is a combination of the budget of the Public Health Service and the Food and Drug Administration so that you might get an overall view of the Department. The Food and Drug Administration is included in the line "Disease prevention, consumer protection, and environmental control," and it accounts for $69.9 million in appropriations in 1969 out of the $336 million shown on the chart.

Mr. LAIRD. The expected supplemental is not included in these figures, is it?

Mr. CARDWELL. Yes, sir.

Mr. LAIRD. You have included a supplemental that hasn't been submitted to the Congress in the $156,000,000 to partnership for health?

Mr. CARDWELL. That is right. The $20 million. As I explained earlier, our belief is that it will be submitted this week to the Congress.

Mr. LAIRD. I thought maybe you would wait until the fiscal year was over.

Mr. CARDWELL. We have health research construction grants and education construction grants, programs operated by the Public Health Service. Consistent with our policy toward holding down construction in 1969, there are reductions in both programs.

However, by use of carryover balances, there is an increase in program level in 1969 of the health-education facilities construction program. There would be places for 464 new students in 1969 through these construction activities.

The budget of the Public Health Service and the Food and Drug Administration taken as the health budget of the Department gives emphasis to the partnership for health, the health-manpower program, and I would also call your attention to the Center for Health Services Research and Development. Secretary Cohen referred to this yesterday as a part of our extra effort to find new ways to improve the

delivery of health care and services. This is receiving attention in 1969.

The National Institutes of Health does show an increase of about $76 million. As you examine the NIH budget, you will find that every institute of each one of the regular institutes shows some increase. You will also find that both health research and health training grants are continued at the same level of new activity as in the prior budget. There are increases in fact in the program level for collaborative research at NIH.

NIMH also would show quite a significant increase, and I would also call your attention to the fact that included in that part of the budget this year for the first time is the budget for St. Elizabeths Hospital.

CHANGES IN 1969 BUDGET FOR SOCIAL AND REHABILITATION SERVICE

MAJOR CHANGES IN THE 1969 BUDGET FOR THE SOCIAL AND REHABILITATION SERVICE

[In millions of dollars]

	1968		1969	
	Appropriations	Obligations	Appropriations	Obligations
Work incentives	40	40	135	135
Maintenance payments	2,985	2,985	3,052	3,052
Medical assistance	1,808	1,808	2,118	2,118
Social services, innovation, and administration	467	467	595	595
Rehabilitation services and research	377	376	443	443
Maternal and child health and welfare	236	235	298	298
Mental retardation	34	32	30	42
Development of programs for the aging	17	17	26	26
Other SRS programs	87	87	126	126
Total	6,051	6,047	6,823	6,836

Mr. CARDWELL. This is the budget for the new Social and Rehabilitation Service. This is a new agency created by the Secretary since we appeared here last year. It combines the activities of the old Vocational Rehabilitation Administration, the old Children's Bureau——

Mr. FLOOD. Is this new agency created by the Secretary affected by the stop order that appeared this morning on the whole reorganization of HEW?

Mr. COHEN. No, Mr. Chairman. That had already taken place previously.

Mr. FLOOD. This is separate and distinct from the reorganization that has been referred to in this morning's papers.

Mr. COHEN. Yes, that is right. They distinguish the one you are referring to by calling it the health reorganization.

Mr. CARDWELL. The maintenance payments line, the medical assistance line, and a part of the social services innovation and administration line are all in this uncontrollable program. They show significant increases in 1969, partly because of an increase in numbers of participants in the program. In fact, the maintenance payments level for 1969 is expected to go up to about 8 million persons receiving maintenance payments——

Mr. FLOOD. What is a maintenance payment?

Mr. COHEN. A maintenance payment is cash given to a person for food, shelter, and clothing as distinguished from medical care, in the next line.

Mr. CARDWELL. Now, the medical care line is the so-called medicaid program. There has been an increase of about $310 million to cover an increase in persons to participate in programs from 7.38 million people in 1968 to about 8.3 million in 1969, a considerable increase.

Mr. LAIRD. Mr. Chairman, the three items he is now referring to all used to be a part of the appropriation grants to State for public assistance. I wonder if the primary reason why the budget now shows three items is to make it more difficult for people to see how rapidly those grants to the States for public assistance are growing. It would be a little more difficult now to go back and compare them for the last 10 or 12 years when they are in separate items like that now, and were not in the past.

Mr. CARDWELL. They aggregate about $5.9 billion in 1969.

Mr. LAIRD. And they are underestimated already by about $350 million?

Mr. CARDWELL. We have been taking the closest look possible at that. When the social services and rehabilitation comes up a week or so from now, they should have some current data for you. Based on data received from the States in about mid-February, it looks as if we might be on target for 1969. There is about $60 million worth of costs we are not sure about.

QUALITY OF DATA FROM STATES

Mr. FLOOD. What is your opinion of the quality of the reports you get from the States in this specific area, across the board?

Mr. KELLY. They are not timely enough and not good enough. When the President met with the Governors last week, he asked that the Department of Health, Education, and Welfare, the Bureau of the Budget, and the Governors get together and develop a plant study which will result in a more precise forecast for public assistance and medicaid.

Mr. FLOOD. This is your only source of raw intelligence.

Mr. KELLY. That is correct.

Mr. LAIRD. You have an FTS line now that you can use to call them up. I can call them up and get better estimates than you do. Most of the States have these lines. I would object if you had to pay $1.75 to make a phone call, but you don't.

Mr. KELLY. I do not think that is the problem.

Mr. LAIRD. I would agree with you that it took longer by mail a few years ago. It sometimes took you 2 months to get an estimate, but now you can get it fast.

Mr. KELLY. If I thought you could get on the telephone and get an estimate, I would do it. I don't know whom you can call that knows a whole lot more than we know. In the area of social security we have developed an estimating technique and a sampling procedure that allow us to be currently apprized as to what is developing in study estimates in depth.

Mr. FLOOD. Are these actuarials third parties?

Mr. KELLY. It is a professional group that is separate.

Mr. FLOOD. Do you contract with them?

Mr. KELLY. No, we have an Office of Actuarials in Social Security which is one of the best professional groups of actuarials you will find.

Mr. FLOOD. It is an in-house operations?

Mr. KELLY. It is, but it utilizes a different technique and it is projected over a long period of time. This Office has developed a high degree of competence.

We hope that we can learn to both professionalize the estimate in public assistance and develop a sampling technique comparable with social security. We hope this will keep us more adequately informed on a more timely basis of trends than the present elongaed and cumbersome reporting procedure.

Mr. FLOOD. Could you pass this on to the several States?

Mr. KELLY. That is our hope.

Mr. FLOOD. I mean that technique?

Mr. KELLY. Yes.

Mr. CARDWELL. May I continue, Mr. Chairman?

MEDICAID ESTIMATES

Mr. LAIRD. Mr. Chairman, there is just one point I would like make now and then I will not interrupt again. This business of the estimates for medical assistance, there are about seven States that receive about 60 percent of the title XIX money.

Mr. KELLY. Eight.

Mr. LAIRD. Very well, eight, then. These States for 1969 are in a better position to estimate than they were in 1968. On the basis of what they know now you are going to find right at the present time that the current estimate is $75 million off.

Mr. CARDWELL. As you know, the real problem——

Mr. LAIRD. Is that correct?

Mr. CARDWELL. I don't know. I cannot say whether it is or not. I think the real problem is going from those eight States to the estimated 48 States that are believed will be participating in the program in 1969, therefore making payments against the program. This is the real problem. It is a very difficult problem. We just lack an adequate base of experience from which to make estimate.

Mr. KELLY. Mr. Laird, we do not have any interest in having anything but the best figure available. However, by moving into the medicaid area and owing to the change in the nature of provision of medical cost in welfare, we are in a new area and we have not learned to estimate it well.

Mr. LAIRD. The only thing is I do not want you people in the executive branch to play the old game of understating estimates. The legislative branch used to do this with these appropriations, too.

You know what I am talking about.

Mr. KELLY. I do, indeed. Let me say that when Social Rehabilitation Service comes up they will have the most current information available on how the estimates are now going compared with how we thought they were going to go. To the best of our knowledge these are good estimates. You do have a group representing the House Appropriations Committee now investigating the technique of estimating, and one of the areas that they are exploring is whether or

not we did endeavor knowingly to underestimate the assistance payments. I think they have found no evidence of this. But they will speak for themselves and report back to you. It is our responsibility to prepare the best estimates that we are capable of and to put them before you, with the best data that we have available. That is what we are going to try to do.

Mr. FLOOD. Go ahead.

SOCIAL SERVICES INNOVATION AND ADMINISTRATION

Mr. CARDWELL. If we might look at the next item, "Social services innovation and administration." There is an increase of about $128 million. First, let me describe what the item includes. State welfare agencies are required to provide certain social services and assistance to individuals to participating in the program. The Social Security Amendments of 1967 set up requirements, for example, for the local agencies to give attention to illegitimacy, to determining work capacities of adults in the family as well as older children in the family, and to family management, the management of resources, money management within the family, and that sort of thing.

Mr. FLOOD. Your line item says social services innovation and administration. What do you mean by innovation?

Mr. CARDWELL. This activity also includes assistance to State agencies to permit them to train their own personnel and also to engage in experiments and innovations in management. The $105 million would go to the area of illegitimacy, family planning, and strengthening of the family itself as a unit.

Mr. FLOOD. That would be dictated by the 1967 amendments to the Social Security Act.

Mr. CARDWELL. Yes. The "Rehabilitation services" line really describes programs of the Vocational Rehabilitation Administration within the new agency. The increase is $67 million. Of that amount, $59 million is for the basic grants, and about three and a half million is for the new authority enacted last year to provide rehabilitation services to migratory farmworkers.

MATERNAL AND CHILD HEALTH AND WELFARE

The next item, "Maternal and child health and welfare," is receiving high priority in the overall budget for 1969. There is an increase in appropriations of about $62 million. In obligations the increase is roughly the same.

Mr. FLOOD. Just yesterday the President sent a message to Congress further emphasizing child health.

Mr. CARDWELL. Yes. There are two significant items in this increase that I would like to call your attention to, and hope you would examine when you talk to the Social Rehabilitation Service. One is an increase of $18½ million for family planning purposes to reach about a million women in 1969. There is a $7 million item for pilot child comprehensive health centers.

Mr. FLOOD. I might add that this message to which I just referred, that was sent to the Congress yesterday by the President, includes an item further emphasizing family planning.

Mr. CARDWELL. The next item, "Mental retardation," shows a net decrease in appropriations of about $4 million. This relates to construction of university-affiliated mental retardation centers. The program level would go up in 1969 by $10 million, owing to the use of balances.

Mr. FLOOD. Use of unexpended balances?

Mr. CARDWELL. That is correct.

Next is the program of "Administration on aging." There is a $9 million increase there, about $6 million of which would be for the basic grants to States to assist them in developing programs for older citizens.

CHANGES IN 1969 BUDGET OF SOCIAL SECURITY ADMINISTRATION

TRUST FUND EXPENDITURES BY PURPOSE

[In millions of dollars]

	1968	1969
Retirement and survivors benefit payments	20,742	23,711
Disability insurance benefit payments	2,118	2,521
Health insurance benefit payments:		
Hospital insurance	3,369	3,865
Medical insurance	1,473	1,656
Administrative expenses	795	856
Payment to railroad retirement account and other	486	346
Total	28,983	32,955

MAJOR CHANGES IN THE 1969 BUDGET FOR THE SOCIAL SECURITY ADMINISTRATION

[In millions of dollars]

Federal funds	1968		1969	
	Appropriations	Obligations	Appropriations	Obligations
Retirement benefits for uninsured persons over 72			226	226
Hospital insurance for the uninsured	541	541	465	465
Supplementary medical insurance contributions	739	739	895	895
Military service credits	105	105	105	105
Total	1,385	1,385	1,691	1,691

MAJOR CHANGES IN THE 1969 BUDGET FOR OTHER HEW PROGRAMS

[In millions of dollars]

	1968		1969	
	Appropriations	Obligations	Appropriations	Obligations
Special institutions (Howard University)	36	37	37	47
	(26)	(29)	(29)	(38)
Higher education for international understanding			11	11
Public and educational broadcasting	5	5	33	33
General administration	21	21	29	29
Total	63	63	110	120

Mr. CARDWELL. We thought you might be interested in taking a quick look at the trust fund. There is an array of expenditures by purpose. We show that there would be an increase of about $3 billion in retirement survivors benefit payments and an increase in the dis-

ability insurance benefit payments of about $400 million. The health insurance benefit payments go up in 1969, partly owing to increased cost and partly to increased participation. In the case of the medical insurance portion, there is an increase related in part to the change in payment, the $3 to $4 increase that becomes effective in April. Administrative expenses will also go up in the Social Security Administration in 1969 because of a larger workload.

SOUNDNESS OF SOCIAL SECURITY TRUST FUND

Mr. FLOOD. As the result of an unfortunate article within the past year in an unnamed magazine of considerable circulation there has been generated a considerable fear among retirees under the social security system as to the security of the trust fund. If you are not in a position to comment on that, will you have the proper social security people indicate the facts?

Mr. COHEN. Mr. Chairman, in reply to that article, the title of which was, I believe, "How Secure Is Your Social Security," I prepared a rebuttal which I would be glad to insert in the record at this point.

Mr. FLOOD. I would like to have that at this point in the record.

(The information follows:)

STATEMENT BY WILBUR J. COHEN, UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Mr. Charles Stevenson's article on "How Secure is Your Social Security?" in the October issue of Reader's Digest is misleading, and in my opinion, creates anxiety and fears about the financing of our social security system that are groundless.

I state categorically that:

The social security system is soundly financed.

Present and potential future beneficiaries of social security will get the benefits provided by the social security law.

I

Mr. Stevenson begins his article by saying our "social security insurance is in trouble." This is not so.

The subtitle of Mr. Stevenson's article says that "Recent disclosures are raising grave doubts as to how much—if anything—today's taxpayer will get back when his time for retirement comes." Use of the words "disclosures," "grave doubts" and "if anything" can only result in worry to millions of people who are now drawing social security benefits or expect to draw them in the future. This worry is wholly without factual basis.

The article seeks to depict Chairman Wilber D. Mills and the ranking minority member, Representative John W. Byrnes, of the House Committee on Ways and Means as profoundly alarmed about the basic design and fiscal integrity of the social security program and about the course that the program is taking. The facts, however, are that as recently as 5 weeks ago these men jointly supported legislation in the House of Representatives, the Social Security Amendments of 1967 (H.R. 12080), which builds upon the present social security program and, with careful attention to actuarial soundness, makes needed improvements in the benefits of the program.

The implication that Representative Byrnes, the ranking minority member of the Committee on Ways and Means, agrees with the charges made by Mr. Stevenson flies in the face of the fact that Mr. Byrnes was a cosponsor of the social security bill now before Congress and is contradicted by his remarks on the floor of the House of Representatives during the debate on the bill. At that time he stated:

"I personally do not feel that the burdens imposed by this bill are greater than the taxpayers will be willing to pay. After all, today's taxpayer is tomorrow's

beneficiary. I was very glad to join the chairman of our committee in sponsoring the social security bill—a bill which gives due consideration to the needs of our elderly citizens as well as those who are called upon to pay the taxes."

Representative Byrnes went on to say that: "Everyone paying taxes today can do so with the knowledge that he is participating in a sound program of social insurance which will provide commensurate benefits in the event of his death or disability."

The House committee report on H.R. 12080, which was signed by 24 out of 25 members of the Committee on Ways and Means, bears ample witness to the care and thoroughness which the committee has devoted to assuring the continued soundness of the social security program.

The proposals contained in H.R. 12080 were considered during 18 days of public hearings over a period of 6 weeks, and during 64 executive sessions over a period of 16 weeks. Following debate, the House approved the bill by the overwhelming nonpartisan vote of 415 to 3. The bill reaffirms the soundness of the contributory, wage-related social security program.

The soundness of the social security system has been examined a number of times by groups of independent, nongovernmental representatives of business, insurance, labor, and the public.

In 1957, under the Eisenhower administration, an Advisory Council on Social Security Financing was appointed by Secretary Flemming. It reported as follows:

"The Council finds that the present method of financing the old-age, survivors, and disability insurance program is sound, practical, and appropriate for this program. It is our judgment, based on the best available cost estimates, that the contribution schedule enacted into law in the last session of Congress makes adequate provision for financing the program on a sound actuarial basis."

Among the members of the Council who made this statement were the President of a Federal Reserve bank, two actuaries—one from a private insurance company and one from a university—and representatives of business, labor, and professional groups.

The most recent Advisory Council on Social Security, again made up of outstanding experts in the field, examined thoroughly all of the issues connected with the "security" of social security. Like the preceding Council they concluded, in their report of January 1965, that the social security program is soundly financed and that its income—out into the long-range future—will be sufficient to meet its obligations.

Both Advisory Councils took note of such charges as those made in the article to the effect that social security taxes are used for purposes other than social security, that the trust funds contain only I O U's, and that the system is "in the red" by hundreds of billions of dollars. Both Councils found these charges to be without foundation.

II

The article says that the social security program puts a "squeeze on the young." This is not so. The fact is that even without taking into account that social security benefits have been and will continue to be increased from time to time as changes occur in wage levels and cost of living, young workers as a group will get social security protection worth 20 to 25 percent more than they will pay in social security contributions. This is the case under present law and would be the case under the House-passed bill and under the administration's proposal.

Young workers could not buy comparable insurance protection from private insurance companies at anywhere near the amount they pay for their social security protection.

The article takes no account of the fact that the benefits provided by the present social security law are very much lower than the benefits that will actually be paid when today's young workers reach retirement age. As wages rise—as they have throughout the history of the country—benefits can be increased without increasing the contribution rates. This is because the contributions are a percentage of covered payroll and because, as wages go up, income to the system increases more than the corresponding liabilities.

As a matter of fact, if benefits were not increased as wage levels rise over the years, the contribution rates scheduled in present law would be too high, and they could be reduced. Whether benefits are increased or contribution rates are reduced the result would be the same; namely, more protection in relation

to contributions than is shown by analyses that assume no change in wage levels and in benefits.

The calculations referred to in the article assume that the covered employee would have within his control an amount of contributions paid by his employers equal to the amount of his own social security contributions. This assumption rests on a misconception of the nature of the social insurance program and indeed the nature of private group insurance. If such an assumption were used, the whole fabric of private group life insurance, annuity insurance, and other forms of group insurance in this country would have to be regarded as inequitable.

As a general rule, under private group insurance plans the employer contribution is not allocated to each employee in an amount related to the employee's own contribution. On the contrary the employer contribution, as in the case of social security, is what makes it possible to pay larger benefits to workers and their survivors who are in the upper age brackets when the group insurance plan goes into effect than could be paid only on the basis of the worker's own contributions.

I believe it bears repeating that even without taking into account the fact that benefits will be increased in future years, even young workers covered under social security will get insurance protection worth 20 to 25 percent more than the value of their contributions, and moreover, they will actually do much better than that when account is taken of the fact that social security benefits can and will be increased as wage levels go up without any need to increase the contribution rate.

In deciding whether young people get their money's worth it must be kept in mind that social security provides not only retirement protection but also survivors and disability insurance protection. While Mr. Stevenson's figures do take into consideration the fact that social security provides protection against loss of income due to death and disability and also provides hospital insurance protection at age 65, most of his discussion ignores the importance of these parts of the program. That importance may be illustrated by an example: The value of the social security survivors insurance protection provided under the House-passed bill in the case of the worker whose earnings are about the median earnings of regularly employed men ($550 per month) who dies at age 35 leaving a wife aged 32 and two small children is about $56,000. Were this worker to become disabled at age 35, the value of the disability insurance protection to him and his family would be about $59,000.

Social security is a sound and equitable program for the young and the old.

III

Mr. Stevenson's article contains nearly two columns on the so-called *Nestor* case, decided by the U.S. Supreme Court in 1960 (pp. 76–77). Mr. Stevenson distorts the legal issues. He has several quotes which to a lawyer and a general reader would appear to be from the Court's decision. But they are not. He not only does not quote from the Court's decision but fails to mention that the Court decision reversed the contention of the Justice Department brief (prepared in the Eisenhower administration) that the program is not an insurance program. What the U.S. Supreme Court actually said was:

"The social security system may be accurately described as a form of social insurance, enacted pursuant to Congress' powers to 'spend money in aid of the general welfare,' whereby persons gainfully employed, and those who employ them, are taxed to permit the payment of benefits to the retired and disabled, and their dependents."

The fact is that the Supreme Court decision rejected many of the contentions made in the brief and stated that: "The interest of a covered employee under the (Social Security) Act is of sufficient substance to fall within the protection from arbitrary governmental action afforded by the due process clause."

Thus, as the Supreme Court stated, although the Congress can modify rights granted under the statute, it cannot do so in an arbitrary way. The right to benefits under social security, as the Court has said, is protected under the due process clause of the U.S. Constitution against denial or diminution by arbitrary Government action.

IV

The article attempts to show that social security is unsound by referring to unfunded outstanding obligations of $350 billion and stating that under the administration bill this amount will rise to $417 billion (pp. 79–80). The $350 billion referred to is the amount that would be needed—if social security were

a private, voluntary insurance program—to pay off all obligations on the assumption that there would be no new entrants into the system. The idea of there being a huge unfunded liability in the social security system is wholly meaningless and irrelevant for any practical purposes. There is no need in a Government program such as social security for funding on the basis referred to in the article. It would not only be unnecessary but also unwise to build up such a huge accumulation of social security funds. No life insurance expert nor social security expert, nor business nor labor organization, and no advisory council or committee of the Congress has ever recommended such funding.

The most recent Advisory Council on Social Security—an independent group of experts in the field which reviewed all aspects of the social security program over a period of 18 months—stated in its 1965 report:

"The Council is in agreement with the previous groups that have studied the financing of the program that it is unnecessary and would be unwise to keep on hand a huge accumulation of funds sufficient, without regard to income from new entrants, to pay all future benefits to past and present contributors. A compulsory social insurance program is correctly considered soundly financed if, on the basis of actuarial estimates, current assets plus future income are expected to be sufficient to cover all the obligations of the program; the present system meets this test. The claim sometimes made that the system is financially unsound, with an unfunded liability of some $300 billion, grows out of a false analogy with private insurance, which because of its voluntary character cannot count on income from new entrants to meet a part of future obligations for the present covered group."

V

The article is in error in saying that the social security changes recommended by President Johnson would take persons out of poverty "partly by raising the Federal income taxes" of other people over 65. (p. 79). Under the President's proposal, over 2 million persons would be removed from poverty (1.6 million aged 65 and over and 0.5 million under age 65) by the increase in the amount of the social security benefits—especially the increase in the minimum benefit from the present $44 a month to $70. There is no truth in the statement in the article that the method of removing these people from poverty would be through raising income taxes.

The article speaks disparagingly of the improvement of social security benefits for the purpose of reducing the number of persons on assistance or relief. But this has been the objective of the social security program since it was enacted in 1935. This was the original congressional intent. In fact, the carrying out of this intent has been one of social security's great achievements. The proportion of the aged on welfare has decreased from about 22 percent in 1950 to about 10 percent today. We hope to decrease the proportion to 5 percent. Increasing the level of social security benefits will aid in this objective.

VI

One more of the many inaccuracies contained in the article is the allegation in the article that social security contributions are put into the Treasury's general fund (p. 76). The fact is that the contributions are automatically appropriated by law to the social security trust funds, which are kept separate from one another and from the general funds of the Treasury and can be used only for the payment of the benefits and administrative expenses under the social security program.

VII

Mr. Stevenson says that the Government is discouraging beneficiaries from augmenting their incomes by collecting social security contributions with no comparable increase in benefits and by withholding benefits from those beneciaries who earn over $1,500 a year (p. 79).

The purpose of the social security program as determined by the Congress is to pay benefits when there is a loss of earnings because of death, disability, or retirement. The law prescribes a test—generally referred to as the retirement test—for determining whether such loss of earnings has occurred. The amount of the retirement test and whether there should be any retirement test is certainly a question which warrants discussion.

What Mr. Stevenson didn't say in his article is that eliminating the retirement test would increase the cost of the program by $2 billion a year. The addi-

tional cost would be incurred to pay benefits to about 2 million people, many of whom are fully employed and earning as much as they ever did. The vast majority of social security beneficiaries—some 20 million other persons—either are unable to work or cannot find a job and, therefore, would not be helped one iota by the elimination of the retirement test. Would this be an intelligent and equitable way to spend $2 billion a year additional?

The author's statement that beneficiaries who work and pay social security contributions get no comparable increase in benefits may give the impression that this work cannot increase their benefits or that, if it can, the benefit increases are insignificant. The fact is that the beneficiary who works can get a benefit increase if he has even just a single year in which his earnings are more than his earnings in any one of the past years that were used in computing his benefits.

In short, Mr. Stevenson didn't tell a full or fair story on the retirement test.

VIII

The article concludes that further study of and basic changes in social security are called for. Some of the concluding remarks are repetitions of misleading assertions made earlier and some go further.

The article raises a number of questions about what will happen to the social security program in the future after whatever temporary tinkering the House and Senate may do regarding the President's program—as if the House and Senate are not comprised of the elected representatives of the American people and as if the President is not responsible to the American people. It is through such processes as the article calls congressional deliberation and debate—that this Nation builds its public programs, orders its economy, and carries on the affairs of Government, and this will doubtless be true in the future.

The article goes on to suggest, on the basis of the increases in social security contribution rates that have been enacted over the years, that private pensions may not be able to remain afloat. Such scaremongering ignores the fact that social security has not prevented the rapid growth of private pensions. Private pensions have made tremendous strides since the 1930's, when social security began. There were only about 400 private pension plans in 1935 when social security was enacted. Today there are over 60,000.

With regard to Mr. Stevenson's proposal to establish a "blue ribbon commission," over the years since the Committee on Economic Security submitted its report to President Roosevelt and the original Social Security Act was enacted in 1935, there have been numerous independent studies of social security by advisory councils composed of highly respected and knowledgeable citizens. For instance there was an Advisory Council Report in 1939, 1948, 1959, and 1965. Since 1956, studies by advisory councils have been provided for in the social security law itself, and there have been periodic studies by these councils. Through the councils, consisting of representatives of employees, employers, the self-employed, and the general public, the social security program has had the benefit of a great deal of intelligent and thoughtful examination. Under the law, the next advisory council, scheduled to be appointed in 1968 (under the bill recently passed by the House, it would be appointed in 1969), will review all aspects of the social security program including the status of the social security trust funds in relation to the long-range commitments of the program and will make a report of its findings and recommendations to the board of trustees of each of the social security trust funds and to the Congress.

IX

Mr. Stevenson has not clarified any fundamental issues. He has not pointed out the great unmet social needs. What he has done has been a great disservice to the millions of social security beneficiaries and the millions who are counting on social security benefits in the future. He has obfuscated and confused the major policy issues in social security. A critical and constructive review of social security would be welcome. A glib and superficial attack on a program so important to millions of Americans is not a contribution to the American people.

Mr. COHEN. I might say, Mr. Chairman, as I point out in the article citing the chairman of the Ways and Means Committee in connection with this, the Ways and Means Committee, which has substantive jurisdiction over this program went into the matter of the financial and actuarial soundness of the social security system comprehensively as they have done each time. The program is both actuarially and financially sound.

The major difficulty arises, as you know, because of the reference in the article that if the system were a private insurance system it would have to have something in the nature of $350 billion more reserves than it has now. Of course, the Congress and these committees have always said that a social security program handled by Congress does not have to be financed the same way a private insurance company is. You have to assume a private insurance company might go out of business. Therefore, private insurance companies always have to have enough reserves to pay off all their liabilities.

The difference between the way the social security system is handled and the way private insurance is handled has created a great deal of misunderstanding. Both Members of Congress and our Department received hundreds and hundreds of letters from old people who thought their social security was going to be stopped because it was actuarially unsound. We did our best to try to persuade them that was not true.

Mr. SMITH. They publish that same kind of story about every 3 years. President Eisenhower had a blue-ribbon commission including some top executives in the insurance industry and they found just what you said to be the fact.

Mr. COHEN. Yes, sir. Senators Harry Byrd and Russell Long have been chairmen of the Senate Finance Committee that has handled this legislation on the Senate side for many years, and Mr. Doughton, Mr. Cooper, and Mr. Mills, have been chairmen of the Ways and Means Committee over the 30 years that the system has been in effect. I think if you know those gentlemen you can appreciate that they saw to it each time that the system was amended it was kept actuarially and financially sound.

The actuarial reports of the system, the reports during the Eisenhower administration and subsequent reports all show that the Congress has been very conscientious, extremely so, in assuring that the final bill that passed always provided enough income over the total future of the system to take care of all the future estimated liabilities.

You have the problem of estimating, as Mr. Laird mentioned a few moments ago, but Congress has provided for periodic reaxaminations of the finances of the system. As you all know, Congress has always adjusted the income and the outgo in relation to its experience.

Mr. LAIRD. Mr. Chairman, I think it would be interesting, because of the significant effect it has on the budget deficit in the new presentation—and I am for the new presentation of the budget—to show the receipts of the trust funds along with the expenditures. The receipts, I think, this year will total between $5 and $6 billion more than

expenditure from the trust funds. Those receipts now are used to offset general budget expenditures for the first time in the 1969 budget. They will show up as a cash income and will offset $5 billion worth of general obligations other than trust fund expenditures for the first time.

Mr. KELLY. They do show on chart 4.

Mr. MICHEL. As far as the social security trust fund is concerned, that chart shows a difference of $4 billion, plus.

Mr. LAIRD. Yes, but there are other trust funds. I think it is closer to 5 or 6 billion that was picked up in total to offset the budget deficit.

Mr. CARDWELL. So that we might move on, I would like to make two more points about this item.

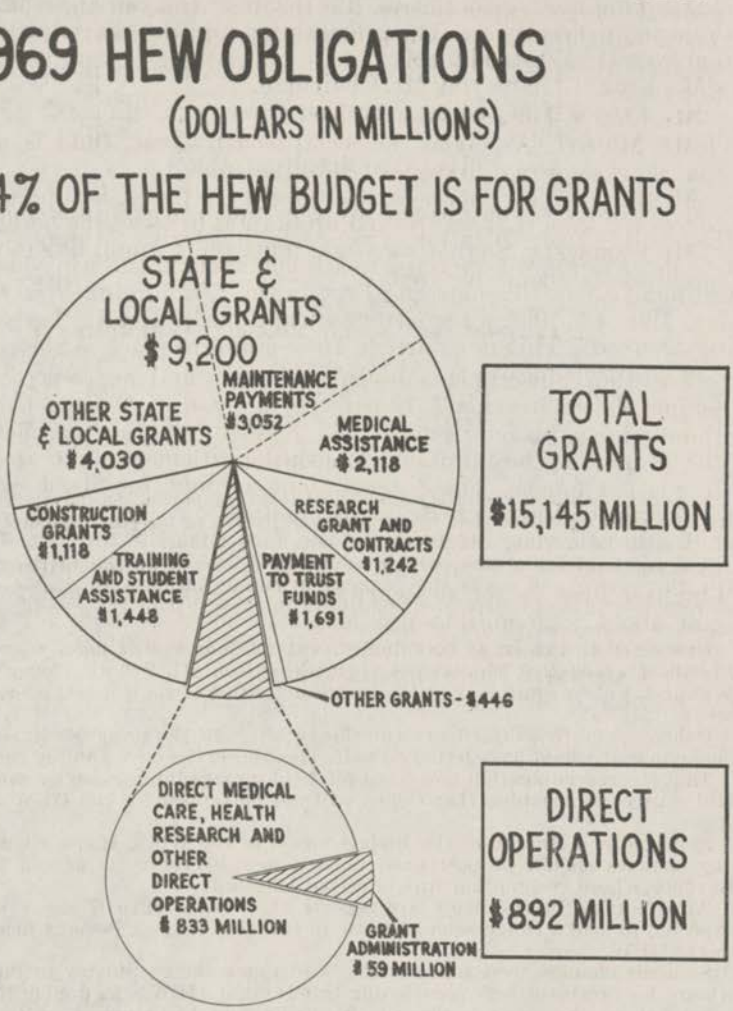
EFFECT OF 1967 SOCIAL SECURITY AMENDMENTS

The 1967 amendments become effective and are reflected in this budget. They provide a 13-percent increase in benefits this year to those who receive retirement and survivor's benefit payments under the program. The minimum monthly entitlement went up from $44 to $55 per month. These items alone account for about $2.6 billion of that $2.9 billion increase on the first line.

I also call your attention to the fact that the number of persons to be served by the program will go up by about a million in 1969. One last item on social security, the Prouty amendment which will cost about $226 million provides retirement benefits for uninsured persons over age 72. It becomes effective the first of 1969.

Mr. CARDWELL. There is one last chart.

DISTRIBUTION OF HEW BUDGET BY TYPE OF RECIPIENT INSTITUTION



Mr. CARDWELL. This chart attempts to take the HEW budget and break it down to show how much of it goes from the Federal Government to other institutions, State and local governments, colleges and universities, medical schools and wherever. About 94 percent of the total budget in 1969 will go out in the form of grants and assistance to other institutions, a total of $15,145 million of general funds. Direct operation would account for about $692 million of the budget, something around 6 percent.

Mr. FLOOD. Both of these presentations by the fiscal officers and these charts were most informative. The charts were better prepared than those you generally see. The presentation and the charts were so clear that even I understood them.

Mr. KELLY. Thank you, Mr. Chairman.

Mr. FLOOD. Now, as between you three, you can field these questions as you see fit.

HEALTH REORGANIZATION

Mr. Secretary, you did not say very much in your statement about the pending reorganization of your health activities. I wrote this question down because I expected to ask you about this during yesterday's testimony. Now this morning I see in the Washington Post for Tuesday, March 5, 1968, a news story encaptioned, "Health Agency Shifting Shelved." This news article I am going to place in the record.

(The article follows:)

HEALTH AGENCY SHIFTING SHELVED

(By Eve Edstrom)

President Johnson yesterday shelved at least temporarily a mammoth regrouping of health activities that was a prime objective of his just-resigned Secretary of Health, Education, and Welfare John W. Gardner.

The reorganization plan, which would have broken up the sacrosanct Public Health Service and made the research-oriented National Institutes of Health more powerful and independent had been in the draft of the President's health message as late as Friday of last week.

But when the message was finally sent to Congress at noon yesterday, the President asked that no changes be made within HEW until Under Secretary Wilbur J. Cohen could look at the health activities of the entire Federal Government.

Cohen, as much as Gardner, was the architect of the proposed internal HEW shakeup that would have left the Public Health Service as a holding company.

That the reorganization now has been held up was interpreted by some Capitol Hill sources as meaning that Cohen will not be tapped for the HEW Secretaryship.

Reportedly, a Bureau of the Budget memo to the White House suggested that any changes should be postponed until a new Secretary is named to succeed Gardner whose resignation was effective March 1.

Also figuring in the delay are reports that Rep. Edith Green (D-Oreg.) is expected to lead a congressional battle to transfer War on Poverty health activities to HEW.

So many changes were made in the health message on Sunday in Puerto Rico, where the President was vacationing briefly, that HEW was unable to schedule a briefing on the message prior to its being sent to Congress, as is the usual custom.

Instead, Special Presidential Assistant Joseph A. Califano, Jr., conducted a briefing in Puerto Rico on Sunday. HEW's briefing was not held until 6 p.m. yesterday, principally because no copies of the message were available here until the President's early afternoon return, and partly because Cohen was testifying on Capitol Hill.

Brushing aside the much-publicized Gardner-Cohen reorganization plans, the President's message merely directed HEW's Secretary "to submit to me a modern plan of organization to achieve the most efficient and economical operation of the health program of the Federal Government." The President also recommended the Health Personnel Act of 1968 to modernize HEW's health personnel system.

In discussing the health organization plan, Califano said it would be begun "at least for the time being" by Cohen.

Cohen, in response to a reporter's question, said he believed the President's proposed study could be accomplished "expeditiously," possibly within 30 to 60 days. The study would not focus on whether HEW should take over existing

programs but on future interrelationships with such agencies as the Defense Department or the Veterans' Administration, which operates the largest medical care services in the world.

This same view was shared by Dr. Philip R. Lee, Assistant HEW Secretary for Health, who was slated to be in command of the reorganization. He would have been elevated to a new Under Secretaryship for Health, if approved by Congress.

Postponement of the reorganization also was a blow to Assistant Surgeon General James A. Shannon, Director of the National Institutes of Health.

Shannon had emerged as the victor in the now-shelved reorganization plan, having won his long-sought goal of bringing health manpower activities as well as medical education under NIH's wing. Medical men who agree with Shannon that support of medical schools should come under NIH reportedly urged the White House to press forward with the reorganization plan.

Mr. FLOOD. We would like to have your comments, Mr. Secretary.

Mr. COHEN. Mr. Chairman, in my statement which I completed on Friday, I had written as follows:

The second major change is still under discussion. Its purpose is to strengthen and improve the coordination of the Department's scattered health programs by giving the Assistant Secretary for Health overall direction and policy responsibility for health programs. The new alinement will group our health activities under three major subdivisions, research, health services and environmental health, and consumer protection. This arrangement will give us greater flexibility in dealing with the States and communities, hospitals, and universities, and the health professions. We hope, too, that it would serve to improve the delivery of health services to the people who are most in need of health care.

This health reorganization which has been worked on very extensively and very carefully over many months had both Secretary Gardner's and my complete approval.

We did submit it as we do in all of these efforts to the Bureau of the Budget for their review and consideration. I believe that the major question that arose at the time the health message was coming up was what about the health reorganization of these functions in HEW in relation to other health functions in other places in the Government.

Mr. FLOOD. Such as the Department of Defense and the Veterans' Administration.

Mr. COHEN. That is what the newspapers say. In my opinion another important one is the Office of Economic Opportunity. The question was raised in discussions with the Bureau of the Budget about the relationship between the health functions and the neighborhood health center, family planning, and the total OEO health services.

POSSIBLE TRANSFER OF OEO FUNCTIONS

Mr. FLOOD. Of course, you are aware that there is an effort of some substance being made in the House this session to transfer certain of those programs, if not all of them, to HEW.

Mr. COHEN. Yes, I am very well aware of that. That is one of the questions the Bureau of the Budget asked—what our view would be on those kinds of questions.

Mr. FLOOD. I ask you the same thing.

Mr. COHEN. My own personal opinion, and it represents only my personal opinion, is that there may be merit in the transfer of the OEO health functions to HEW. Let us consider first the family planning activities that they now engage in. Congress has by explicit statutory authority in both the aid to dependent children program and the maternal and child health program now given HEW that responsibility.

It might be wise, both in connection with the economy and efficiency of administration and simplification for the States and communities, at some point along the line to consider putting those together with what OEO is doing.

Similarly, the question of the neighborhood health centers. The OEO has developed what I think is a very splendid—I commend them for their innovation and development—system of approximately 40 neighborhood health centers that are now being developed. But it would seem to me at some point that they might be more closely interrelated with what the Public Health Service is doing.

Mr. FLOOD. What is a neighborhood health center?

Mr. COHEN. A neighborhood health center is a unit, usually in a very highly congested urban area, in which people can walk in and obtain services in that center. If services are not available immediately there persons can be referred to the proper place without having to go to five or 10 different places and lose a great deal of time and energy.

In effect, the President has now asked us to look at our plan in terms of other health activities that are now administered by other agencies of the Federal Government, and see to what extent, if any, those should be brought into alinement with our proposal.

Mr. LAIRD. Some of the States are doing that right now, and going ahead and bringing them together.

Mr. COHEN. I think one of the most significant things that has happened has been the development of State departments of health and welfare. Within Wisconsin, for instance, as well as eight or 10 other States this new development has brought all of the agencies in the State that relate to health and welfare together under a single commissioner. These departments then have subdivisions, you might say, somewhat like we have in HEW—commissioners for different areas. I think the reason for this is the development of the medicaid program which is a method of financing medical care for the indigent. This program has both health and welfare aspects. Medical services for indigents have traditionally been provided in the welfare departments because they were taking care of indigent people. But these programs have a high component of medical care. Many States are developing new single agencies which administer both health and welfare programs and in some cases programs in vocational rehabilitation and aging also.

I think quite frankly, Mr. Chairman, this is not only the trend of the times but it is also a method of State administrative organization that I have recommended to the Governors and suggested they consider very carefully. I think it is a well-conceived idea.

EFFECT OF HEALTH MESSAGE ON PROPOSED REORGANIZATION

Mr. FLOOD. Just what is the import of the President's message as it affects the public Health Service reorganization? Is it just put on the shelf?

Mr. COHEN. Mr. Chairman, I think the President's message has not shelved the plan in any sense. I think it has postponed it until we can complete the action I described. It is my hope that I can make a report to the President within the next 30 to 60 days on this matter.

Mr. FLOOD. It is suggested that your reorganization plan would have placed health-manpower activities as well as medical education under the wing of the National Institutes of Health. Did the reorganization plan contemplate that?

Mr. COHEN. Yes, the proposal we had under discussion contemplated that. I would say, Mr. Chairman, there are many factors to take in mind in that kind of consideration. In connection with the manpower aspect it has seemed to me that one of the great problems in the recruitment of health manpower—doctors, dentists, nurses, medical technicians—is closely related to the academic community. One must consider very carefully the relationship of educational institutions to the recruitment of medical manpower.

Mr. FLOOD. Your reorganization would in effect put all the support of medical schools under the wing of NIH?

Mr. COHEN. That was one of the factors that was considered. I think the recruitment of medical manpower is so important, and the National Institutes of Health has done such a distinguished job in past years of working with the higher education institutions that we could perhaps accelerate the recruitment, training development, and expansion if we gave the NIH this program.

EFFECT OF REORGANIZATION ON CHILDREN'S BUREAU

Mr. FLOOD. Will the health and medical programs of the children's bureau be affected by this reorganization?

Mr. COHEN. In the plan that Secretary Gardner and I had proposed we made no change in the organizational status of the Children's Bureau, or in the programs now administered by it. However, all of the medical groups we met with in the organization urged as a matter of principle that health programs be transferred from where they were now to be more closely interrelated with the other health services. Here is one of those issues on which there is a good deal to be said on both sides of the question. There is a very, very strong constituency that believes the Children's Bureau should continue to administer these programs and the Children's Bureau should be kept intact with its medical, social service, and juvenile delinquency activity. I have to say to you quite frankly when I was Chairman of President Kennedy's Task Force on Health and Social Security in 1960, I did recommend at that time transfer of the health functions of the Children's Bureau to the PHS. All I can say to you is that a ton of bricks fell on me before I could even make any presentation of my point of view. They said, "Why are you against children?" Of course, that reorganization proposal never even got half way to first base—it was dead.

Mr. FLOOD. It never got off the ground.

Mr. COHEN. That is right. I think the situation now, 7 years later, is possibly a little different.

Mr. FLOOD. It would be only half a ton of bricks this time.

Mr. COHEN. It would still be maybe a half a ton of bricks. I would not, at this moment, recommend transfer of the Children's Bureau activities to this new organization just to save the Members of Congress the vast amount of mail that would come in from all over the country if such a proposal were made. I think you recall that in the Social and Rehabilitation Service reorganization we thought of trans-

ferring the crippled children's program out of the Children's Bureau to be put in with the vocational rehabilitation, so they could be merged. There was such opposition against that from practically all of the States and all of the professional people that the Senate wrote in an amendment to prohibit this, but the amendment was taken out in conference. On that basis, we never made the transfer. That is just an illustration of the very, very strong feeling that people have about this.

Mr. FLOOD. It is good to know that your antennas are so finely attuned to the public will.

Mr. COHEN. After two or three experiences that occurs.

Mr. LAIRD. We have another Wisconsinite here in town that works very hard on this. Her name is Kathryn Lenroot. She was the original Children's Bureau Chief and she was able to stimulate quite a bit of effort.

Mr. COHEN. She certainly did. She and Martha Elliott, who succeeded her. Maybe I should tell you a little about their point of view.

Both Mrs. Lenroot and Martha Elliott take the position that if children's interests are to be carried out in terms of Federal programs, there must be a strong, independent, comprehensive unit in the Government that looks after their interests. This was the idea I believe President Taft and President Theodore Roosevelt had back in 1912 when they set up the Bureau. To have a focus, to have a place that speaks for the children like the Veterans' Administration speaks for the veterans and the Railroad Retirement Board speaks for their people.

They feel very strongly that it should remain comprehensive and complete and not be split up. I think there are a good many people in the country who share that point of view.

REORGANIZATION AND PRIVATE INTEREST GROUPS

Mr. FLOOD. There have been comments in the press to the effect that this proposed reorganization you have planned would diminish the influence of what are known as private pressure groups. If it would, how would it, or do you disagree with these statements?

Mr. COHEN. If I understand your question correctly, I do not believe it would have any significant effect either for or against the status of private interest groups.

Mr. FLOOD. I don't think the press, and certainly I do not use the phrase "private pressure groups" in a sense of aspersion. One of the good things about your program over the last x number of years has been this extraordinary generation of interest in the private sector of all types and kinds of programs.

Mr. COHEN. I favor the participation of the private interest groups. After all, we are spending taxpayers' money in the development of this program. I always felt that they have a right as well as a duty to express themselves and give an indication to both the legislative and executive branches as to what they think is important, what they think is unimportant, where the priorities are, and how we can do the program better.

Mr. FLOOD. There is nothing in this reorganization proposal to muzzle them or cut the legs out from under them.

Mr. COHEN. If there were, I would be opposed to it, Mr. Chairman, because I think the participation of these people in these programs is what makes it acceptable to the people in the local community.

REDUCTION OF MEDICAL COSTS

Mr. FLOOD. There have been a number of comments, I am sure you know, that one of the benefits to be gained from the reorganization would be a reduction of medical costs.

This is in the front of everybody's mind. How would this proposed organization contribute to such savings?

Mr. COHEN. In terms of the total medical costs throughout the country, our major effort is in the development of the National Center for Health Services Research and Development. What we need to do is to raise the stature of, give some additional funds to, and recruit people for a program totally focused on how to bring a greater degree of economy and efficiency into health services. You will recall in my earlier statement when we discussed this question that I suggested a number of ways in which we could work. One way is to redesign hospitals so that the use of nurses and other personnel is more efficient. Another way is to develop extended care facilities, skilled nursing homes, and intermediate care facilities so that individuals are not placed in the most expensive type of institution simply because another less expensive type of institution was not available. For instance, Congress this last year created——

Mr. FLOOD. Or frequently not placed in them at all in a certain number of cases.

Mr. COHEN. Yes; that point involves social and ethical considerations. If they were not placed in them at all, and they were at home, they might die sooner, but there would not be a cost.

Mr. FLOOD. I am speaking of unnecessary hospitalization.

Mr. COHEN. As I said yesterday, the experts seem to agree that there are a lot of people who are hospitalized unnecessarily.

Mr. FLOOD. I have just said that.

Mr. COHEN. Your point is corroborated by people who have worked in the field. We must begin to focus on outpatient care, so that diagnosis and treatment for outpatient care will occur.

Mr. FLOOD. We agree. Where in the reorganization plan do you contribute to this?

Mr. COHEN. We have placed this center I am talking about, which would have this responsibility, as a key element in the reorganization. What I am saying is, by giving increased support and increased prestige to these efforts we can accelerate this type of development.

Mr. FLOOD. I have before me from the Washington Post of Tuesday, March 5, and of March 4, two separate articles dealing with medical costs. The March 4 article, entitled "President Asks Curbs on Medical Cost Rise," embraces many of the things you are talking about. The March 5 article in the same paper is captioned "LBJ Asks Price Lid on Drugs—Curbs Sought on Those Used in Medicare."

(The articles follow:)

LBJ Asks Price Lid on Drugs—Curbs Sought on Those Used in Medicare

(By Victor Cohen)

A tight lid on the prices the Government will pay for prescription drugs in medicare and other Federal programs was recommended yesterday by President Johnson.

In his health message, he asked Congress to authorize establishment of a "reasonable cost range" for drug reimbursement in medicare, medicaid and maternal and child health programs.

This would "make certain," he said, "that the American taxpayer does not pay needlessly high and exorbitant prices" for the drugs in these programs.

WIDER IMPACT SEEN

Experts in health economics say the proposal—the passion of Senator Russell Long, Democrat, of Louisiana—would almost certainly have a much wider impact.

Special Presidential Assistant Joseph Califano said yesterday the administration feels drug firms will lower their prices to everyone, rather than risk losing any federally financed business.

The proposed lid could not go on until 1970. It will take that long, officials said, to study the effectiveness of all drugs and establish which make in each case is both most reasonably priced and effective.

PROTECTIONS ASKED

The President proposed three other steps to control costs of medical care and protect patients:

He directed the Secretary of Health, Education, and Welfare to begin extensive tests of "incentives" to prevent unnecessary hospitalization and to control hospital costs by encouraging efficiency and penalizing waste.

He asked Congress to authorize new payment methods to encourage this new efficiency. He did not use the terms "financial incentives" or "financial penalties," but many hospital men have been discussing these methods.

He asked Congress to authorize publication this year of a "U.S. Compendium of Drugs."

This would cost $6 million a year to prepare and keep up to date.

FDA Commissioner James L. Goddard has leaned toward such a compendium to replace commercial sources that doctors now depend on for drug information. But Goddard has said telling doctors what brand of drugs to prescribe for federally financed patients would "encroach" on medical practice.

As the President put that idea yesterday, the doctor would be "free to select more expensive drugs of the same quality and effectiveness if he chooses," but the Government would pay only the approved cost.

Thus patients could be expected to howl if doctors prescribed the more expensive drugs.

The President's cost-cutting proposals were by far the most spectacular part of his message.

It covered much other ground, however, with four other major goals. Together, these would increase Federal health spending from $14 to $15.6 billion a year—but some $8 billion of the present sum is for medicare and medicaid.

The President's other major goals were:

1. "To reduce sharply" the Nation's "inexcusably high rate of infant mortality."

Here, he recommended a $58 million increase in fiscal 1969 spending for maternal and child health programs, $25 million of it to expand maternity and infant centers and clinics.

He proposed a Child Health Act of 1968 to supply authority "to provide comprenhensive medical care for every needy mother and her infant."

He asked $1.4 billion, a $215 million increase, for child health services. Much of this would be spent in poverty areas.

He asked a boost in family planning—birth control—funds from $25 million in fiscal year 1968 to $61 million in 1969. He has directed the HEW Secretary to start a Center for Population Studies and Human Reproduction in the National Institute of Child Health at Bethesda, and asked $12 million for its first year.

2. "To meet the urgent need for more doctors, nurses, and other health workers."

Here, he asked a Health Manpower Act, of 1968 to build classrooms and other facilities to train health workers; to expand enrollments and improve curriculums; and strengthen loan, scholarship, and other financial aid programs. He asked $290 million for these.

He asked $195 million to continue a 2-year-old partnership for health program—it supplies funds for State and regional health planning.

He sought $100 million to double spending on regional medical programs to improve heart, cancer, and stroke treatment and training.

3. To lower the "shocking" accident death toll. He directed the Secretaries of Transportation, HEW, and Defense to devise an experimental program—perhaps using helicopters—to help States design better ambulance and rescue systems.

4. To launch a "Nationwide volunteer effort to improve the health of all Americans."

Here he asked State and local governments, private health businesses, and groups of all kinds to join in a many-sided effort, including medical examination of every child under age 5; expansion of private health insurance; new local health centers, and physical fitness programs.

He announced a new President's Council on Physical Fitness and Sports, a Cabinet-level group chaired by Vice President Hubert H. Humphrey.

Commenting on the President's proposal for a drug price lid, C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, asked that "price alone not be the only consideration" in picking drugs. "Quality too must be maintained" so Federal aid recipients "do not become second-class citizens," he said.

PRESIDENT ASKS CURBS ON MEDICAL COST RISE

(By Garnett D. Horner)

President Johnson today proposed a $15.6 billion health in America program, including a call for Government action to take the lead in stemming soaring costs of medical care.

He told Congress that the Government should not, in effect, approve "robbery of private citizens" by OK'ing payment of $11 for a drug used in federally supported health programs if a $1.25 drug is equally effective.

In his special message to Congress, Johnson proposed some new programs and expansion of many existing ones in a comprehensive drive to assure every American the right to better health and efficient medical care.

He dispatched his message from his weekend working holiday retreat at Ramey Air Force Base, P.R., before taking off in midmorning for a flight to Washington. It returned him to the White House early this afternoon.

Johnson demonstrated at the Strategic Air Command outpost in the sunny Caribbean that he may be learning, during his fifth year as Chief Executive, to relax somewhere besides his Texas ranch.

For the first time since he became President, he had traveled far from Washington to a place other than his ranch to take as much of a "day off" as a President can get.

He seemed to enjoy thoroughly his stay there from late Saturday until this morning. He appeared thoroughly relaxed and in fine fettle as he quit the golf course only after darkness fell on both Saturday and Sunday nights.

But his weekend was not all play. He did considerable work on the health message, which included these five "major new goals":

"1. To reduce sharply the inexcusably high rate of infant mortality in the United States.

"2. To meet the urgent need for more doctors, nurses, and other health workers.

"3. To deal with the soaring cost of medical care and to assure the most efficient use of our health resources.

"4. To lower the shocking toll of deaths caused by accidents in America.

"5. To launch a nationwide volunteer effort to improve the health of all Americans."

$50 BILLION COST CITED

Johnson noted that nearly $50 billion a year is spent in the United States for health. The Government is paying $14 billion of that amount this year, up from $5 billion 4 years ago, he said. And Federal expenditures for health are budgeted at nearly $16 billion in the 1969 fiscal year.

These figures include costs of medicare and medicaid.

His most specific proposal to help stem rising medical care costs was aimed at the drug industry. He asked Congress to authorize the Secretary of the Health, Education, and Welfare Department to "establish a reasonable cost range to govern reimbursement for drugs now provided under medicare, medicaid, and the maternal and child health programs."

This action would not affect directly what an individual not benefiting from those programs would pay to get a prescription filled. But administration officials hope HEW's "reasonable cost range" for drugs—when set, probably not before 1970—would serve as a guideline that could drive down "exorbitant" drug prices generally.

"We must make certain," Johnson said, "that the American taxpayer does not pay needlessly high and exorbitant prices for prescription drugs used in federally supported programs.

"Recent surveys have shown, for instance, that 12 drugs of the same type range in retail price from $1.25 to $11 for 30 tablets.

"The taxpayer should not be forced to pay $11 if the $1.25 drug is equally effective," Johnson continued. "To do this would permit robbery of private citizens with public approval."

Under his proposal, a physician would be free to select more expensive drugs of the same quality and effectiveness if he chose, but reimbursement under the Federal program would be limited to the payment range established by HEW.

Saying that "it is appropriate that the Government—which pays more than 20 percent of the Nation's medical bill—take the lead in stemming soaring medical care costs," Johnson also asked that the HEW Secretary be authorized to move toward holding down rising hospital costs.

"We must test incentives designed to control the cost of hospital care," he said.

Under his proposal, HEW would have authority to "employ new methods of payment as they prove effective in providing high quality medical care more efficiently and at lower cost" in the medicare, medicaid, and maternal and child health programs.

Presidential Assistant Joseph A. Califano, Jr., said several formulas could be explored. Currently, hospitals are reimbursed on a cost-plus basis for care for patients under the Federal programs.

Noting that a recent survey showed a variation of as much as 100 percent in the rate of 10 leading hospitals, Califano said that, for example, HEW could pay a medicare patient's hospital bill on the basis of the average cost of similar hospitalization or fees could be negotiated.

Calling for exploration of ways to prevent unnecessary hospitalization, Johnson said all cost-cutting tests require cooperation of doctors, hospitals, and insurance companies.

In a move toward preventing "senseless and unnecessary" deaths from auto and other accidents, Johnson said he is directing the HEW, Transportation and Defense Secretaries to devise a test program to help States and communities develop effective rescue systems."

Noting that military experience in Vietnam has shown that the lives of many injured persons can be saved by prompt medical attention, Johnson said that in the case of accidents in the United States:

"The compelling need is for modern, effective rescue systems to give immediate attention to accident victims—on the spot and while they are being sped to hospitals."

Johnson said he has directed HEW to establish a Center for Population Studies and a Human Reproduction in the National Institute of Child Health and Human Development. He asked $12 million to finance research activities in the center's first year of operation.

Aims of this research would include improvement of birth-control methods, providing family planning information for those who want to, and helping "thousands of others who are unable to have the children they desire."

Johnson asked an increase from $25 million in the current fiscal year to $61 million in fiscal 1969 "so that 3 million women can have access to family planning help if they so desire."

He also called for a new Health Manpower Act of 1968 to combine and expand five existing laws in this field to promote "better and faster" training for more health workers.

He advocated a new formula for Federal grants to medical schools to encourage an increase in enrollments and graduates.

OTHER PROPOSAL

Other recommendations in the message included:

A new Child Health Improvement and Protection Act aimed at assuring "comprehensive medical care for every needy mother and her infant" by 1973.

A $58 million increase in appropriations for the maternal and child health care programs in fiscal 1969.

Appropriation of $1.4 billion—an increase of $215 million—for child health services under medicaid and other Federal health programs.

$1.5 billion for health research to pave the way for more "breakthroughs."

Publication of an official U.S. Compendium of Drugs—available not only to doctors and pharmacists but also to the general public—that would contain "complete and accurate" information about prescription drugs.

Extension of regional concentration of resources to attack heart disease, cancer, stroke and related illnesses, increasing funds by almost 100 percent to $100 million.

INCENTIVES TO CONTROL MEDICAL COSTS

Mr. FLOOD. These articles discuss many of the things you mentioned in your affirmative statement yesterday. I see in the President's statement, so this paper reports, the suggestion that HEW begin extensive tests on "incentives" to prevent unnecessary hospitalization and to control hospital costs by encouraging efficiency and penalizing waste.

Mr. COHEN. Yes, sir.

Mr. FLOOD. What is an incentive to control costs, and how would you penalize waste? I am sure you have thought about this.

Mr. COHEN. Yes, sir.

Mr. FLOOD. There are two things here. What is an incentive to control costs and how do you penalize waste? I serve on two hospital boards and I would like to know.

Mr. COHEN. First, let me tell you what the statutory base is, and what the President proposes. Then I will answer your question in relation to these points.

Last year Congress passed section 402 of the Social Security Act. This was a provision added by the Ways and Means Committee. It authorized the Secretary to engage in experiments with hospitals, nursing homes, and physicians to discover ways and means of reducing costs. The President has now proposed an amendment to this provision, to provide that as soon as one of those experiments has been completed and shown it to be feasible, if the law were so amended, the Secretary could put that into effect immediately. Those are the two statutory provisions. Now to answer your question, the present method of reimbursing hospitals under both medicare and medicaid sometimes has been called a cost plus formula. By that oversimplification it is meant that if the hospital increases its cost, and it is a reasonable cost in connection with the law, we are required to pay that cost. So if the hospital had some new type of service, if it raised the wages of its nurses, if it put in some new equipment and that increased cost, we are required to pay for it.

The objection has been made to that reimbursement formula is that it has no dampening effect upon the institution to keep costs within

control because if the institution raises costs it will be reimbursed through medicare and medicaid for whatever it costs. There are several ways we could experiment to reduce the cost.

Mr. FLOOD. Are you thinking of financial incentives and financial penalties?

Mr. COHEN. Yes, sir.

For instance, one that might be typical would be for the hospital to present a budget for a given year and for us to go over that budget just like this committee does in connection with our budget. After the budget is approved for a particular item we might say that if the hospital can reduce costs below that item in the budget we might let it keep half or a third or two-thirds of the savings, whatever might be worked out.

Mr. LAIRD. A kind of negative income tax.

Mr. COHEN. I would not call it that. The idea would be to try to stimulate them to control costs. I will give you another illustration where I think there are possibilities of economy. Suppose there were 10 hospitals in a community, and they got together and formed a corporation or a foundation or a unit, either public or private, and bought all their food or bought all their supplies from one unit. Suppose that by doing so they could reduce the cost of either the food or the linen or the laundry or whatever it is by 10 percent. If they did that over a period of time, we might say to them let us take 8 percent of that savings and you keep 2 percent, so you have a financial incentive to introduce these economies.

Mr. FLOOD. What would be a financial penalty? What would they be penalized for?

Mr. COHEN. A financial penalty might be something of his sort: There are 10 hospitals in the community, and by a survey you discover that you need only one cobalt unit for the community because there is only one patient a day that needs it and you can transport them. Hospital No. 2 says we are going to put in our own cobalt unit and it will cost $50,000. We might say if you put that in, we will not count that service cost either for amortization or service under medicare. That would be a penalty for including the machine. I might say that is a very controversial item. We proposed it in actual statutory legislation last year in this form. We said that before a hospital could get paid for any type of equipment over $50,000, or for any new construction, they would have to have that new construction or equipment approved by the State health department. If it were not approved, we would not pay for the amortization of it and in some cases, not even for the service itself. The hospitals, as you can imagine, objected very strongly to what they called public review of their private expenditures. However, since that time we have been talking with the hospitals and we have been pointing out that this whole matter of the increase in the equipment in a hospital is a very serious thing. There is a good deal of duplication and shortage of personnel. We would hope we could work out something along this line.

Mr. FLOOD. Are you concerned if these hospitals make use of hardware which is acquired for research and development in the actual patient care in institutions?

Mr. COHEN. I believe we do not pay, as far as medicare and medicaid are concerned, for the research aspects.

Mr. FLOOD. No; but in research and development certain institutions acquire certain pieces of hardware. They are in that institution. There they are in room 1. There is a patient in room 2 who needs that equipment. What is your position with reference to moving that equipment which exists for the purpose of research and development into the actual operation of the patient care of the hospital in profitmaking institutions?

Mr. KELLY. I think we would not treat it so much as a matter of profit. We think the equipment that is made available should have maximum use.

You should not have idle equipment simply because it was purchased for a given purpose. We think we should avoid repurchasing equipment because another project comes along and needs this equipment. Even if it has already been procured for research, we would not want to procure it again for another project.

We would expect them to get maximum utilization of the equipment.

COMPENDIUM OF DRUGS

Mr. FLOOD. Mr. Secretary, I do not want to analyze this message that just came to the Congress yesterday by the President, because that is the province primarily of the legislative committees if there is law proposed. In that message I gather the President makes quite a point of asking for a price lid on drugs. I know considerable examination of this problem is being made in both branches of the Congress this very day.

For the purpose of this record, do you have any opinions about Government creation of what the message calls a U.S. compendium of drugs, as distinguished from the existing practice of commercial sources preparing such a compendium?

Mr. COHEN. Mr. Chairman, I very strongly favor the development of this compendium. At the present time, under regulations of the Food and Drug Act each manufacturer of drugs must put into the prescription drugs that he sells to a pharmacist what we call a package insert. This is a complete explanation of the drug, its contraindications, hazards, and side effects.

Mr. FLOOD. That defines what a compendium is.

I am glad you said that. My question is: What is your reaction with reference to the compendium being done by the U.S. Government as distinguished from the current practice of having such a compendium or compendiums done by the private sector?

Mr. COHEN. The reason I was giving you this information is that the compendium is a substitute for these package inserts which the manufacturers are now required to make. Roughly speaking, Mr. Chairman, the costs to the manufacturers of the drugs of the package inserts would be equivalent to the cost of the compendium which under the proposed legislation they would have to bear.

So I think in answer to your question, it is perfectly proper for the Government to organize the compendium from the material submitted by the manufacturers in lieu of their responsibility to print and distribute the package inserts.

Mr. FLOOD. I have heard the figure of $6 million as a probable figure for the creation of such a compendium and continuation of it.

Is that a lot for such a purpose?

Mr. COHEN. I think it is a very substantial sum, but it is approximately our estimate of what the cost of the production and distribution of the package inserts is.

Mr. FLOOD. In other words, your answer is that it is not an excessive figure?

Mr. COHEN. Not only do we think it is not excessive, but the production of the compendium would make this information available to a lot more people than the package inserts are. For instance, we would, among other things, print a copy of this compendium and have it available in every one of our social security offices, so if you wanted to know information about a drug, you could go to a social security office and find out.

Mr. FLOOD. It is no longer a trade secret?

Mr. COHEN. It is not a trade secret, but if you wanted to get one now you would have to call up the pharmacist and he might say I cannot find one right now, come around later. We would make this compendium available. We would put it in every library, we would put it in every social security office.

So in addition to the physicians and the pharmacists the public would also have access to it.

CONSERVATIVE ASPECTS OF HEW 1969 BUDGET REQUEST

Mr. FLOOD. I am sure there are going to be a number of Members—and I am sure you are aware of this—who will disagree with your suggestion that this is even a conservative budget, let alone an austere budget, as it has been described by some of you. For instance, you have requests for increased numbers of Federal employees all the way through the budget: Food and Drug, an increase of 200; Office of Education, 423; Public Health Service, over 1,500; and so forth.

If somebody asks me, what is conservative or austere about that, what do I say?

Mr. COHEN. I would answer this way, sir. The tremendous volume of new legislation Congress has passed in the last 3 years has placed a simply monumental task on the Department to not only administer these programs and administer them well, working with the States and the private sector, but also to evaluate the programs and to give you in this committee and in the substantive legislative committees all the information you request.

I would neither characterize these increases as liberal or conservative. I believe they represent an intelligent evaluation of the needs of each particular program in order to carry out what Congress intended the program to accomplish.

PERSONNEL SUMMARY

Mr. FLOOD. Will you place in the record the total increase of personnel by agency and an explanation of each increase?

Mr. COHEN. I will be glad to put that in the record.

(The information follows:)

STAFFING INCREASES BY AGENCY

	1968	1969	Increase
Food and Drug Administration	5,387	5,587	+200
Office of Education	3,389	3,812	+423
Public Health Service	[1] 45,362	47,927	+2,565
Social and Rehabilitation Service	[1] 2,039	2,223	+184
Social Security Administration	[1] 54,201	55,951	+1,750
Office of the Secretary	[1] 2,981	3,454	+473
Total, Department of Health, Education, and Welfare	113,359	118,954	+5,595

[1] Includes proposed 1968 supplementals: Public Health Service, 106; Social Security Administration, 4,619; Social and Rehabilitation Service, 75; Office of the Secretary, 230; total, 4,823.

Major elements of staffing increases

1. Public Health Service ..... +2,565
   National Institutes of Health ..... +588
   For laboratory and clinical research (247), collaborative research and development (30), review and approval of grants (73), program direction (47), professional and technical assistance (18), division of research facilities and resources (16), division of computer research and technology (7), international center (10), research supporting services (48), clinical supporting services (47), and administrative management (45).
   Air pollution ..... +439
   For added responsibilities in research (161), abatement and control (220), motor vehicle pollution control (17), and training (41).
   Indian health ..... +427
   For improved care of Indian population.
   National Center for Health Services Research and Development ..... +109
   Community health services ..... +96
   Urban and industrial health activities ..... +234
   For solid wastes (77), occupational health (40), injury control (49), and water supply and shellfish (68).
   Communicable diseases activities ..... +159
   For communicable diseases (146), and venereal diseases (13).
   National Institute of Mental Health ..... +130
   For intramural research (21), mental health services (6), special mental health programs (51), and Saint Elizabeths Hospital (52).
   Direct patient care ..... +85
   For operation of hospitals and clinics (49), and medical care for special groups (36).
   All other health functions ..... +298
   For new and expanded programs in the areas of national health statistics (63), comprehensive health planning and services (53), health manpower education and utilization (51), chronic diseases (35), other related areas (85), and radiological health (11).
2. Social Security ..... +1,750
   For meeting increased workloads with an increase in productivity of 4.2 percent, and operation of Bureau of Federal Credit Unions (32). The 1967 Amendments to the Social Security Act have augmented the existing pattern of long-term growth of the benefit rolls.
3. Office of the Secretary ..... +473
   For public information (10), title VI, Civil Rights Act (66), Center for Community Planning (5), expanded field staff (65), audit workload (100), educational broadcasting facilities (13), higher education for international understanding (30), and improved direction and overall management (184).
4. Education ..... +423
   For administration of expanding programs, including title IV, Civil Rights Act (35), with emphasis on review, evaluation, and planning.

Major elements of staffing increases—Continued

5. Food and Drug	+200
For medical evaluation (6), scientific research and evaluation (35), education and voluntary compliance (22), regulatory compliance (24), drug abuse control (60), executive direction and administrative support (13), and establishing pesticide tolerances (40).	
6. Social and Rehabilitation Service	+184
For maternal and child health and family and child welfare services (45), medical assistance (41), assistance payments (32), mental retardation (18), regional coordination and direction (18), and other related areas (30).	
Net change	+5,595

Mr. KELLY. If I could comment on that, I really believe we can overemphasize the importance of Federal personnel in measuring the size of a budget.

Mr. FLOOD. That would be interesting.

Mr. KELLY. The grant programs amount to $15 billion, the direct operations to $833 million, and the administration of the grant programs to around $60 million. The administration of the grant programs can be so limited in the amount of money spent and in the number of staff used that you would not get the value out of the $15 billion worth of grants. It is a tremendous responsibility to impose on an agency to assure that these funds are used for the purpose for which they were made available and that the highest quality of services are being rendered with them.

When you move into the area which accounts for a very substantial portion of the increase of the administration of the social security program, where you are administering a program in the $30 billion range, the failure to be able to stay even with the workload means that you are going to fail to get checks out on time, to have them accurate, and to have claims processed.

I really believe that, as you examine this budget with each of the operating agencies that come before you, you will find that the workloads imposed on the administration to carry out the responsibilities assigned to it are tremendous. These are conservative estimates of staffing requirements.

COMPARISON OF STAFFING DETAIL 1967, 1968, 1969

Mr. FLOOD. In view of the comprehensive answer you just gave, I suspect you thought I might ask you that. Will you please place a personnel table—this is something else—in the record similar to the one on page 50 of last year's hearing?

(The information follows:)

SUMMARY OF STAFFING DETAIL—FISCAL YEARS 1967, 1968, 1969

	1967			1968			1969		
	Positions	Man-years	End-of-year employment	Positions	Man-years	End-of-year employment	Positions	Man-years	End-of-year employment
Food and Drug Administration	5,366	4,760	4,525	5,387	4,870	4,900	5,587	5,052	5,045
Office of Education	3,254	2,827	2,624	3,389	3,201	2,900	3,812	3,670	3,207
Public Health Service	43,113	39,686	38,739	45,360	43,976	41,270	47,927	47,051	43,131
Social and Rehabilitation Service	2,028	1,744	1,667	2,039	1,942	1,870	2,223	2,054	2,004
Social Security Administration	48,246	[1] 46,516	47,186	54,201	[1] 51,152	52,270	55,951	[1] 54,027	53,540
Office of the Secretary	2,646	2,434	2,210	2,981	2,726	2,830	3,454	3,222	3,173
Total, DHEW	104,653	99,018	[2] 97,792	113,357	107,867	106,040	118,954	115,076	[3] 110,100
End-of-year employment only:									
Overallocation						−540			−600
Budget Bureau ceiling						105,500			109,500
As shown in President's budget (full-time permanent positions)			95,900			105,400			108,800

[1] Excludes overtime equivalent as follows: 1967, 3,743 man-years; 1968, 4,414 man-years; 1969, 1,901 man-years.
[2] Includes figure of 841 for Freedmen's Hospital.
[3] 1969 end-of-year employment estimate assumes agencies will fill 73 percent of new positions.

1969 CONSTRUCTION BUDGET

Mr. FLOOD. It would be unreasonable as well as unrealistic to characterize the budget for construction programs as anything but very conservative.

What problems do you see in the future because of this very severe cutback in 1968 and 1969? You did touch upon that, Mr. Kelly, to some extent, but this is a flat question. What problems do you foresee? I know about your carryover from 1968 to 1969 and hence the reduction in the requests for 1969.

Mr. KELLY. If economic circumstances were to permit it, we would like to see a larger budget for construction. We do not argue that the needs contemplated by the substantive legislation are any less. We are only saying that the necessity for fiscal constraint causes us to request a lesser amount than authorized for the construction facilities. We know that in the area of higher education, mental health, the community facilities, and mental retardation community facilities we are going to defer the date on which services will be available and that we are going to cause a degree of compression of facilities, particularly on college campuses for larger enrollment, as a result of this fiscal constraint.

We are hopeful that, as soon as the economic situation will permit, we can make up for this loss in time in providing needed facilities.

Mr. FLOOD. You understand that this subcommittee in the very immediate future will be under the guns of interested parties in these things.

AUTHORIZATIONS VERSUS REQUESTS

The budget is also quite conservative when compared with the authorizations. Would you submit a table showing the authorizations for 1969, the request and the difference, item by item with suitable subtotals and grand totals?

Mr. KELLY. We would like to do that and we do have such a table. The biggest single item arises out of the Elementary and Secondary Education Act; $2.1 billion has been authorized. We are requesting $1.2 billion.

Mr. CARDWELL. We have a very comprehensive table which we can furnish.

(The information follows:)

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS

OFFICE OF EDUCATION

[Excludes programs for which there is no specific 1969 authorization]

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriation requested	Estimated obligations
Elementary and secondary educational activities:								
Elementary and Secondary Education Act of 1965 (Public Law 89-10):								
Title I, educationally deprived children	$1,191,000,000	$1,191,000,000	$2,000,637,050	$1,200,000,000	$1,200,000,000	$809,637,050	$9,000,000	$9,000,000
Title II, library resources	104,457,000	99,234,000	167,375,000	46,000,000	46,000,000	68,141,000	−53,234,000	−53,234,000
Title III, supplementary educational centers and services	208,750,000	187,876,900	527,875,000	189,163,000	189,163,000	339,999,000	1,287,000	1,287,000
Title V, strengthening State departments of education:								
Grants to States	25,287,590	25,287,500	76,000,000	33,250,000	33,250,000	50,712,500	7,962,500	7,962,500
Special projects	4,462,500	4,462,500	4,000,000	1,750,000	1,750,000	−462,500	−2,712,500	−2,712,500
Title VII, bilingual education programs (Public Law 90-247)			30,000,000	5,000,000	5,000,000	30,000,000	5,000,000	5,000,000
Title VIII:								
Dissemination of information (Public Law 89-750)			3,700,000	2,000,000	2,000,000	3,700,000	2,000,000	2,000,000
Dropout prevention projects (Public Law 90-247)			30,000,000	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000
Total	1,533,957,000	1,507,860,000	2,839,587,050	1,507,163,000	1,507,163,000	1,331,727,050	−697,000	−697,000
School assistance in federally affected areas:								
Maintenance and operations (Public Law 874):								
Payments to local educational agencies	389,200,000	368,390,000	520,000,000	365,390,000	365,390,000	151,610,000	−3,000,000	−3,000,000
Payments to other Federal agencies	27,000,000	27,000,000	30,000,000	30,000,000	30,000,000	3,000,000	3,000,000	3,000,000
Construction (Public Law 815):								
Assistance to local educational agencies	12,317,000	12,300,498	69,362,000	4,107,000	32,512,000	57,061,502	−8,193,498	20,211,502
Assistance for school construction on Federal properties	10,000,000	11,852,000	10,000,000	10,000,000	13,334,000	−1,852,000	−1,852,000	1,482,000
Technical services	620,000	620,000	638,000	638,000	638,000	18,000	18,000	18,000
Total	439,137,000	420,162,498	630,000,000	410,135,000	441,874,000	209,837,502	−10,027,498	21,711,502

See footnotes at end of table.

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS—Continued

OFFICE OF EDUCATION—Continued

[Excludes programs for which there is no specific 1969 authorization]

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriation requested	Estimated obligations
Education professions development activities:								
Education Professions Development Act (Public Law 90-35) (title V, Higher Education Act of 1965, Public Law 89-329):								
Sec. 504, encouragement of educational careers			$2,500,000	$1,500,000	$1,500,000	$2,500,000	$1,500,000	$1,500,000
Pt. B-2, State grants for recruitment of educational personnel			50,000,000	15,000,000	15,000,000	50,000,000	15,000,000	15,000,000
Pt. C, fellowships for teachers and related educational personnel	$35,000,000	$35,000,000	205,000,000	43,500,000	43,500,000	170,000,000	8,500,000	8,500,000
Pt. D, institutes and training programs for other than higher education personnel	39,750,000	39,750,000	70,000,000	53,400,000	53,400,000	30,250,000	13,650,000	13,650,000
Pt. E, institutes and training programs for higher education personnel	2,500,000	2,500,000	21,500,000	15,000,000	15,000,000	19,000,000	12,500,000	12,500,000
Total	77,250,000	77,250,000	349,000,000	128,400,000	128,400,000	271,750,000	51,150,000	51,150,000
Teacher Corps:								
Education Professions Development Act (Public Law 90-35) (title V, Higher Education Act of 1965, Public Law 89-329): Pt. B-1, Teacher Corps	13,500,000	13,500,000	46,000,000	31,100,000	31,100,000	32,500,000	17,600,000	17,600,000
Higher educational activities:								
Program assistance (Bankhead-Jones Act, Public Law 74-182): Colleges of agriculture and the mechanic arts	11,950,000	11,950,000	11,950,000	11,950,000	11,950,000			
Construction:								
Higher Education Facilities Act of 1963 (Public Law 88-204):								
Title I, grants for construction of undergraduate academic facilities	400,000,000	274,452,112	936,000,000	67,000,000	200,000,000	661,547,888	−207,452,112	−74,452,121

State administration and planning	7,000,000	7,000,000	7,000,000	7,000,000	7,000,000			
Title II, grants for construction of graduate academic facilities	50,000,000	33,000,000	120,000,000	8,000,000	25,576,994	87,000,000	−25,000,000	−7,423,006
Total	468,950,000	326,402,112	1,074,950,000	93,950,000	244,526,994	748,547,888	−232,452,112	−81,875,118
Expansion and improvement of vocational education:								
Vocational Education Act of 1963 (Public Law 88-210):								
Grants to States	199,309,000	198,225,000	202,500,000	199,309,000	199,309,000	4,275,000	1,084,000	1,084,000
George-Barden Act (Public Law 79-586):								
Title I, vocational education in agriculture, home economics, trades and industry, and distributive occupations	29,686,000	29,686,000	29,686,000	29,686,000	29,686,000			
Title II, vocational education in practical nurse training (Public Law 84-911)	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000			
Title III, area vocational education programs (Public Law 85-864)	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000			
Supplemental acts:								
Puerto Rico (Public Law 71-791)	105,000	105,000	105,000	105,000	105,000			
Virgin Islands (Public Law 81-462)	40,000	40,000	40,000	40,000	40,000			
Guam (Public Law 84-896)	80,000	80,000	80,000	80,000	80,000			
American Samoa (Public Law 87-688)	80,000	80,000	80,000	80,000	80,000			
Total	249,300,000	248,216,000	252,491,000	249,300,000	249,300,000	4,275,000	1,084,000	1,084,000
Libraries and community services:								
Library Services and Construction Act (Public Law 84-597):								
Title I, public library services	35,000,000	35,000,000	55,000,000	35,000,000	35,000,000	20,000,000		
Title II, construction of public libraries (Public Law 88-269)	27,185,000	33,602,493	60,000,000	9,185,000	18,185,000	26,397,507	−24,417,493	−15,417,493
Title III, interlibrary cooperation (Public Law 89-511)	2,375,000	2,256,000	10,000,000	2,281,000	2,281,000	7,744,000	25,000	25,000
Title IV-A, State institutional library services (Public Law 89-511)	2,120,000	2,014,000	10,000,000	2,094,000	2,094,000	7,986,000	80,000	80,000
Title IV-B, library services to the physically handicapped (Public Law 89-511)	1,320,000	1,254,000	5,000,000	1,334,000	1,334,000	3,746,000	80,000	80,000
Adult Education Act (title III, Elementary and Secondary Education Amendments of 1966, Public Law 89-750): Adult basic education	40,250,000	38,640,000	70,000,000	50,000,000	50,000,000	31,360,000	11,360,000	11,360,000
Total	108,250,000	112,766,493	210,000,000	99,894,000	108,894,000	97,233,507	−12,872,493	−3,872,493

See footnotes at end of table.

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS—Continued

OFFICE OF EDUCATION—Continued

[Excludes programs for which there is no specific 1969 authorization]

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriation requested	Estimated obligations
Educational improvement for the handicapped:								
Education of the Handicapped Act (title VI, Elementary and Secondary Education Act of 1965, Public Law 89-750):								
Title VI, education of handicapped children:								
Pt. A, preschool and school programs	$15,000,000	$14,250,000	$167,375,000	$32,000,000	$32,000,000	$153,125,000	$17,750,000	$17,750,000
Pt. B, regional resource centers (Public Law 90-247)			7,750,000	2,000,000	2,000,000	7,750,000	2,000,000	2,000,000
Pt. C, innovative programs (Public Law 90-247)			3,000,000	1,000,000	1,000,000	3,000,000	1,000,000	1,000,000
Pt. D, personnel recruitment and information (Public Law 90-247)			1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Grants for teaching in the education of handicapped children (Public Law 85-926): Teacher education	24,500,000	24,500,000	37,500,000	30,000,000	30,000,000	13,000,000	5,500,000	5,500,000
Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164): Research and demonstration	11,100,000	11,100,000	14,000,000	13,900,000	13,900,000	2,900,000	2,800,000	2,800,000
Loan service of captioned films for the deaf (Public Law 85-905): Captioned films and media services (Public Law 90-247)	2,800,000	2,800,000	8,000,000	4,750,000	4,750,000	5,200,000	1,950,000	1,950,000
Total	53,400,000	52,650,000	238,625,000	84,650,000	84,650,000	185,975,000	32,000,000	32,000,000
Research and training:								
Vocational Education Act of 1963 (Public Law 88-210): Vocational education research	11,550,000	11,550,000	22,500,000	15,700,000	15,700,000	10,950,000	4,150,000	4,150,000
Higher education facilities loan fund:								
Higher Education Facilities Act (Public Law 88-204), title III, loans for construction of academic facilities	100,000,000	150,000,000	400,000,000	100,000,000	150,000,000	250,000,000	−50,000,000	----------

Office of the Surgeon General—Comprehensive health planning and services:								
Comprehensive Health Planning and Public Health Services Amendments of 1966 (Public Law 89-749), as amended by Partnership for Health Amendments of 1967 (Public Law 90-174)—Public Health Service Act:								
Sec. 314(a), grants to States for comprehensive State health planning	$5,000,000	$7,250,000	$10,000,000	$9,750,000	$9,750,000	$2,750,000	$2,500,000	$2,500,000
Sec. 314(b), project grants for areawide health planning	7,500,000	5,000,000	10,000,000	10,000,000	10,000,000	5,000,000	5,000,000	5,000,000
Sec. 314(c), project grants for training, studies, and demonstrations	2,500,000	2,500,000	5,000,000	5,000,000	5,000,000	2,500,000	2,500,000	2,500,000
Sec. 314(d), grants for comprehensive public health services	60,250,000	60,250,000	[1] 90,000,000	[1] 76,800,000	[1] 76,800,000	29,750,000	16,550,000	16,550,000
Sec. 314(e), project grants for health services development	77,500,000	[3] 72,500,000	[1] 95,000,000	[1] 90,000,000	[1] 95,000,000	22,500,000	17,500,000	22,500,000
Total, Office of the Surgeon General	152,750,000	147,500,000	210,000,000	191,550,000	196,550,000	62,500,000	44,050,000	49,050,000
Bureau of Health Manpower:								
Health Manpower education and utilization:								
Graduate public health training amendments (Public Law 88-497)—Public Health Service Act:								
Sec. 306(a), public health traineeships	8,000,000	8,000,000	10,000,000	8,000,000	8,000,000	2,000,000	0	0
Sec. 309(a), project grants to schools for graduate public health training	4,500,000	4,500,000	9,000,000	5,500,000	5,500,000	4,500,000	1,000,000	1,000,000
Comprehensive Health Planning and Public Health Services Amendments of 1966 (Public Law 89-749) as amended by Partnership for Health Amendments of 1967 (Public Law 90-174)—Public Health Service Act, sec. 309(c), grants to schools of public health	4,000,000	4,000,000	[1] 6,000,000	[1] 4,600,000	[1] 4,600,000	2,000,000	600,000	600,000
Health Professions Educational Assistance Amendments of 1965 (Public Law 89-290) and Veterinary Medical Education Act of 1966 (Public Law 89-709)—Public Health Service Act:								
Sec. 742(a), health professions student loans	15,000,000	15,000,000	26,500,000	17,300,000	17,300,000	11,500,000	2,300,000	2,300,000
Sec. 770, grants to improve the quality of schools of medicine, dentistry, osteopathy, optometry, and podiatry	52,500,000	49,675,000	80,000,000	66,000,000	66,000,000	30,325,000	16,325,000	16,325,000

See footnotes at end of table.

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS—Continued

PUBLIC HEALTH SERVICE—Continued

[Excludes programs for which there is no specific 1969 authorization]

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriation requested	Estimated obligations
Bureau of Health Manpower—Continued								
Health manpower education and utilization—Continued								
Allied Health Professions Personnel Training Act of 1966 (Public Law 89-751)—Public Health Service Act:								
Sec. 792, grants to improve the quality of training centers for allied health professions	$9,750,000	$3,750,000	$17,000,000	$17,000,000	$17,000,000	$7,250,000	$7,250,000	$7,250,000
Sec. 793, allied health traineeships	1,500,000	1,500,000	3,500,000	2,500,000	2,500,000	2,000,000	1,000,000	1,000,000
Sec. 794, allied health new methods grants	1,000,000	1,000,000	3,000,000	2,100,000	2,100,000	2,000,000	1,100,000	1,100,000
Sec. 861(h), opportunity grants for nursing education	5,000,000	[4] 5,250,000	7,000,000	6,800,000	[5] 7,050,000	1,750,000	1,550,000	1,800,000
Nurse Training Act of 1964 (Public Law 88-581)—Public Health Service Act:								
Sec. 805(a), grants for improvement of nurse training	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	0	0	0
Sec. 806(a), payment to diploma schools of nursing	3,000,000	3,000,000	10,000,000	3,000,000	3,000,000	7,000,000	0	0
Sec. 821(a), traineeships for advanced training of professional nurses	10,000,000	10,000,000	12,000,000	11,000,000	11,000,000	2,000,000	1,000,000	1,000,000
Sec. 824, nursing student loans	16,000,000	[6] 9,610,000	30,900,000	9,700,000	9,700,000	21,290,000	90,000	90,000
Total, health manpower education and utilization	134,250,000	125,285,000	218,900,000	157,500,000	157,750,000	93,615,000	32,215,000	32,465,000
Construction of health educational facilities:								
Health Professions Educational Assistance Amendments of 1965 (Public Law 89-290)—Public Health Service Act, sec. 720, grants for construction of teaching facilities for medical, dental, and other health professions schools	175,000,000	116,700,000	170,000,000	75,000,000	127,194,907	53,300,000	−41,700,000	10,494,907
Allied Health Professions Personnel Training Act of 1966 (Public Law 89-751)—Public Health Service Act, sec. 791, grants for construction of teaching facilities for allied health professions	3,000,000	2,000,000	13,500,000	1,800,000	2,800,000	11,500,000	−200,000	800,000
Nurse Training Act of 1964 (Public Law 88-581)—Public Health Service Act, sec. 801(a) (1) and (2), construction of new facilities for collegiate, associate degree, and diploma schools of nursing	25,000,000	16,700,000	25,000,000	8,000,000	21,462,606	8,300,000	−8,700,000	4,762,606

Total, construction of health educational facilities	203,000,000	135,400,000	208,500,000	84,800,000	151,457,513	73,100,000	−50,600,000	16,057,513
Total, Bureau of Health Manpower	337,250,000	260,685,000	427,400,000	242,300,000	309,207,513	166,715,000	−18,385,000	48,522,513
Bureau of Disease Prevention and Environmental Control:								
Solid Wastes Disposal Act (Public Law 89-272), sec. 210	15,602,000	15,352,000	20,000,000	17,534,000	17,534,000	4,648,000	2,182,000	2,182,000
Air Quality Act (Public Law 90-148):								
Sec. 104:								
Research			90,000,000	31,300,000	[7] 42,300,000	86,400,000	27,700,000	38,700,000
Proposed Supplemental	14,600,000	3,600,000						
Sec. 309:								
Other	64,185,000	[8] 66,311,000						
Facilities	1,815,000		95,000,000	75,433,000	75,433,000	27,289,000	7,722,000	7,722,000
Proposed supplemental	1,400,000	1,400,000						
Total, Bureau of Disease Prevention and Environmental Control	97,602,000	86,663,000	205,000,000	124,267,000	135,267,000	118,337,000	37,604,000	48,604,000
Bureau of Health Services:								
Community Health Services:								
Community Health Services Extension Amendments of 1965 (Public Law 89-109)—Public Health Service Act, sec. 310, migratory workers	8,045,000	8,045,000	[9] 9,000,000	8,976,000	8,976,000	[9] 955,000	931,000	931,000
Partnership for Health Amendments 1967 (Public Law 90-174)—Sec. 304, research and demonstrations relating to health facilities and services	[10] 20,000,000	[10] 20,000,000	40,000,000	[1] 28,000,000	[1] 28,000,000	20,000,000	8,000,000	8,000,000
Total, Community Health Services	28,045,000	28,045,000	49,000,000	36,976,000	36,976,000	20,955,000	8,931,000	8,931,000
Hospital construction activities:								
Hospital and Medical Facilities Amendments of 1964 (Public Law 88-443)—Public Health Service Act, sec. 601, construction grants:								
Hospitals and centers	130,000,000	128,498,000	125,000,000	112,800,000	134,595,000	−3,498,000	−15,698,000	6,097,000
Modernization	50,000,000	44,458,000	55,000,000	49,600,000	52,534,000	10,542,000	5,142,000	8,076,000
Long-term care facilities	70,000,000	63,010,000	70,000,000	65,000,000	72,719,000	6,990,000	1,990,000	9,709,000
Diagnostic and treatment centers	20,000,000	17,176,000	20,000,000	18,000,000	20,565,000	2,824,000	824,000	3,389,000
Rehabilitation facilities	10,000,000	9,626,000	10,000,000	9,000,000	10,436,000	374,000	−626,000	810,000
Total, hospital construction activities	280,000,000	262,768,000	280,000,000	254,400,000	290,849,000	17,232,000	−8,368,000	28,081,000
Indian health activities:								
Menominee Indian grants (Public Law 89-653):								
School district costs	150,000	150,000	150,000	150,000	150,000	0	0	0
Public welfare benefits	100,000	100,000	100,000	100,000	100,000	0	0	0
Health and sanitation services	100,000	100,000	100,000	100,000	100,000	0	0	0
Total, Indian health activities	350,000	350,000	350,000	350,000	350,000	0	0	0
Total, Bureau of Health Services	308,395,000	291,163,000	329,350,000	291,726,000	328,175,000	38,187,000	563,000	37,012,000

See footnotes at end of table.

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS—Continued

PUBLIC HEALTH SERVICE—Continued

[Excludes programs for which there is no specific 1969 authorization]

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriation requested	Estimated obligations
National Institutes of Health:								
Grants for construction of health research facilities:								
Health Research Facilities Amendments of 1965 (Public Law 89–115)—Public Health Service Act, sec. 704, construction grants	$35,000,000	$38,400,000	$189,000,000	$8,400,000	$20,608,000	$150,600,000	—$30,000,000	—$17,792,000
Regional medical programs:								
Heart Disease, Cancer, and Stroke Amendments of 1965 (Public Law 89–239)—Public Health Service Act, sec. 901, education, research training, and demonstration grants	53,900,000	48,900,000	[11] 62,900,000	62,900,000	93,800,000	14,000,000	14,000,000	44,900,000
Gorgas Memorial Laboratory (Public Law 89–181): (22 U.S.C. 278)	500,000	500,000	500,000	500,000	500,000			
Total, National Institutes of Health	89,400,000	87,800,000	252,400,000	71,800,000	114,908,000	164,600,000	—16,000,000	27,108,000
National Institute of Mental Health:								
Community mental health resource support:								
Grants for construction of community mental health centers (Public Law 88–164, sec. 201, Community Mental Health Centers Act, as amended by Public Law 90–31, sec. 2, Mental Health Amendments of 1967)	45,000,000	45,380,000	60,000,000	15,000,000	60,000,000	14,620,000	—30,380,000	14,620,000
Grants for initial staffing of community mental health centers: (A) Initial grants (Public Law 88–164, sec. 201, Community Mental Health Centers Construction Act of 1963, as amended by Public Law 89–105, sec. 224, Community Mental Health Centers Construction Act of 1965)	22,108,000	22,108,000	26,000,000	22,079,000	22,079,000	3,892,000	—29,000	—29,000
Grants for Construction and Operation of Narcotic Addict Rehabilitation Facilities (Public Law 89–793, sec. 402, Narcotic Addict Rehabilitation Act of 1966) (additional authorizing legislation proposed)	4,000,000	4,000,000	[12] 8,000,000	8,000,000	8,000,000	4,000,000	4,000,000	4,000,000
Total, National Institute of Mental Health	71,108,009	71,488,000	94,000,000	45,079,000	90,079,000	22,512,000	—26,409,000	18,591,000

Other Public Health Service:								
National Library of Medicine:								
Medical Library Assistance Act of 1965 (Public Law 89-291)—Public Health Service Act:								
Sec 378(a), regional branches of the National Library of Medicine	0	0	2,000,000	0	0	2,000,000	0	0
Sec. 393(i), assistance for construction of facilities	3,750,000	10,000,000	10,000,000	----------	1,250,000	----------	−10,000,000	−8,750,000
Sec. 394(a), grants for training in medical library sciences	1,000,000	1,143,127	1,000,000	1,000,000	1,433,000	−143,127	−143,127	289,873
Sec. 395, assistance to special scientific projects	100,000	12 0000	500,000	100,000	200,000	330,000	−20,000	80,000
Sec. 396(a), research and development in medical library science and related fields	1,600,000	1,486,000	3,000,000	1,700,000	2,588,000	1,514,000	214,000	1,102,000
Sec. 397(a), grants for improving and expanding the basic resources of medical libraries and related instrumentalities	2,500,000	3,537,392	3,000,000	2,500,000	2,800,000	−537,392	−1,037,392	−737,392
Sec. 398(a), grants for establishment of regional medical libraries	1,500,000	680,128	2,500,000	1,500,000	2,415,000	1,819,872	819,872	1,734,872
Sec. 399(a), financial support of biomedical scientific publications	800,000	679,815	1,000,000	327,000	585,000	320,185	−352,815	−94,815
Total, other Public Health Service	11,250,000	17,646,462	23,000,000	7,127,000	11,271,000	5,353,538	−10,519,462	−6,375,462
Total, Public Health Service	1,067,755,000	962,945,462	1,541,150,000	973,849,000	1,185,457,513	578,204,538	10,903,538	222,512,051
SOCIAL AND REHABILITATION SERVICE [13]								
Grants to States for vocational rehabilitation services: Vocational Rehabilitation Amendments of 1967 (Public Law 90-99), sec. 2	$287,000,000	$287,000,000	$500,0000,000	$345,900,000	$345,900,000	$213,000,000	$58,900,000	$58,900,000
Mental retardation:								
Community service facilities construction (Public Law 90-170)	18,000 000	12,657,302	30,000,000	6,000,000	18,000,000	17,342,698	−6,657,302	5,342,698
University-affiliated facilities construction (Public Law 90-170)	6,600,000	8,751,099	20,000,000	6,600,000	6,600,000	11,248,901	−2,151,099	−2 151,099
Initial staffing (Public Law 90-170)	0	0	10,000,000	8,358,000	8,358,000	10,000,000	8,358,000	8,358,000
Total	24,600,000	21,408,401	60,000,000	20,958,000	32,958,000	38,591,599	−450,401	11,549,599

See footnotes at end of table.

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1959 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS—Continued

SOCIAL AND REHABILITATION SERVICE—Continued

[Excludes programs for which there is no specific 1969 authorization]

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriation requested	Estimated obligations
Maternal and child health and welfare:								
Social Security Act, as amended (Public Law 90-248): [14]								
Title V, maternal and child health and crippled children's services:								
(a) Maternal and child health services	$50,000,000	$50,000,000	----------	$50,000,000	$50,000,000	----------	----------	----------
(b) Crippled children's services	50,000,000	50,000,000	----------	65,000,000	65,000,000	----------	$15,000,000	$15,000,000
(c) Special project grants: Maternity and infant care	30,000,000	30,000,000	----------	55,000,000	55,000,000	----------	25,000,000	25,000,000
(d) Special project grants: Health of school and preschool children	37,000,000	36,900,000	----------	42,000,000	42,000,000	----------	5,100,000	5,100,000
(e) Special project grants: Dental	0	0	----------	1,000,000	1,000,000	----------	[15] 1,000,000	[15] 1,000,000
(f) Training	7,000,000	7,000,000	----------	10,000,000	10,000,000	----------	3,000,000	3,000,000
(g) Research	5,900,000	5,700,000	----------	13,300,000	13,300,000	----------	7,600,000	7,600,000
(h) Evaluation	0	0	----------	1,000,000	1,000,000	----------	[15] 1,000,000	[15] 1,000,000
Total	179,900,000	179,600,000	[15] $250,000,000	237,300,000	237,300,000	$70,400,000	57,700,000	57,700,000
Title IV, pt. B, child welfare services	46,000,000	46,000,000	100,000,000	46,000,000	46,000,000	54,000,000	0	0
Development of programs for the aging:								
Older Americans Act of 1965 Public Law 89-73, as by Public Law 90-42:								
Title III, grants to States for community planning services and training	10,550,000	10,022,000	16,000,000	16,000,000	16,000,000	5,978,000	5,978,000	5,978,000
Title IV, grants and contracts for research and demonstrations	4,155,000	4,142,000	(10,000,000)	7,000,000	7,000,000	(3,613,000)	2,858,000	2,858,000
Title V, training grants and contracts	2,245,000	2,245,000	----------	3,000,000	3,000,000	----------	755,000	755,000
Total	16,950,000	16,409,000	26,000,000	26,000,000	26,000,000	9,591,000	9,591,000	9,591,000

Social services, administration, training, and demonstration projects:								
Expansion and development of undergraduate and graduate programs: Social Security Act, as amended (Public Law 90-248), title VII, sec. 707			5,000,000	3,000,000	3,000,000	5,000,000	3,000,000	3,000,000
Total, social and rehabilitation service	554,450,000	550,417,401	941,000,000	679,158,000	691,158,000	390,582,599	128,740,599	140,740,599
SPECIAL INSTITUTIONS								
American Printing House for the Blind (act of Mar. 3, 1879, as amended)	$1,225,000	$1,225,000	(17)	$1,340,000	$1,340,000	(17)	$115,000	$115,000
National Technical Institute for the Deaf (Public Law 89-36)	2,615,000	2,035,000	(17)	800,000	1,903,000	(17)	−1,815,000	−127,000
Model Secondary School for the Deaf (Public Law 89-694):								
Salaries and expenses	425,000	425,000	(17)	400,000	400,000	(17)	−25,000	−25,000
Construction	275,000		(17)	445,000	720,000	(17)	170,000	720,000
Subtotal, model school	700,000	425,000	(17)	845,000	1,120,000	(17)	145,000	695,000
Gallaudet College (Public Law 83-420):								
Salaries and expenses	2,919,000	4,519,000	(17)	3,785,000	5,504,000	(17)	861,000	985,000
Construction	2,196,000	1,757,000	(17)	675,000	675,000	(17)	−1,521,000	−1,082,000
Subtotal, Gallaudet College	5,115,000	6,276,000	(17)	4,460,000	6,179,000	(17)	−655,000	−97,000
Howard University (act of Mar. 2, 1867, as amended):								
Salaries and expenses	15,534,000	30,892,000	(17)	18,330,000	32,550,000	(17)	2,796,000	1,658,000
Construction	3,926,000	6,555,000	(17)	2,209,000	10,994,000	(17)	−1,717,000	4,439,000
Freedmen's	6,937,000	10,221,000	(17)	8,739,000	12,023,000	(17)	1,802,000	1,802,000
Subtotal, Howard University	26,397,000	47,668,000	(17)	29,278,000	55,567,000	(17)	2,881,000	7,899,000
Total, special institutions [18]	36,052,000	57,623,000	(17)	36,723,000	66,114,000	(17)	671,000	8,485,000

See footnotes at end of table.

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS—Continued

OFFICE OF THE SECRETARY

[Excludes programs for which there is no specific 1969 authorization]

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriation requested	Estimated obligations
Educational broadcasting facilities: Public Broadcasting Act of 1967 (Public Law 90-129), title I, construction of facilities			$12,500,000	$12,500,000	$12,500,000	$2,000,000	$12,500,000	$12,500,000
Public broadcasting program: Public Broadcasting Act of 1967 (Public Law 90-129), title II, establishment of nonprofit education broadcasting corporation	$4,000,000	$4,000,000	([19])	20,000,000	20,000,000	[19] 11,000,000	16,000,000	16,000,000
Higher education for international understanding: International Education Act of 1966 (Public Law 89-698), title I, grant programs for advanced and undergraduate international studies			90,000,000	10,200,000	10,200,000	50,000,000	10,200,000	10,200,000

[1] Includes 1 percent for program evaluation.
[2] Includes $20,000,000 proposed supplemental. Excludes $5,000,000 transfer to National Center for Health Services Research and Development.
[3] Includes $15,000,000 obligations in proposed supplemental. Excludes $5,000,000 transfer to National Center for Health Services Development.
[4] Includes $500,000 unobligated balance brought forward into 1968 and excludes $250,000 carried forward into 1969.
[5] Includes $250,000 unobligated balance brought forward into 1969.
[6] Excludes $6,390,000 transferred to the health professions education and nurse training funds.
[7] Includes $11,000,000 balance brought forward.
[8] Includes $4,040,000 balance brought forward.
[9] Legislation pending, assume authorization will be at least $9,000,000.
[10] Sec. 314(e)(3), $5,000,000; sec. 624, $9,173,000; proposed supplemental, $5,827,000.
[11] Previous authorization expired with 1968; subsequent authorization to be requested.
[12] Legislation to be requested.
[13] Excludes programs for which there is an indefinite authorization.
[14] Contains change in authorization effective in fiscal year 1969.
[15] Program authorized by 1967 Social Security Amendments to be initiated in fiscal year 1969.
[16] Authorization covers entire child health program.
[17] Indefinite for all special institutions.
[18] Includes proposed supplementals.
[19] Act authorizes $9,000,000 for fiscal year 1968. Legislation will be proposed to provide $20,000,000 for fiscal year 1969 for transfer to the corporation.

NATIONAL INSTITUTES OF HEALTH

Mr. FLOOD. There is another place where you are on the conservative side. Except for Child Health and Human Development, not a one of the National Institutes of Health has as much as a 5-percent increase.

Mr. Kelly, you made quite a point in your presentation about these across-the-board cuts under House Joint Resolution 888, what you did and what you did not do and where the priorities were. I actually thought you were telling me that NIH was pretty well taken care of. But when it comes to 1969, only one of the NIH Institutes has as much as a 5-percent increase. Why did you hold them down so tightly? These increases of 2, 3, and 4 percent, won't even cover the increased cost of doing business.

I got the impression from your previous statements that you were giving them priority treatment.

Mr. KELLY. Let me try it another way, sir, if I might. I think there is no question that the NIH budget before you is a conservative one. But if we had applied House Joint Resolution 888 across the board, and not selectively in the way in which we explained to you, we would have made a cut of almost 10 percent in the NIH. We did not make the cut there because we gave it a much higher priority. In fact, we are continuing to fund as many new research projects in 1968 as the Congress had approved, and we are approximatey funding that same level in 1969. But they will have to tighten their belt.

Mr. FLOOD. You did that and they will have to tighten their belt. I do not mind their tightening their belt, but what about the situation where these increases of 2, 3, and 4 percent won't even cover the increased cost of doing business? That is more than tightening your belt.

Mr. KELLY. It will permit the granting institutions to continue with the same level of new projects as the Congress approved and as we are proposing in 1969. Their cost sharing is going to have to absorb the increased cost of doing business in order to get that financial support. This is a part of the tightening of the total level of the Federal budget.

JOHN E. FOGARTY CENTER

Mr. FLOOD. Mr. Secretary, the committee set out the John E. Fogarty Center as a separate appropriation after it was sent up last year as a mere item under "Buildings and facilities." Now it appears as one activity under "General research and services," and the name "John E. Fogarty" has been dropped. The narrative explanation in the budget does not even mention John Fogarty's name.

Mr. COHEN. I am not aware of why we dropped it out of the presentation, but in my statement I clearly indicated——

Mr. FLOOD. I am not talking about your statement.

Mr. KELLY. The justification refers to it as the "John E. Fogarty Center."

Mr. CARDWELL. It is a matter of the technical preparation of the budget.

Mr. FLOOD. The justifications contain it. I am talking about the budget itself—the President's budget of last January.

Mr. CARDWELL. Yes, sir. The President's budget does not.

Mr. FLOOD. Did you try to have this corrected in the President's budget?

Mr. CARDWELL. I will put it this way. The budget we submitted to the Bureau of the Budget identified this as an item under the name of "John E. Fogarty."

Mr. FLOOD. And when it came out of the Budget Bureau that identity had been eliminated.

Mr. CARDWELL. Yes, sir.

Mr. FLOOD. Another reason why I think the Bureau of the Budget should be under the jurisdiction of the legislative and not the executive branch of the Government, as it is in the State of California. This is what I would like. This is just another very good reason.

Mr. COHEN. I want to say this, though. As far as I am concerned we will do everything possible within the Department to give very high prominence to the John E. Fogarty Center.

Mr. FLOOD. If you do not, we will.

Mr. CARDWELL. In fact, I have a letter on my desk which is on its way to Mr. Kelly and Mr. Cohen, which proposes some renovation beginning immediately with a stone house on the campus of NIH as the first step toward the establishment of the Center itself. We will send this to the committee very shortly.

REPORT OF THE HOUSE COMMITTEE ON GOVERNMENT OPERATIONS

Mr. FLOOD. We will discuss this in more detail with Dr. Shannon but we would like you to comment on the latest criticism of NIH by the Government Operations Committee and the recently issued reply.

Mr. COHEN. As you know, we have presented our comments on the report that was submitted.

I believe you have a copy of that, and at some point we will want to put in the record our response so that it is available. We review each of the individual points.

Mr. FLOOD. This is a much more voluminous document than we usually print in our record but I do think it should be available to all who are interested. Is this the situation—can anyone get a copy?

Mr. COHEN. Yes, indeed.

Mr. FLOOD. To whom should a person write to to get a copy?

Mr. COHEN. A copy will be mailed to anyone who addresses a request to Office of Public Information, Department of Health, Education, and Welfare, Washington, D.C.

I believe the report will show that we have taken their comments and criticism into account. We have recognized the merit of some points.

I think when you are running as big an establishment as the NIH, no one could contend that we do everything perfectly and that we are not subject to constructive criticism. We indicate the points at which we will be undertaking action, the points at which some other Government agencies have responsibility, and those points at which we are in disagreement. So I think what you would want to do is go over them in detail and see exactly our response. I think our response is both constructive and intelligent, Mr. Chairman.

UNIFORM STIPEND POLICY

Mr. FLOOD. In NIH, in the Office of Education and, in fact all through the Department's justifications we see funds for stipends, fellowships, dependents' allowances, and so forth, for people going on to advanced study in various specialties. How much uniformity is there in these allowances? What do you do to prevent one agency from outbidding another for these advance students? How can you stop piracy between these agencies?

Mr. COHEN. There is no question that there is a great deal of difference in the stipends.

This year, at least, in connection with the education stipends we are proposing a method of trying to rationalize them. However, I would think you would still find some significant differences.

Perhaps Mr. Kelly would like to comment on these differences.

Mr. KELLY. We have just completed a study, Mr. Chairman, and we are very pleased to say that we have developed a system that is fully responsive to your question. We have identified a uniform system of establishing stipends and a uniform system of modifying them. Although the study deals with the Department of Health, Education, and Welfare; we coordinated our activities with the National Science Foundation, NASA, and the Bureau of the Budget. Talking about the colleges and professional football teams going after players, they are amateurs compared to the scramble for these people.

We would be glad to give you a report that establishes a single rate for each type of stipend, depending on whether the studies are postdoctoral, predoctoral, whether or not they are first year, second year, or third year. There is also a uniform rate for the dependency allowance.

Mr. FLOOD. When will that be effective?

Mr. KELLY. We have now issued it to operating agencies and it is immediately effective.

If the rate requires an increase in the level of stipend for students, the institutions are not to decrease the number of students and they will have to budget for it in 1970. If they are now over the stipend level, they shall not decrease those that are already enrolled, but future enrollees in that program will be at the new level. Then we have put together an interagency committee with representatives of every one of our programs on it, and they will review the stipends. No one may change the stipend level except through this new mechanism.

Mr. FLOOD. This sounds good. Let us keep an eye on this.

Mr. KELLY. Yes, sir.

INTERNATIONAL EDUCATION PROGRAM

Mr. FLOOD. You are requesting funds again, a fourth time, for the international education program.

We will discuss this with the Assistant Secretary for Education and others later in these hearings, but, as Acting Secretary, do you want to make a special plea for it?

Mr. COHEN. I certainly would, Mr. Chairman. I believe enactment of this statute by the Congress for international understanding is an extremely important proposal.

PROPOSED CHANGES IN BILL LANGUAGE IN THE BUDGET

Mr. FLOOD. Mr. Secretary, I understand that if your experts had it to do over again there would be some changes in the language of the bill as it appears in the budget. Suppose you just place in the record any changes that you would like to make and the reasons for them.

(The information requested is as follows:)

PROPOSED CHANGES IN THE LANGUAGE OF THE HEW APPROPRIATION BILL IN THE PRESIDENT'S BUDGET

Where insertions have been made, they are indicated by italics. Deletions from the language of the 1968 act are shown by black brackets. The explanations identify the changes in the language, contained in the 1969 budget, that are proposed.

OFFICE OF EDUCATION

Language:

Educational Improvements for the Handicapped

For grants for training and for training necessary expenses for research and demonstrations with respect to handicapped children pursuant to the Act of September 6, 1958, as amended (20 USC 611–617), and section 302 *and title V* of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, as amended (20 USC 618); for expenses necessary to carry out the Act of September 2, 1958, as amended (42 USC 2491–2492); and for grants [to States] and contracts under title VI of the Elementary and Secondary Education Act of 1965, as amended (20 USC 871–880), [$53,400,000] $85,225,000: Provided, That not to exceed $575,000 shall be available for necessary expenses of advisory committees, for services of specialists in reviewing applications for assistance, and for program evaluation.

Explanation

The insertion of "and title V" will permit the funds requested to be used for financing the new program for training physical education and recreation personnel for mentally retarded and other handicapped children. This new authority was added by the Mental Retardation Amendments of 1967 as title V of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. The proposed language change would permit the support of training and research and demonstration programs in this special area.

Language: Research and Training

For research, surveys, training, dissemination of information, and demonstrations in education and in librarianship as authorised by the Cooperative Research Act [of July 26,1954], as amended (20 USC 331–[332 (b)] 332 (b) [, as amended by title IV of the Elementary and Secondary Education Act of 1965, and the Elementary and Secondary Education Amendments of 1966]; section 4 (c) of the Vocational Education Act of 1963 (20 USC 35 [C]c(c)); section 224 (a)(1) of the Higher Education Act of 1965 [Public Law 89–329]; and section 602 [and title VII] of the National Defense Education Act of 1958 [as amended (20 USC ch. 17; Public Law 88–665), $90,967,600], as amended (20 USC 1034 (a)) $142,300,000 of which [$1,250,000] $6,000,000 shall be available for program evaluation without regard to the provision in subsection 2 (a)(2) of said Cooperative Research Act [of July 26, 1954,] as amended, and [$13,550,000] $15,700,000 shall be available for research [and special project activities], experimental, developmental, and pilot projects under section 4 (c) of said Vocational Education Act of 1963: Provided, that not to exceed $500,000 shall be available for necessary expenses for advisory committees, and for services of specialists in reviewing applications for assistance.

Explanation

The deletion of "and title VII" conforms with the Administration's Higher Education Amendments of 1968 which would allow this authority to expire. The educational media program now funded under title VII would in the future be funded under the broader authority of the Cooperative Research Act.

SOCIAL AND REHABILITATION SERVICE

Language: Mental Retardation

To carry out, except as otherwise provided for, sections 301, 303, and 311 of the Public Health Service Act, relating to the prevention, treatment, and amelioration of mental retardation, and parts B, C, and D of the Mental Retardation Facilities Construction Act (42 USC 2261, et seq.), $30,056,000, of which $6,600,000, shall remain available until expended, for grants for facilities pursuant to part B of the Mental Retardation Facilities Construction Act, $6,000,000, shall remain available until June 30, 1970, for grants for facilities pursuant to part C of the Mental Retardation Facilities Construction Act, and $8,358,000 shall be available for grants pursuant to part D of the Mental Retardation Facilities Construction Act: Provided, That there may be transferred to this appropriation from "Community mental health resource support" an amount not to exceed the sum of the allotment adjustment made by the Secretary pursuant to section 212 (c) of the Community Mental Health Centers Act: *Provided further, That allotments to States for the fiscal year ending June 30, 1969, pursuant to section 132 of the Mental Retardation Facilities Construction Act shall include, in addition to funds appropriated herein, funds appropriated for this purpose for the fiscal year ending June 30, 1968, but not alloted to States for that fiscal year.*

Explanation

HEW plans to use the $6 million which was not alloted in 1968 (because of HJR 888) for the Construction of Community service facilities in 1969. However, the basic act does not provide authority to allot funds in the second year of availability. The proposed change in the language provides the necessary authority.

AID TO IMPACTED AREAS

Mr. FLOOD. What legislation is being proposed by your shop to amend Public Law 874? Suppose you describe Public Law 874 first.

Mr. KELLY. Mr. Chairman, 874 is a law enacted in the early fifties to provide operation and maintenance assistance to school districts that were affected by the presence of the children of Federal workers who either lived and worked on Federal property or worked on Federal property and lived off of it.

Mr. FLOOD. This is also known as the impacted area program.

Mr. KELLY. Yes.

Mr. FLOOD. Do you happen to have in your pocket this afternoon any amendments to this program?

Mr. KELLY. No, but we are developing something to submit to the Congress designed to lower the cost of the Federal impact legislation and the entitlement, in order that those Federal funds which are spent for aid to education can be more heavily devoted to the disadvantaged youngster.

Mr. FLOOD. This is the afternoon of Tuesday, March 5. Have you heard in the last few days of any action taken in the other body with regard to this legislation?

Mr. KELLY. Yes, sir. The Senate added to the urgent deficiency appropriation an amount of money sufficient to bring it to full entitlement, almost $91 million, and it is this full entitlement we would like modified. We would like to get the legislative committee to reconsider the basis for eligibility and entitlement because of the Federal impact.

Mr. FLOOD. What other legislation are you proposing this session?

Mr. CARDWELL. Mr. Chairman, could I make a point about the last item? The proposal would not reduce funding requirements before 1970.

Mr. KELLY. Assistant Secretary Huitt has a summary.

Mr. FLOOD. What is your position, Mr. Huitt?

Mr. HUITT. Assistant Secretary for Legislation, Mr. Chairman.

Shall I run through the legislative proposals we are bringing up this session?

Mr. FLOOD. Yes. Suppose you indicate for us now some of the chief pieces of legislation you propose, and a short analysis, and then for the record supply amplification of those main bills and a list of any other bills that are not in that category, perhaps.

EDUCATION

Mr. HUITT. In the education field, we have a very large Higher Education Act. I might say the characteristic of most of these pieces of legislation is——

Mr. FLOOD. When you say you have such an act, are you writing it? Is it before the House? What is its position?

Mr. HUITT. There have been hearings in the House and will be heard in the Senate a couple of days in the middle of the month and then 3 more days at the end of March.

Mr. FLOOD. What does it propose in broad, sweeping terms?

Mr. HUITT. In the main, this bill extends and strengthens the Higher Education Act of 1965, the National Defense Education Act of 1958. It makes improvements in the guaranteed student loan program. It combines three kinds of student assistance: the NDEA loans, the educational opportunity grants, the work-study program, and a single program which makes it possible for the colleges to make a single application and get a single grant, with some flexibility allowed, so they can shift money from one fund to another, up to 20 percent.

There are some new items in it, one called a Network for Knowledge Act, which will give some support to colleges and universities who want to combine and share some of the strength they have.

Mr. FLOOD. Who thinks up these phrases?

Mr. COHEN. It is a joint effort.

Mr. HUITT. This particular title is taken from the President's statement when he signed the Public Broadcast Act.

This would make it possible for institutions who want to share a computer, library sources, professors, or some kinds of closed-circuit television to do so with the Government paying only for the connections, not for the rest of the costs, but for the connections.

There will be some assistance to the Nation's graduate schools, the attempt here being to help those schools which are not in the very first ranks——

Mr. FLOOD. If there is anybody left in the graduate schools.

Mr. HUITT. Yes, sir, if there is anybody left in the schools. This would not help the first 15 or 20 centers of excellence, like Harvard and so forth, but the next hundred who are good graduate schools and

who could afford to be strengthened will get some help from this piece of legislation.

Mr. FLOOD. You are aware there is quite a rumbling in the provinces about these 10 or a dozen Ivy League-type schools. Other schools and universities are complaining they are being discriminated against and, of course, it is true that they have been. Will this help that situation?

Mr. HUITT. Yes, sir. That is pretty much what is in the higher education amendment.

VOCATIONAL EDUCATION

We also have a Vocational Education Act called partnership for earning and learning. This will combine a number of scattered vocational education authorities. There is the Smith-Hughes Act, and the George Barden Act and the Vocational Educational Act of 1963. This is a kind of rigid framework. This will put them all together in one act and will make it much more flexible for the States. Where hitherto they have had to match on every project that they approve, now they will only have to match statewide the Federal money.

Mr. FLOOD. I don't get the distinction.

Mr. HUITT. If the matching is, say, 50–50, they will not have to require every local community who gets a project to match 50–50. They might take Federal funds and pay 100 percent of it in one district and then in the same instance not use any money at all in some others.

Mr. FLOOD. That makes sense.

Mr. HUITT. Then this new act also has some project grants for innovation in vocational education.

Mr. FLOOD. What innovation?

Mr. HUITT. In this case it is an effort to make vocational education a little more realistic and a little more useful.

Mr. FLOOD. How?

Mr. HUITT. For instance, some educators might want to put in something to start vocational education in junior high schools. They might want to do some experimenting with work study or something like that, tying in with the local employment service to make sure that their programs have been really working. But this is only a little bit of money to encourage them to try tyings that they have not attempted before.

Mr. FLOOD. What is another major one?

CONSUMER LEGISLATION

Mr. HUITT. We have several pieces of consumer legislation that I think we ought to mention. One is the Wholesome Fish and Fisheries Products Act. This will set the Government to the business, or I should say the Food and Drug Administration, to the business of setting standards for wholesomeness in fish products.

Mr. FLOOD. Are you using as a precedent what the Congress did in the Meat Act?

Mr. HUITT. It is very much like that.

This would require the Food and Drug Administration to set some safety and quality standards and to enforce those standards. It also would apply to imported fish and fish products.

Mr. FLOOD. Imported fish products in the sense of maintaining the standard of quality or in the sense of a restriction of import?

Mr. HUITT. No, sir; standard of quality, only that.

HAZARDOUS RADIATION ACT

Then there is one which has already had some hearings in the House called a Hazardous Radiation Act.

There would be the development of standards by the Public Health Service with the enforcement of those standards——

Mr. FLOOD. You don't mean just in uranium mining now. You mean television——

Mr. HUITT. Television, electronic products, sound products which radiate.

Mr. FLOOD. Anywhere that the consumer might be affected?

Mr. HUITT. Yes, sir. This began with the discovery some television sets were emitting radiation. This is an attempt to see that this kind of thing doesn't happen and to set up provisions where such can be recalled.

Mr. FLOOD. The manufacturers themselves, particularly two of them, have done considerable work on this on their own, have they not?

Mr. HUITT. Yes, sir; that is correct.

MEDICAL DEVICE SAFETY ACT

Then we have another one which we thought up last year called the Medical Device Safety Act. This, in effect, divides medical devices into about four classes, those which can be rendered safe by setting standards. In a word, there are quite a lot of them on the market already——

Mr. FLOOD. Is this hardware?

Mr. HUITT. Yes. In this case bone pins, catheters and things of that kind. Then there is another type which goes into or on the body which emits radiation into the body and which would be required to be precleared. That is, they would have to submit to the Food and Drug Administration the specifications for the devices before they were put on the market, much as drugs are now. They would then have to be precleared before they could be sold.

Mr. FLOOD. You are talking about some new kind of hardware, as well?

Mr. HUITT. We are talking about the field of medical devices. Where some device is likely to be dangerous where it is going to be put in the body, or where it is going to be put on the body, then it will have to be precleared for safety and reliability by the Food and Drug Administration. Then where there is a large class of devices, such as bone pins and so forth, where standards can be set for the materials used, for the sizes of them or something of that kind, then the standards would be set.

Mr. FLOOD. Those are embraced in a series of bills?

Mr. HUITT. No, sir; this is one bill.

Mr. FLOOD. What is the status?

Mr. HUITT. No hearings have been held yet in either House.

Mr. FLOOD. It has been filed?

Mr. HUITT. Yes, sir.

Mr. FLOOD. In both Houses, I presume?

Mr. HUITT. No, sir; only in the House of Representatives.

Mr. FLOOD. Would you pick one other for the purpose of this hearing and then list the others for the record?

HEALTH MANPOWER AMENDMENTS

Mr. HUTT. All right, sir. I think the one I would pick is the health manpower amendments in which we renew a number of very important health bills. The Health Professions Education Assistance Act, the Health Research Act, the Nurse Training Act; this whole array of acts which equip professionals to go out into the country and to work. This bill is aimed at meeting the manpower requirements in the medical field. All of these have been on the books for some time.

Mr. FLOOD. I understand this much-discussed President's message of yesterday indicates at some point that an effort will be made to divert some of the manpower training funds into the area of medicine, dentistry, and scientific and medical technician training. Is that correct, as distinguished from the broad scope of manpower?

Mr. COHEN. I wouldn't say to divert it.

Mr. FLOOD. It is not a diversion?

Mr. COHEN. It is not a diversion. It is an emphasis. It is a continuation and accentuation of the programs.

Mr. FLOOD. I had the impression it was a diversion.

Mr. COHEN. I do not believe so.

Mr. HUTT. This would take care of physicians, optometrists, nurses, allied health professions. These technicians and people like that——

Mr. FLOOD. Chiropractors?

Mr. HUTT. No, sir, they are not in. These persons who are paramedical people, who are technicians who support the doctors, all of these would be trained under this bill. We think it is a very important one.

(The requested detail concerning the Department's legislative program follows:)

1968 LEGISLATIVE PROGRAM IN DRUGS AND CONSUMER PROTECTION

I. U.S. DRUG COMPENDIUM ACT OF 1968

Authorizes the Secretary of HEW to publish an up-to-date, complete compendium of lawfully available drugs together with useful prescribing information.

Drugs listed by generic name.

Compendium paid for by the drug industry.

Pricing information contained in a supplement.

II. MEDICARE-MEDICAID DRUG COST DETERMINATION ACT OF 1968

Authorize the Secretary of HEW to establish a reasonable cost range for drugs supplied under the present medicare, medicaid, and maternal and child health programs.

Cost range would not exceed the amount at which a drug is generally available by its generic name, unless there is a sole supplier, or if the drug sold by brand name has distinct therapeutic advantages.

III. DANGEROUS DRUG PENALTY AMENDMENTS OF 1968

Makes the illegal manufacturing and traffic in hallucinogenic drugs (including LSD) and other depressant and stimulant drugs a felony.

Makes personal possession of such drugs a misdemeanor.

IV. WHOLESOME FISH AND FISHERY PRODUCTS ACT OF 1968

Authorizes the Secretary of HEW to establish continuous inspection of fish processing plants and appropriate inspection of vessels.

Regulations for the storage and handling of fish.
Grants to States to improve intrastate fish inspection.
Federal takeover of intrastate fish inspection if States do not develop adequate programs with in 2 years.

V. HAZARDOUS RADIATION ACT OF 1968

Authorizes mandatory standards for electronic products to protect against hazardous radiation.
Research on the biological effects and control of radiation hazards.
Notification and recall by manufacturer of electronic products on the market emitting excessive radiation.

VI. MEDICAL DEVICE SAFETY ACT OF 1968

Divides medical devices into three categories: First, those devices which would be safe when manufactured under Federal mandatory standards, such as bone pins, catheters, and diathermy machines; second, those devices, such as artificial kidneys and other organ substitutes, that would go through a clearance procedure before being put on the market; third, common patient-care devices, such as crutches and band aids, not requiring any regulation."

VII. METHOD OF PAYMENT OR REIMBURSEMENT UNDER MEDICARE, MEDICAID AND CHILD HEALTH

Authorizes the Secretary, after experimentation, to utilize different methods of payment or reimbursement under the medicare, medicaid, and child health law, when he finds that such methods will provide incentives for increasing the economy and efficiency of health services without adversely affecting the quality of such health services.

1968 LEGISLATIVE PROGRAM IN EDUCATION

HIGHER EDUCATION AMENDMENTS OF 1968

Extend and strengthen the Higher Education Act of 1965 (expiring June 30, 1968)—contains various technical amendments.
Extend and strengthen the National Defense Education Act of 1958 (expiring June 30, 1968)—contains various technical amendments.
Extend the Higher Education Facilities Act of 1963 (expiring June 30, 1969).
Education for the public service.
Grants to colleges and fellowships for graduate students to strengthen preparation for careers in the public service (State, local, and Federal Government—$10 million in fiscal year 1969).

Educational Opportunity Act

Combine NDEA loans, educational opportunity grants, work-study into a more flexible student-aid package, giving college student-aid officers more discretion in use of Federal funds.
Improvements in guaranteed student loan program.
Remedial programs for college students, to follow up on the public investment in talent search, Upward Bound, etc., provide project grants for special programs helping disadvantaged students succeed in college and, possibly, go on to graduate school—$15 million in fiscal year 1969.

Networks for Knowledge Act

Encourage sharing of expensive resources (library services, computers, faculty) to spread quality research and instruction among the Nation's colleges—$8 million in fiscal year 1969.

New strength for the Nation's graduate schools

Increase institutional or cost-of-education grants accompanying graduate fellowships from $2,500 to $3,500 (all fellowships; all Federal agencies).
Grants to help develop a larger number of high-quality graduate schools.

PARTNERSHIP FOR EARNING AND LEARNING

Amendments to Vocational Education Act of 1963 to make it more flexible and more effective.

Consolidate scattered vocational education authorities into one State-plan program.

Project grants for improvement of occupational education for all students through model or exemplary programs—$15 million in fiscal year 1969.

LEGISLATIVE PROGRAM IN HEALTH—1968

I. HEALTH MANPOWER AMENDMENTS OF 1968

Extend the health professions educational assistance program for 4 additional years. Grants would be authorized for construction of facilities, education improvement, and student assistance. Eligible institutions would include those engaged in the training of physicians, dentists, optometrists, podiatrists, and osteopaths.

Extend the nurse training program for 4 additional years to provide assistance to diploma, collegiate, and associate degree schools of nursing. Assistance would include construction grants, support and program improvement grants, and student assistance.

Extend the allied health professions personnel training program for 1 additional year. Grants for construction of teaching facilities, educational improvement grants, development grants and advanced traineeships would be provided to schools engaged in the training of those personnel in the professions allied to the medical profession, such as medical technologists.

Extend the graduate public health training program for 4 additional years. Assistance would include public health traineeships as well as project grants to schools of public health, schools of nursing, and schools of engineering for public health training.

Extend the health research facilities construction program for 4 additional years. This would expand the Nation's research capacity in the field of health.

II. PUBLIC HEALTH PERSONNEL ACT OF 1968

Amends the Public Health Service Act to establish an improved and modernized health personnel system in the Department of Health, Education, and Welfare.

III. HEALTH SERVICES ACT OF 1968

Extends the Heart, Cancer, and Stroke Amendments of 1965. The regional medical programs were authorized for 3 years by the Heart Disease, Cancer, and Stroke Amendments of 1965. Their purpose is the development and implementation of action programs to capitalize on new medical knowledge and techniques, and evolve more effective organization of health resources for delivering the full benefits of currently available knowledge and skills for the diagnosis and treatment of heart disease, cancer, and stroke.

Extends the Migrant Health Act of 1962. Extends program of grants for health services for migratory agricultural workers for 2 years.

Authorizes a 2-year program of grants for the prevention and treatment of alcoholics and narcotic addicts; to be known as the Alcoholic and Narcotic Addicts Rehabilitation Amendments of 1968.

IV. CHILD HEALTH ACT OF 1968

A maternal and child health program for families unable to afford such care themselves. It would afford access to health services, beginning with prenatal care of the mother and continuing through the baby's first year of life.

V. THE SAFE DRINKING WATER ACT OF 1968

Amend section 361 of the Public Health Service Act to permit the establishment of drinking water standards to cover toxic and radioactive materials in connection with any water supplies to which Public Health Service regulations apply.

VI. THE SOLID WASTE DISPOSAL ACT OF 1968

Extends for 1 year the Solid Waste Disposal Act of 1965. The current act permits a balanced attack on the solid waste problem through research on the problem and its effects, support of projects to demonstrate improved waste management techniques, technical assistance and training and support of State solid waste planning.

TWO-YEAR TECHNICAL SCHOOLS

Mr. FLOOD. Is there any suggestion about trying to establish more of or to enlarge the existing 2-year technical schools for the whole broad field of paramedical technical assistants?

Mr. HUTT. They would be assisted. The nurse training program, for instance, includes the so-called associate degree schools; that is, the 2-year schools, and much of the allied health professions training is done in the junior colleges. I would think this is a great boost to them.

Mr. FLOOD. I have the impression we are far behind in these 2-year technical training schools. I should know more about it than I do, but I heard so much about this on my European trip several years ago in Germany and Russia. I was terribly impressed by these people. The Russians and the Germans certainly gave me briefings and presentations upon what a fantastic job they are doing in this area of the 2-year technical training schools. Some people don't want to be doctors or dentists, they want to be technicians.

Mr. COHEN. I think you might find it interesting if I put this table at this point in the record. I have here the most recent table about the junior college enrollment by States.

(The table follows:)

Total opening enrollment of 2-year institutions, fall 1967 [1]

Region and State:	*Number*
Total, United States and outlying areas	1,499,194
New England	49,133
Connecticut	10,385
Maine	285
Massachusetts	30,830
New Hampshire	1,115
Rhode Island	4,794
Vermont	1,724
Mideast	212,193
Delaware	2,375
District of Columbia	2,608
Maryland	21,134
New Jersey	12,038
New York	143,226
Pennsylvania	30,812
Great Lakes	213,239
Illinois	93,005
Indiana	2,310
Michigan	83,173
Ohio	21,973
Wisconsin	12,778

Footnote is on p. 169.

Total opening enrollment of 2-year institutions, fall 1967 [1]—Continued

Region and State—Continued	*Number*
Plains	73,262
Iowa	17,078
Kansas	13,207
Minnesota	12,850
Missouri	22,037
Nebraska	3,372
North Dakota	4,361
South Dakota	357
Southeast	192,522
Alabama	17,141
Arkansas	2,574
Florida	82,833
Georgia	14,177
Kentucky	3,558
Louisiana	128
Mississippi	19,138
North Carolina	24,403
South Carolina	4,932
Tennessee	5,588
Virginia	15,457
West Virginia	2,593
Southwest	119,233
Arizona	21,814
New Mexico	1,454
Oklahoma	21,814
Texas	83,491
Rocky Mountain	25,461
Colorado	11,960
Idaho	6,003
Montana	882
Utah	2,659
Wyoming	3,957
Far West	608,871
Alaska	85
California	527,975
Hawaii	177
Nevada	----
Oregon	21,457
Washington	59,177
Outlying areas	5,280
Canal Zone	1,284
Guam	----
Puerto Rico	2,700
Virgin Islands	1,296

[1] Includes degree-credit enrollment of 1,023,000, as well as non-degree-credit enrollment. Degree-credit enrollment reflected on p. 1509, has not been projected by individual States.

Mr. FLOOD. I am getting impressed by these junior and community colleges.

Mr. COHEN. For instance, in Pennsylvania, between 1965 and 1966 junior college enrollment increased 46 percent.

Mr. FLOOD. Do you have any of these, Mr. Laird, Mr. Michel?

Mr. MICHEL. We have a new college in Peoria that has been under way now less than a year and a half or so and we are up to over 3,500 students.

Mr. FLOOD. We just got one in Wilkes-Barre and it appears to be a very exciting thing.

Mr. MICHEL. We have another big bond issue coming up in Illinois.

Mr. FLOOD. One thing that impresses me about these things. A boy or girl can attend school for 2 years and then if they want to go to work and earn some money they can do it. At the same time, there is night school at various colleges and universities in the area where they can go ahead with 3 or 4 more years and get a degree if they are so inclined. I don't know to what extent we have developed this in this Nation. Apparently not very far.

Mr. COHEN. It has been going very rapidly. The increase in enrollment in the last 4 years has averaged about 15 percent per year. It is now at nearly 1.5 million, whereas in 1963 it was only 850,000.

Mr. FLOOD. Is that a lot of people for these schools?

Mr. COHEN. Yes; in terms of the recent period. I think they will grow still more. I have no question in my mind——

FUNDING 2-YEAR SCHOOLS

Mr. FLOOD. Can the community afford these things? Mr. Michel said they were going to have a bond issue? Can these communities handle this? We hear that some communities can't afford anything more. Now, how can they afford these?

Mr. KELLY. Turning it around the other way, both in terms of the public expenditure of funds——

Mr. FLOOD. They can't afford not to afford it?

Mr. KELLY. That is right. This is a much more economical system of providing higher education.

Mr. MICHEL. One of the biggest selling points in this current bond issue—and since they are making the pitch to a number of farmers and it is a pretty hard issue to sell the farmers now with taxes going up—the point is used that, with your children striving for a college education, here is an opportunity to cut costs of dormitory and travel by having them to go to a first-rate school right here at home.

Mr. COHEN. It might save a man $4,000 or $5,000 per child, or more.

Mr. HUTTT. I might just comment on the junior colleges a minute since I began my teaching career in one. I think one of the great by-products of them is that it does put the technical student and the kid who is going on to get an advanced degree perhaps, on the same campus.

Mr. FLOOD. We must make this respectable.

Mr. HUTTT. I think it is.

Mr. FLOOD. To run around with an A.B. in your hip pocket is not everything.

Mr. CARDWELL. There is title III in the Higher Education Act of 1965 which provides some assistance for so-called developing institutions and in some cases the community college can draw money from the program.

Mr. FLOOD. Where are you going to get faculties for my community college and Mr. Michel's community college? Where are you stealing these people, from somebody else?

Mr. HUTTT. I think we can get them out of the regular supply of people for the colleges.

Mr. FLOOD. There is no supply.

Mr. HUTTT. It is coming out. This is where I started and a lot of people started. I think the worst thing we could do would be to train people to be junior college teachers. This sets them aside as not quite college teachers.

Mr. FLOOD. There is more piracy going on among these schools and colleges than there ever was on the Barbary Coast.

Mr. HUTTT. You can get some very good teaching in these junior colleges if you have a young man who is on the make, who is trying to get a graduate degree and wants a start in teaching, and who knows this is the gateway. If he is good enough, he can go ahead and teach it harder.

Mr. FLOOD. Suppose you are a smart young teacher in my community college in Wilkes-Barre. You start writing papers and appearing on television. There is a man coming down from Cambridge in the next 6 months and you are gone.

Mr. HUTTT. We used to have a dean at the University of Wisconsin who used to say if Harvard wanted to hire away our professors for the last 5 or 6 years of their lives, Harvard was welcome to them. I don't think you can do much better than get the first 2 or 3 years of teaching of an ambitious and able young man who wants to go on.

Mr. FLOOD. A very good point.

Mr. COHEN. Junior colleges do have this advantage, especially in large metropolitan areas. Take, for instance, in the Washington area where they have the junior college in Montgomery County. They have classes between 4 and 8 o'clock and they can use people there in the community who have other types of employment. You can get French teachers, science teachers, and so on.

I think we should not overlook part-time people, particularly wives and women who do not want to work full time.

Mr. FLOOD. That is a good point.

ELIMINATION OF POVERTY IN THE UNITED STATES

You made a speech early in December to the effect that the United States can end poverty by 1985. It says here in the Milwaukee Journal, December 4, 1967: "United States can end poverty by 1985, Cohen says."

What is the so-called poverty line under the current definition?

Mr. COHEN. It runs now about $3,300 for a family of four.

Mr. MICHEL. When did it go to $3,300?

Mr. COHEN. It is adjusted by prices. It was roughly $3,200 a couple of years ago and that level, without changing it, is just adjusted for price level. It is adjusted for size of family. It is now roughly $1,600 for a single aged person, and roughly $2,000 for an aged couple.

There were about 40 million persons in poverty in 1959 and by these same standards adjusted for prices, there are about 26 million at the present time.

The yardstick remained the same except for applying it to the changed population and the prices. So we are down now to the point where we have decreased the number in poverty by about 14 million over that period of time.

I would estimate that with continued economic growth over the next 10 or 20 years, we could reduce the number in poverty by another 10 or 15 million.

Mr. FLOOD. Then you are not going to run out of poverty by 1985.

Mr. COHEN. I think it is going to get tougher as we go along. Now, of the number now in poverty, about 5 million are aged, over 65.

If you look at it this way, Mr. Chairman, I don't see any reason why, in the foreseeable future we couldn't work it out so that the 5 million poor people age 65 and over are removed from poverty. We have the mechanism now through the social security program by which, perhaps not all at one stroke, but by raising the payments and adjusting——

Mr. FLOOD. Can you keep up with the increasing age of the population and the population ratio?

Mr. COHEN. Certainly with respect to the aged. I think there we have what I would call a first responsibility because those people have worked and contributed to this Nation. Many of them have paid into social security, a large proportion of them have very low resources and I would think that by the next 5 or 10 years we could have a system that would, in effect, take those 5 million people out of poverty.

By that time I would say that we could be down to maybe a total group in poverty in the nature of 10 or 15 million. By 1985, if you took the aged out of poverty and there had been economic growth so another 10 or 15 million were taken out of poverty, we might come to a situation where we only had a hard core of 5 or 10 million left in poverty out of a population, let's say, of 250 million which would represent, instead of 15 percent of the population, maybe 2, 3, or 4 percent.

If, at that time, the load were that low, it would seem to me it would not be economically infeasible to have some type of a program that would, in effect, raise their income up to——

Mr. FLOOD. Put a rifle right on that target.

Mr. COHEN. Yes. I think quite frankly the big difficulty will not be a financial one by that time, but a broad question of public policy as to whether that should be achieved through an income program alone, or through an income and work and training program. When we get to that hard core at the end, they may be people who have very low intelligence, and very little educational and training potential. They may be people for whom we may have to have what I would call a sheltered workshop approach. They may be people who would be of very limited ability to do very expert things——

WORK MOTIVATION

Mr. FLOOD. Let me ask you this: Suppose you identify in the town of B that there are 24 men who are able to work, and simply refuse point blank to take pretty good jobs that pay well. They won't get off the front porch and they are physically and mentally able and the job is across the street.

What should we do, would you say, with those 24 men?

Mr. COHEN. Well, I don't think I have a good answer for that type of case. We find a number of people who lack motivation.

I think you are always going to have 24 like that. The only thing I think we can do is to set up the kind of training courses and the kind of opportunities and the kind of incentives that will attract them to work. I will say quite frankly, you are going to find some that you just can't effectively deal with.

Mr. FLOOD. There is a human equation there where laws, the Constitution and nothing else can handle it.

Mr. COHEN. I go back to my point on motivation. I think the key element that I would try to emphasize is working with the young people where you instill motivation in them when they are young. When you have that fellow when he is 23 or 24 and he is of the caliber you are talking about, you already have a tough problem. He has probably been the kind of fellow who has seen his father not work, has seen his father desert the family, or has seen his father get by by selling drugs or selling tickets or being a bookie or whatever it is.

Mr. FLOOD. I don't mean the teenagers either. I mean men older than that.

Mr. COHEN. From my discussions with the child psychologists, and the people who have been working on this problem, the point I think where we are all influenced is by the pattern that our parents set for us.

Mr. FLOOD. I am not talking about that broad sociological sweep. I am talking about the fellow sitting on the front porch when you and I know there is a job across the street for him. He won't take it and I can't make him take it.

JOB QUALIFICATIONS

Mr. MICHEL. Like yesterday, it was pointed out in Chicago there are 500 jobs waiting in the Post Office Department and they can't get people to fill them. The Post Office Department, of all things, in the city of Chicago.

Mr. FLOOD. On the other hand, in San Francisco they put in that program with 400 people after their riots. A very high percentage of these fellows can never possibly pass a civil service examination, but their work production on their supervisors' sheets is equal to, or in some cases better than, the people who have passed the examination.

The Civil Service Commission puts out job descriptions in which they say, "You must have a college degree or the equivalent thereof." In this San Francisco Post Office, why can't 75 of these boys, whom their supervisors mark as equal or superior to some of the people who have passed the examination, why can't they be assured of some kind of permanence in their job because of "the equivalent thereof," in lieu of an examination?

Mr. COHEN. I have discussed that problem many times with many people. I think sometimes with jobs we make educational requirements which are unnecessary.

Mr. FLOOD. I am sure of that.

Mr. COHEN. I am convinced of that.

Mr. KELLY. There has been a movement in the last couple of years to utilize a certain number of jobs in public service and to encourage

the private sector to do similarly, to employ people who don't meet the competition, to employ, for example, the mentally retarded.

Mr. FLOOD. I saw in the paper the other day that the Civil Service Commission is considering this kind of thing for veterans returning from Vietnam who can't meet examination standards. They are about to permit these fellows to take these jobs. Do you know under what conditions they are accepted?

Mr. KELLY. They get an appointment that is subject to being confirmed by a noncompetitive examination.

Mr. FLOOD. With that as a precedent, why couldn't that system be extended to these fellows in the San Francisco Post Office?

Mr. COHEN. My son dropped out of school and worked in the post office for 1 year. I think from what he told me that there are many, many jobs there that individuals could do without the rigid specifications that they had in the past.

Mr. FLOOD. Will that take law to do what I think should be done?

Mr. KELLY. To do it on any large scale.

This is what we are now asking private business to do. It is very hard to adjust your concept of management from one in which you searched for the best qualified person and in which you disposed of the least productive employee, to one in which you now try to utilize the people who are not the most productive employees in our society, retain them and make them useful and productive citizens.

Mr. COHEN. In that connection, I think this National Alliance of Business that Henry Ford is now heading and Mr. Beebe is the executive officer, may well be one of the most significant things to happen, because it may have an impact on the employer himself. It may convince the employer to make a greater effort.

UNOBLIGATED AND UNEXPENDED BALANCES

Mr. FLOOD. We hear more and more talk in the Congress about the vast unexpended balances that should be used before we appropriate more funds.

Would you place in the record a table showing, by appropriation, the unobligated balaces carried forward from 1967 to 1968 and the estimated carryover from 1968 to 1969. And then do the same for the obligated balances that remain unexpended.

In some of these there will be significant amounts. If and when a significant amount appears, you should have a paragraph or so of explanation.

Mr. KELLY. Very well.

(The information requested follows:)

ANALYSIS OF CARRYOVER BALANCES

	Unobligated balance brought forward		Obligated but unexpended balance brought forward	
	Beginning of 1968	Beginning of 1969	Beginning of 1968	Beginning of 1969
FOOD AND DRUG ADMINISTRATION				
Salaries and expenses			$12,396,000	$15,921,000
Buildings and facilities	$21,149,000	$16,332,000	520,000	3,186,000
Total, Food and Drug Administration	21,149,000	16,332,000	12,916,000	19,107,000
OFFICE OF EDUCATION				
Elementary and secondary educational activities			506,554,000	660,456,000
School assistance in federally affected areas	51,158,000	49,233,000	161,049,000	209,270,000
Education professions development activities			4,559,000	4,772,000
Teacher Corps			1,451,076,000	1,508,122,000
Higher educational activities	48,124,000	197,472,000	183,464,000	178,404,000
Expansion and improvement of vocational education	2,448,000		45,437,000	106,453,000
Libraries and community services	15,417,000	9,000,000	35,465,000	48,415,000
Educational improvement for the handicapped			48,391,000	75,578,000
Research and training	30,781,000	29,581,000	2,732,000	14,332,000
Foreign language training and area programs			1,225,000	113,000
Educational research and training (special foreign currency program)	213,000		7,747,000	7,419,000
Salaries and expenses			7,627,000	7,896,000
Civil rights educational activities			212,637,000	18,637,000
Defense educational activities			637,000	672,000
Arts and humanities educational activities				
Colleges for agriculture and the mechanic arts			3,791,000	
Promotion of vocational education, act of Feb. 23, 1917				
Student loan insurance fund	3,750,000	3,646,000		
Higher education facilities loan fund	101,230,000	50,000,000	187,150,000	304,689,000
Payment of participation sales insufficiencies				
Total, Office of Education	253,121,000	339,022,000	2,859,541,000	3,145,228,000
PUBLIC HEALTH SERVICE				
Office of the Surgeon General:				
Salaries and expenses, Office of the Surgeon General			299,000	401,000
Comprehensive health planning and services	2,500,000	5,000,000	1,341,000	84,666,000
Subtotal, Office of the Surgeon General	2,500,000	5,000,000	1,640,000	85,067,000
Health manpower:				
Health manpower education and utilization		250,000	8,360,000	108,549,000
Construction of health educational facilities	59,058,000	126,658,000	258,107,000	305,507,000
Dental services and resources			4,956,000	
Nursing services and resources			11,199,000	
Health professions education fund	12,380,000	14,436,000		
Nurse training fund	8,347,000	9,748,000		
Payment of sales insufficiencies				
Subtotal, health manpower	79,785,000	151,092,000	282,622,000	414,056,000
Disease prevention and environmental control:				
Chronic diseases	1,857,000		58,635,000	19,329,000
Communicable diseases	2,610,000	2,610,000	17,023,000	22,951,000
Air pollution	4,040,000	11,000,000	17,901,000	36,212,000
Urban and industrial health			11,625,000	22,608,000
Radiological health			7,869,000	6,206,000
Injury control			2,532,000	
Control of tuberculosis			7,607,000	1,463,000
Control of venereal diseases			1,900,000	
Occupational health			3,142,000	
Foreign quarantine activities			665,000	
Subtotal, disease prevention and environmental control	8,507,000	13,610,000	128,234,000	108,769,000
Health services:				
Community health services		17,500,000	60,636,000	31,247,000
Patient care and special health services			4,354,000	4,496,000
Hospital construction activities	237,046,000	239,969,000	496,512,000	565,059,000
Indian health activities			9,832,000	15,305,000
Construction of Indian health facilities	10,382,000	10,068,000	11,567,000	9,432,000
Emergency health activities	8,627,000	7,574,000	2,263,000	4,263,000
Medical care services			6,134,000	
Subtotal, health services	256,055,000	275,111,000	591,963,000	629,802,000

ANALYSIS OF CARRYOVER BALANCES—Continued

	Unobligated balance brought forward		Obligated but unexpended balance brought forward	
	Beginning of 1968	Beginning of 1969	Beginning of 1968	Beginning of 1969
PUBLIC HEALTH SERVICE—Continued				
National Institutes of Health:				
Biologics standards			$2,638,000	$3,145,000
National Cancer Institute			121,557,000	138,297,000
National Heart Institute			113,459,000	128,742,000
National Institute of Dental Research			18,345,000	23,167,000
National Institute of Arthritis and Metabolic Diseases			77,807,000	88,651,000
National Institute of Neurological Diseases and Blindness			71,244,000	90,467,000
National Institute of Allergy and Infectious Diseases			96,489,000	72,812,000
National Institute of General Medical Sciences			110,847,000	141,780,000
National Institute of Child Health and Human Development			42,155,000	49,190,000
Regional medical programs	$25,900,000	$30,900,000	26,680,000	62,335,000
Environmental health sciences			18,278,000	18,279,000
General research and services, NIH			55,354,000	64,329,000
Grants for construction of health research facilities	15,608,000	12,208,000	150,037,000	149,437,000
John Fogarty center for advanced study in health science		50,000		386,000
Construction of mental health-neurology research facilities	615,000	34,000	4,798,000	1,379,000
General research support grants			47,816,000	47,816,000
National Institute of Health management fund			5,933,000	5,933,000
Subtotal, National Institutes of Health	42,123,000	43,192,000	963,437,000	1,086,145,000
National Institute of Mental Health:				
Mental health research and services	1,479,000		224,199,000	252,577,000
Community mental health resource support	45,380,000	45,000,000	78,828,000	139,376,000
St. Elizabeths Hospital, salaries and expenses			1,938,000	2,769,000
St. Elizabeths Hospital, buildings and facilities	11,808,000	10,604,000	687,000	74,000
Subtotal, National Institute of Mental Health	58,667,000	55,604,000	305,652,000	394,796,000
Other Public Health Service:				
National health statistics			3,168,000	3,222,000
National library of medicine	10,567,000	4,171,000	8,098,000	23,606,000
Buildings and facilities	33,878,000	35,046,000	16,130,000	5,044,000
Scientific activities overseas (special foreign currency program)	850,000	850,000	13,333,000	18,333,000
Retired pay of commissioned officers			4,206,000	5,006,000
Subtotal, other Public Health Service	45,295,000	40,067,000	44,935,000	55,211,000
Total, Public Health Service	492,932,000	583,676,000	2,318,483,000	2,773,846,000
SOCIAL AND REHABILITATION SERVICE				
Grants to States for maintenance payments				694,000,000
Work incentive activities				25,000,000
Grants to States for medical assistance				525,000,000
Social services, administration, training, and demonstration projects				135,000,000
Grants to States for public assistance			889,109,000	44,985,000
Assistance for repatriated U.S. nationals			92,000	110,000
Grants for rehabilitation services and facilities	$949,000	$1,405,000	$46,207,000	$58,032,000
Mental retardation				
Maternal and child health and welfare			66,653,000	79,953,000
Development of programs for the aging			7,545,000	12,412,000
Rehabilitation research and training			25,476,000	27,623,000
Cooperative research or demonstration projects			2,655,000	2,505,000
Research and training (special foreign currency program)	581,000	581,000	6,542,000	6,722,000
Social and rehabilitation service, salaries and expenses			1,561,000	1,806,000
Assistance to refugees in the United States			8,867,000	10,628,000
Grants for correctional rehabilitation study			600,000	600,000
Juvenile delinquency and youth offenses			6,338,000	
Total, Social and Rehabilitation Service	1,530,000	1,986,000	1,031,645,000	1,624,376,000
SOCIAL SECURITY ADMINISTRATION				
Payment to trust funds for health insurance for aged	100,000,000			
Payments for military service credits			105,000,000	105,000,000
Total, Social Security Administration	100,000,000		105,000,000	105,000,000

ANALYSIS OF CARRYOVER BALANCES—Continued

	Unobligated balance brought forward		Obligated but unexpended balance brought forward	
	Beginning of 1968	Beginning of 1969	Beginning of 1968	Beginning of 1969
SPECIAL INSTITUTIONS				
American Printing House for the Blind				
National Technical Institute for the Deaf	$528,000	$1,103,000	$36,000	$1,131,000
Model Secondary School for the Deaf, salaries and expenses				90,000
Model Secondary School for the Deaf construction		275,000		
Gallaudet College, salaries and expenses			126,000	188,000
Gallaudet College construction	$520,000	$959,000	$138,000	$422,000
Howard University, salaries and expenses			1,045,000	1,779,000
Howard University construction	12,713,000	10,084,000	3,029,000	6,484,000
Freedmen's Hospital, salaries and expenses			1,836,000	1,912,000
Total, special institutions	13,761,000	12,426,000	6,270,000	12,006,000
OFFICE OF THE SECRETARY				
Salaries and expenses, Office of the Secretary			1,709,000	1,332,000
Office of Field Coordination, salaries and expenses			43,000	97,000
Office of the Comptroller, salaries and expenses			292,000	569,000
Office of Administration, salaries and expenses				170,000
Surplus property utilization			75,000	86,000
Office of the General Counsel, salaries and expenses			182,000	262,000
Educational broadcasting facilities	164,000		14,988,000	8,491,000
Total, Office of the Secretary	164,000		17,289,000	11,007,000
Total, Department of Health, Education, and Welfare	882,657,000	953,442,000	6,381,144,000	7,690,570,000

Explanation of Unobligated Balances

The main reason why unobligated balances are so large in 1968 and 1969 is the constraint which has been placed on all domestic programs in the last couple of years. In 1967, the effort to combat inflation, caused a slowdown in many programs, particularly construction grants. As a result, larger than budgeted unobligated balances built up. In 1968, Public Law 90–218 required a very significant cutback in the Department's programs. In construction programs alone a reduction of $337 million was made. Cutbacks in annual appropriations will be returned to the Treasury or applied to finance the pay raise or other supplemental requirements. In multiyear accounts, funds not obligated in 1968 because of the cutback will be available for obligation. The availability of these unobligated balances was taken into account when appropriation requests were being developed for 1969. As a result, these requests are much lower than would have been the case if the cutback balances had not been available. For example, a higher program level in the construction of health educational facilities can be supported with a 1969 appropriation which is $118 million lower than the amount appropriated in 1968.

Other, more ordinary, factors are also involved in the unobligated balances. Delays in planning and the implementation of plans can cause funds to remain unobligated longer than anticipated when the budget request was prepared. In some construction grant accounts, such as the Hill-Burton programs, funds are normally alloted to the States in the year of appropriation but for the most part not obligated until the next fiscal year. In some cases when a supplemental is to be enacted late in the fiscal year, Congress will extend the availability for 6 months beyond the end of the year.

The following material provides information on the unobligated balances in appropriations included in the Labor-HEW bill.

FOOD AND DRUG ADMINISTRATION

Buildings and facilities

1968 unobligated balance $21,149,000

Three million, seven hundred and forty thousand dollars was carried forward due to delays in the construction of laboratory No. 1 (Beltsville). These delays were caused by the reorganization of the Food and Drug Administration, the time required to get the approval of the National Capital Planning Commission

and design problems; $10,882,000 was carried forward due to delays in the district office modernization program caused by changes in site locations and related design problems. The remaining $6,527,000 was carried forward because of construction delays in other projects and the procedure whereby certain equipment funds are not obligated until the facilities for their use are ready for occupancy.

1969 unobligated balance---------- $16,332,000

Eleven million, nine hundred and nine thousand dollars was placed in reserve for obligations to be incurred in subsequent years as part of the obligation reduction program required by Public Law 90-218. The remaining $4,423,000 is carried forward due to further delays in the construction of laboratory No. 1 (Beltsville) and the district office modernization program. The delays in the construction of laboratory No. 1 has been caused by the necessity to change certain design specifications due to rising construction costs. The delays in the district office modernization program have been caused by site relocation and design clearance problems.

OFFICE OF EDUCATION

School assistance in federally affected areas

1968 unobligated balance---------- $51,158,000

This program of school construction (Public Law 815), ordinarily has a carryover of unobligated funds from one year to the next because of the lag between the time applications are received and tentatively approved and the time that final approvals are made and contracts let by the local school district. In fiscal year 1967 there was a $30 million supplemental appropriation for this program enacted on May 29, 1967. The late date of this supplemental meant that a much larger amount than usual was carried over into the following fiscal year since applications could not be verified and processed in time to obligate funds by June 30.

1969 unobligated balance---------- $49,323,000

There would ordinarily have been some carryover of unobligated funds from 1968 to 1969. However, the passage of House Joint Resolution 888 (Public Law 90-218) which is holding obligations and expenditures down in 1968 resulted in a much higher than usual carryover of unobligated funds into 1969.

Higher educational activities

1968 unobligated balance---------- $48,124,000

Unobligated balance includes (1) $7,452,000 for undergraduate facilities construction which was unused by some States but has been reallotted and will be used by other States in fiscal year 1968; (2) $577,000 for graduate facilities construction; (3) $3,227,000 for educational opportunity grants which consists of $1,800,000 from the fiscal year 1967 program to combat inflation which lapses at the end of 1968, and $1,427,000 resulting from a normal level of adjustments among institutions within each State as of June 30, 1967; and (4) $36,868,000 for insured student loans which consists of $7,285,000 in advances for reserve funds of State and nonprofit private guaranteed agencies, and $29,583,000 in interest payments. Due to the very tight money market in 1967, the loan volume did not meet previous expectations. It is anticipated that the balance for reserve funds will be used in 1968 since there is no new appropriation this year and since many State agencies have exhausted their reserve capacity; and that the balance-for-interest payments will be sufficient to meet the estimated requirements for interest and fees payments in 1968.

1969 unobligated balance---------- $197,472,000

Unobligated balance consists of (1) $133 million for undergraduate facilities construction as a result of the 1968 cutback which, when added to the 1969 appropriation request of $67 million, will provide a total of $200 million, or $74,452,000 less than the 1968 level; (2) $17,577,000 for graduate facilities construction as a result of the 1968 cutback which, when added to the 1969 appropriation request of $8 million, will provide a total of $25,577,000, or $7,423,000 less than the 1968 level; (3) $9 million for educational opportunity grants as a result of the 1968 cutback which, when added to the 1969 appropriation request of $140,600,000, will provide a total of $149,600,000 which will fund all

continuing awards and a lesser level of new awards than in 1968; (4) $32,295,000 for interest payments for insured student loans which, when added to the 1969 appropriation request of $62,900,000, will provide a total of $95,195,000 which is estimated to be sufficient for the expected requirements for interest and fees payments during that year; and (5) $5,600,000 for work-study programs which, when added to the 1969 appropriation request of $139,900,000, will provide a total level of $145,500,000.

Expansion and improvement of vocational education

1968 unobligated balance---------- $2,448,000

Under the insured loan program for vocational students the unobligated balance includes (1) $1,577,000 for advances for reserve funds and (2) $871,000 for interest payments. Due to the restricted money market in 1967, the loan volume did not meet previous expectations. It is anticipated that the balance for reserve funds will be used in 1968 since there is no new appropriation this year and since many State agencies have exhausted their reserve capacity; and that the balance for interest payments will be sufficient to meet the estimated requirements for interest and fees payments in 1968.

Libraries and community services

1968 unobligated balance----------$15,417,000

The unobligated balance for public library construction was allotted but unused by some States in 1967 since these funds would be available to them in 1968 to carry out approved construction projects.

1969 unobligated balance---------- $9,000,000

The unobligated balance for public library construction results from the 1968 cutback which, when added to the $9,185,000 appropriation request, will provide 204 construction projects in 1969 compared with 380 projects in 1968.

Research and training

1968 unobligated balance---------- $30,781,000

The unobligated balance represents funds available for construction of educational research facilities. These funds were not used in 1967 due to a longer period of planning than was previously anticipated so that the new regional laboratories and research and development centers could become well enough established to anticipate facilities requirements with a better understanding of future research needs.

1969 unobligated balance---------- $29,581,000

Most of this unobligated balance represents a deliberate 1968 holdback in provision of support facilities and equipment for the regional educational laboratories and research and development centers, taken in the face of a need for stringent economies.

Educational research and training (special foreign currency program)

1968 unobligated balance---------- $213,000

The unobligated balance was unused in 1967 primarily for the United Arab Republic projects which were discontinued due to the Middle East war. This amount has been utilized in 1968 to support selected uncompleted projects previously initiated under 1-year funding arrangements.

Student loan insurance fund

1968 unobligated balance---------- $3,750,000

Unobligated balance, from 1966 and 1967 appropriations, is a result of a lesser volume of student loans in 1967 than had previously been anticipated due to the stringent money market in that year. However, this Federal insurance program, during the first 6 months of 1968, was implemented in 17 States for college students and in seven States for vocational students. The estimated usage of $1,304,000 will be sufficient to cover payments for defaults during fiscal year 1968; therefore, no appropriation has been requested for this year.

1969 unobligated balance---------- $3,646,000

No funds are requested for 1969 since it is estimated that the unobligated balance plus collections on insurance premiums will be sufficient to cover defaults on insured student loans during that year.

Higher education facilities loan fund

1968 unobligated balance $101,230,000

The unobligated balance is a result of the fiscal year 1967 program to combat inflation, under which a construction loan level of $200 million was maintained—$100 million from $200 million in appropriations and $100 million from participation sales to the private credit market.

1969 unobligated balance $50,000,000

Under the 1968 cutback, the construction loan level of $150 million will be maintained by usage of $50 million from the unobligated balance of $100 million, and $100 million in participation sales. The remaining balance of $50 million, together with $100 million in new appropriation, will maintain in 1969 the fiscal year 1968 loan level—$150 million.

PUBLIC HEALTH SERVICE

Comprehensive health planning and services

1968 unobligated balance $2,500,000

In April 1967, a supplemental of $2,500,000 was enacted for formula grants to States. These grants were to be used to begin comprehensive health planning. This was a new program, and Congress made the Funds available for 2 years in order to assure orderly implementation.

1969 unobligated balance $5,000,000

A 1968 supplemental of $20 million for rat control is presently before the Congress. The funds would be available until December 31, 1968. If approved, the plan is to obligate $15 million prior to June 30 and the remaining $5 million before December 31. The delay in obligation is to give adequate time for providing technical assistance to prospective grantees and to refine proposals prior to making awards.

Health manpower education and utilization

1969 unobligated balance $250,000

As a result of the cutback required by Public Law 90–218, $250,000 of the $5 million appropriated in fiscal year 1968 for nursing opportunity grants was deferred for obligation.

Construction of health educational facilities

1968 unobligated balance $59,058,000

Funds under this authority remain available until expanded. Funds are earmarked when applications are approved. However, obligations are frequently not made until a later stage of the project planning process. These fundings delays are with the full consent of the interested parties and are similar to the two-phase mechanicism used in the Hill-Burton program. These practices have been followed historically in this program, and the $59,058,000 unobligated balance represents a normal phenomenon.

1969 unobligated balance $126,657,000

This unobligated balance of $69,057,000 may be attributed to the normal management practices described above. The remaining $67,600,000 may be attributed to reductions required in the fiscal year 1968 program in order to comply with Public Law 90–218. The 1969 budget assumes availability of these reserve funds so that the 1969 construction programs can be maintained at a slightly higher level than was maintained in 1968 with an appropriation of $84,800,000, $118,200,000 less than the 1968 appropriation.

Health professions education fund

1968 unobligated balance $12,380,000

This program was established through a supplemental appropriation late in fiscal year 1967. These funds were used to provide the initial capitalization for a revolving fund to give loans to health professions students.

1969 unobligated balance $14,436,000

The revolving fund concept, as embodied in the basic legislation, provides that notes received from schools will be sold, with the proceeds, in this case $14,436,000, being carried forward into the subsequent fiscal year to give new loans. This balance represents the proceeds from sales in fiscal year 1968.

Nurse training fund

1968 unobligated balance $8,347,000

This program was established through a supplemental appropriation late in fiscal year 1967. These funds were used to provide the initial capitalization for establishing a revolving fund to give loans to nursing students.

1969 unobligated balance $9,748,000

The revolving fund concept, as embodied in the basic legislation, provides that notes received from schools will be sold with the proceeds, in this case $9,748,000, being carried forward to give new loans in the subsequent fiscal year. This balance represents the proceeds from sales in fiscal year 1968.

Chronic diseases

1968 unobligated balance $1,857,000

These funds represent the unobligated balance for implementation of mental retardation planning grants. The Congress made these funds available for 2 years to enable sufficient time for effective planning and implementation. The balance of $442,000 relates to 1966 new obligations authority, and $1,415,000 is from 1967 new obligational authority.

Communicable diseases

1968 unobligated balance $2,610,000

These funds represent the unobligated balance for the community immunization program. Funds for this program are available for 2 years. A carryover balance is, therefore, a normal occurrence.

1969 unobligated balance $2,610,000

To comply with Public Law 90–218 obligation of the 1967 carryover of $2,610,000 was delayed until fiscal year 1969.

Air pollution

1968 unobligated balance $4,040,000

The 1967 supplemental, enacted late in the fiscal year, for the initiation of a sulfur oxide research program provided that the funds should be available until December 31, 1967.

1969 unobligated balance $11,000,000

Due to changing circumstances since submission of the President's budget in January, the anticipated unobligated balance at the beginning of 1969 will be only $3 million, not $11 million. The original estimate was predicated upon a supplemental request of $16 million. The supplemental actually submitted to Congress is $8,355,000. The anticipated unobligated balance of $3 million is for the sulfur oxide program which funds remain available until expended.

Community health services

1969 unobligated balance $17,500,000

The entire balance of $17,500,000 relates to the program of construction grants for community services facilities for the mentally retarded. Although the balance appears under the head "Community Health Services," it will be transferred to "Mental Retardation" as soon as the 1969 Appropriation Act establishes this account.

Seven million dollars of the balance results from the obligation ceiling imposed by Public Law 90–218. The remaining $10,500,000 will occur because the nature of the program often requires more than a 12-month period of time between the planning stage and the formal obligation of funds.

Hospital construction activities

1968 unobligated balance $237,046,000

Funds are available for 2 years, since many projects require considerable planning time. A two-phased obligation mechanism has evolved because of this characteristic. Funds are alloted in the year appropriated, but over half of the funds are not obligated until the next fiscal year. This is normal practice and has occurred throughout the history of the program.

1969 unobligated balance $239,969,000

This includes $227,169,000 attributable to the normal obligational lag explained above, and an additional $12,800,000 attributable to the effects of Public Law 90–218. Appropriation language has been proposed to the Congress to make this $12,800,000 available for allotment in 1969, thus reducing the amount of new obligational authority being requested.

Regional medical programs

1968 unobligated balance $25,900,000

This program was initiated in 1966. A review of the program in 1967 indicated that it would be prudent to expand the program less rapidly than originally anticipated. This approach was possible because funds for this program are available for 2 years.

1969 unobligated balance $30,900,000

The carryover is required primarily because of the cutback required by Public Law 90–218.

Grants for construction of health research facilities

1968 unobligated balance $15,608,000

The carryover of 1967 funds resulted from the administration's program combat inflation.

1969 unobligated balance $12,208,000

The entire balance results from the cutback required by Public Law 90–218.

John Fogarty Center for advanced study in the health sciences

1969 unobligated balance $50,000

The $50,000 is to allow for contingencies arising in relation to the architectural-engineering contract for the Fogarty International Center.

Construction of the mental health-neurology research center

1968 unobligated balance $615,000

Represents the estimate of the amounts required for construction to be accomplished in fiscal year 1968, the majority of the construction having been initiated in earlier years.

1969 unobligated balance $34,000

These funds will be used for the final installation of specialized equipment and other requirements relating to completion of the project.

Mental health research and services

1968 unobligated balance $1,479,000

The supplemental to fund the new program begun under the Narcotic Addict Rehabilitation Act, approved late in fiscal year 1967, provided that the funds should be available until December 31, 1967.

Community mental health resource support

1968 unobligated balance $45,380,000

Like the Hill-Burton program, this program recognizes that additional time is required for the planning of complex facilities. Therefore, the basic legislation provides that funds shall be available for 2 years. A two-phased obligation mechanism has evolved because of this characteristic. All funds are allotted in the year appropriated, but less than half are obligated in the same year. This is normal practice and has obtained throughout the history of the program. For example, the unobligated balance at the beginning of 1966 was $35 million; at the beginning of 1967, $43 million; and at the beginning of 1968, $45,380,000.

1969 unobligated balance---------- $45,000,000

As explained above, unobligated balances are usual in this program. However, because of the requirements of Public Law 90–218, the 1968 unobligated balance was placed in reserve for obligation in 1969. As a result, a higher program level will be attained with an appropriation which is $13 million less than in 1968.

St. Elizabeths Hospital, buildings and facilities

1968 unobligated balance---------- $11,808,000

The Bureau of the Budget placed $6,700,000 in reserve pending resolution of problems relating to the CT–10 rehabilitation building. The remainder of the balance is due to GSA delays in accomplishing rewiring and plumbing projects.

1969 unobligated balance---------- $10,604,000

The sum of $6,700,000 is still in reserve for the CT–10 project. The remainder is due to delays in completing air-conditioning projects.

National Library of Medicine

1968 unobligated balance---------- $10,367,000

The sum of $7,500,000 for construction grants was placed in reserve as part of the 1967 program to combat inflation. The balance consisted of reserves in training, research, and support grants. These moneys are all available for 2 years and were delayed to assure orderly program development.

1969 unobligated balance---------- $4,171,000

The entire balance results from the cutback required by Public Law 90–218.

Buildings and facilities

1968 unobligated balance---------- $33,878,000

The carryover is attributable to the large number of ongoing construction projects. Delays in approval of program concepts, difficulties in preparation of architect-engineer studies, slippages in construction schedules, and other uncertainties are the principal reasons for the accumulation of unobligated balances.

1969 unobligated balance---------- $35,046,000

The sum of $25,046,000 is attributable to the factors outlined above. An additional $10 million is due to the necessity to comply with Public Law 90–218.

Scientific activities overseas (special foreign currency program)

1968 unobligated balance---------- $850,000

The unoligated balance is due primarily to adjustments in exchange rates. These adjustments, in effect, made it possible to support more projects, but occurred too late in the fiscal year to obtain the required reserve authority from the Treasury Department.

1969 unobligated balance---------- $850,000

The $850,000 carried into 1968 was not obligated because of the obligation ceiling imposed by Public Law 90–218.

SOCIAL AND REHABILITATION SERVICE

Grants for rehabilitation services and facilities

1968 unobligated balance---------- $949,000

This balance was derived from the following activities:

Expansion grants	$74,000
Statewide planning of rehabilitation services	694,000
Construction and initial staffing of rehabilitation facilities and workshop	181,000
Total	949,000

The balances in these activities resulted in part from the 1967 deferral of programs and obligations and in part because the nature of these programs often require more than a 12-month period of time between the planning stage and the final obligation of funds.

1969 unobligated balance $1,405,000

The entire balance results from the imposition of a ceiling on obligations in 1968. Among the items selected for reduction were:

Expansion grants	$224,000
Construction and initials staffing of rehabilitation facilities and workshops	1,181,000
Total	1,405,000

Subsequent to the submission of the 1969 President's budget, the Congress approved in H.R. 15399 that $405,000 of the balance to be carried forward into 1969 be reprogramed and utilized in 1968 to apply against the proposed supplemental for statewide planning of rehabilitation services. This action will reduce the actual balance brought forward in 1969 from the $1,405,000 estimated in the President's budget to $1 million. The remaining $1 million balance will be utilized together with a requested appropriation of $1,090,000 to maintain the 1968 program level for the construction program.

Research and training (special foreign currency program)

1968 unobligated balance $581,000

The unobligated balance of $581,000 brought forward from 1967 into 1968 represents (1) a reserve to cover commitments for projects which are still in process between the United States and foreign governments and which have not yet been finalized; and (2) a reserve to cover possible fluctuations in foreign currency rates which would affect current and budget year payments against obligations made in prior years.

1969 unobligated balance $581,000

Most of the balance brought forward from 1968 into 1969 results from the imposition of a ceiling on obligations in 1968. A smaller portion of the balance results from the need to maintain certain reserves as noted above in the explanation for the 1968 unobligated balance.

SPECIAL INSTITUTIONS

National Technical Institute for the Deaf

1968 unobligated balance $528,000

Unobligated balance was due to delay in the signing of the agreement between the Department and the Rochester Institute of Technology.

1969 unobligated balance $1,108,000

Unobligated balance is due to slippage in architectural planning and purchase of land.

Model secondary school for the deaf, construction

1969 unobligated balance $275,000

Architectural planning delayed because no agreement has been signed between the Department and Gallaudet College.

Gallaudet College, construction

1968 unobligated balance $520,000

For the most part, this unobligated balance is due to delays in planning.

1969 unobligated balance $959,000

A small portion of this balance is due to delays in planning.

The largest portion is due to ceilings imposed by the Budget Bureau necessitated by the 1968 cutback.

Howard University, construction

1968 unobligated balance $12,713,000

Virtually all of this unobligated balance was due to delays in architectural planning.

1969 unobligated balance $10,084,000

Nearly all of this unobligated balance is due to delays in architectural planning. However, Howard plans to obligate $10,994,000 in 1969.

OFFICE OF THE SECRETARY

Educational broadcasting facilities

Unobligated balance for 1968, $164,000.

This balance is due to lower administrative costs than we originally estimated in fiscal year 1967. This balance is being used to defray some of the administrative costs associated with the educational broadcasting program in fiscal year 1968.

EXPLANATION OF OBLIGATED BUT UNEXPENDED BALANCES

Once obligations are incurred, there is usually some delay until funds are actually disbursed from the Treasury. For construction programs, this delay can stretch over several years as plans are completed and construction progresses. For research, training, and demonstration project grants, money is disbursed during the time period covered by the grant as the grantee needs it rather than in a lump sum when the grant is awarded. The same also applies to formula grants to States. The unexpended balances shown in the table are reasonable considering the overall size of the Department's programs.

CIVIL DEFENSE ACTIVITIES

Mr. FLOOD. Do you have anything in here for civil defense or emergency planning funds of any kind in the appropriations handled by our subcommittee?

Mr. KELLY. No. The "Emergency health" appropriation is handled under independent offices.

PRESIDENT'S COMMISSION ON CIVIL DISORDERS

Mr. FLOOD. One final question: What is your evaluation of the report of the President's Commission on Civil Disorders?

I know you haven't had time to analyze it, but that is quite a startling document.

Mr. COHEN. It is. I had a discussion with all of my commissioners on Monday concerning it, particularly with Commissioner Howe on the education provisions and Miss Switzer on the welfare rehabilitation provisions, and I have asked them to get the complete report and have their staffs look at it.

I think that many of the recommendations that are in there have a great deal of merit, but I think one question is how fast could they be put into effect. Many of them require working in the education field with the States and the localities, and getting people to implement them is not something that you can do overnight.

What I would like to do and what I have asked my commissioners to do is look over and assess those recommendations and try to establish priorities as to these you might do immediately and these you might do in a second step or in a third step. I think the Commission establishes big overall patterns, but it is something like saying "Eat three meals all at once."

Mr. FLOOD. Would this be an omnibus bill or a series of bills?

Mr. COHEN. I think it would have to be a series of bills. They would go to different committees and I think they would have different implications. The welfare provisions, for instance, would all go to the Ways and Means Committee. The education ones would go to Labor and Education. Some of the health ones would go to Interstate and Foreign Commerce.

Mr. LAIRD. You are not going to send that legislation up right away?

Mr. COHEN. Not that I am aware of, no. I felt it was proper for us to work out what these meant, what the manpower requirements would be, what the implications would be in the States before we made any real substantive recommendation on them.

Mr. FLOOD. You have no timetable as yet.

Mr. COHEN. No, I would first like to review what is involved.

HEALTH ECONOMICS

Mr. FLOOD. Dr. Lyle N. Peterson, M.D., vice president of the University City Science Center, which embraces 20 medical schools, technical schools, hospitals, and universities in the greater Philadelphia area; Mr. Willis J. Wynn, the dean of the Wharton School of Finance and Commerce of the University of Pennsylvania; and the dean of the medical school of the university have proposed some very interesting areas of research in health economics. Are you aware of their work in this area?

Mr. COHEN. Yes, sir. I think the effort that they are making at the university to cross-fertilize the thinking between the medical experts and the economists is one of the most promising developments in medical care that is taking place. Health and medical care in the United States, as I said to you the other day, is now a $50-billion-a-year business and for too long we have had a situation——

Mr. FLOOD. Excuse me. I have before me a list of the research areas being considered for investigation by the Leonard Davis Institute of Health Economics of the University of Pennsylvania. This is an institute which is financed by a philanthropist, Mr. Leonard Davis, and it is called the Leonard Davis Institute of Health Economics.

I will also place in the record at this point a paper by Dr. Lyle Peterson on the University City Science Center itself.

I think it would be very worthwhile for you and your people to keep in touch with them.

(The document referred to follows:)

Scientific and Technical Information Acquisition and Application: A Vital National Problem

(Lysle H. Peterson, Vice President, Health and Life Science, University City Science Center)

The United States enjoys its present position and exhibits a so-called technological gap because it has developed a "system" to acquire and apply information with unprecedented productivity. The "system" now produces at a rate which more than doubles the amount of useful information each decade and also applies that information to the development of goods and services to a greater extent than does any other nation. Health, education, welfare, and defense must be included as examples of goods and services which have been significantly improved by applying information.

In this document, the process of development and improvement of goods and services by application of information is defined as applied problem solving in contrast to scientific problem solving which is primarily acquisition of new knowledge and is sometimes referred to as pure or scientific research. Indeed, President Johnson has noted that while scientific information is valuable to the scholar, to be generally useful to mankind, the information must be applied to solve man's problems.

It has taken many decades to develop this capacity, and extensive expenditures for the development of a very large and complex array of interrelated activities have occurred. This resulting "system" is composed of universities, colleges, industries, Government agencies and a variety of other institutions. If the United States is to sustain its momentum, retain its position, and progress, it must continue to acquire increasing amounts of scientific and technical information, and must also continue to apply this rapidly expanding information base to solve applied problems. Furthermore, national and community problems themselves are increasing in scope and complexity.

It should be noted that the responsibilities of universities and colleges in the "system" for information acquisition and application is vital. Academic institutions are not only the Nation's major resource for education and scientific research but also, because they contain a major part of the Nation's information, should effectively participate in the solution of community and national problems.

Even before the Vietnam struggle forced this country to revise its priorities to provide more funds for defense, it was considered prudent to seek more effective mechanisms by which academic institutions could carry out their responsibilities. The Vietnam conflict has made it essential, indeed critical, that improved effectiveness be developed.

Reduction of funds, limitations of manpower, changing faculty and student attitudes and the increased scope and complexity of applied problems have made it more difficult for academic institutions to sustain their educational, and scientific activities as well as to participate in applied problem solving. Not only is their growth threatened but even their present activities may be disrupted. Hence, a vital component of the Nation's information acquisition and application "system" is in doubt. There is grave concern that the damage caused by cutbacks and disruption of the "system" will take many years to repair, assuming that repair is possible in the highly competitive world situation.

To meet this challenge there is now being developed in Pennsylvania a mechanism aimed at improving the effectiveness of the "system" especially the role of the universities and colleges in the "system." The mechanism is known as the University City Science Center (UCSC). Its objectives are to:

1. Improve the effectiveness and utilization of scientific and technical manpower for acquiring and applying information to solve problems.

2. Improve the interrelations of academic institutions, industry and Government as a team in problem solving.

3. Relieve the management of academic institutions of primary responsibilities for applied problem solving thus, providing freedom to develop more effective mechanisms for education and scientific problem solving.

4. Improve the effectiveness of academic institutions participating in the solution of community and national applied problems.

The mechanism has so far been primarily developed and tested in the problem areas related to health and life sciences.

The UCSC is a nonprofit corporation or consortium of virtually all of the universities and colleges in the greater Philadelphia region. The 20-member institutions include five medical schools, one osteopathetic school, a verterinary school, dental schools, and many teaching-research hospitals. These academic resources also contain more than 15,000 faculty members. This extensive pool represents experts from every scientific and technical discipline.

The UCSC has already developed and tested a mechanism by which this extensive array of information and expertise can be applied more effectively to the solution of health, education, welfare and defense problems—at both the community and national level. The UCSC has demonstrated the feasibility of its mechanism. With further development its usefulness can be extended to a broader array of problems and to serve as a prototype for other regions of the country.

The principle of the mechanism may be briefly described as that of task-forcing of manpower and of systems management of applied problem solving. The manner in which the UCSC has responded to one type of national goal may be used as an example of the operation of the mechanism. The National Heart Institute has awarded the UCSC a contract to define the control to regulate the performance of artificial hearts so that when embedded in the body the artificial device will respond to varying body requirements. This is a criticial aspect of the Nation's artificial heart program and represents one type of applied problem. Solution of this problem requires detailed knowledge from a spectrum of disciplines extending from surgery through medicine, physiology and several engineering and veterinary schools; and industry. It is far more effective, and even necessary, to derive this array of expertise from an array of individuals who collectively possess the spectrum of required knowledge rather than to rely on fewer individuals who could only superficially cover the spectrum of required knowledge. The second consideration is that only a small part of the total knowledge of each individual in the task force is required for that particular problem. To take up more of their time would deprive their other responsibilities. Therefore, proper management of the problem solving activity should utilize only that proportion of each expert's time which is appropriate to his area of expertise. Thus, for example, 10 percent of 30 experts' time is far more effective, with proper planning and management, than 100 percent of three men's time when a wide spectrum of information is required.

The solution of most major health, education, and welfare problems requires many disciplines in addition to the health and life sciences; for example, economics, sociology and engineering. Also, there is increasing evidence that economic and defense developments are interrelated to health, education and welfare.

A rule of thumb for many academic institutions is that their faculties could devote approximately 20 percent of their time to such activities as applied problem solving without disruption of their primary academic responsibilities. Applying that approximation to the UCSC concept indicates that its resources are equivalent to a 3,000-man, full-time scientific and technical institution. Not only is this a very sizable national resource, but also the effective and available spectrum of disciplines and expertises approximately five times greater than a 3,000-man, full-time institution. Furthermore, this is accomplished by a process which should not disrupt the academic community. On the other hand, to draw 3,000 able scientists and teachers from the universities and colleges to establish, for example, a captive nonprofit institution to solve such problems would be not only an unnecessary disruption but also the selection of expertise would be unnecessarily limited.

The UCSC is also developing this approach to other types of problem solving. It is planning a regional kidney dialysis program to centralize the care of patients lacking kidney function and who would die without care. Today this care is economically unfeasible and ties up excessive manpower because it is dispersed in many institutions. The UCSC by virtue of having regional representation can deal with the political as well as the technical problems. The UCSC is also the corporate "umbrella" for the regional medical program of the area (see accom-

panying map) which includes about 10 million persons, in three States, over 10,000 physicians and more than 200 hospitals.

The UCSC is also applying the approach to several different types of applied problems for NASA, the National Library of Medicine, USPHS, NIH, and DOD. They extend from activities such as analyzing the Nation's medical libraries to planning a system for developing computerized models of the body.

All of these problems are attacked using a small "inhouse" staff for program management and by utilizing the resources of the academic institutions and industry. Several of the programs involve interaction with industries in the region and throughout the country when appropriate. The UCSC staff is less than 5 percent of the number derived from the academic institutions and industry for solving applied problems.

It is believed that the UCSC not only represents the next generation mechanism which the Nation and the communities should develop for extending the resources of universities and colleges beyond their walls, but it now exists and is sufficiently tested to be effectively used by the Nation at this time to meet today's challenge.

It is believed that it would be quite appropriate for the UCSC to be utilized, for example, by the Department of Health, Education, and Welfare and the Department of Defense and their divisions as the equivalent of "think tanks" which have heretofore been developed in so-called captive, nonprofit institutions. It is believed that the UCSC concept can be more effective in many applied problem areas because:

1. There is a more extensive resource of experts and facilities to be utilized.
2. The utilization rate of resources is higher.
3. The relative costs of problem solving are lower due to the higher utilization rate of resources.

Finally, the UCSC is not competitive with, nor disruptive of, academic institutions and most industries in the community. Rather, it supplements their own limitations and extends their resources.

It is respectfully requested that the UCSC concept be given appropriate hearing by Government planners so that its concept and resources can be best developed and utilized by the Nation and its communities.

ACADEMIC-INSTITUTIONAL MEMBERSHIPS OF THE UNIVERSITY CITY SCIENCE CENTER

Bryn Mawr College
The Children's Hospital of Philadelphia
Drexel Institute of Technology
Hahnemann Medical College and Hospital of Philadelphia
Haverford College
Jefferson Medical College and Medical Center
Lafayette College
Lehigh University
Mercy Douglas Hospital
Misericordia Hospital
Pennsylvania Hospital
Philadelphia College of Osteopathy
Philadelphia College of Pharmacy and Science
Philadelphia College of Textiles and Science
Presbyterian-University of Pennsylvania Medical Center
Swarthmore College
Temple University
University of Pennsylvania
Villanova University
Woman's Medical College of Pennsylvania

RESEARCH AREAS BEING CONSIDERED FOR INVESTIGATION BY THE LEONARD DAVIS INSTITUTE OF HEALTH ECONOMICS, UNIVERSITY OF PENNSYLVANIA

I. Evaluation of the role of health (and health expenditures) in a society.

II. Determination of an optimum method for reimbursing skilled nursing homes for benefits provided under governmental programs.

III. Development (and a demonstration test) of a utilization review sytsem for drug benefit programs.

IV. Assessment of the economic implications of providing ambulatory care facilities in hospitals.

V. Determination of the impact of various operational aspects of group practice prepayment plans on the growth of such plans.

VI. Analysis of the operational relationships among governmental levels involved in title XIX programs.

VII. Evaluation of the influence of deductible provisions on the use of health services (and hence the impact on both health and costs).
VIII. Formulation of a system for reviewing the services provided by outpatient (nonhospital) medical laboratories.
IX. Determination of the efficiency in the use of existing facilities by certain hospitals.
X. Evaluation of the optimum size and structure for regional planning of health care facilities.
XI. Evaluation of methods of purchasing physicians' services for the medically indigent in New York City.

REPORT BY UNIVERSITY CITY SCIENCE CENTER

Mr. COHEN. I think that the research areas that they are considering for investigation are certainly well thought through and represent 11 of some of the most important areas of health and medical research. I think that, for instance, their point IX—determination of the efficiency of the use of existing facilities by certain hospitals—I think that is one of the highest priority research areas we have in the field. How to bring efficiency into the hospital utilization.

They might well develop a project on how to take the services of nurses, as we talked about, and by using more lesser-skilled personnel, reduce the number of nurses that are required in a given hospital area.

Mr. LAIRD. We have projects like that.

Mr. COHEN. Yes.

Mr. FLOOD. But this is merely one item of a very large program. I know about that. As as a matter of fact, I talked to them about that one.

Mr. KELLY. In establishing this new center for health services research and development, we are trying to bring together all of the funds that are available in the Public Health Service that relate to this sort of thing.

Mr. COHEN. Let me say, Mr. Chairman, there is one point I want to make in connection with this. Mr. Laird pointed out that we are making studies in connection with nurse utilization and a number of other studies.

One of the problems that perplexes me most—I do not have the answer to this—is that we frequently have a research project and we prove a certain point in a certain area and then somehow the results of that do not get distributed nationally. It seems to me that there ought to be a certain amount of regional decentralization in these projects so that the ideas are fanned out from a particular institution in that area. Some part of these projects should be——

Mr. FLOOD. Now, this goes beyond what we call regional medicine.

Mr. COHEN. Yes. I am talking about only the point that Mr. Laird in effect raised, that we sometimes do find the answer to a question—many times we find it—and then we find that it isn't disseminated.

I really think that part of the answer to that question is doing some of these projects, or variations of the same projects, in at least three or four different places in the United States so there will be opportunities to work with the local people, and implement the findings more widely.

Mr. FLOOD. Now, take a look at that index of suggestions. Would you care to comment on any other areas?

OUTPATIENT CARE

Mr. COHEN. Yes. No. 4 is entitled "Assessment of Economic Implications of Providing Ambulatory Care Facilities in Hospitals."

I interpret that to mean studying ways to expand outpatient care in the communities so that not as many people have to go into hospitals and stay overnight.

In other words, if a day in the hospital is costing $55 and somehow you can make arrangements through outpatient care that only cost $10 or $15 or $20 a day, then you have really taken a very, very important step.

Mr. FLOOD. Or if a fellow is working day shift he can go there at 7:30 and get out by 10 o'clock maybe.

Mr. COHEN. That is correct, and I would say this: They have done a very interesting thing in England with day-care hospitals. They are hospitals in which people come from 9 to 5 and then go home. The families take them home so that it cuts the cost to about half.

Now, if we could develop some services like that, if they could show how those work, and if you could persuade the community to develop them——

Mr. FLOOD. Select one more of their topics please and comment on it.

DRUG UTILIZATION REVIEW SYSTEM

Mr. COHEN. Let me take No. 3. This is entitled "Development of a Demonstration Test of a Utilization Review System of Drug Benefit Programs."

What I understand that to mean is this: There are many types of generic drugs which can be used in any program the price of which are very substantially less than the brand name drugs, but one wouldn't want to use those generic drugs unless you knew absolutely that they were equivalent in quality and potency to the brand name drugs.

If you set a utilization review system of, let's say, a physician, a pharmacist and a nurse, to pass upon them in the community, you might well be able to reduce the cost both to the patient and to the Government of the price of those drugs.

Mr. FLOOD. I have several motives for exploring this proposal today. Not only am I excited by the potential of the idea itself, for which there seems to be no horizon of good. I am also proud, very proud that an undertaking of this sort should be initiated by a distinguished group in the Philadelphia area.

I would like you to write a letter and tell me in what ways I can urge them to continue. These are very practical people. These are not dreamers; they mean business. I want to help them.

COMMENTS REGARDING ACTING SECRETARY

I have before me the Wall Street Journal for Friday, March 1, 1968. and I refer to page 1 thereof under the title "Washington Wire."

In here I see this statement with reference to a subtitle, "Johnson's Cabinet," and I quote:

HEW Under-Secretary Cohen becoming acting chief today, will find himself burdened with administrative chores. He will have little time for hatching new ideas.

Well, I wish to take exception to that because knowing the aforementioned Acting Secretary Cohen, it is my opinion that not only will he be able to handle the additional administrative chores, but without any doubt he will also have time, or find it, to "hatch new ideas."

Mr. COHEN. Thank you very much, Mr. Chairman, for that vote of confidence. I would like to say this, that it is my intent in administrative matters to try to run our programs efficiently and economically. I think as administrators that one of our first responsibilities in our stewardship to Congress is to see that the money you give us is wisely spent and used for the purposes that Congress intended it. But I believe also that we have heavy responsibilities in the fields of health, education, and welfare, and that we must always recognize that our programs will never be completed. No matter how much we know, there are always ways to improve the programs. We welcome constructive criticism, and we welcome ideas on how to improve.

Mr. FLOOD. You are using the "we" rhetorically. I am talking about you, Acting Secretary Cohen, period.

Mr. Laird.

VOCATIONAL EDUCATION STUDY

Mr. LAIRD. Mr. Secretary, back some 24 months ago this committee funded a study in the 1967 Health, Education, and Welfare Appropriation Act covering vocational education and the many other job training programs. This study was to be undertaken by a committee appointed by the Secretary of HEW in consultation with the Secretary of Labor and the Director of OEO. Such a commission was appointed. It is my understanding that report has now been filed with you.

Mr. COHEN. I have seen a copy of the last draft of the report. It has been sent out to the members of the committee for their final review, and I understand that some members of the committee asked for one more reading to go over their final changes. I hoped that we would have it here to you by the time of the hearings but since the members have asked for one more meeting to review it, I would hope we could have it to you within the next month.

Mr. CARDWELL. Our objective is to have it here when the Commissioner of Education testifies.

ORGANIZATION OF FEDERAL VOCATIONAL EDUCATION

Mr. LAIRD. Mr. Secretary, this important area of job education and training is the worst mess we have ever had in the history of our country's educational system. We have 28 separate programs with a major impact in this area that are receiving major funding through the Department of Labor, the Office of Economic Opportunity, and the Department of Health, Education, and Welfare. We heard a lot in our hearings about the CAMPS program, which is something that was brought into being in the last few months to help make some administrative sense of this confusion. We also have a fairly new Manpower Administration in the Department of Labor, with regional mapower offices in eight regions of the United States, to coordinate the vocational education programs, the job training programs, the impact programs, and the many other manpower training programs. I have

met with these regional people from time to time, and, as a matter of fact, I had a very interesting meeting in Wausau, Wis., on about the 26th of January.

I wrote to the Secretary about that experience. I was just shocked at the competition and lack of real direction we are faced with right now. It seems that one of the most important jobs the Office of Education can carry out in the next decade is in the area of education for jobs and education for vocations. It seems to me, and it has for some time, that the primary responsibility here is an educational one. We are talking about getting people into jobs and finding a place for them in our society. But instead of building up the Office of Education with vocational programs, this budget continues to tear them down.

(The letter referred to follows:)

JANUARY 26, 1968.

Hon. JOHN W. GARDNER,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR JOHN: I was indeed shocked and disappointed to learn of your resignation as Secretary of the Department of Health, Education, and Welfare.

I have served on the Appropriations Committee handling the Department of Health, Education, and Welfare ever since this Department was created and I know from this experience that there has never been a man as capable in the top position of this Department. It will be many many years before any administration will be able to find a replacement that could be your equal.

Early this month, I visited with you before leaving for my congressional district. At that time we discussed briefly some of the reorganization problems of the Department as well as the possibility of selecting a new Director of NIH very soon. I still hope that I will be able to sit down with you before you leave to discuss these reorganization plans and the NIH problem as I do have some pretty definite ideas.

I realize that you have been primarily concerned with the reorganization of the health program and have not been concentrating on the matter of job education and job training programs. This is an area where perhaps the worst mess exists of any area of education today. I took the trouble of meeting with my district's vocational school people in Wausau, not only members of the faculty, but also administrators in the area of the manpower training programs, vocational education programs, OEO programs, and the others in this area. When you get down to the local level, these programs are really a jungle. Over a year and a half ago, I wrote language into the appropriation bill for the Departments of Labor and Health, Education, and Welfare creating a committee on the administration of training programs. The concern which I expressed to you after this committee was appointed has been fully borne out in the last 4 or 5 months. This committee was structured quite frankly so that it would be oriented toward the Office of Education and HEW. I realize that many problems exist in the Office of Education involving the administration of vocational and technical education and that this Office has been downgraded because of the activities of OEO and the Department of Labor. The relegation of vocational education in the Office of Education to a position where it does not possess any decisionmaking powers is no reason for completely ignoring the possibility of creating an effective job education and job training division in the Office of Education. The committee on administration of training programs believes that the Office of Education evidently is too weak in the area of vocational education to take over the administration and supervision of manpower programs. Perhaps it is weak, but if we are going to have any real direction in these programs, the authority should be concentrated in one place. The attitudes of the Office of Education regarding vocational education are natural incentives to the Department of Labor and OEO to move into the field of vocational education and manpower training. I had hoped that this area would be one of the major areas for rebuilding in the HEW Department. This is the weakest area of the Department of Health, Education, and Welfare at the present time and unless we stop the trend which has developed over the period of the last 5 or 6 years, the Office of Education will be out of job education and job training activities entirely. I had hoped that the Committee on Administration of Training

Programs could be the jumping-off place for revitalizing HEW in this important area.

John Fogarty and I have used the technique of setting up these committees and task forces whether it be in the area of food and drugs, cancer, mental retardation, et cetera, in order to dramatize and revitalize various programs during the last 16 years. The Committee on Administration of Training Programs which will report within the very near future will merely call for more coordination between agencies and between bureaus within each major agency. In other words, I believe an opportunity is being missed to do some very constructive work to improve our job education and job training programs and to remove the terrible waste and inefficiency that presently exists. I have example after example of how applications for job training programs are peddled from one agency to the next—turned down one place, approved some palce else. It seems that this committee just refused to really get down to the real guts of this problem. As the author of the amendment creating the committee, I am indeed disappointed.

With best wishes and kindest personal regards, I am,

Sincerely yours,

MELVIN R. LAIRD,
Member of Congress.

Mr. LAIRD. What is your comment on that?

Mr. COHEN. First, let me say that I am a very, very strong supporter of vocational education. I happen to have gone to primary school right across the street from the Milwaukee Vocational School. Having visited that building many times and having had many school friends there, I have always been impressed by the very wonderful job they have done. I think I have a very good picture of what a good vocational school program could contribute. I would say it would be great if we could have something like the Milwaukee Vocational School in every major area of the country. I felt first that our Vocational Education Act of 1917 was in major need of reform and improvement. I was involved in the revisions in 1963. I worked to get that act through the Congress. I am very proud of what we were able to accomplish.

I might say at that time I learned a very difficult lesson. I had a meeting in my office one night with the Employment Service people and the education people which was nearly a knock-down, drag-out fight. There were very strong differences between the education and Employment Service people in 1963. I think you and I know that there has always been a difference of opinion between those people. I tried very hard to get them to work together. I would say this: they are working together much better today in 1968 than they were in 1962–63. But there is still a strong feeling, I would say, of competitiveness or dissatisfaction between these two groups, both of whom feel, in terms of their professional responsibility that one or the other should have the entire responsibility in this area. I feel that vocational education ought to be improved in several major respects. I think that the vocational education program ought to be improved in the amount of money available in Federal grants, and that the money ought to be specified over a 5-year period, so that States could better plan the expansion of their programs and the recruitment of their personnel.

If you are a State or local vocational administrator I think you would find that you would like to know as you plan your program what is expected of you next year and the year after. That would be point No. 1 in my effort from a statutory standpoint, to have a 5-year increase in the appropriation level.

Secondly, I would change over from the 1-year plan requirements we have now to a 5-year plan requirments. Third, I would put special money in to allow them, as Mr. Huitt was pointing out for special projects, to innovate and go into new areas in working with other

people in the community. After I have said that I think the big question still remains that you have raised: Is it possible to interrelate the work of the Labor Department and the Employment Service with the educational authorities. Here again there are strong feelings on both sides.

I think there is some need for a closer interrelationship. When you come down to the key question—should both of those be in one Federal agency or not—you naturally find very, very strong feelings, somewhat akin to the point I made earlier about the status of the Children's Bureau. I do not think it is possible right now, Mr. Laird——

Mr. LAIRD. It is not going to be possible if you wait another year or two, because the manpower training program in the Department of Labor is already getting underway.

Mr. COHEN. Yes.

Mr. LAIRD. This subcommittee did its part to delay creation of the regional manpower offices in the Department of Labor, waiting for the Office of Education in the Department of Health, Education, and Welfare to move. It was held up here very deliberately with the understanding that perhaps there would be some move on the part of Health, Education, and Welfare. Manpower education should be the responsibility of Health, Education, and Welfare, if we are going to have real coordination. I can show you places today where the Division of Vocational Education in Health, Education, and Welfare has turned down various projects, and where they have been resubmitted and approved in the Manpower Administration. I can show you cases where vocational education schools in Wisconsin and other places in the United States have started courses. Within 10 days the Manpower Administration of the Department of Labor started the very same courses and went out and recruited people for them.

I think they should have been recruiting all right, but they should have been recruiting for the courses that had been set up and started just 2 weeks earlier. These are both federally supported to a large extent. It just does not seem to me that there is any real direction to this program today.

Mr. COHEN. I think the problem arises in the question of whether you think it is desirable to put together in one agency both what we would call the in-school training and the out-of-school training.

As you know, some people feel that all in-school training should be in the Office of Education. Some feel that out-of-school training—that is, on-the-job training for people who are above school age—should be in the Labor Department. This is one way of looking at it. Another way to look at it is to say it is all a labor function of the labor market and it should be entirely in the Labor Department. The third way is to view it as entirely a matter of education and training and, therefore, should be in an educational complex. I think right now you cannot find unanimity on a philosophical basis for putting those together.

Mr. LAIRD. I know the very successful work that was done with the on-the-job training programs right after World War II. As you know, most of that work was done through our educational institutions. Our vocational schools did a tremendous job. Now you are really cutting back on them.

Mr. COHEN. Could I give you this illustration? As you know, last

year we submitted to the Congress a proposal that put all of the work training of welfare recipients in HEW, superseding the work experience program and title V of the Economic Opportunity Act and the work training program of title IV of the Social Security Act. After extensive hearings the Ways and Means Committee adopted that provision. When it went to the Senate, there was a tremendous opposition to it, and the Senate took that provision out and gave that responsibility to the Labor Department. The final bill provided that that kind of work and training would be the responsibility of the Labor Department. There is a very good illustration, it seems to me, of the most recent action that Congress took.

Mr. LAIRD. That action was taken, as you know, after the manpower regional offices were set up. But that action would not have been taken if HEW had moved ahead in the manpower training program.

Mr. COHEN. My analysis is somewhat different than that, Mr. Laird. I think the issue that came out in both the executive sessions in the House and Senate and the conference committee was that it was wiser to have the Labor Department do the training and take on that responsibility, and have the welfare agency do the referral and the day care of the children of working mothers.

I think there was no question about the ability of HEW and the State welfare departments to undertake this.

They have done, in my opinion, a rather commendable job. I think it was based upon a broad policy decision on what I would call a philosophical question of how to divide up these responsibilities.

The original action that we sponsored in the House was reversed by the final committee simply on that basis, in my opinion.

Mr. LAIRD. I think that is true. Responsibility for coordination is moving toward the Labor Department. It is getting away from the Office of Education. That is my very point. It has to be one place or the other. We tried to make clear 24 months ago that the Department of Health, Education, and Welfare should be moving in that direction.

The committee made this one of the major points in our conference report. I think you really have a jungle now.

I come from a State that has had a long, illustrious history in vocational education, a State that had the first mandatory property tax earmarked for vocational education. We were the first State to do this. We set up a vocational training program so that every area of our State must be in a vocational school district. Now, to see the Department of Labor start competing for classes in these same school districts dismays me.

Mr. FLOOD. How do you get representation from the different school districts on the controlling board?

Mr. LAIRD. The regular school districts do not have anything to do with the vocational school districts in Wisconsin. They are separate districts entirely. A certain proportion is levied against each county budget to pay for the vocational school system. The vocational school system is a separate school system in our State.

In my congressional district with 15 counties, I presently have only two vocational school districts.

These vocational teachers are being asked to moonlight for the Department of Labor, to which I have no objection. The problem is that these teachers already give the same courses in vocational school. In Menominee County the Department of Labor had recruiters

getting people to take the course. That in itself is not objectionable. I am all for recruiters to get people to take the course. But I do not know why they could not have taken the same course in the vocational school. The difference is fantastic when you compare the cost between these courses.

Mr. COHEN. I think on the point you make that we might well explore some amendments to the pertinent legislation that would establish some more effective relationship between vocational education and the manpower development and training program. This was exactly the point in 1963 in the Vocational Education Act that was the cause for this great big issue that I mentioned earlier. In 1963 I could not get the two groups to get together and agree to consult with each other because at that time they felt so strongly.

Mr. LAIRD. There were pressures to make the Bureau of Apprenticeship into the Bureau of Apprenticeship and Training, and this committee for many years refused to let them go into training. We said this is the responsibility of the Office of Education. We did not want it in the Department of Labor. We kept telling the Office of Education this was their area, to start planning. Now the Office of Education has been downgraded in their vocational education responsibilities. The time has come to now give consideration to my proposal for a new Department of Education and Manpower Training.

Mr. Secretary, I do hope this will be given very careful attention. This committee has the responsibility for funding all of these programs, whether it be in OEO or Labor or HEW. I am frankly concerned that we are not now getting proper management with 28 major programs in this area now being separately funded.

SAVINGS AND DEFERRALS UNDER HOUSE JOINT RESOLUTION 888

Mr. Secretary, I would like to know the extent to which the cutbacks which you referred to in your statement were real savings, and the extent to which they amounted only to a deferral of obligations and expenditures, I refer to House Joint Resolution 888 which was requested by the President. I could not tell from the charts and from your statement what amounted to a real saving and what to a deferral.

Mr. KELLY. I think the entire amount of $770 million referred to on the charts are obligations that would have been incurred this year had the President's budget been approved as submitted. If they had been obligated, those funds would have had to be dispersed, some this year and some next, to pay for the occurrence of the obligation.

In terms of lapsed appropriations, all of the annual appropriations that are involved will lapse, or be applied to the pay increase or other purposes with the authorization of the Congress. On the multiconstruction, where the preponderance of the reduction in construction occurred, those funds carry over and remain available. However, in requesting the Congress to provide new appropriations in 1969, we have taken into consideration those carryovers, and have thus asked for considerably less funds than we would have before. It is true that, in the prior reduction program, most of our emphasis was on deferment rather than actual program cutoff.

Mr. LAIRD. How much will lapse?

Mr. CARDWELL. At the end of this year $103 million would have lapsed. We have applied $19 million to the payroll. That leaves about $83 million on hand at the moment.

Mr. LAIRD. So actual savings will be $83 million?

Mr. CARDWELL. No, it is much more. There is $137 million in supplemental appropriations that were not requested this year.

Mr. LAIRD. That is not much of a saving. Congress has the power to appropriate without a request. Maybe Congress should credit that as a saving on its books as well. It is like saying because I did not buy that car today I saved $6,000.

Mr. KELLY. The proposal to submit the supplementals was included in the President's budget and the reason we are not asking for it is because of this joint resolution. The $347 million of carryover in the construction funds are being applied to a reduction in the request for appropriations in 1969. I honestly believe you can say that the total $594 million of reduction that we were required to make by this resolution are a savings. We would have spent the money had it not been for that joint resolution. The appropriation request in 1969 would be higher had it not been for this predicament.

Mr. LAIRD. I guess that is something we cannot prove or disprove, really. I would like to have put in the record here how much is actually going to lapse. You think that is around $103 million?

Mr. CARDWELL. After absorption of the pay raise. That would be lapsing of annual appropriation. It does not recognize the point Mr. Kelly made concerning multiappropriation.

(The information follows:)

BALANCES LAPSING AS A RESULT OF THE CUTBACK REQUIRED BY H.J. RES. 888 (PUBLIC LAW 90-218)

	Gross unobligated balance lapsing (reserves in annual accounts)	Proposed use of reserves to absorb 1968 pay raises	Proposed use of reserves to finance supplementals	Estimated net unobligated balance lapsing
FOOD AND DRUG ADMINISTRATION				
Salaries and expenses	$2,417,000	$2,054,000	----------	$363,000
OFFICE OF EDUCATION				
Elementary and secondary educational activities	30,057,000	194,000	$26,739,000	3,124,000
School assistance in federally affected areas	20,832,000	18,000	20,500,000	314,000
Higher educational activities	7,898,000	598,000	----------	7,300,000
Expansion and improvement of vocational education	1,084,000	----------	----------	1,084,000
Libraries and community services	1,901,000	----------	----------	1,901,000
Educational improvement for the handicapped	750,000	----------	----------	750,000
Salaries and expenses	713,000	666,000	----------	47,000
Civil rights educational activities	66,000	29,000	----------	37,000
Total, Office of Education	63,301,000	1,505,000	47,239,000	14,557,000
PUBLIC HEALTH SERVICE				
Office of the Surgeon General:				
Salaries and expenses	262,000	262,000	----------	----------
Comprehensive health planning and services	2,873,000	112,000	2,761,000	----------
Total, Office of the Surgeon General	3,135,000	374,000	2,761,000	----------
Health manpower: Health manpower education and utilization	3,365,000	317,000	3,012,000	36,000
Disease prevention and environmental control:				
Chronic diseases	498,000	393,000	----------	105,000
Communicable diseases	1,569,000	1,150,000	419,000	----------
Air pollution	2,269,000	355,000	1,914,000	----------
Urban and industrial health	1,069,000	404,000	----------	665,000
Radiological health	440,000	325,000	----------	115,000
Total, disease prevention and environmental control	5,845,000	2,627,000	2,333,000	885,000

See footnotes at end of table.

	Gross unobligated balance lapsing (reserves in annual accounts)	Proposed use of reserves to absorb 1968 pay raises	Proposed use of reserves to finance supplementals	Estimated net unobligated balance lapsing
PUBLIC HEALTH SERVICE—Continued				
Health services:				
Community health services	$470,000	$324,000	$146,000	
Patient care and special health services	82,000	82,000		
Hospital construction activities	156,000	152,000		$4,000
Emergency health activities	133,000	133,000		
Total, health services	841,000	691,000	146,000	4,000
National Institutes of Health:				
Biologics standards	327,000	197,000		130,000
National Cancer Institute	2,676,000	1,034,000	1,642,000	
National Heart Institute	2,594,000	2,395,000		199,000
National Institute of Dental Research	551,000	184,000		367,000
National Institute of Arthritis and Metabolic Diseases	2,170,000	560,000	1,610,000	
National Institute of Neurological Diseases and Blindness	2,578,000	2,174,000		404,000
National Institute of Allergy and Infectious Diseases	1,422,000	682,000	740,000	
National Institute of General Medical Sciences	1,351,000	147,000	1,199,000	5,000
National Institute of Child Health and Human Development	846,000	260,000		586,000
Regional medical programs	97,000	69,000		28,000
Environmental health sciences	357,500	93,000		264,500
General research and services	1,996,000	190,000	1,635,000	171,000
Total, National Institutes of Health	16,965,500	7,985,000	6,826,000	2,154,500
National Institute of Mental Health: Mental health research and services	2,584,000	1,899,000	683,000	2,000
Other PHS:				
National health statistics	227,000	174,000		53,000
National Library of Medicine	248,000	184,000		64,000
Total, Other PHS	475,000	358,000		117,000
Total, Public Health Service	33,210,500	14,251,000	15,761,000	3,198,500
SOCIAL AND REHABILITATION SERVICE				
Grants for rehabilitation services and facilities	660,000		660,000	
Maternal and child health and welfare	300,000			300,000
Development of programs for the aging	541,000			541,000
Rehabilitation research and training	26,000	2,000		24,000
Salaries and expenses [1]	845,000	628,000		217,000
Assistance to refugees in the United States	75,000	34,000		41,000
Total, Social and Rehabilitation ervice	2,447,000	664,000	660,000	1,123,000
OFFICE OF THE SECRETARY				
Salaries and expenses, Office of the Secretary	312,000	206,000		106,000
Salaries and expenses, Office of Field Coordination	167,000	140,000		27,000
Salaries and expenses, Office of the Comptroller	259,000	233,000		26,000
Salaries and expenses, Office of Administration	65,000	65,000		
Salaries and expenses, Office of General Counsel	106,000	106,000		
Total, Office of the Secretary	909,000	750,000		159,000
Total, Department of Health, Education, and Welfare	102,284,500	19,224,000	63,660,000	19,400,500

[1] Excludes mental retardation activities which are shown with the community health services appropriation.

BLOCK GRANTS FOR EDUCATION

Mr. LAIRD. Mr. Secretary, you were very interested and very helpful in passing the Comprehensive Health Planning and Services Act, which moved in the direction of block grants for health activities within the States. I am interested in your support of the block-grant approach, the functional type grant in the area of health. How soon do you think we can move toward that in education?

Mr. COHEN. Let me say this, Mr. Laird: I think we could move faster in the welfare field than we could in the educational field. As I have discussed with Congressman Quie, on the television, on radio and in the committee, I think the function of bringing various categorical units together is related to the experience that the State and Federal officials have had in the programs. A categorical program, I think, is really designed by Congress to develop a specific degree of achievement or accomplishment in a program by focusing the public attention on it, and by raising the State and local funds for it. After that has been accomplished, it would seem to me it is wise then to try to bring that program into some larger orbit.

The education programs in the Elementary and Secondary Education Act of 1965 are so recent that I think it would be wise for us to have a little more experience before suggesting major changes in the way they might be better packaged together. We have had the welfare programs in the different categories now for some 30 years. I feel they are long overdue for under block grants. I tried repeatedly last year to see if we could not introduce a wider block grants into the amendments that were passed because we have had 30 some years of experience in this field. I would hope that we could develop that in the welfare field rather shortly.

I think in the education field, with the sensitivity that people have about the different elements in the education program—which I would be glad to discuss—we probably are still several years away from being able to undertake this approach.

There are steps I think could well be explored. I am going to ask our staff to explore them.

For instance, one might as a bridge toward the block grant approach have some provisions for some partial interchange of money between the programs; that is, giving some greater degree of flexibility to the State or the locality in the use of some of the funds. As you know, this year we are putting together what you might call a block grant for student financial aid, giving a greater degree of flexibility for the institutions to transfer to 20 percent of the funds. I think that offers the possibility of a step in that direction.

I would say that I would hope that we could proceed toward a wider block grant as fast as can be.

Mr. LAIRD. Mr. Kelly made quite a speech in favor of shifting toward the functional approach in the Department. I have been using quotes from that quite regularly.

Mr. COHEN. I think as an expression of general public policy it is correct.

Let me give you this illustration of what we are talking about. Would you put vocational education into the block grant? When you are talking about this, I could say quite frankly if we did that as part of the block grant, we probably would have a great deal of opposition. I do not think the vocational education field is ready for it.

Mr. Chairman, may I put something in the record?

Mr. FLOOD. Yes.

BUDGET ESTIMATES CONTINGENT UPON ENACTMENT OF EXTENSION LEGISLATION

Mr. COHEN. You asked earlier about the legislation, and I would like to put in the record the programs that are expiring at the end of this year for which extension legislation will be proposed. There is extension legislation involving $907 million made up largely of expiring legislation in the education field, which totals $738 million, expiring legislation in the health field of $80 million, and expiring legislation in vocational rehabilitation of $90 million. Knowing the past practices of this committee I would assume you would find yourself with the problem of not being able to include any amounts in the appropriation bill for 1969 unless the Congress had continued the expiring legislation.

We have tried to impress upon the chairman and ranking members of the substantive committees the importance of extending this legislation so that you could complete your action on the bill.

I would like to put this in the record and I certainly would like to suggest to you that if possible you urge the chairman of the substantive committees, as we have, to take prompt action on the expiring legislation. We have tried our best and will continue to try to get it completed before you complete your action.

Mr. FLOOD. The insertion will be made, without objection.

Mr. COHEN. Yes. I just wanted you to know that we were trying to accomplish that result.

(The information follows:)

PROGRAMS EXPIRING AT THE END OF FISCAL YEAR 1968 FOR WHICH EXTENSION LEGISLATION WILL BE PROPOSED

Summary

[In thousands]

Expiring legislation	*Amount included in President's budget*
Office of Education	$737,900
Public Health Service	79,900
Social and Rehabilitation Service	90,396
Total, Department of Health, Education, and Welfare	908,196

Office of Education

The Higher Education Act of 1965 (Public Law 89-329):	
Title I: Community service and continuing education programs	10,000
Title II: College library assistance and library training and research	42,300
Title III: Developing institutions	35,000
Title IV: Student assistance:	
Part A.—Education opportunity grants	149,100
Part B.—Guaranteed loans:	
Section 422.—Advances	12,500
Section 431.—Federal insurance program	
Part C.—College work-study (title I–C of the Economic Opportunity Act)	139,900
Title VI: Financial assistance for the improvement of undergraduate instruction	14,500

PROGRAMS EXPIRING AT THE END OF FISCAL YEAR 1968 FOR WHICH EXTENSION LEGISLATION WILL BE PROPOSED—Continued

Office of Education—Continued

Expiring legislation	[In thousands] *Amount included in President's budget*
National Defense Education Act of 1958 (Public Law 85-864):	
Title II: Loans to students	$192,000
Title III: Financial assistance for strengthening instruction in science, math, modern foreign languages and other critical subjects	17,950
Title IV: National defense fellowships	86,600
Title V: Guidance, counseling, and testing Part A.—Grants to States	22,000
Title VI: Language development: Section 601.—Centers and Fellowships	16,050
National Foundation on the Arts and Humanities (Public Law 89-209): Section 12—Financial assistance for strengthening instruction in the Humanities and the Arts [1]	----------
Total, Office of Education	737,900

[1] Pending legislation would subsume program of $500,000 under NEA, title III.

PROGRAMS EXPIRING AT THE END OF FISCAL YEAR 1968 FOR WHICH EXTENSION LEGISLATION WILL BE PROPOSED

Public Health Service

Expiring legislation	[In thousands] *Amount included in President's budget*
Public Health Service Act:	
Section 310.—Grants for health services to migratory farm workers	$9,000
Title IX: Regional medical programs—heart, cancer and stroke	62,900
Narcotic Addict Rehabilitation Act: Section 402.—Community assistance program	8,000
Allied Health Professions Personnel Training Act (sales insufficiencies): Sections 744 and 827.—Authority to operate student loan revolving funds	------
Total, Public Health Service	79,900

PROGRAMS EXPIRING AT THE END OF FISCAL YEAR 1968 FOR WHICH EXTENSION LEGISLATION WILL BE PROPOSED

Social and Rehabilitation Service

Expiring legislation	[In thousands] *Amount included in President's budget*
Vocational Rehabilitation Act, 1965 (29 U.S.C. ch. 4):	
Section 3.—Grants to States for innovation projects	$3,200
Section 4(a)(1).—Grants for research, demonstrations, training and traineeships	64,306
Section 4a(2)(A).—Grants for expansion of VR services	11,000
Section 12.—Grants for construction of rehabilitation facilities and workshops (including initial staffing, statewide planning for facilities' needs, project development for individual facilities)	1,890
Section 13.—Workshop improvement:	
Grants for training services	6,000
Workshop improvements grants	4,000
Total, social and rehabilitation service	90,396

NUMBER OF PEOPLE ELIGIBLE FOR PUBLIC ASSISTANCE

Mr. MICHEL. Mr. Cohen, in your statement you stated that although 27 million persons are living in poverty, only about 8 million are receiving public assistance. Does that mean to suggest that 19 million would actually be eligible for public assistance?

Mr. COHEN. No.

Mr. MICHEL. To the best of your knowledge what number of those between 8 million and 27 million would be eligible but have not applied?

Mr. COHEN. If you would permit me to go back to the 35 million in 1965, for which I do have the figures, at that time there were 7.4 million receiving public assistance.

It was our estimate that 8.7 million additional were categorically eligible under the public assistance titles of the Social Security Act but were not receiving it. In other words, you might say there is about an equivalent number who are in the categorical groups but are not now receiving public assistance. This information is contained in detail in the chart section of my presentation. I might give you these figures. Our estimate of 8.7 million is made up of 3.3 million aged, 3.5 million children, 200,000 disabled, and 1.7 million persons who are either family heads or the spouses of those family heads.

COMPARISON OF OVERALL 1968 AND 1969 BUDGET

Mr. MICHEL. You are proposing here a total of $15.4 billion for fiscal 1969 which is an increase of $900 million over last year. What supplementals should we expect and in what amount?

Mr. CARDWELL. $1,690 million, probably adjusted downward however by the time they arrive by way of specific proposals.

Mr. KELLY. In arriving at the $900 million increase, the supplementals had already been taken into account. They had been assumed to be enacted in 1968 in order to compare the 1969 and 1968 figures on a comparable basis.

Mr. MICHEL. Then if everything goes the way you would like, we would appropriate about two and a half billion more in 1969 than in 1968?

Mr. CARDWELL. No. If you assume that you will make the appropriations that are being requested as 1968 supplementals, then we would be asking for a $900 million net increase.

Mr. MICHEL. What will be the total of the supplementals in 1968?

Mr. KELLY. That is the $1,690 million. They are all 1968 supplementals.

Mr. FLOOD. If the gentleman would yield, of course, we have passed one supplemental.

Mr. CARDWELL. $1,135 million.

Mr. MICHEL. You have a half billion to go.

Mr. KELLY. Roughly.

Mr. CARDWELL. In the $15.4 billion appropriation request for 1969, there is also $83 million that would be identified with new legislation and funding requirements related thereto in 1969, which has not yet been acted on by the Congress.

Mr. MICHEL. We have a breakdown of the $83 million in the charts we had this morning, have we not?

Mr. CARDWELL. That is correct.

TOTAL NEW POSITIONS IN BUDGET FOR HEW

Mr. MICHEL. How many new positions are asked for the Department?

Mr. CARDWELL. A net increase in positions of 5,595. I can give you a breakdown of those by agency.

Mr. MICHEL. That is for 1969?

Mr. CARDWELL. Yes, sir.

Mr. MICHEL. Does that include supplementals?

Mr. CARDWELL. That would assume supplementals have been enacted, but I do not think any of the supplementals involve staffing to any degree. There is one supplemental that does involve staffing in 1968 and that is the Social Security administrative expenses. That is in 1968.

Mr. MICHEL. How many people are involved in that?

Mr. CARDWELL. Between 1,200 and 1,400.

Mr. MICHEL. What would that be attributed to?

Mr. CARDWELL. Increased workload in 1968.

Mr. MICHEL. Due to what?

Mr. KELLY. There are two aspects of it. One is that we underestimated the amount of claims we would receive and the amount of work. You provided us with a contingency fund, and we have reprogramed to use it.

Secondly, the Congress enacted the Social Security Amendments of 1967 and has not yet considered the workload that relates to this increased activity. We are now proceeding on a deficiency basis to start that work.

As a matter of fact, just yesterday, the recipients of social security received the increased benefits as a result of the social security amendments.

Mr. MICHEL. The mere fact that we raised benefits 13 percent does not of itself cause a bigger workload.

Mr. COHEN. There were other amendments that increased the number of persons eligible by several hundred thousand. Those would all be new claims. Changes with respect to widows, disabled persons, and increases in the retirement test, all created a new class of eligible people.

Mr. CARDWELL. There would be about a million increase during the 12-month period, and that million increase in beneficiaries would produce additional work. In 1969, there are 1,750 additional Social Security jobs related to further increases in the workload anticipated in 1969. Of the 5,595 that we identify, about 1,750 are related to Social Security.

Mr. MICHEL. Where is the balance in general breakdowns?

Mr. CARDWELL. 250 in the Food and Drug Administration, 423 in the Office of Education, 2,565 in Public Health Service.

NUMBER OF SOCIAL SECURITY RECIPIENTS

Mr. MICHEL. We have now many social security recipients currently?

Mr. CARDWELL. Twenty-four million.

Mr. MICHEL. Is that today, March 5, 1968?

Mr. COHEN. Yes.

Mr. MICHEL. How many will we have in fiscal 1969?

Mr. CARDWELL. About 25 million at the end of the year.

Mr. MICHEL. What will 1970 show, another million? Will there be a steady incline or will it be a curve?

Mr. COHEN. It is still going up.

The aged population is increasing by about 300,000 a year. Considering the fact that the retirement test has been liberalized, I would think it would still go up substantially.

Mr. MICHEL. Roughly, how many in the course of a year come on the rolls in social security by reason of a disability?

Mr. COHEN. We have, at the present time, a little bit over a million disabled persons on the rolls. I would say that for fiscal year 1969 we can expect a net increase of about 200,000 in the number of disabled beneficiaries. If you take the new entrants the number will be substantially larger because you have people dropping off. The number of claims estimated to be filed by persons because of their disability in 1969 is 800,000.

Mr. KELLY. They are not all determined to be eligible.

Mr. COHEN. It is estimated that about 450,000 of these claims will actually be approved.

Mr. KELLY. Those that are approved and go on the disability roll when they reach eligibility as aged then go off disability and go to the aged.

Mr. CARDWELL. But each aspect has a workload requirement.

Mr. COHEN. The total increase is about 200,000 from one fiscal year to the next. But in order to get that increase of 200,000 we processed nearly a million claims because of the ineligibles and the high turnover because of mortality.

PROGRAM PLANNING AND BUDGETING SYSTEM

Mr. MICHEL. Are you using the PPBS system?

Mr. CARDWELL. Yes.

Mr. MICHEL. I know last year in the hearings you said you were experimenting with it. You are full steam on that.

Mr. KELLY Yes, sir, we have done a very extensive job on it.

Mr. MICHEL. Is it working out all right?

Mr. KELLY. I think it has made a real contribution to planning and decisionmaking.

Mr. CARDWELL. Some of the analyses that PPBS would produce really have not had time to take place. There are a lot of things underway.

We brought in a very good staff and it looks very good.

Mr. MICHEL. Is it satisfactory for working out priorities?

Mr. COHEN. It certainly is helpful when we make decisions about where to put our money and where to put our emphasis, to know exactly what the cost effectiveness of different programs is. I would like to make this point, though. In making policy decisions, a lot more judgment is involved besides just considering the cost effectiveness of various proposals. There are a lot of other factors both social and economic and political and psychological that are involved. But I think it is good for an administrator in making a policy decision to have firm data about what dollars he is putting in and what the actual results will be.

It has been very helpful to us and I would expect it will be more so as time goes on.

Mr. MICHEL. It would be kind of difficult in the education field, particularly, to evaluate it on a dollar and cents basis.

Mr. COHEN. Yes, mainly because in education we cannot evaluate the return for a long period. How and when do you know the effectiveness of money you are putting into a nursery school? Do you look at it 2 years later and you say it has this return? You may not know what the net effect has been until 5 years, 10 years, or 15 years later. These analyses help you but they cannot be the sole factor.

Mr. KELLY. In addition to cost effectiveness, the basic work of organizing the systems of evaluation of effectiveness has been assigned to the staff. Thus, you can evaluate various educational programs on a basis other than cost effectiveness. How well these systems are doing and which parts of the program are doing better than other parts, in order to determine the best kinds of projects and what information to disseminate throughout the educational system, are still matters of evaluation.

SALES OF PARTICIPATION CERTIFICATES

Mr. MICHEL. In how many programs will you be resorting to sales participation certificates, if any?

Mr. CARDWELL. None in 1969.

Mr. MICHEL. Throughout the Department?

Mr. CARDWELL. Throughout the Department.

EFFECT OF ACROSS-THE-BOARD PERCENTAGE BUDGET REDUCTIONS

Mr. MICHEL. How do these arbitrary percentage cutbacks work. If, for example, we saw a resumption of the mood that took over the Congress in the last session and there were a 5-percent across-the-board cutback in your appropriation?

Mr. COHEN. As you know, we did not apply it absolutely across the board. We tried to use our judgment. We made some variations. As Mr. Kelly pointed out, when it comes to patient care in our public health hospitals and in St. Elizabeths our standing policy is to try to exempt that. There are actual human beings in a hospital receiving care and the need is right there. It would seem to us to be foolhardy to cut that back because you are diretly and adversely affecting people right here now. So we exempt these hospitals and take a little higher reduction somewhere else.

Congress in its wisdom recognized that you cannot really cut the trust fund programs. It is a different animal and that program is expanding. I would say whenever you have to make a cut there ought to be some exceptions and variations to recognize the different parts of the program. Insofar as Congress gave us discretion, I think we used it reasonably wisely and well. We did the best we could under the circumstances.

Mr. CARDWELL. There is no question these cuts will hurt. The Congress is going to feel the pressures of some of the affected institutions. We are receiving many letters every day from university presidents.

PROPOSED IMPACTED AREAS LEGISLATION

Mr. MICHEL. With regard to your legislative proposal that would amend this Impacted Areas Act, has there been any thought given to

limiting this simply to the military impact as distinguished from simple civilian employment?

My point is that Federal employees in the Washington area, living in Virginia and Maryland, are like employees working for a steel company or the Caterpillar Tractor Co. They are going to be here for a lifetime job, and they ought to be paying taxes like everybody else. The Federal Government is like another employer. To me there is a definite distinction of an irregular influx of military over which you have no control.

Mr. KELLY. Our present thinking is somewhat similar to that. We have two thoughts. We have not completed the specifications, but we have developed a number of items that we priced out that resulted in the identification of what the price would be in the budget. We have considered the possibility that where the person goes to school in a community different from where the Federal employee works, and this would be like in the Federal Government where people work in the city of Washington but reside outside the city, that we would recognize a lesser impact than where the work situation and the home situation were in the same community.

Another area that is being considered in the development of the specification is the feeling that every community bears some impact of the Federal employment, whether it be military or nonmilitary. They only become eligible for a benefit when they exceed some threshold. Currently, it is 3 percent. Our thought is that maybe every community should have to absorb that basic 3 percent or whatever the eligibility threshold is. We think that when a community becomes eligible, it should only get paid for the excess over that eligibility, rather than going back and counting from zero on up.

Mr. MICHEL. I think that is a good point. At least it is a step in the right direction. For example, I have an agricultural laboratory, one of the four big ones in the country, in Peoria. Once you are there it is practically a lifetime job unless you get transferred, as you would in private industry, to some other plant. It seems to me there should not be any special concession just because they happen to work for the Federal Government.

Mr. KELLY. The concept is not that a person who lives in his own home is getting any special benefit, but that the property on which he works is tax exempt. If he were working for a private employer, that employer would be contributing to the taxation.

ADULT BASIC EDUCATION

Mr. MICHEL. Do you have any statistics on the adult basic education program? You said during the hearings last year you would be trying to get better statistics for this year.

Mr. KELLY. Perhaps when the agency testifies you can get them in more detail. The cost effectiveness evaluation of this program was as great or greater than any other program; the return on the dollar from the adult education program was identified in the cost effectiveness analysis as being one of the greatest. Thus, emphasis was put on the program in this budget.

Mr. CARDWELL. The budget goes from $40 to $50 million in 1969.

Mr. MICHEL. How many people do we expect to be involved in adult

education programs in 1969? Why don't you supply that for the record. Let me know what we had in 1968 and 1967.

Mr. COHEN. I can tell you. We had 293,000 students in fiscal 1967 in adult basic education.

Mr. MICHEL. And supply it for 1968 and 1969 with a comparable dollar figure of appropriated funds.

Mr. COHEN. Yes, sir.

(The information follows:)

PARTICIPATION AND FUNDING IN ADULT BASIC EDUCATION PROGRAMS

	Number of participants	Appropriation
1967 actual	293,000	$29,128,000
1968 estimate	319,000	38,640,000
1969 estimate	411,000	50,000,000

Mr. COHEN. Here it is. The 293,000 I gave for 1967, the estimate for 1968 is 319,000 and the 1969 estimate is 411,000. As a matter of fact, I think in light of Mr. Laird's question, this whole table might be put in. This is the table from a special analysis which has all of the participants in all of these programs. You would have the whole thing in the record.

Mr. FLOOD. I think that should be done, without objection.

(The information follows:)

PARTICIPANTS IN SELECTED VOCATIONAL AND TRAINING PROGRAMS

[In thousands]

Category and program	1967 actual	1968 estimate	1968 estimate
Structural training:			
On the job	125	186	281
Institutional	134	129	170
Job Corps	99	98	98
New careers	14	10	13
MDTA part-time and employability training		57	63
Indian manpower activities	11	13	14
General work experience:			
Youth school and summer work	454	310	469
Community work experience	216	126	121
Classroom education:			
Vocational education	6,900	7,500	8,600
Adult basic education	293	319	411

HIGHER EDUCATION FACILITIES

Mr. MICHEL. Doesn't the 1969 budget reflect a cutback in college facilities?

Mr. CARDWELL. In higher education facilities. The appropriations would be cut to $75 million.

Mr. MICHEL. What was the original appropriation?

Mr. CARDWELL. The original appropriation was $450 million. The effect of House Joint Resolution 888 brought that down to $300 million. So it would be from $300 million to $75 million. On program level because of balances, the program would be carried in 1969 on the basis of obligations of $226 million. It is still a reduction below 1968.

COLLEGE ENROLLMENT 1967–75

Mr. MICHEL. At this point in the record would you put in the figures of college enrollment for this year, and what the projections are for the next 5 years?

My point here is that I am sure they will show a marked increase in each one of the upcoming 5 years. It is kind of hard to square that ballooning enrollment with a cutback in funds for construction.

Mr. COHEN. I think you will be interested to know our estimate shows that the 6 million mark in degree credit enrollments in higher education was reached in 1967. We estimate that over 7 million students will be enrolled by 1969, over 8 million by 1972, and over 9 million by 1975.

Mr. MICHEL. This is all institutions of higher learning.

Mr. COHEN. That is correct. That is a very substantial increase. That means we will have a 50-percent increase in the next 8 years. In 8 years we will go from 6 million students to 9 million students.

Mr. MICHEL. Since we were giving some attention to the junior college area, could you show what the projections are as to the percentage of increase which is made up of junior college enrollment. As we discussed before, we do not really need housing facilities for them, although we do need buildings, classrooms, laboratories.

Mr. KELLY. We will get those figures for you. In the amount of money available for higher education facilities, a special priority is given to junior colleges and we will give you that breakdown.

(The information follows:)

PERCENTAGE OF ENROLLMENT IN HIGHER EDUCATION INSTITUTIONS IN JUNIOR COLLEGES

Year	Enrollments in higher education institutions	Enrollments in junior colleges	Percent of total
1967	6,541,000	1,023,000	15.6
1968	6,923,000	1,093,000	15.8
1969	7,050,000	1,127,000	16.0
1970	7,299,000	1,182,000	16.2
1971	7,604,000	1,242,000	16.3
1972	7,976,000	1,316,000	16.5
1973	8,335,000	1,386,000	16.6
1974	8,684,000	1,458,000	16.8
1975	8,995,000	1,521,000	16.9

ADVISORY COMMITTEES IN HEW

Mr. MICHEL. How many advisory groups, Mr. Cohen, do we presently have at HEW?

Mr. COHEN. We added them up one time, and there were hundreds. I would say we have a good 150 or so that are made up of statutory and quasi-statutory ones. Then we have a number that are nonstatutory.

Mr. MICHEL. The very response you give me, I guess, in part prompts my question, because we are so inclined to let this thing get out of reason. When you say, "Oh, for goodness sakes, we must have hundreds," we don't know. It seems to me if we are really going to be organized and utilize their advice, we ought to be able to say we have 176.

Mr. COHEN. I can give you the exact number. I just do not have it at the top of my head. We have the exact number. We have them all listed in a book. This is a problem I have given a lot of attention to. Actually, I spend a very sizable fraction of my time on the issues of appointing members to advisory councils because I think those of you who are Members of Congress know that every time an advisory council is appointed, which has 12 members, we get probably 120 different nominations from Members of Congress. While this is perfectly proper, it

creates quite a problem both for you and for me. With 120 nominees for 12 positions, you are bound to make somebody annoyed who doesn't get it.

These are prestigious people who want to be members. The appointment of those members takes a great deal of time. Saying that, I would also like to say that I think the existence of the advisory committees is extremely important to our Department. I do not think we could funcion without them, because we are dealing with a lot of sensitive areas in health and education where you need the consent of the people who are involved for your program to work. If you try to enforce some kind of regulation on them, they are going to rebel. So an advisory committee is the key, it seems to me, to making the program work. Yet more and more the advisory committee appointment process has taken up a great deal of the time of our senior officials. I would hope, and we are trying to do this, we could consolidate some of them where they have related functions.

Mr. MICHEL. Have you ever broken out a figure of what these advisory committees cost?

Mr. COHEN. I think we did one time. A couple of years ago we did for a certain area. I think they are well worth the money we spend. When an advisory committee is appointed in an area and they have a specific function to perform, they are excellent. Let me give you an illustration. When the medicare program was established, Congress established the Health Insurance Benefits Advisory Committee. It is made up of about 16 members. We have put an AMA person on it, we put a nurse on it, we put representatives of the health professions on it. We could not have made medicare work and gotten the cooperation of the interested parties without that advisory committee. The statute merely provided that we consult with them. I did not say we had to take their advice. I think we took their advice maybe 99.9 percent of the time. It made the difference between day and night in making that program work.

The AMA and the other groups consulted with us.

Mr. MICHEL. Where would the expenses of that advisory committee be couched?

Mr. COHEN. It would be allocated to the administrative cost of the medicare program from that account.

Mr. MICHEL. Would that be the case for most other advisory committees?

Mr. KELLY. Yes, NIH has all of their own accounts. There are some in the Office of the Secretary. We have recently created an Advisory Council on Grants and Administration, and it is funded by the appropriation you made for my office. It has 15 members and they meet four times a year. I think they are making an extraordinary contribution to simplyfying and improving our ability to deal with States, localities, colleges, and universities with uniform grants standards and procedures.

HOSPITAL COSTS

Mr. MICHEL. Mr. Cohen, I would certainly underscore the chairman's comments on your statement. It is a most comprehensive one and very informative and I commend you on it. In it you mentioned

the increasing medical costs and hospital costs. How much did they increase this past year?

Mr. COHEN. About 14 percent. There is a 7-percent figure I think I used in which I said medical costs during the last year went up about 7 percent when you add everything together; that is, physicians' services, drugs, and so on.

Mr. MICHEL. Then to recap, you say over the past 7 years hospital costs have increased roughly on the average of 7 percent a year?

Mr. COHEN. Over the last 20 years, roughly from 1946, the end of World War II, to around 1966, the average annual increase in hospital costs was about 7 percent.

In the last year or two the annual increase has been approximately double.

Mr. MICHEL. Fourteen percent for last year and the year before.

Mr. COHEN. Approximately that. So that gives you some measure. As I said in my explanation earlier, a very large part of it is the recent increases related to increases in salaries of nurses and other groups.

Mr. MICHEL. Minimum wage played a part in that.

Mr. COHEN. Yes, minimum wage had a great effect. In many southern localities the minimum wage had as much effect as an increase averaging $10 per day. When you translated the unit cost into a per diem cost, it had a very substantial effect.

Mr. KELLY. There are a tremendous number of custodial workers in a hospital.

Mr. MICHEL. We were talking about hospital costs.

Mr. COHEN. Yes.

OVERALL MEDICAL COSTS

Mr. MICHEL. Do you also have a figure for overall medical costs?

Mr. COHEN. Yes, we do.

Mr. MICHEL. Is that the figure that goes into computing the cost-of-living index?

Mr. COHEN. Yes. We get that from the Bureau of Labor Statistics.

Mr. MICHEL. What was the increase over last year? Supply it for the record. I would like to have that increase of this year over last and the previous year over the year before.

Mr. COHEN. Yes, sir.

(The information follows:)

Average annual changes in the medical care price index

	Percent
1960–65	+2.5
1965–66	+4.4
1966–67	+7.0

Mr. MICHEL. Those are the figures that the Bureau of Labor Statistics uses?

Mr. COHEN. Yes. You have to remember that this is the overall figure. When you come to applying it to either medicare or medicaid then you have to modify it by the fact that certain things are included and excluded in these programs. For instance, the cost of drugs has not gone up at all over a recent period of time, while physician costs have gone up and hospital costs have gone up markedly. If you analyze a particular program, you cannot use the Bureau of Labor Statistics.

NURSING HOME COSTS

Mr. MICHEL. How about nursing home costs?

Mr. COHEN. Nursing home costs have gone up for somewhat the same reasons as hospital costs have. The minimum wage law had its effect on both nurses and custodial personnel. There is one other reason. Congress in both the extended care provisions of medicare and the skilled nursing home provisions of medicaid required the nursing homes to upgrade their nurse component, so it was truly medical. The more nurses you put in the higher your unit cost. So nursing home costs have been going up markedly, too.

Mr. MICHEL. Do your statistics reflect an increase in doctors' fees?

Mr. COHEN. Yes. We have analyzed to what effect the increase has been in the fee and to what extent in the utilization and to what extent it has been for the doctor getting paid for people who used to get free care.

There are three separate factors. Let us say the house call goes from $5 to $6 as an illustration. Second, let us say the doctor makes more house calls. Third, let us say previously if you were indigent he did not charge but he now charges. You really have isolated three different factors. These three factors have a somewhat different effect. In the medicaid program, as well as the medicare program, some of the increase in cost has been that doctors are now getting paid for services that they previously either did not charge for at all or charged less for. So their incomes may be larger even if they did not increase their fee.

The same thing is happening with hospitals. Some hospitals were charitable organizations, and if a person could not pay, they accepted some part payment or the Community Chest gave the rest or they had some modification of it. Now with medicare and medicaid they are charging the full amount to the program. So you have a composite of these three factors.

COST OF DENTAL CARE

Mr. MICHEL. Has the cost of dental care increased along the same curve as medical costs?

Mr. COHEN. This is an interesting point I explored very carefully and I will tell you why. I tried to find out whether dentist fees have risen because generally speaking dentist fees are not covered by medicare. In fact, they are practically not covered at all. Dentists' fees did not rise as rapidly as physicians' services for the first year of medicare. But for the first 12-month period the cost rose about 5 percent, whereas during that period physicians' services rose 7 percent. The interesting point is, to break it down, that psychiatrists' fees increased about 4 percent, whereas obstetrical care increased almost 9 percent. There are differential effects in the whole area. I conclude that roughly a 5-percent increase as shown by the dentist's increase was probably inevitable whether you had medicare or not. That represents to me an area in which there was no particular impact by the medicare program.

Medicare does not include obstetrical care and that went up 9 percent. I think you were in a period of time when prices were going up about 3½ percent, and roughly what happened is that medical care or the physicians' services went up roughly twice as fast, if you want to make

a generalization, but very differently for the different groups. I would suspect even if there had been no medicare or medicaid program with a 3½-percent price rise there would have been approximately a 5-percent rise as exhibited by the dentists' fees. That is the conclusion I come to from an analysis of this.

STAFFING REDUCTION UNDER HOUSE JOINT RESOLUTION 888

Mr. MICHEL. Somewhere in the summary of the budget I read that there was an $8 million cut in staffing and administrative cost.

Mr. KELLY. You made a reduction in 1968 of 1,020 positions to effect the 2-percent reduction.

CONSTRUCTION ESTIMATES FOR ELEMENTARY, SECONDARY, AND HIGHER EDUCATION

Mr. MICHEL. What will your estimates be for elementary and secondary and higher education construction for this next year?

Mr. CARDWELL. Appropriations for higher education facilities construction would be $75 million. There is no construction per se for elementary and secondary except that provided for by Public Law 815.

Mr. FLOOD. Of course use of heavy carryovers also affects the level of construction.

Mr. KELLY. The elementary and secondary are the only funds that we spend for construction in connection with the program. Title I funds can be used, but there are no funds categorically appropriated for construction.

Mr. MICHEL. What percentage of title I would be used for construction?

Mr. KELLY. In the first year it was fairly high, but that was because the funds were made available quite late in the year and this was the easiest way to program funds. I think the figure ran around $200 million. We have worked to discourage the use of funds for construction in the hope that they will be used for services, remedial reading, and so forth. I would guess, therefore, that the total amount going into construction now is below $100 million out of the $1,200 million.

Mr. CARDWELL. On the "15" figure, that was $15 million below the appropriation level for 1968.

FAMILY PLANNING

Mr. MICHEL. How much does the Department plan to spend on family planning services?

Mr. COHEN. The total in 1969 is, as I recall, $56 million.

Mr. MICHEL. What was the total for 1968?

Mr. CARDWELL. $28 million in 1968 and $56 million in 1969.

Mr. MICHEL. Just doubled.

Mr. COHEN. I think we have a very nice table on that, Mr. Michel. We might put that in the record. It is just a small table.

Mr. MICHEL. Does it break that down a little bit?

Mr. COHEN. Yes. It breaks down what is services, what is training, counseling, and so on. All the components of it. We can put that in the record.

(The table appears at pp. 585 and 586.)

Mr. MICHEL. Some people look at that figure and say: "That will buy you an awful lot of pills, $56 million." Of course, we know it is something other than that.

Mr. COHEN. There is personnel and, according to our policy, people must have a choice. The medical services are not simply a matter of pills. We try to refer people to the physicians. There is physicians' advice on the spacing of children and any other type of advice they would want.

RAT CONTROL

Mr. MICHEL. How much under the "partnership for health" funds are you spending for rat control? Is that that $20 million figure?

Mr. CARDWELL. We had $20 million in the 1968 supplemental for rat control.

Mr. MICHEL. But this has not arrived?

Mr. COHEN. That has not arrived yet.

Mr. MICHEL. Do you have any idea whether that portion of it is going to be downgraded or upgraded?

Mr. COHEN. I can tell you that I made a very special appeal several times to the Bureau of the Budget for the full amount. I was very conscious of Mr. Laird's role in that and I urged very strongly that it be favorably considered.

Mr. MICHEL. Do you have any guidelines on how you propose to spend the rat control money?

Mr. COHEN. There were some guidelines put out recently to the States for the submission of projects.

Mr. MICHEL. Will there be any kind of allocation by formula to the States in this item?

Mr. KELLY. The formula for the Partnership for Health Act applies to this. It is special project money under the Partnership for Health Act, and uses that same basic allocation formula by States. It is in accord with the State plan.

Mr. CARDWELL. This will be discussed when the Surgeon General comes up.

POVERTY

Mr. MICHEL. Mr. Cohen, you refer several times in your statement to this disparity between those living in poverty and squalor and the affluent. While we all, I am sure, have in mind doing everything we possibly can to bring those who want to improve their lives—and I guess some of those who don't altogether have the will—and move out of poverty and into the affluent society, I get the general impression in several of your statements that you would like in the end an equalization. Well, that is probably farfetched and probably unfair, but I know some of your critics would tend to read that into some of your statements and in cold black and white print with no amplification, one could very well get that inference.

I don't ever expect to have the resources or wherewithal of a Rockefeller: it just won't happen, but sometimes, with some of the things we have been saying and doing with respect to the disadvantaged and the underprivileged, it seems to me we do raise a lot of false hopes in that what we are really striving for is getting everybody up to some even par, and that is never going to happen. I don't expect to ever realize

all the things I might have my eyes fixed upon. I would think whenever we have an opportunity to make these public appearances and official statements, that we don't tend to go overboard and get carried away and raise all these hopes too high because we know there is a long time between what we can propose and what we realize.

Mr. COHEN. Let me say this: Nothing that I said in my statement should give the impression that I believe in reducing incomes or opportunity to some equal level for everyone. I think that would stifle initiative and destroy what has really made America great.

What I had in mind is that we have the resources in the country to provide incentives to people who want to work hard and want to achieve higher incomes, while at the same time we have the resources to accomplish something that no nation has ever accomplished, and that is, providing a minimum level of opportunity for everybody in the country. Also, underscoring as well your other point, I think this requires long-term improvements in education and work and training and not merely giving money to people. If you just give money to people, you can avoid the poverty problem for that moment of time, but you haven't created the incentives that will alleviate or eliminate poverty in the next generation.

Mr. MICHEL. As Scripture quotes, "The poor ye will have with you always," and I think there are always going to be some of those that you will never get off dead center.

EDUCATION AND POVERTY

Mr. COHEN. I believe if we were to be able, as I said earlier, to get our problem down to a 5, 4, 3 percent, we would do what society has always done, which is to take care of those that we know are failures in one way or another.

My main concern is, from the years I have studied this problem, and particularly since the Education Act has been established that the place for our major emphasis should be to encourage motivation in young children between the ages of 3 and 6 years old. By that I mean unless there are patterns of work behavior and incentives that children see in their family and community at the earliest opportunity, the problem becomes difficult. The older they get, the more difficult they are. When those 24 people are 24 years old, you have a problem 24 times as difficult in dealing with as when they are 4 years old. That is why I believe that the Headstart program, the nursery school program, and the elementary education program, are the places to put our money for the future. Every dollar, I think, invested in there will pay great dividends in the future. We have problems today we are going to have to live with.

What I meant by that is, as we get an opportunity to reexamine these programs, as we get an opportunity to maybe have a few more choices as to where we put our money, in time I would hope that we can expand in this area constructively, give more training—I agree with Mr. Laird—develop the vocational education program. I would also develop the junior college. I would, as I said earlier, put many, many more counselors right down into the elementary school.

Again, when a boy or girl is already 16, 17, or 18, and is going to drop out of school, your batting average of success is probably very

low. But if you put those counselors in the fourth and fifth grade and begin to direct them, where you see a boy or girl who has difficulty, and start to advise them and counsel them and get them into some activity, you might save those kids. Then, there would probably be fewer dropouts and fewer people on the welfare rolls.

The other area that I think is extremely important is the whole area—and Commissioner Howe can talk about this—of sex education for boys and girls in school. We have these 300,000 illegitimate births, that I talked about, a year, and about 70,000 of them are for girls under the age of—I forget—17, 18, and 19; a large proportion of those ultimately get on the welfare rolls. They have large families that become dependent on other people. Even if the father earns a minimum wage, he can't support them. They become the problem—as the social workers say—the problem families in the community.

I think if we spotted these five or six areas and put more money and emphasis on them, we would successfully deal with our problems—not for the people who are here today—but for the people in the next decade.

PROGRAMS FOR THE POOR

Mr. SHRIVER. I want to refer to your statement that you gave at the beginning of the hearing. Page 7, where you say, "Total funding of programs directly aiding the poor more than doubled." From $9.5 billion in fiscal year 1960 to an estimated $24.6 billion in fiscal year 1968, and $27.7 billion in 1969; what are those programs?

Mr. COHEN. The largest single item is, of course, the social security program. Those portions of the payments made to people who are poor. Not all of it is social security, but social security and public assistance, and other types of cash benefit payments made up $15.9 billion of that $27.7 estimate in 1969.

Then the next largest single factor are health programs, $4.7 billion, which would include such aspects as medicare and medicaid and other health programs, and OEO, et cetera.

The third biggest component is $2.9 billion, which would be other social welfare and economic services that might be part of housing and other parts of the OEO program.

Then there is $2.5 billion in education, which is the estimate of that proportion of education expenditures that goes to people in this poverty group. Then there is $1.6 billion in the work and training programs, making a total of $27.7 million.

Mr. CARDWELL. Programs like Headstart and Follow Through—various types of the OEO programs—are continued in their appropriate place in either education or health.

Mr. SHRIVER. The reason I asked that is that last year I recall on the floor of the House a figure of over $30 billion was used instead of the $24 billion, and I wondered if anything had been left out in the figures that are shown here.

Mr. COHEN. I think the problem is that the total programs in which the poor are involved is a larger figure than this. Take social security. Social security provides a large part of its payments to the poor, but some of the payments are not to the poor. These figures represent estimates of that proportion of the social security payments that are made to the poor.

Now, this subject has some margin of error and somebody might have added in some part that was not made directly to the poor. There is another concept which is called the "near poor." That term refers to people just above the poverty line who, if they become unemployed for example, may drop below. But we are using here only the classification of "poor," not the "near poor." There may have been different concepts used in arriving at these different figures.

CHILD HEALTH ACT OF 1967

Mr. SHRIVER. On page 20—and you did discuss this more fully—the Child Health Act of 1967 is discussed. You are going to put into the record a summary of that program.

Mr. COHEN. Yes, I am.

Mr. SHRIVER. I am curious to know to whom this care is to be given. Mothers in low-income families? What is included in the low income?

Mr. COHEN. Yes, the low income figure tends to serve as outside limit, but it depends on how much money a State gets by its formula. A State might limit it more drastically if it didn't have adequate funds, or it might raise the limits in special cases. Let me give you a hypothetical example in the program for crippled children. If a man with five children came in with a crippled child and the crippling condition of the child involved a very large expenditure—let's say it was a blue baby that involved heart surgery and attention for a year—and if we had an income of $6,000 or $7,000, or even more, the State might take care of it on the grounds that for that particular crippling condition of that child in relation to his family size, the family was low income for that purpose. But that would be up to the State. That would be a determination of the State.

SOCIAL WORK MANPOWER

Mr. SHRIVER. I had a letter the other day from a professor in a school in my district where they are trying to start a program to educate in the college more social workers. It has just started. You talked about the need for manpower and womanpower in connection with fields of social work education. Is this becoming a problem?

Mr. COHEN. In the Social Security Amendments of 1967, Congress did write in a new authorization for expansion of both undergraduate and graduate programs in social work and we have included $3 million, as I recall, in that public welfare estimate. That $3 million is for training and undergraduate education for social work.

Mr. SHRIVER. Would there be a possibility, for instance, for this college to make application? They are just starting, really, a program to fill the needs in my State.

Mr. COHEN. Section 707 of the Social Security Act will permit—once you give us the funds for 1969—for that school to apply for what we call faculty grants to permit the faculty to be expanded. This is a project grant application. If you appropriate the $3 million, we would then be able, upon their submission and meeting the criteria, to do it.

We also make grants for stipends to the students, as well, both through the Children's Bureau at the present time, and the Public Health Service. So a school could get two types of aid. One which

would be helping to expand the faculty and the other would help students.

Mr. SHRIVER. I think that would be rather important as we expand this program.

Mr. COHEN. There is no question about that.

NEW APPROACHES TOWARD FINANCING ELEMENTARY AND SECONDARY EDUCATION

Mr. SHRIVER. Now, on page 29, you say we need to reconsider local and State methods of financing elementary and secondary education, and the role of Federal financial help in a three-way partnership, if these imbalances are to be corrected.

What are you thinking about?

Mr. COHEN. Well, for instance, what I am thinking about is the fact that the per-pupil expenditures in education vary so widely throughout the States. In 1966–67 per pupil expenditure in elementary and secondary education averaged $569 for the United States as a whole, but ranged from $912 for the State of New York to $335 a year in Mississippi.

Now, I feel that when you look at what some of the Southern and poorer States are doing, you discover that they are trying to make a very gallant effort to raise their level. Their incomes are less and they have a harder time in raising this level. But we know from the statistics on mobility that a lot of people who are educated in Mississippi, Alabama and other places later move to other States. They go to Illinois, Kansas, Pennsylvania, or some other State. It seems to me that, when you talk about the role in title I of the Elementary and Secondary Education Act, at some point we ought to consider taking some of the burden for the future off the real estate tax, and financing part of it through title I. To take part of this burden off would require the raising of very substantial funds. Let's say you wanted to bring all States' average per pupil expenditures up to the US. average That would require about $200 more per pupil in Mississippi. I think it would probably be very difficult for Mississippi and these other States that are below the national average to raise more through the real estate tax. Maybe they could raise more through the sales tax, but if you are going to bring the educational level of the country up to some minimum, I feel that you have to reconsider the way we finance education through State and local taxes and the way we provide money under title I.

Mr. KELLY. As I recall, Mississippi is at the low level, not because they don't want to make as great a contribution toward education. They are actually providing a greater proportion of their resources to education than is the national average.

IMPACTED SCHOOL AID

Mr. SHRIVER. Let me take that one step further. There is a school district just outside my home city. The district is no longer in my congressional district, but for 17 years it has been largely supported, the school district, by Public Law 874, the impacted area program. We have had this program for 16 or 17 years. There isn't any tax base.

Of course, they live in houses, but there is no industry there that is taxable. The students are from the air base where Government houses are occupied by the people who are in the Air Force, and the number of kids is growing because during the Vietnam war more airmen are there and certain dependents are there to be in the school district to be educated. Then also there is a Government facility, a large plant in the school district—the facility is owned by the Federal Government. It is used by one of our large manufacturing companies. This poses a considerable problem for this school district, and there are others over the country like it, but yet the administration is requesting less money for the impacted area program for fiscal year 1969 and I note for 1970 the administration is proposing a $100 million reduction in this program that originally started because of the impact of Federal activity upon school districts, such as the one I briefly described.

What is the solution to this?

Mr. COHEN. We may be talking about 1976 or some period like that but not 1969. I think in the designing of an appropriate program—and I thought Mr. Laird was going to question me about this in connection with block grants in education—my thinking is that at some time we should have a law that took away all these categorical grants. Maybe we should put the money all together—and there would have to be substantially more money—and make the grant to the State, but require the State, in doing that, to have some good type of equalization program. Then they could take the Federal money and the State money and see to it that localities or school districts in the State were brought up to some kind of a minimum level. That would seem to me more consistent with the Federal responsibility. The Federal Government's interest, it seems to me, ought to be expressed, in terms of education, that every child and every school district meet some minimum level. Then if the school district and the State want to go beyond that minimum level, they could. But may I put it this way—and you, Mr. Michel, you asked the question—I see no really great difference between the Federal Government's concern with a child of a parent who is some type of a contractor with the United States, in connection with some Federal contractor or some type of establishment that is going to be there forever, and disadvantaged children who are poor, or from some community where there is no tax base at all. They are all Federal citizens, they are all going to be future taxpayers and of concern to the Federal Government, and I would think that at some point where we had some experience with title I and the other programs, we would look toward a program that would give the State the responsibility of meeting some minimum for every school district in the State.

I will tell you another thing, though, I would make that contingent, Mr. Shriver, about the further consolidation of school districts.

This has been going on, but we still have 20,000 school districts in the United States.

Mr. SHRIVER. Mr. Cohen, I was talking about the school districts where the Federal Government loaded the school district with children to educate; where there is an air base or any army base or some Federal facility that has caused the impact upon that school district,

and that is the way the impacted area program originally started, but it got loaded down some place along the way.

Mr. COHEN. Here is an anomaly, too. I think I can show you some school districts where there has been that Federal impact and the net result is those children have a better school and better education than other children in the geographical neighborhood where there isn't that impact.

Mr. SHRIVER. Not the kind of school I was describing. They list me over here in Virginia and I pay real estate taxes and all the taxes they have over there.

Mr. COHEN. I think the money could be well used in some area where they are not meeting some kind of minimum level of education.

Mr. SHRIVER. How about this year when they are going to be 20 percent short? Where there is a real Federal impact because of Federal activities, because of an air base or an Army base?

Mr. KELLY. I think the point you are making, Mr. Shriver, is a good one. The program has gotten loaded down. There are some very acute situations and there are some situations where there is a feeling that there is more or less of a bonanza that comes from this program.

I have observed three presidents who felt a sense of frustration with the Federal impact program. Communities importuned the Federal Government to locate facilities in the community because this was a benefit. Then they felt that they were being disadvantaged if they were not given the funds to educate the children that came as a result of this.

Various studies have indicated that there are inequities. I think there is no question that when you prorate a lesser amount of money than full entitlement, that the district that has the greatest Federal impact is disadvantaged in this proration. The loss should be modified so that entitlements are more equitable.

Mr. SHRIVER. I think the extension of the program a few years ago and the fact it was tied onto the Elementary and Secondary Education Act is one of the reasons that bill got through the House at the time. Now you are going to cut back some of these school districts this year by 20 percent. I think they are all crying for a little help.

Mr. MICHEL. I think you have a very legitimate complaint where there is the influx of a military base. I think we have a cut and dried Federal obligation and I would just as soon see it taken care of.

If I might make another observation, about 12 years ago I served on a subcommittee on Federal-State relationships, and as I recall we were comparing some real estate tax rates. There was an outlandish discrepancy between my hometown and several Southern States in what we were paying in an average three-bedroom rambler as compared to the three-bedroom rambler in another State. I think we were paying three times as much in real estate taxes, 80 percent of which goes for education in my area. If we are going to use that as the big tax revenue base for education locally I will say say this: I am sure you could get the farmers in rural areas to support the proposition of the revamping of a real estate tax because there is an inequity for farmers who have one or two children and 80 percent of their real estate taxes are going to education; for the farmer it is disproportionate.

Mr. COHEN. I noticed that in 1957 or 1958 when I supported a bond issue in my local community. We lost the referendum for the bond issue

three times. More bond issues failed for schools in this last year than ever before. You have this kind of a problem: Farmers, older people, and others are not voting for bond issues for schools any more. They say, "Look, we have raised our children. We have paid our taxes. They are very high and we are not going to increase them."

I can understand it. I have talked with them, but, on the other hand, that doesn't help the young people coming along. As you say, I think something new has to be developed here to take that burden off or we are not going to meet that educational need. I have seen it firsthand.

FUTURE FARMERS OF AMERICA

Mr. SHRIVER. I read someplace that about $50,000 a year is being used by your Department for free office space, supplies, and staff assistants for the Future Farmers of America Foundation. What is the story on that?

Mr. COHEN. I saw something in the paper on it, but I haven't the facts.

Mr. SHRIVER. Is it true?

Mr. KELLY. There was a report with respect to it and there was an answer prepared by the Office of Education. I don't have the facts.

Mr. SHRIVER. Will you put it in the record?

Mr. KELLY. I will.

(The information requested is as follows:)

JANUARY 8, 1968.

Hon. BILL BROCK,
House of Representatives,
Washington, D.C.

DEAR MR. BROCK: Secretary Gardner has asked me to respond to your letter of December 21.

I am enclosing a copy of a statement prepared as a result of our recently completed examination of the questions raised by Congressman Rumsfeld in the matter of the Future Farmers of America and the Future Farmers of America Foundation, Inc., since this appears to be the basis for most of the inquiries we have received.

I hope that this material will provide answers to any questions that you may have on the matter. As you can see, the facts in this situation are and always have been a matter of public record.

While the lines of separation in activities as closely intertwined as those of the Future Farmers of America, the Future Farmers of America Foundation, Inc., and the Future Farmers of America Foundation sponsoring committee are difficult to define and maintain, I believe that all persons concerned have acted in good faith.

From my review of the enclosed material, it would not appear that we have any real question of legality of the operation and, as nearly as I can determine, those persons responsible for the administration of the program have been carrying out the intent of the Congress in passing Public Law 81–740.

We must admit that the relationships involved in these activities in the past have gone so smoothly and have been so noncontroversial that we have had no occasion to review the implementation of our policies in this matter. We do, therefore, welcome this opportunity for a reassessment. As indicated in the enclosed report, we are reaffirming our policy of a complete detachment of any fundraising activities by Office of Education-housed personnel, and we shall take any action necessary to assure that detachment in the future. If the Congress feels that a more substantive change in the relationship is necessary and desirable, we shall, of course, be guided by any modification in its directives.

Please let me know if I can be of further assistance.

Sincerely yours,

HAROLD HOWE II,
U.S. Commissioner of Education.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, OFFICE OF EDUCATION—RESPONSE TO VIEWS EXPRESSED BY CONGRESSMAN DONALD RUMSFELD ON NOVEMBER 20, 1967, CONCERNING "FEDERAL INFLUENCE UPON OPERATIONS OF PRIVATE VOLUNTARY ORGANIZATIONS" [1]

The first assertion by Congressman Rumsfeld is:

"First. Public Law 740, chapter 823, section 18, authorizes the U.S. Commissioner of Education to provide Federal Government assistance to the Future Farmers of America, a national organization for students of vocational agriculture, but it in no way provides for assistance to the Future Farmers of America Foundation, Inc., an entirely separate corporation established for the sole purpose of raising and distributing funds."

In our opinion the current relationship between the Office of Education and the Future Farmers of America Foundation, Inc., which consists of making available to the foundation the nominal services of Office of Education employees in connection with serving as officers and trustees of the foundation and office space for employees of the foundation paid by the foundation, is in accord with Public Law 740, 81st Congress, which constitutes the Federal charter of the Future Farmers of America. Section 18 of that law authorizes the U.S. Commissioner of Education to make available to the federally chartered Future Farmers of America, personnel, services, and facilities. Paragraphs (6) and (9) of section 4 confer on this organization the following powers:

> "(6) to take and hold by lease, gift, purchase, grant, devise, or bequest any property, real or personal, necessary for attaining the objects and accomplishing the purposes of the corporation subject to applicable provisions of law of any State (A) governing the amount or kind of real and personal property which may be held by, or (B) otherwise limiting or controlling the ownership of real and personal property by, a corporation operating in such State;
>
> * * * * * * *
>
> "(9) to use the corporate funds to give prizes, awards, loans, and grants to deserving students and young farmers for the purposes set forth in section 3;"

Mr. Rumsfeld and his constituent do not question the authority of the Office of Education to provide assistance to the federally chartered Future Farmers of America, and presumably would have no objection to such assistance if the Future Farmers of America itself exercised the powers now exercised by the Foundation because of the authority granted to the Future Farmers of America in paragraphs (6) and (9) of section 4 quoted above. The crux of the objection, therefore, seems to be that the Office of Education has been improperly providing assistance to an organization which has remained a corporation separate from the Future Farmers of America. To substantiate this position, reference is made to the language in section 19 of Public Law 740, which provides that:

SEC. 19. The corporation may acquire the assets of the Future Farmers of America, a corporation organized under the laws of the State of Virginia, and of the Future Farmers of America Foundation, Incorporated, a corporation organized under the laws of the District of Columbia, upon discharging or satisfactorily providing for the payment and discharge of all of the liabilities of such corporations."

It is our opinion that absorption of the Future Farmers of America Foundation, Inc., by the federally chartered Future Farmers of America is not a necessary prerequisite to Office of Education assistance to the Foundation as Mr. Rumsfeld and his constituent seem to suggest. While it is true that section 19, quoted above, authorizes the federally chartered Future Farmers of America to acquire both the Virginia-incorporated Future Farmers of America and the District of Columbia-incorporated Foundation, section 20 requires as a prerequisite for the statute taking effect only "* * * the filing * * * of affidavits signed by the incorporators named in the first section of this Act to the effect that the Virginia corporation known as the Future Farmers of America has been dissolved in accordance with law. * * *" Dissolution of the District of Columbia corporation known as the Future Farmers of America Foundation, Inc., was not so required.

Therefore, it is our conclusion that the Office of Education may under Public Law 740 lend the same type of assistance to the Foundation as it does to the

---

[1] See Congressional Record, Nov. 20, 1967, pp. H15648–H15650.

federally chartered Future Farmers of America on the ground that the Foundation, in carrying out its functions of receiving private donations and distributing the proceeds therefrom as prizes, awards, and student financial assistance, is acting as an instrumentality of the Future Farmers of America itself. This conclusion is evident not only from the provisions of Public Law 740 discussed above, but also from (a) article 4 of the Certificate of Incorporation of the Foundation, which confers on the Foundation powers within the scope of those conferred on the federally chartered Future Farmers of America in section 4 of Public Law 740, and (b) article 7 of the Certificate of Incorporation, which provides that the Board of Directors of the Future Farmers of America shall constitute a majority of the Board of Trustees of the Foundation.[2]

The second assertion made by Congressman Rumsfeld is:

"Second. My constituent appeared to be correct in his belief that the FAA Foundation was enjoying an extra-legal relationship with the Office of Education."

The substance of this point is substantially the same as the first assertion which was discussed above.

The third assertion refers to a statement by Mr. Alford that "the FFA Foundation, Inc., is not a fund-raising organization," and asserts that this is in contradiction to the provisions of the Certificate of Incorporation of the Foundation, to claims made in Foundation publications, and to actual practices of the Foundation.

The Future Farmers of America Foundation, Inc., was established in 1944 for the purpose of allowing private organizations and corporations to contribute funds for awards, prizes, and financial assistance in connection with vocational education in agriculture and other FFA activities. The Foundation Certificate of Incorporation (in art. 4) and bylaws (in art. 1) specifically provide that "The objects and purposes of 'The Future Farmers of America Foundation, Inc.' are to *receive*, maintain and hold * * * any property. * * * and to deal with and expend the income and/or principal * * * for such educational activities * * * as in the judgment of the Board of Trustees will stimulate and promote the best interests of students and former students of vocational education in agriculture on a local, State, or national basis * * *."[3] [Emphasis supplied.]

In light of this language, Mr. Alford's statement can only be reasonably interpreted as meaning that the Foundation, acting through its Board of Trustees of Executive Committee (as required under art. 7 of its Certificate of Incorporation and arts. 5 and 11 of its bylaws),[4] does not engage directly in the actual solicitation of contributions which it receives to carry out its purposes.

It is therefore our opinion that Mr. Alford's statement is consistent with the Certificate of Incorporation and bylaws referred to above and statements contained in brochures published by the Foundation.

The brochure entitled "Future Farmers of America Foundation, Inc.—Donors 1967" provides that—

"The responsibility of raising funds for the Foundation, at the suggestion of donors themselves, is in the hands of a *Sponsoring Committee*. The Chairman is the person who contacts donors and potential donors to obtain the funds needed each year for the Foundation program. A new Sponsoring Committee Chairman is elected by the donors every year."

In addition, the following statement is found on page 11 of the Future Farmers of America Foundation, Inc.: Information and Statement of Policies (Bulletin No. 3, revised 1962):

"An 'Advisory Committee,' composed of one representative from each donor, was formed to meet one day each year with the Board of Trustees to review the program and to make any suggestions they might have. It was this group who suggested that the donors, through a 'Sponsoring Committee,' assume the responsibility of raising funds for the Foundation, leaving program development and administration to the Board of Trustees."

As his fourth assertion Congressman Rumsfeld claims that Mr. Alford's contention "that 'all solicitation of contributions' for the FFA Foundation are handled by an independent sponsoring committee appears on its face to be deceptive."

---

[2] Taken from pp. 26 and 27 of the Future Farmers of America Foundation, Inc.: Information and Statement of Policies, Bulletin No. 3, revised 1962. (See attachment A.)
[3] See pp. 227–228 of attachment A.
[4] See pp. 227–229 of attachment A.

As described in the brochures of the foundation quoted in connection with the third assertion, the operational structure of the foundation has been so organized that all direct solicitation of funds is supposed to be conducted by an independent sponsoring committee composed entirely of donors rather than by the officers or members of the board of trustees. Although the sponsoring committee is associated with the foundation, members thereof are not eligible for membership on the board of trustees, which pursuant to article 7 of the certificate of incorporation and article 14 of the bylaws [5] is limited to educators. Accordingly, although the sponsoring committee solicits funds in the name of the foundation, neither the committee nor any of its individual members are empowered to make program development policy determinations or to stipulate the use of funds received.

The Chief of Agricultural Education, Office of Education, and professional members of his staff meet and consult with the chairman of the sponsoring committee. The purpose of such meetings and consultations is only to indicate immediate goals of, set forth annual needs for, and discuss general plans of the foundation as determined by the board of trustees. Such activities in no way constitute actual solicitation of funds from members of the business community.

Congressman Rumsfeld's fifth assertion is that "Mr. Alford's statement that the FFA Foundation sponsoring committee 'has never used Federal office space, telephone, or mail service' is, I am told, inaccurate."

No meetings or other activities of this committee are held in the Office of Education, and no Federal office space, telephones, or mail service are ever made available to this committee. All letters of solicitation are written on stationery purchased by and bearing the letterhead of the firm or organization with which the chairman (or other committee member) is affiliated; and the cost of mailing is borne by private or foundation funds. No Federal funds are used for such expenditures.

In his sixth assertion, Congressman Rumsfeld states that "Mr. Farrar's comment that the FFA Foundation coordinator 'does not engage in fund solicitation' is not true." The coordinator referred to by Mr. Farrar is employed by the foundation to assist in administering the program of the foundation. His major duties and responsibilities, as established by the National FFA board of trustees, include (1) preparing of appropriate materials to interpret foundation activities to FFA members, teachers, and others; (2) administering the incentive awards program in keeping with the purposes of the foundation and the FFA; (3) maintaining all foundation records; (4) selecting regional and national award winners; (5) preparing a suggested agenda for the FFA Foundation board of trustees annnual meeting; and (6) providing consultative assistance to the chairman of the sponsoring committee. No item in his job description authorizes the coordinator to solicit funds for the foundation. Such activities by the coordinator have been prohibited by the board of trustees of the FFA Foundation by whom he is employed.[6] The foundation coordinator is not employed to raise funds for the foundation. This responsibility is assumed solely by the donors through the chairman of the sponsoring committee.

In spite of this, a recently completed examination of past correspondence signed by the coordinator has revealed sentences which could be reasonably construed as solicitation. While this is not illegal since the FFA Corporation is authorized to receive gifts under Public Law 81–740, it is contrary to the policy of the foundation and the Office of Education and the ban on solicitation has been reaffirmed to all employees, Federal or non-Federal, housed in Office of Education quarters and connected with the foundation or corporation. No future problems are expected.

The seventh assertion made by Congressman Rumsfeld is:

"Seventh. Despite an admission by Mr. Farrar that the FFA Foundation is a corporation separate and apart from the Future Farmers of America, the Office of Education continues to provide assistance to the foundation without authorization of any kind."

The substance of this assertion is, again, substantially the same as the first which was discussed in this paper.

As his eighth assertion, Congressman Rumsfeld states that—

"Secretary Gardner had apparently missed the point of the Special Presidential Commission on which he served * * * that * * * 'No Federal agency shall pro-

---

[5] See pp. 227 and 230 of attachment A.

[6] See minutes of meeting of board of trustees of the Future Farmers of America Foundation Oct. 10, 1966, p. 231. (See attachment B.)

vide any covert financial assistance or support, direct or indirect, to any of the Nation's educational or private voluntary organizations.'"

The implication of this statement is that Office of Education assistance has been provided to the foundation in a covert fashion. A review of documents published by the FFA and the foundation indicate that this is not the case. Specifically, the back cover of the brochure entitled "Future Farmers of America Foundation, Inc.—Donors '67" lists the names and professional affiliation of each of the members of the board of trustees of the foundation. This list clearly indicates that six of the 15 members of the board are employees of the U.S. Office of Education. In addition, the brochure entitled "The Future Farmers of America Foundation, Incorporated: Information and Statement of Policies' states (on p. 11) that the foundation program is "to be administered by a board of trustees composed entirely of * * * nine representatives from the States and six from the Agricultural Education Branch of the U.S. Office of Education." Furthermore, the last sentence of the "Foreword," signed and prepared by the former national adviser of the Future Farmers of America and president of the Future Farmers of America Foundation, Inc., states that "Questions or comments for further clarification are sincerely invited," and lists as the address to which such inquiries should be directed, "Director, Agricultural Education Branch, Office of Education, U.S. Department of Health, Education, and Welfare." On the basis of the above-quoted examples of statements in documents made available to the public by the foundation, it is clear that no attempt has been made to conceal the relationships between Office of Education personnel and the foundation.

In addition, no attempt has been made by either the Department or the foundation to conceal the fact that Federal office space and related services have been provided to the coordinator of the foundation.

In addition to the eight specific assertions discussed above, Mr. Rumsfeld's statement raises four other issues discussed below:

(*a*) Mr Rumsfeld states that "In refutation of the claims of Mr. Alford and Mr. Farrar, I submit that the evidence is that until Tuesday, October 31, 1967, the U.S. Office of Education was illegally providing $34,743.67—General Accounting Office estimate—in assistance annually to the FFA Foundation. * * *"[7] The period during which the $34,743.67 was allegedly spent is not stated.

Four employees of the Office of Education devote a portion of their time to activities connected with the foundation. The time devoted to such activities and the prorated salary costs per year for each of the four Office of Education employees are as follows:

Name	Number of days per year	Prorated salary
H. N. Hunsicker, Chief, agricultural education	5	$330.80
W. P. Gray, agricultural youth organization specialist	10	621.60
Connie English, secretary to H. N. Hunsicker	2	32.80
Virginia Nicholson, program assistant	156	5,397.60
Total	173	6,382.80

In addition, office space is provided for the foundation coordinator, who is employed and paid by the foundation. Although the precise rental value of the space provided cannot be readily calculated, it is clearly insubstantial since the entire space measures 9 by 10 feet, includes a desk, bookcases, files, and an FFA-owned duplicating machine which is frequently used by other staff members in connection with nonfoundation purposes.

All correspondence directly concerned with the operation of the Future Farmers of America and the foundation is prepared by secretaries employed by the FFA on stationery provided by the foundation or by the FFA. Postage stamps and most office supplies used by the foundation are purchased by the FFA or the foundation.

The Government telephone (both local and FTS) is used in connection with foundation activities. Since the cost for telephone service is charged to the Department on an overall, as opposed to individual call, basis, the additional cost to the Department of such calls is minimal.

[7] See Congressional Record, Nov. 20, 1967, p. H–15649, col. 3.

(*b*) Mr. Rumsfeld maintains "that Mr. J. C. Foltz, coordinator of the FFA foundation, is headquartered in the Office of Education and that his primary duty is to contact donors and prospective donors in order to solicit contributions for the FFA foundation awards program. Mr. Foltz is a professional fundraiser." [8] A precise listing of responsibilities and duties of the foundation coordinator is set out above in answer to the sixth assertion. It has been noted in this connection that there has apparently been some violation of the policy of no solicitation.

(*c*) Mr. Rumsfeld also states "that there exists an undesirable relationship between a branch of the Federal Government—Office of Education, Department of Health, Education, and Welfare—and a private youth-education organization—FFA foundation. Not only is this relationship undesirable but it is also without legal justification." [9] The reply made above to the first, second, and seventh assertions is also applicable to this statement.

(*d*) Mr. Rumsfeld further states that "I discovered the alarming fact that partisan political considerations sometimes influence decisions made in the U.S. Office of Education. For partisan political reasons, the Office of Education vetoed a decision of the FFA foundation to transfer all foundation activities from the Office of Education to quarters rented with foundation funds." [10] The foundation is a privately chartered organization operated under a board of trustees, the majority of whom are not Office of Education employees. Accordingly, the Office of Education is not in a position to veto or prevent, for political or any other reasons, any decision made by the foundation regarding the location of its employees.

In the same paragraph Mr. Rumsfeld also makes reference to a deletion in a draft letter concerning a proposal to move the offices of Mr. Foltz to FFA-owned facilities near Mount Vernon. The draft to which Mr. Rumsfeld refers was prepared in order to provide Mr. Alford with information regarding background facts and practices of the FFA and the foundation sufficient to enable him to reply to a June 5 inquiry made by Mr. Rumsfeld. At the time of Mr. Rumsfeld's inquiry, no decision had been reached by the foundation board of trustees with respect to the question of whether or not to relocate Mr. Foltz for space reasons. For this reason only, and not for any political considerations, the reference to the question of Mr. Foltz's office location was deleted from the draft prepared for Mr. Alford's use.

(*e*) Mr. Rumsfeld finally states that, "It is interesting to note that Mr. Hunsicker, a full-time employee of the Office of Education, also wears five FFA and FFA Foundation titles." [11] Mr. Husicker, in his capacity as Chief of Agricultural Education in the Office of Education, is, pursuant to Public Law 740, serving as national adviser of the Future Farmers of America, whose duties include acting as chairman of the FFA board of directors and of its governing committee.[12] The Chief of Agricultural Education is also designated in the certificate of incorporation and bylaws of the Future Farmers of America Foundation, Inc., as president of its board of trustees and, in the bylaws, as chairman of its executive committee.[13]

As can be seen from the proration of time expended by Mr. Hunsicker in connection with foundation activities (see p. 10 of this statement), the total number of working days expended by Mr. Hunsicker in connection with foundation activities is so minimal as to in no way prevent or interfere with his ability to fully carry out his other duties in the Office of Education.

---

[8] See Congressional Record, Nov. 20, 1967, p. H15649, vol. 3, par. 2.
[9] See Congressional Record, Nov. 20, 1967, p. H15649, col. 3, par. 3.
[10] See Congressional Record, Nov. 20, 1967, p. H15649, col. 3, par. 4.
[11] See Congressional Record, Nov. 20, 1967, p. H15650, col. 1, par. 2.
[12] See secs. 7(c), 8(a), and 8(d) of Public Law 740.
[13] See art. 7 of certificate of incorporation of the foundation and art. 7 of its bylaws set out on pp. 227 and 229 of attachment A.

[Attachment A]

APPENDIX I

GENERAL PROVISIONS OF THE CERTIFICATE OF INCORPORATION

The Future Farmers of America Foundation, Incorporated

FIRST

The name of the corporation shall be: "The Future Farmers of America Foundation, Incorporated."

SECOND

The term for which it is organized shall be perpetual.

THIRD

The principal office of the said Corporation shall be located in Washington, D.C.

FOURTH

The objects and purposes of "The Future Farmers of America Foundation, Inc.," are to receive, maintain and hold, by request, devise, gift, or otherwise, either absolutely or in trust, for any of its purposes, any property, real or personal, fund or funds, without limitation as to amount or value; to convey such property and to invest and reinvest and principal; and to deal with and expend the income and/or principal of the Corporation for such educational activities and in such manner as in the judgment of the Board of Trustees will stimulate and promote the best interests of students and former students of vocational education in agriculture on a local, State, or national basis. As an amplification of said purposes and without in any way limiting the same or the discretion of the Board of Trustees, it is contemplated that said funds may be expended:

(a) To financially assist deserving students of vocational agriculture, and young farmers under 30 years of age who were former students of vocational agriculture, through loans or grants in becoming statisfactorily established in a farming occupation;

Source: *The Future Farmers of America Foundation, Incorporated: Information and Statement of Policies* (Bulletin No. 3, Revised, 1962).

(b) To promote and stimulate interest in agricultural leadership among students of vocational agriculture;

(c) To promote and develop interest on the part of the general public in vocational agriculture, including farm mechanics, and activities of the Future Farmers of America and New Farmers of America;

(d) To provide prizes and awards to deserving students who have achieved distinction in vocational agriculture, including farm mechanics activities, on a local, State, or national basis, and to administer, direct, or supervise the granting of same;

(e) To publish an annual report of the activities of the Corporation, including a statement of receipts and expenditures, and to print such other documents, pamphlets, or bulletins as may be approved from time to time by the Board of Trustees.

FIFTH

The Corporation is not for profit and shall have no capital stock.

SIXTH

The private property of private funds of the incorporators or members of the Board of Trustees shall not be subject to the payment of corporate debts.

SEVENTH

The direction and management of the affairs and business of the Corporation, including the control and disposition of its property and funds, shall be vested in a Board of Trustees, fifteen in number, except for the first year as specified in Article Nine, and composed of the Director and the four Regional Program Plan-

ning Specialists of the Agricultural Education Branch in the U.S. Office of Education, the National Executive Secretary and the National Treasurer of the Future Farmers of America, and the four State Supervisors of Agricultural Education who are elected on a regional basis to serve on the National Board of Directors of the Future Farmers of America, together with four other persons who shall be originally named, chosen, appointed, or elected in accordance with the method prescribed in the By-Laws of the Corporation.

EIGHTH

No portion of the property, real or personal, nor any part of the income or principal of the Corporation shall inure to the benefit of any member of the Board of Trustees, officer, or employee of the Corporation or to any individual having a personal or private interest in the activities of the Corporation nor shall any such member of the Board of Trustees, officer, or employee, or individual receive or be lawfully entitled to receive any pecuniary profit from the operations thereof, except reasonable compensation for services rendered by employees of the Corporation, such necessary travel or other expenses as may be incurred by employees or members of the Board of Trustees, or both, while discharging their official duties and responsibilities as said employees or members of the Board of Trustees.

NOTE.—The Certificate of Incorporation for the Future Farmers of America Foundation, Inc., was granted on March 29, 1941, signed by Wm. J. Thompkins, Recorder of Deeds for the District of Columbia.

APPENDIX II

BY-LAWS

THE FUTURE FARMERS OF AMERICA FOUNDATION, INCORPORATED

ARTICLE I. OBJECTS AND PURPOSES

The objects and purposes of "The Future Farmers of America Foundation, Incorporated" are to receive, maintain and hold, by bequest, devise, gift, or otherwise, either absolutely or in trust, for any of its purposes, any property, real or personal, fund or funds, without limitation as to amount or value; to convey such property and to invest and reinvest any principal; and to deal with and expend the income and/or principal of the Corporation for such educational activities and in such manner as in the judgment of the Board of Trustees will stimulate and promote the best interests of students and former students of vocational education in agriculture on a local, State, or national basis.

ARTICLE II. LOCATION OF PRINCIPAL OFFICE

The principal office of the Corporation shall be in the City of Washington, District of Columbia.

ARTICLE III. MEETINGS

1. The annual meeting of the Board of Trustees shall be held during the month of July, unless otherwise arranged by the Board.
2. Other meetings of the Board shall be held at such times and places as the Board shall prescribe.
3. Special meetings of the Board may be held at the call of the President, or upon the written request of four members.
4. Notice of meetings shall be given by mailing the same to the usual address of said Trustees, not less than thirty days prior to any meeting.

ARTICLE IV. QUORUM

A quorum at any meeting of the Board shall consist of a majority of the members of the Board.

ARTICLE V. BOARD OF TRUSTEES

1. The direction and management of the affairs and business of the Corporation, including the control and disposition of its property and funds, shall be vested in a Board of Trustees, fifteen in number, except for the first year as specified in Article Nine of the Articles of Incorporation, and composed of the

Director and the four Regional Program Planning Specialists of the Agricultural Education Branch in the U.S. Office of Education, the National Executive Secretary and the National Treasurer of the Future Farmers of America, and the four State Supervisors of Agricultural Education who are elected on a regional basis to serve on the National Board of Directors of the Future Farmers of America, together with four other persons who shall be originally named, chosen, appointed, or elected in accordance with the method prescribed in these By-Laws of the Corporation.

2. The Board of Trustees shall possess and exercise all of the powers and authority of the Foundation, and all such powers and authority as shall be necessary to complete execution of the purposes of the Foundation, except as limited by its Articles of Incorporation or by these By-Laws.

ARTICLE VI. OFFICERS

1. The officers of the Corporation shall be a president, a vice-president, a secretary, and a treasurer.

2. All officers must be members of the Board of Trustees.

3. The Director of the Agricultural Education Branch of the U.S. Office of Education shall be the president; the ranking Regional Program Planning Specialist in point of seniority, of the Agricultural Education Branch of the U.S. Office of Education shall be the vice-president; the National Executive Secretary of the Future Farmers of America shall be Secretary; and the National Treasurer of the Future Farmers of America shall be the treasurer.

ARTICLE VII. THE PRESIDENT

The President shall preside over all meetings of the Board of Trustees and Executive Committee and shall make such reports to the Trustees as he may deem necessary, or as may be properly required of him by the Board of Trustees, and perform such other duties and exercise such other powers as may be imposed upon him from time to time by the Board of Trustees.

ARTICLE VIII. THE VICE-PRESIDENT

The Vice-President shall perform the duties and exercise the powers of the President during the absence or incapacity of the President.

ARTICLE IX. DUTIES OF THE TREASURER

1. It shall be the duty of the Treasurer to have the care and custody of all funds and property of the Corporation and to deposit funds and documents in such bank, banks, trust company, or depositories as the Board of Trustees or the Executive Committee shall designate. He shall, under the direction of the Executive Committee, disburse all moneys by check.

2. The Treasurer shall give the Corporation a bond in the amount stipulated by the Board of Trustees, at the expense of the Corporation, with surety satisfactory to the Board of Trustees, for faithful performance of the duties of his office and for delivery, upon demand by said Board, of all books, papers, vouchers, records, money, and other property of whatever kind belonging to the Corporation that have been in his custody.

3. The Treasurer's accounts shall be audited annually by an auditor or auditors not connected with the Corporation, who shall be named by the Board of Trustees.

ARTICLE X. DUTIES OF THE SECRETARY

The Secretary shall prepare, under the direction of the President, and Executive Committee, dockets of business and shall take and keep true and accurate minutes of all meetings of the Corporation and shall discharge such duties as shall be assigned to him by the Board of Trustees.

ARTICLE XI. EXECUTIVE COMMITTEE

1. There shall be an executive committee to consist of the President, the Secretary, and the four Regional Program Planning Specialists of the Agricultural Education Branch of the U.S. Office of Education.

2. During intervals between meetings of the Board, the Executive Committee shall exercise all powers conferred on it by the Board of Trustees in the management and direction of the business and the conduct of the affairs of the Corporation.

3. It shall keep a record of its proceedings and report the same to the Board of Trustees at each next succeeding meeting.

ARTICLE XII. THE FISCAL YEAR

The fiscal year of the Board shall commence on the first day of January in each year and shall end on the following thirty-first day of December.

ARTICLE XIII. ADVISORY COMMITTEES

There may be Advisory Committees designated by the Board of Trustees, These committees shall be composed of persons whose advice and counsel may be deemed helpful in determining policies and formulating and carrying out specific programs of work.

ARTICLE XIV. ELECTIVE MEMBERS OF THE BOARD OF TRUSTEES

1. The four other persons authorized by the Certificate of Incorporation to serve on the Board of Trustees shall be chosen from any field of education.

2. These other persons shall be elected, one from each administrative region of the Agricultural Education Branch of the U.S. Office of Eduaction, by the States of the region. Each State in the region shall be entitled to one vote to be cast by a representative of the agricultural education staff of the State. In case the elected member of the Board from any Region is ill, or otherwise unable to attend a scheduled meeting, a person with full powers to act shall be appointed from that Region by the President of the Board of Trustees of the FFA Foundation. (*In practice, the regions will elect an alternate member of the Board who shall be the one appointed by the President unless the alternate member also is unable to serve.*)

3. At the time of the first election one person each from the Pacific and Southern Regions will be elected for a term of two years, and one person each from the Central and North Atlantic Regions will be elected for a term of one year. When the terms of office of these four persons expire, their successors will each be elected for a two-year term.

4. The terms of office of these four other members of the Board of Trustees will begin July 1, 1945.

5. Whenever a vacancy occurs among these four members of the Board of Trustees other than from expiration of term of office, the remaining Trustees shall fill the vacancy until a successor has been elected and qualified.

6. All elective members of the Board of Trustees shall continue in service until their successors have been elected and qualified.

ARTICLE XV. AMENDMENTS

These By-Laws may be amended at any meeting by an affirmative vote of a majority of all Board members, provided that at least thirty days' notice has been given to all members of the Board of Trustees of the character of the proposed amendment, or amendments, to be voted upon.

[Attachment B]

MINUTES OF MEETING OF BOARD OF TRUSTEES OF THE FUTURE FARMERS OF AMERICA FOUNDATION, KANSAS CITY, MO., OCTOBER 10, 1966

October 10, 1966.

A special meeting of the board of trustees of the Future Farmers of America Foundation was called to order at 1 p.m., Monday, October 10, 1966, in room M–4 of the Hotel President, in Kansas City, Mo., by H. N. Hunsicker, president of the board. Those present, in addition to Mr. Hunsicker, included:

H. M. Byram, chairman, vocational agricultural education, Michigan State University, East Lansing, Mich.

Paul J. Foster, director, agricultural education, State Board for Vocational Education, Denver, Colo.
C. W. Hill, professor, division of agricultural education, Cornell University, Ithaca, N.Y.
R. H. Tolbert, professor and head, agricultural education, College of Education, University of Georgia, Athens, Ga.
D. C. Aebischer, chief, agricultural education, rural division, State Board of Vocational and Adult Education, Madison, Wis.
T. L. Faulkner, State supervisor of agricultural education, State Department of Education, Montgomery, Ala.
P. B. Kirk, State director of agricultural education, State Department of Education, Cheyenne, Wyo.
W. H. Wayman, State supervisor, vocational agricultural, State Department of Education, Charleston, W. Va.
J. M. Campbell, State supervisor, agricultural educational, and treasurer of the FFA Foundation, Richmond, Va.
J. K. Bailey, Office of Education, Denver, Colo.
H. E. Edwards, Office of Education, Chicago, Ill.
M. C. Gaar, Office of Education, Atlanta, Ga.
B. F. Rawls, Office of Education, Kansas City, Mo. (for Mr. Taft).
W. P. Gray, national FFA executive secretary, Office of Education, Washington, D.C.

Others attending the meeting were James Durkee, president, NVATA, University of Wyoming, Laramie, Wyo.; and Edward J. Hawkins, manager, Future Farmers Supply Service, Alexandria, Va.

The president explained that the principal reasons for holding this specially called meeting of the board of trustees were to consider the report of the ad hoc FFA Foundation committee, which met in Washington, D.C., on September 22, 1966; and to outline a plan of action with reference to employing a coordinator of the FFA Foundation. This ad hoc committee was authorized by the board of trustees at its July 1966 meeting.

Report of ad hoc FFA Foundation committee.—The report was presented by Mr. Paul J. Foster, a member of the committee, and was considered item by item. Several constructive suggestions were offered by members of the board, and the report was revised accordingly. Members of the ad hoc committee emphasized the fact that the coordinator of foundation activities should not make direct solicitation of foundation funds, but should assist the chairman of the FFA Foundation sponsoring committee, and augment the work of his office.

Amended ad hoc committee report accepted.—It was moved by Mr. Edwards, chairman of the ad hoc FFA Foundation committee, that the report of this committee, as revised, be accepted. The motion was seconded by Mr. Foster and carried.

Mr. Kirk commended the ad hoc committee for a job well done.

Authorization for employment of coordinator of FFA Foundation activities.—It was moved by Mr. Aebischer, seconded by Dr. Bailey, and carried, that the governing committee be authorized to employ a coordinator of FFA Foundation activities.

Executive session.—Mr. Kirk asked for the names of prospective applicants for the position of coordinator, at which time the president of the board called for an executive session and the matter was discussed at length.

Guidelines for State awards for new and developmental programs.—Upon resumption of the meeting, the president called upon Dr. Bailey who presented a report on guidelines for the States to follow in preparing plans for the use of FFA Foundation funds for new and developmental programs. These guidelines were discussed at some length and appropriate revisions were made.

It was moved by Dr. Bailey, seconded by Mr. Kirk, and carried, that the guidelines for State awards for new and developmental programs, as amended, be accepted.

Financial statement accepted.—Mr. J. M. Campbell, treasurer of the FFA Foundation, presented a statement of receipts and expenditures of the FFA Foundation for the period January 1, 1966, through September 30, 1966. The report was accepted by unanimous consent.

Action delayed on classification of donors.—The president of the board referred to action taken at the July meeting relative to classification of donors according to the amount of money contributed. He reported that some donors have expressed opposition to this proposal, and believe that it would prove detrimental.

It was moved by Mr. Kirk, seconded by Dr. Bailey, and carried, that the board of trustees delay the classification of donors at this time and that the matter be discussed further at the July board meeting.

Action delayed on appointment of ad hoc committee to study leadership development in the FFA.—The president of the board stated that, if there were no objections, he would like to delay the appointment of the ad hoc committee, authorized at the July meeting, to sudy leadership development in the FFA, until the results obtained from a proposed national study and workshop on leadership in all vocational youth organization categories, to be conducted by Dr. Tenney, can be appraised. There were no objections so the committee appointment was postponed.

Appreciation expressed to board of trustees.—The president expressed appressed appreciation to members of the board of trustees for their willingness to meet in Kansas City.

The meeting was adjourned at 3 : 30 p.m.

WM. PAUL GRAY, *Secretary.*
H. N. HUNSICKER, *President.*

CONSTRUCTION

Mr. SHRIVER. Is there any money requested for construction in the 1969 request?

Mr. COHEN. Yes; Hill-Burton construction and school construction.

Mr. KELLY. $673 million, I believe, is requested for the total of construction grants, loans, and direct construction.

Mr. SHRIVER. That was shown in the statement this morning.

Mr. KELLY. Yes, sir.

Mr. SHRIVER. What is in the pipeline is also shown there?

Mr. KELLY. Yes.

TIMELINESS OF PAYMENTS UNDER MEDICAID

Mr. SHRIVER. I have noticed in the papers in my district articles from time to time recently about slow payment to pharmacies and to doctors under medicaid. Is that faulty administration at the State level? That is in your Department, isn't it?

Mr. COHEN. It is the State that makes the payments in the medicaid program. I think it is largely because they have been swamped in the initial stages of the program. In many cases they have been speeded up. We have had a particularly bad problem in New York on the pharmacies. I can recall several other spotty places. The States are trying to improve, but that is a matter for State administration, Mr. Shriver.

Mr. SHRIVER. I thought so, but I thought I should also ask the question.

Mr. COHEN. Let me say this: There have been, from time to time, some complaints about medicare with regards to the payment of hospitals and to physicians. As I explained to another member of the committee who asked me about that—I think Mr. Smith asked—there have been some States where the so-called intermediary has not been prompt or efficient. We have tried to clear that up and our record on that is much, much better than it has been. That is an area for which we share a direct responsibility.

Mr. SHRIVER. I believe that is all the time I will take this afternoon. Thank you.

Mr. COHEN. Thank you.

Mr. MICHEL. Thank you, Mr. Cohen. We appreciate your testimony.

Mr. COHEN. Thank you, sir.

Mr. FLOOD. As has been done for each of the last several years, we will place in the record the several historical, statistical, and program statements on subjects of particular interest that we ask you to prepare each year.

(The material referred to follows:)

PROGRAM INFORMATION AND STATISTICS

REQUESTS IN THE 1969 BUDGET FOR WHICH LEGISLATIVE AUTHORITY IS DUE TO EXPIRE BEFORE 1969

Appropriation	Program and authorizing law	1969 request under expired legislation
Elementary and secondary educational activities.	National Defense Education Act:	
	Grants to States for guidance, counseling, and testing	$22,000,000
	Equipment and minor remodeling	17,950,000
Education professions development activities.	National Defense Education Act: College teacher followships	86,600,000
Higher educational activities	Higher Education Act of 1965:	
	Program assistance:	
	Strengthening developing institutions	35,000,000
	Undergraduate instructional equipment and other resources:	
	Television equipment	1,500,000
	Other equipment	13,000,000
	Student aid: Educational opportunity grants	149,100,000
	Insured loans—advances for reserve funds (includes vocational student loans under the National Vocational Student Loan Insurance Act which would be merged with the Higher Education Act in 1969 under proposed legislation).	12,500,000
	National Defense Education Act: Direct loans	192,000,000
	Economic Opportunity Act: Work-study programs (proposed legislation would transfer program to Higher Education Act).	139,900,000
Libraries and community services	Higher Education Act of 1965:	
	University community service program	10,000,000
	College library resources	25,000,000
	Librarian training	8,250,000
	Acquisition and cataloging by Library of Congress	5,500,000
Research and training	Higher Education Act of 1965: Library improvement	3,550,000
Foreign language training and area programs.	National Defense Education Act: Language and area programs	16,050,000
Community health services	Migrant health program, sec. 310 of the Public Health Service Act.	8,976,000
Regional medical programs	Title IX of the Public Health Service Act	62,900,000
Social and rehabilitation service	Vocational Rehabilitation Act of 1965 as amended:	
Grants for rehabilitation services and facilities.	Grants for innovation of rehabilitation services	3,200,000
	Grants for expansion of vocational rehabilitation services	11,000,000
	Grants for construction and initial staffing of rehabilitation facilities and workshops.	1,890,000
	Grants for training services	6,000,000
	Grants for workshop improvement	4,000,000
Rehabilitation research and training.	Research and demonstration grants	23,971,000
	Training grants	29,310,000
	Special center program	11,025,000

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS (EXCLUDES PROGRAMS FOR WHICH THERE IS NO SPECIFIC 1969 AUTHORIZATION)—Continued

OFFICE OF EDUCATION

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriations requested	Estimated obligations
ELEMENTARY AND SECONDARY EDUCATIONAL ACTIVITIES								
Elementary and Secondary Education Act of 1965 (Public Law 89-10):								
Title I—Educationally deprived children	$1,191,000,000	$1,191,000,000	$2,000,637,050	$1,200,000,000	$1,200,000,000	$809,637,050	$9,000,000	$9,000,000
Title II—Library resources	104,457,000	99,234,000	167,375,000	46,000,000	46,000,000	68,141,000	−53,234,000	−53,234,000
Title III—Supplementary educational centers and services	208,750,000	187,876,000	527,875,000	189,163,000	189,163,000	339,999,000	1,287,000	1,287,000
Title V—Strengthening State Department of education:								
Grants to States	25,287,500	25,287,500	76,000,000	33,250,000	33,250,000	50,712,500	7,962,500	7,962,500
Special projects	4,462,500	4,462,500	4,000,000	1,750,000	1,750,000	−462,500	−2,712,500	−2,712,500
Title VII—Bilingual education programs (Public Law 90-247)			30,000,000	5,000,000	5,000,000	30,000,000	5,000,000	5,000,000
Title VIII:								
Dissemination of information (Public Law 89-750)			3,700,000	2,000,000	2,000,000	3,700,000	2,000,000	2,000,000
Dropout prevention projects (Public Law 90-247)			30,000,000	30,000,000	30,000,000	30,000,000	30,000,000	30,000,000
Total	1,533,957,000	1,507,860,000	2,839,587,050	1,507,163,000	1,507,163,000	1,331,727,050	−697,000	−697,000
SCHOOL ASSISTANCE IN FEDERALLY AFFECTED AREAS								
Maintenance and operations (Public Law 874):								
Payments to local educational agencies	389,200,000	368,390,000	520,000,000	365,390,000	365,390,000	151,610,000	−3,000,000	−3,000,000
Payments to other Federal agencies	27,000,000	27,000,000	30,000,000	30,000,000	30,000,000	3,000,000	3,000,000	3,000,000
Construction (Public Law 815):								
Assistance to local educational agencies	12,317,000	12,300,498	69,362,000	4,107,000	32,512,000	57,061,502	−8,193,498	20,211,502
Assistance for school construction on Federal properties	10,000,000	11,852,000	10,000,000	10,000,000	13,334,000	−1,852,000	−1,852,000	1,482,000
Technical services	620,000	620,000	638,000	638,000	638,000	18,000	18,000	18,000
Total	439,137,000	420,162,498	630,000,000	410,135,000	441,874,000	209,837,502	−10,027,498	21,711,502

EDUCATION PROFESSIONS DEVELOPMENT ACTIVITIES								
Education Professions Development Act (Public Law 90-35) (title V, Higher Education Act of 1965, Public Law 89-329):								
Sec. 504—Encouragement of educational careers			2,500,000	1,500,000	1,500,000	2,500,000	1,500,000	1,500,000
Pt. B-2—State grants for recruitment of educational personnel			50,000,000	15,000,000	15,000,000	50,000,000	15,000,000	15,000,000
Pt. C—Fellowships for teachers and related educational personnel	35,000,000	35,000,000	205,000,000	43,500,000	43,500,000	170,000,000	8,500,000	8,500,000
Pt. D—Institutes and training programs for other than higher education personnel	39,750,000	39,750,000	70,000,000	53,400,000	53,400,000	30,250,000	13,650,000	13,650,000
Pt. E—Institutes and training programs for higher education personnel	2,500,000	2,500,000	21,500,000	15,000,000	15,000,000	19,000,000	12,500,000	12,500,000
Total	77,250,000	77,250,000	349,000,000	128,400,000,	128,400,000	271,750,000	51,150,000	51,150,000
TEACHER CORPS								
Education Professions Development Act (Public Law 90-35) (title V, Higher Education Act of 1965, Public Law 89-329): Pt. B-1—Teacher Corps	13,500,000	13,500,000	46,000,000	31,100,000	31,100,000	32,500,000	17,600,000	17,600,000
HIGHER EDUCATIONAL ACTIVITIES								
Program assistance: Bankhead-Jones Act (Public Law 74-182): Colleges of agriculture and the mechanic arts	11,950,000	11,950,000	11,950,000	11,950,000	11,950,000			
Construction: Higher Education Facilities Act of 1963 (Public Law 88-204):								
Title I, grants for construction of undergraduate academic facilities	400,000,000	274,452,112	936,000,000	67,000,000	200,000,000	661,547,888	−207,452,112	−74,452,112
State administration and planning	7,000,000	7,000,000	7,000,000	7,000,000	7,000,000			
Title II, grants for construction of graduate academic facilities	50,000,000	33,000,000	120,000,000	8,000,000	25,576,994	87,000,000	−25,000,000	−7,423,006
Total	468,950,000	326,402,112	1,074,950,000	93,950,000	244,526,994	748,547,888	−232,452,112	−81,875,118
EXPANSION AND IMPROVEMENT OF VOCATIONAL EDUCATION								
Vocational Education Act of 1963 (Public Law 88-210): Grants to States	199,309,000	198,225,000	202,500,000	199,309,000	199,309,000	4,275,000	1,084,000	1,084,000
George-Barden Act (Public Law 79-586):								
Title I, vocational education in agriculture, home economics, trades and industry, and distributive occupations	29,686,000	29,686,000	29,686,000	29,686,000	29,686,000			
Title II, vocational education in practical nurse training (Public Law 84-911)	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000			
Title III, area vocational education programs (Public Law 85-864)	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000			

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS (EXCLUDES PROGRAMS FOR WHICH THERE IS NO SPECIFIC 1969 AUTHORIZATION)—Continued

OFFICE OF EDUCATION

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriations requested	Estimated obligations
EXPANSION AND IMPROVEMENT OF VOCATIONAL EDUCATION—Continued								
Supplemental acts:								
Puerto Rico (Public Law 71-791)	$105,000	$105,000	$105,000	$105,000	$105,000			
Virgin Islands (Public Law 81-462)	40,000	40,000	40,000	40,000	40,000			
Guam (Public Law 84-896)	80,000	80,000	80,000	80,000	80,000			
American Samoa (Public Law 87-688)	80,000	80,000	80,000	80,000	80,000			
Total	249,300,000	248,216,000	252,491,000	249,300,000	249,300,000	$4,275,000	$1,084,000	$1,084,000
LIBRARIES AND COMMUNITY SERVICES								
Library Services and Construction Act (Public Law 84-597):								
Title I, public library services	35,000,000	35,000,000	55,000,000	35,000,000	35,000,000	20,000,000		
Title II, construction of public libraries (Public Law 88-269)	27,185,000	33,602,493	60,000,000	9,185,000	18,185,000	26,397,507	−24,417,493	−15,417,493
Title III, interlibrary cooperation (Public Law 89-511)	2,375,000	2,256,000	10,000,000	2,281,000	2,281,000	7,744,000	25,000	25,000
Title IV-A, State institutional library services (Public Law 89-511)	2,120,000	2,014,000	10,000,000	2,094,000	2,094,000	7,986,000	80,000	80,000
Title IV-B, library services to the physically handicapped, Public Law 89-511	1,320,000	1,254,000	5,000,000	1,334,000	1,334,000	3,746,000	80,000	80,000
Adult Education Act (title III, Elementary and Secondary Education Amendments of 1966, Public Law 89-750):								
Adult basic education	40,250,000	38,640,000	70,000,000	50,000,000	50,000,000	31,360,000	11,360,000	11,360,000
Total	108,250,000	112,766,493	210,000,000	99,894,000	108,894,000	97,233,507	−12,872,493	−3,872,493
EDUCATIONAL IMPROVEMENT FOR THE HANDICAPPED								
Education of the Handicapped Act (title VI, Elementary and Secondary Education Act of 1965, Public Law 89-750):								
Title VI, education of handicapped children:								
Part A, preschool and school programs	15,000,000	14,250,000	167,375,000	32,000,000	32,000,000	153,125,000	17,750,000	17,750,000
Part B, regional resource centers (Public Law 90-247)			7,750,000	2,000,000	2,000,000	7,750,000	2,000,000	2,000,000
Part C, innovative program Public Law 90-247)			3,000,000	1,000,000	1,000,000	3,000,000	1,000,000	1,000,000
Part D, personnel recruitment and information (Public Law 90-247)			1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000

Grants for teaching in the education of handicapped children (Public Law 85-926): Teacher education	24,500,000	24,500,000	37,500,000	30,000,000	30,000,000	13,000,000	5,500,000	5,500,000
Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164): Research and demonstration	11,100,000	11,100,000	14,000,000	13,900,000	13,900,000	2,900,000	2,800,000	2,800,000
Loan service of captioned films for the deaf (Public Law 85-905): Captioned films and media services (Public Law 90-247)	2,800,000	2,800,000	8,000,000	4,750,000	4,750,000	5,200,000	1,950,000	1,950,000
Total	53,400,000	52,650,000	238,625,000	84,650,000	84,650,000	185,975,000	32,000,000	32,000,000
RESEARCH AND TRAINING								
Vocational Education Act of 1963 (Public Law 88-210): Vocational education research	11,550,000	11,550,000	22,500,000	15,700,000	15,700,000	10,950,000	4,150,000	4,150,000
HIGHER EDUCATION FACILITIES LOAN FUND								
Higher Education Facilities Act (Public Law 88-204) title III, loans for construction of academic facilities	100,000,000	150,000,000	400,000,000	100,000,000	150,000,000	250,000,000	−50,000,000	
PUBLIC HEALTH SERVICE								
OFFICE OF THE SURGEON GENERAL COMPREHENSIVE HEALTH PLANNING AND SERVICES								
Comprehensive Health Planning and Public Health Services Amendments of 1966 (Public Law 89-749) as Amended by Partnership for Health Amendments of 1967 (Public Law 90-174):								
Public Health Service Act:								
Sec. 314(a)—Grants to States for comprehensive State health planning	$5,000,000	$7,250,000	$10,000,000	$9,750,000	$9,750,000	$2,750,000	$2,500,000	$2,500,000
Sec. 314(b)—Project grants for areawide health planning	7,500,000	5,000,000	10,000,000	10,000,000	10,000,000	5,000,000	5,000,000	5,000,000
Sec. 314(c)—Project grants for training, studies and demonstrations	2,500,000	2,500,000	5,000,000	5,000,000	5,000,000	2,500,000	2,500,000	2,500,000
Sec. 314(d)—Grants for comprehensive public health services	60,250,000	60,250,000	[1] 90,000,000	[1] 76,800,000	[1] 76,800,000	29,750,000	16,550,000	16,550,000
Sec. 314(e)—Project grants for health services development	[2] 77,500,000	[3] 72,500,000	[1] 95,000,000	[1] 90,000,000	[1] 95,000,000	22,500,000	17,500,000	22,500,000
Total, Office of the Surgeon General	152,750,000	147,500,000	210,000,000	191,550,000	196,550,000	62,500,000	44,050,000	49,050,000

Footnotes at end of table, p. 242.

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS (EXCLUDES PROGRAMS FOR WHICH THERE IS NO SPECIFIC 1969 AUTHORIZATION)—Continued

PUBLIC HEALTH SERVICE—Continued

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriations requested	Estimated obligations
BUREAU OF HEALTH MANPOWER								
HEALTH MANPOWER EDUCATION AND UTILIZATION								
Graduate Public Health Training Amendments (Public Law 88-497):								
Public Health Service Act:								
Sec. 306(a)—Public Health traineeships	$8,000,000	$8,000,000	$10,000,000	$8,000,000	$8,000,000	$2,000,000	0	0
Sec. 309(a)—Project grants to schools for graduate public health training	4,500,000	4,500,000	9,000,000	5,500,000	5,500,000	4,500,000	$1,000,000	$1,000,000
Comprehensive Health Planning and Public Health Services Amendments of 1966 (Public Law 89-749) as amended by Partnership for Health Amendments of 1967 (Public Law 90-174):								
Public Health Service Act: Sec. 309(c)—Grants to schools of public health	4,000,000	4,000,000	[4] 6,000,000	[4] 4,600,000	[4] 4,600,000	2,000,000	600,000	600,000
Health Professions Educational Assistance Amendments of 1965 (Public Law 89-200) and Veterinary Medical Education Act of 1966 (Public Law 89-709):								
Public Health Service Act:								
Sec. 742(a)—Health professions student loans	15,000,000	15,000,000	26,500,000	17,300,000	17,300,000	11,500,000	2,300,000	2,300,000
Sec. 770—Grants to improve the quality of schools of medicine, dentistry, osteopathy, optometry, and podiatry	52,500,00	49,675,000	80,000,000	66,000,000	66,000,000	30,325,000	16,325,000	16,325,000
Allied Health Professions Personnel Training Act of 1966 (Public Law 89-751):								
Public Health Service Act:								
Sec. 792—Grants to improve the quality of training centers for allied health professions	9,750,000	9,750,000	17,000,000	17,000,000	17,000,000	7,250,000	7,250,000	7,250,000
Sec. 793—Allied health traineeships	1,500,000	1,500,000	3,500,000	2,500,000	2,500,000	2,000,000	1,000,000	1,000,000
Sec. 794—Allied health new methods grants	1,000,000	1,000,000	3,000,000	2,100,000	2,010,000	2,000,000	1,100,000	1,100,000
Sec. 861(h)—Opportunity grants for nursing education	5,000,000	[5] 5,250,000	7,000,000	6,800,000	[6] 7,050,000	1,750,000	1,550,000	1,800,000

Nurse Training Act of 1964 (Public Law 88-581):								
Public Health Service Act:								
Sec. 805(a)—Grants for improvement of nurse training	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	0	0	0
Sec. 806(a)—Payment of diploma schools of nursing	3,000,000	3,000,000	10,000,000	3,000,000	3,000,000	7,000,000	0	0
Sec. 821(a)—Traineeships for advanced training of professional nurses	10,000,000	10,000,000	12,000,000	11,000,000	11,000,000	2,000,000	1,000,000	1,000,000
Sec. 824—Nursing student loans	16,000,000	[1] 9,610,000	30,900,000	9,700,000	9,700,000	21,290,000	90,000	90,000
Total, health manpower education and utilization	134,250,000	125,285,000	218,900,000	157,500,000	157,750,000	93,615,000	32,215,000	32,465,000
CONSTRUCTION OF HEALTH EDUCATIONAL FACILITIES								
Health Professions Educational Assistance Amendments of 1965 (Public Law 89-290):								
Public Health Service Act: Sec. 720—Grants for construction of teaching facilities for medical, dental, and other health professions schools	175,000,000	116,700,000	170,000,000	75,000,000	127,194,907	53,300,000	−41,700,000	10,494,907
Allied Health Professions Personnel Training Act of 1966 (Public Law 89-751):								
Public Health Service Act: Sec. 791—Grants for construction of teaching facilities for allied health professions	3,000,000	2,000,000	13,500,000	1,800,000	2,800,000	11,500,000	−200,000	800,000
Nurse Training Act of 1964 (Public Law 88-581):								
Public Health Service Act: Sec. 801(a) (1) and (2)—Construction of new facilities for collegiate, associate degree, and diploma schools of nursing	25,000,000	16,700,000	25,000,000	8,000,000	21,462,606	8,300,000	−8,700,000	4,762,606
Total, construction of health educational facilities	203,000,000	135,400,000	203,500,000	84,800,000	151,457,513	73,100,000	−50,600,000	16,057,513
Total, Bureau of Health Manpower	337,250,000	260,685,000	427,400,000	242,300,000	309,207,513	166,715,000	−18,385,000	48,522,513
BUREAU OF DISEASE PREVENTION AND ENVIRONMENTAL CONTROL								
Solid Wastes Disposal Act (89-272): sec. 210	15,602,000	15,352,000	20,000,000	17,534,000	17,534,000	4,648,000	2,182,000	2,182,000
Air Quality Act (90-148):								
Sec. 104:								
Research			90,000,000	31,300,000	[2] 42,300,000	86,400,000	27,700,000	38,700,000
Proposed supplemental	14,600,000	3,600,000						
Sec. 309:								
Other	64,185,000	[3] 66,311,000						
Facilities	1,815,000		95,000,000	75,433,000	75,433,000	27,289,000	7,722,000	7,722,000
Proposed supplemental	1,400,000	1,400,000						
Total, Bureau of Disease Prevention and Environmental Control	97,602,000	86,663,000	205,000,000	124,267,000	135,267,000	118,337,000	37,604,000	48,604,000

Footnotes at end of tables p. 242.

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS (EXCLUDES PROGRAMS FOR WHICH THERE IS NO SPECIFIC 1969 AUTHORIZATION)—Continued

PUBLIC HEALTH SERVICE—Continued

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriations requested	Estimated obligations
BUREAU OF HEALTH SERVICES								
COMMUNITY HEALTH SERVICES								
Community Health Services Extension Amendments of 1965 (P.L. 89-109):								
Public Health Service Act: Sec. 310—Migratory workers	$8,045,000	$8,045,000	[10] $9,000,000	$8,976,000	$8,976,000	[10] $955,000	$931,000	$931,000
Partnership for Health Amendments 1967 (P.L. 90-174):								
Sec. 304—Research and demonstrations relating to health facilities and services	20,000,000	[11] 20,000,000	40,000,000	[4] 28,000,000	[4] 28,000,000	20,000,000	8,000,000	8,000,000
Total, Community Health Services	28,045,000	28,045,000	49,000,000	36,976,000	36,976,000	20,955,000	8,931,000	8,931,000
HOSPITAL CONSTRUCTION ACTIVITIES								
Hospital and Medical Facilities Amendments of 1964 (P.L. 88-443):								
Public Health Service Act:								
Section 601—Construction grants:								
Hospitals and Centers	130,000,000	128,498,000	125,000,000	112,800,000	134,595,000	−3,498,000	−15,698,000	6,097,000
Modernization	50,000,000	44,458,000	55,000,000	49,600,000	52,534,000	10,542,000	5,142,000	8,076,000
Long-term care facilities	70,000,000	63,010,000	70,000,000	65,000,000	72,719,000	6,990,000	1,990,000	9,709,000
Diagnostic and treatment centers	20,000,000	17,176,000	20,000,000	18,000,000	20,565,000	2,824,000	824,000	3,389,000
Rehabilitation facilities	10,000,000	9,626,000	10,000,000	9,000,000	10,436,000	374,000	−626,000	810,000
Total, hospital construction activities	280,000,000	262,768,000	280,000,000	254,400,000	290,849,000	17,232,000	−8,368,000	28,081,000
INDIAN HEALTH ACTIVITIES								
Menominee Indians grants (Public Law 89-653):								
School district costs	150,000	150,000	150,000	150,000	150,000	0	0	0
Public welfare benefits	100,000	100,000	100,000	100,000	100,000	0	0	0
Health and sanitation services	100,000	100,000	100,000	100,000	100,000	0	0	0
Total, Indian health activities	350,000	350,000	350,000	350,000	350,000	0	0	0
Total, Bureau of Health Services	308,395,000	291,163,000	329,350,000	291,726,000	328,175,000	38,187,000	563,000	37,012,000

NATIONAL INSTITUTES OF HEALTH								
GRANTS FOR CONSTRUCTION OF HEALTH RESEARCH FACILITIES								
Health Research Facilities Amendments of 1965 (Public Law 89-115):								
Public Health Service Act: Sec. 704—Construction grants	35,000,000	38,400,000	189,000,000	8,400,000	20,608,000	150,600,000	−30,000,000	−17,792,000
REGIONAL MEDICAL PROGRAMS								
Heart Disease, Cancer, and Stroke Amendments of 1965 (Public Law 89-239):								
Public Health Service Act: Sec. 901—Education, research training, and demonstration grants	53,900,000	48,900,000	[12] 62,900,000	62,900,000	93,800,000	14,000,000	14,000,000	44,900,000
Gorgas Memorial Laboratory (Public Law 89-181) (22 U.S.C. 278)	500,000	500,000	500,000	500,000	500,000			
Total, NIH	89,400,000	87,800,000	252,400,000	71,800,000	114,908,000	164,600,000	−16,000,000	27,108,000
NATIONAL INSTITUTE OF MENTAL HEALTH								
COMMUNITY MENTAL HEALTH RESOURCE SUPPORT								
Grants for construction of community mental health centers; Public Law 88-164, sec. 201, Community Mental Health Centers Act, as amended by Public Law 90-31, sec. 2, Mental Health Amendments of 1967	45,000,000	45,380,000	60,000,000	15,000,000	60,000,000	14,620,000	−30,380,000	14,620,000
Grants for initial staffing of community mental health centers:								
(A) Initial grants: Public Law 88-164, sec. 201, Community Mental Health Centers Construction Act of 1963, as amended by Public Law 89-105, sec. 224, Community Mental Health Centers Construction Act of 1965	22,108,000	22,108,000	26,000,000	22,079,000	22,079,000	3,892,000	−29,000	−29,000
Grants for construction and operation of narcotic addict rehabilitation facilities: Public Law 89-793, sec. 402, Narcotic Addict Rehabilitation Act of 1966 (additional authorizing legislation proposed)	4,000,000	4,000,000	[13] 8,000,000	8,000,000	8,909,000	4,000,000	4,000,000	4,000,000
Total, National Institute of Mental Health	71,108,000	71,488,000	94,000,000	45,079,000	90,079,000	22,512,000	−26,409,000	18,591,000

Footnotes at end of table, p. 242.

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS (EXCLUDES PROGRAMS FOR WHICH THERE IS NO SPECIFIC 1969 AUTHORIZATION)—Continued

PUBLIC HEALTH SERVICE—Continued

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriations requested	Estimated obligations
OTHER PUBLIC HEALTH SERVICE								
NATIONAL LIBRARY OF MEDICINE								
Medical Library Assistance Act of 1965 (Public Law 89–291):								
Public Health Service Act:								
Sec. 378(a)—Regional branches of the National Library of Medicine	0	0	$2,000,000	0	0	2,000,000	0	0
Sec. 393(i)—Assistance for construction of facilities	$3,750,000	$10,000,000	10,000,000	.....	$1,250,000	.....	−$10,000,000	−$8,750,000
Sec. 394(a)—Grants for training in medical library sciences	1,000,000	1,143,127	1,000,000	$1,000,000	1,433,000	−$143,127	−143,127	289,873
Sec. 395—Assistance to special scientific projects	100,000	120,000	500,000	100,000	200,000	380,000	−20,000	80,000
Sec. 396(a)—Research and development in medical library science and related fields	1,600,000	1,486,000	3,000,000	1,700,000	2,588,000	1,514,000	214,000	1,102,000
Sec. 397(a)—Grants for improving and expanding the basic resources of medical libraries and related instrumentalities	2,500,000	3,537,392	3,000,000	2,500,000	2,800,000	−537,392	−1,037,392	−737,392
Sec. 398(a)—Grants for establishment of regional medical libraries	1,500,000	680,128	2,500,000	1,500,000	2,415,000	1,819,872	819,872	1,734,872
Sec. 399(a)—Financial support of biomedical scientific publications	800,000	679,815	1,000,000	327,000	585,000	320,185	−352,815	−94,815
Total, other Public Health Service	11,250,000	17,646,462	23,000,000	7,127,000	11,271,000	5,353,538	−10,519,462	−6,375,462
Total, Public Health Service	1,067,755,000	962,945,462	1,541,150,000	973,849,000	1,185,457,513	578,204,538	10,903,538	222,512,051

[1] Includes 1 percent for program evaluation.
[2] Includes $20,000, proposed supplemental. Excludes $5,000,000 transfer to National Center for Health Services Research and Development.
[3] Includes $15,000,000 obligations in proposed supplemental. Excludes $5,000,000 transfer to National Center for Health Services Development.
[4] Includes 1 percents for evaluation.
[5] Includes $500,000 unobligated balance brought forward into 1968 and excludes $250,000 carried forward into 1939.
[6] Includes $250,000 unobligated balance brought forward into 1969.
[7] Excludes $6,390,000 transferred to the health professions education and nurse training funds.
[8] Includes $11,000,000 balance brought forward.
[9] Includes $4,040,000 balance brought forward.
[10] Legislation pending—assume authorization will be at least $9,000,000.
[11] Sec. 314(e)(3), $5,000,000; sec. 624, $9,173,000; proposed supplemental, $5,827,000.
[12] Previous authorization expired with 1968; subsequent authorization to be requested.
[13] Legislation to be requested.

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS (EXCLUDES PROGRAMS FOR WHICH THERE IS NO SPECIFIC 1969 AUTHORIZATION)

SOCIAL AND REHABILITATION SERVICE

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriations requested	Estimated obligations
GRANTS TO STATES FOR VOCATIONAL REHABILITATION SERVICES								
Vocational Rehabilitation Amendments of 1967 (Public Law 90-99): Sec. 2	$287,000,000	$287,000,000	$500,000,000	$345,900,000	$345,900,000	$213,000,000	$58,900,000	$58,900,000
MENTAL RETARDATION								
Community service facilities construction (Public Law 90-170)	18,000,000	12,657,302	30,000,000	6,000,000	18,000,000	17,342,698	−6,657,302	5,342,698
University-affiliated facilities construction (Public Law 90-170)	6,600,000	8,751,099	20,000,000	6,600,000	6,600,000	11,248,901	−2,151,099	−2,151,099
Initial staffing (Public Law 90-170)	0	0	10,000,000	8,358,000	8,358,000	10,000,000	8,358,000	8,358,000
Total	24,600,000	21,408,401	60,000,000	20,958,000	32,958,000	38,591,599	−450,401	11,549,599
MATERNAL AND CHILD HEALTH AND WELFARE								
Social Security Act, as amended (Public Law 90-248): [2]								
Title V: Maternal and child health and crippled children's services:								
(a) Maternal and child health services	50,000,000	50,000,000	----------	50,000,000	50,000,000	----------	----------	----------
(b) Crippled children's services	50,000,000	50,000,000	----------	65,000,000	65,000,000	----------	15,000,000	15,000,000

See footnotes at end of table, p. 245.

COMPARISON OF THE 1968 OBLIGATION CEILING WITH 1969 AUTHORIZATIONS, REQUESTED APPROPRIATIONS, AND ESTIMATED OBLIGATIONS (EXCLUDES PROGRAMS FOR WHICH THERE IS NO SPECIFIC 1969 AUTHORIZATION)—Continued

SOCIAL AND REHABILITATION SERVICE—Continued

Appropriation and authorizing legislation	1968		1969			Increase over 1968 obligation ceiling		
	Appropriation	Obligation ceiling	Authorization	Appropriation requested	Estimated obligations	Authorization	Appropriations requested	Estimated obligations
MATERNAL AND CHILD HEALTH AND WELFARE—Con.								
Social Security Act, etc.—Continued								
Title V—Continued								
(c) Special project grants—maternity and infant care.	$30,000,000	$30,000,000	----------	$55,000,000	$55,000,000	----------	$25,000,000	$25,000,000
(d) Special project grants—health of school and preschool children.	37,000,000	36,900,000	----------	42,000,000	42,000,000	----------	5,100,000	5,100,000
(e) Special project grants—dental	0	0	----------	1,000,000	1,000,000	----------	[3] 1,000,000	[3] 1,000,000
(f) Training	7,000,000	7,000,000	----------	10,000,000	10,000,000	----------	3,000,000	3,000,000
(g) Research	5,900,000	5,700,000	----------	13,300,000	13,300,000	----------	7,600,000	7,600,000
(h) Evaluation	0	0	----------	1,000,000	1,000,000	----------	[3] 1,000,000	[3] 1,000,000
Total	179,900,000	179,600,000	[4] $250,000,000	237,300,000	237,300,000	$70,400,000	57,700,000	57,700,000
Title IV, Pt. B: Child Welfare Services	46,000,000	46,000,000	100,000,000	46,000,000	46,000,000	54,000,000	0	0
DEVELOPMENT OF PROGRAMS FOR THE AGING								
Older Americans Act of 1965, Public Law 89-73, as by Public Law 90-42:								
Title III: Grants to States for community planning services and training	10,550,000	10,022,000	16,000,000	16,000,000	16,000,000	5,978,000	5,978,000	5,978,000
Title IV: Grants and contracts for research and demonstrations	4,155,000	4,142,000	----------	7,000,000	7,000,000	----------	2,858,000	2,858,000
Title V: Training grants and contracts	2,245,000	2,245,000	(10,000,000)	3,000,000	3,000,000	(3,613,000)	755,000	755,000
Total	16,950,000	16,409,000	26,000,000	26,000,000	26,000,000	9,591,000	9,591,000	9,591,000
SOCIAL SERVICES, ADMINISTRATION, TRAINING, AND DEMONSTRATION PROJECTS								
Expansion and development of undergraduate and graduate programs—								
Social Security Act as amended (Public Law 90-248) title VII, sec. 707	----------	----------	5,000,000	3,000,000	3,000,000	5,000,000	3,000,000	3,000,000
Total, Social and Rehabilitation Service	554,450,000	550,417,401	941,000,000	679,158,000	691,158,000	390,582,599	128,740,599	140,740,599

[1] Excludes programs for which there is an indefinite authorization.
[2] Contains change in authorization effective in fiscal year 1969.
[3] Program authorized by 1967 Social Security Amendments to be initiated in fiscal year 1969.
[4] Authorization covers entire child health program.

SPECIAL INSTITUTIONS								
American Printing House for the Blind (act of Mar. 3, 1879, as amended)	$1,225,000	$1,225,000	(1)	$1,340,000	$1,340,000	(1)	$115,000	$115,000
National Technical Institute for the Deaf (Public Law 89-36)	2,615,000	2,035,000		800,000	1,908,000		−1,815,000	−127,000
Model Secondary School for the Deaf (Public Law 89-694):								
Salaries and expenses	425,000	425,000		400,000	400,000		−25,000	−25,000
Construction	275,000			445,000	720,000		170,000	720,000
Subtotal, model school	700,000	425,000		845,000	1,120,000		145,000	695,000
Gallaudet College: (Public Law 83-420):								
Salaries and expenses	2,919,000	4,519,000		3,785,000	5,504,000		861,000	985,000
Construction	2,196,000	1,757,000		675,000	675,000		−1,521,000	−1,082,000
Subtotal, Gallaudet College	5,115,000	6,276,000		4,460,000	6,179,000		−660,000	−97,000
Howard University: (Act of Mar. 2, 1867, as amended):								
Salaries and expenses	15,534,000	30,892,000		18,330,000	32,550,000		2,796,000	1,658,000
Construction	3,926,000	6,555,000		2,209,000	10,994,000		−1,717,000	4,439,000
Freedmen's	6,937,000	10,221,000		8,739,000	12,023,000		1,802,000	1,802,000
Subtotal, Howard University	26,397,000	47,668,000		29,278,000	55,567,000		2,881,000	7,899,000
Total, special institutions [2]	36,052,000	57,629,000		36,723,000	66,114,000		666,000	8,485,000
OFFICE OF THE SECRETARY								
EDUCATIONAL BROADCASTING FACILITIES								
Public Broadcasting Act of 1967 (Public Law 90-129): Title I: Construction of facilities			$12,500,000	$12,500,000	$12,500,000	$2,000,000	$12,500,000	$12,500,000
PUBLIC BROADCASTING PROGRAM								
Public Broadcasting Act of 1967 (Public Law 90-129): Title II: Establishment of nonprofit Education Broadcasting Corporation	$4,000,000	$4,000,000	(3)	20,000,000	20,000,000	[3] 11,000,000	16,000,000	16,000,000
HIGHER EDUCATION FOR INTERNATIONAL UNDERSTANDING								
International Education Act of 1966 (Public Law 89-698): Title I: Grant programs for advanced and undergraduate international studies			90,000,000	10,200,000	10,200,000	50,000,000	10,200,000	10,200,000

[1] Indefinite for all special institutions.
[2] Includes proposed supplementals.
[3] Act authorizes $9,000,000 for fiscal year 1968. Legislation will be proposed to provide $20,000,000 for fiscal year 1969 for transfer to the corporation.

FOOD AND DRUG ADMINISTRATION

APPROPRIATIONS AND RESERVES, FISCAL YEAR 1968

Appropriation title	1968 appropriation [1]	Formal reserves			Total reserves	Explanation
		Savings	For obligation in subsequent years	For other contingencies		
Salaries and expenses	$66,000,000			$2,417,000	$2,417,000	Reduction in obligations required by Public Law 90-218.
Buildings and facilities	1,150,000		[2] $9,000,000	[3] 7,332,000	16,332,000	
OFFICE OF EDUCATION						
Elementary and secondary educational activities	$1,677,907,000	$29,863,066		$193,934	$30,057,000	Supplementary educational centers and services—10 percent reduction from $208,750,000 to $187,876,000, —$20,874,000. Equipment and minor remodeling—5-percent reduction from $79,200,000 to $75,240,000, —$3,960,000. Library resources—5-percent reduction from $104,457,000 to $99,234,000, —$5,223,000. Of the $30,057,000 in reserve $193,934 will be requested for transfer to salaries and expenses, Office of Education to partially fund the cost of the postal and pay increases.
School assistance in federally affected areas	439,137,000	20,810,000	$4,105,000	22,000	24,937,000	Maintenance and operations (Public Law 874)—5-percent reduction from $416,200,000 to $395,390,000, —$20,810,000. Construction assistance to local educational agencies—33⅓ percent reduction from $12,317,000 to $8,212,000, —$4,105,000. Technical services—reduction of 2 positions. The savings of $22,000 will be requested for funding the cost of the postal and pay increases.
Teacher Corps	13,500,000					

Higher educational activities	1,158,194,000	6,000,000	196,895,029	98,000	202,993,029	Public community colleges and technical institutes, 33⅓ percent reduction from $100,000,000 to $67,000,000, —$33,000,000. Other undergraduate facilities, 33⅓ percent reduction from $300,000,000 to $200,000,000, —$100,000,000. Graduate facilities, 33⅓-percent reduction from $50,000,000 to $33,000 000, —$17 000,000. Technical services, reduction of 7 positions. The savings of $98,000 will be requested for funding the cost of the postal and pay increases. Educational opportunity grants, 6.4-percent reduction from $140,600,000 to $131,600,000, —$9,000,000. NDEA student loans reduced (no reallotments) from $190,000,000 to $184,000,000, —$6,000,000. Interest payments reduced from $40,000,000 to $7,704,971, —$32,295,029 (revised estimate). College work-study, 4-percent reduction from $139,900,000 to $134,300,000 —$5,600,000.
Expansion and improvement of vocational education	252,900,000	1,084,000			1,084,000	Vocational Education Act of 1963 (grants to States) held to 1967 level, from $199,309,000 to $198,225,000, —$1,084,000.
Library and community services	156,500,000	1,901,000	9,000,000		10,901,000	Interlibrary cooperation, 5 percent reduction from $2,375,000 to $2,256,000, —$119,000. State institutional library services, 5 percent reduction from $2,120,000 to $2,014,000, —$106,000. Library services to the physically handicapped, 5 percent reduction from $1,320,000 to $1,254,000, —$66,000. Construction of public libraries, reduction of 33 percent from $27,185,000 to $18,185,000, —$9,000,000. Adult basic education, grants to States, 5 percent reduction from $32,200,000 to $30,590,000, —$1,610,000.
Educational improvement for the training	53,400,000	750,000			750,000	Preschool and school programs, 5 percent reduction from $15,000,000 to $14,250,000, —$750,000.
Research and training	90,967,000					
Foreign language training and area programs	15,700,000					
Salaries and expenses	37,376,042			713,000	713,000	Reduction in personnel compensation, benefits, and other objects. The reserve of $713,000 will be requested for funding the cost of the postal and pay increases.
Civil rights educational activities	10,000,000	31,000		35,000	66,000	Reduction in personnel compensation, benefits, and other objects. Of the $66,000 in reserve, $35,000 will be requested for funding the cost of the postal and pay increases.
Colleges for agriculture and the mechanic arts	2,550,000					
Promotion of Vocational Education Act of Feb. 23, 1917	7,161,455					
Higher education facilities loan fund	102,625,000					
Arts and humanities educational activities	1,000,000					
Total	4,018,867,497	60,439,066	210,000,029	1,061,934	271,501,029	

[1] Includes proposed supplementals.
[2] Reduction in obligations required by Public Law 90-218.
[3] For obligations to be incurred in future years for planning, construction, and equipping of research and field facilities.

PUBLIC HEALTH SERVICE

Appropriation title	1968 appropriation [1]	Formal reserves			Total reserves	Explanation
		Savings	For obligation in subsequent years	For other contingencies		
Health manpower education and utilization	$164,663,000	$2,948,000	$250,000	$417,000	$3,615,000	
Construction of health educational facilities	203,000,000	0	59,057,513	67,600,000	126,657,513	
Chronic diseases	27,942,000	22,000	0	476,000	498,000	
Communicable diseases	72,109,000	84,000	2,609,996	1,485,000	4,178,996	
Air pollution	64,185,000	1,169,000	0	1,100,440	2,269,440	
Urban and industrial health	41,750,000	228,000	0	841,010	1,069,010	
Radiological health	15,687,000	32,000	0	338,350	370,350	
Community health services	54,234,000	198,000	17,500,000	273,000	17,971,000	
Hospitals and medical care	63,230,000	13,000	0	69,400	82,400	
Hospital construction activities	293,357,000	0	12,800,000	156,000	12,956,000	
General research and services, NIH	81,141,000	1,584,000	0	379,900	1,963,900	
Biologics standards	8,649,000	0	0	233,000	233,000	
National Cancer Institute	183,356,000	1,642,000	0	684,000	2,326,000	
National Heart Institute	167,954,000	145,000	0	2,199,000	2,344,000	
National Institute of Dental Research	30,307,000	250,000	0	232,300	482,300	
National Institute of Arthritis and Metabolic Diseases	143,954,000	1,140,000	0	794,000	1,934,000	
National Institute of Neurological Diseases and Blindness	128,633,000	0	0	2,357,500	2,357,500	
National Institute of Allergy and Infectious Diseases	94,422,000	500,000	0	705 000	1,205,000	
National Institute of General Medical Sciences	160,284,000	907,000	0	388,400	1,295,400	

National Institute of Child Health and Human Development	68,621,000	340,000	0	395,000	735,000	
Regional medical programs	58,814,000	0	30,900,338	78,500	30,978,838	
Environmental health sciences	17,289,000	142,000	0	164,500	306,500	
Construction of Mental health neurology research facility	[2] 0	0	$113,000	0	113,000	
Grants for construction of health research facilities	35,000,000	0	12,207,934	0	12,207,934	
John E. Fogarty Center	500,000	0	50,000	430,000	480,000	
Mental health research and services	246,741,000	1,108,000	0	1,485,000	2,593,000	
Community mental health resource support	100,168,000	0	45,000,000	0	45,000,000	
Salaries and expenses, St. Elizabeths Hospital	9,751,000	0	0	0	0	
Buildings and facilities, St. Elizabeths Hospital	[3] 1,237,000	0	7,506,011	0	7,506,011	
National health statistics	8,317,000	0	0	227,200	227,200	
National Library of Medicine	19,912,000	0	4,117,462	301,500	4,418,962	
Buildings and facilities	[4] 10,715,000	0	0	35,046,104	35,046,104	
Scientific activities overseas	15,000,000	0	850,466	0	850,466	Reserve is amount unobligated from prior years.
Retired pay of commissioned officers	13,391,000	0	0	0	0	
Comprehensive health planning and services	140,676,000	2,750,000	0	123,000	2,873,000	
Office of the Surgeon General, salaries and expenses	8,358,000	0	0	262,000	262,000	
Public Health Service management fund	4,044,000	0	0	70,000	70,000	
National Institutes of Health management fund	53,530,000	0	0	1,705,000	1,705,000	
Payment of sales insufficiencies	250,000	250,000	0	0	250,000	
Total	2,811,171,000	15,452,000	192,962,720	121,017,104	329,431,824	
Indian health activities	82,005,000	0	0	26,300	26,300	
Construction of Indian health facilities	[5] 16,848,000	0	0	10,068,000	10,068,000	
Emergency health activities	9,000,000	0	7,327,310	379,900	7,707,210	

[1] Includes proposed supplementals.
[2] Excludes $1,614,961 available from prior years.
[3] Excludes $11,807,853 available from prior years.
[4] Excludes $33,878,104 available from prior years.
[5] Excludes $10,382,242 from prior years.

Appropriation title	1968 appropriation [1]	Formal reserves			Total reserves	Explanation
		Savings	For obligation in subsequent years	For other contingencies		
Social and Rehabilitation Service						Note: Amounts shown in reserve result from cutback required by H.J. Res. 888 unless otherwise noted.
Assistance for repatriated U.S. nationals	$525,000			$30,000	$30,000	Appropriation language specifies that these funds may be apportioned only to the extent necessary to provide requirements not anticipated in the budget estimates.
Grants for rehabilitation services and facilities	312,790,000			6,404,562	6,404,562	
Mental retardation	33,698,000			17,500,000	17,500,000	
Maternal and child health and welfare	235,600,000	$300,000			300,000	
Development of programs for the aging	16,950,000	541,000			541,000	
Rehabilitation research and training	63,937,000			24,000	24,000	
Research and training (special foreign currency program)	5,000,000			581,108	581,108	
Social and Rehabilitation Service, salaries and expenses	24,709,000			205,000	205,000	
Total, Social and Rehabilitation Service	693,209,000	841,000		24,744,670	25,585,670	
Social Security Administration: Limitation on construction (trust fund).			$48,330,651		48,330,651	No year appropriation; reserve is unobligated balance from prior year appropriations as of June 30, 1968, to remain available until expended.
American Printing House for the Blind	1,225,000					
National Technical Institute for the Deaf	2,615,000		1,108,000		1,108,000	In reserve pending negotiation of architectural contract and firmer schedule of site preparation.
Model secondary school for the deaf: Salaries and expenses	425,000		355,000		355,000	Start of operation delayed. Agreement between HEW and Gallaudet College not signed until late in fiscal year 1968.
Construction	275,000		275,000		275,000	Start of planning for facility delayed because research not completed as scheduled.
Total	700,000		630,000		630,000	

Gallaudet College:						
Salaries and expenses	2,919,000	0	0	0	0	
Construction	2,196,000	0	176,519	0	176,519	$176,519 is held in reserve from funds prior to 1968 (prep dormitory construction).
Total	5,115,000	0	176,519	0	176,519	
Salaries and expenses, Howard University	15,534,000					
Construction, Howard University	3,926,000		10,084,162		10,084,162	75X1032, construction, Howard University, is a no-year appropriation. Planning and construction contemplate obligation of prior appropriated funds at times subsequent to fiscal year 1968.
Howard University, Freedmen's Hospital	6,937,000					
OFFICE OF THE SECRETARY						
Salaries and expenses, Office of the Secretary	[3] 7,179,000 (1,211,000)	106,000		206,000	312,000	Reserves of $312,000 includes $206,000 to be used for fiscal year 1968 pay increase costs and $106,000 for savings.
Salaries and expenses, Office of Field Coordination	2,161,000 (1,815,000)	27,000		140,000	167,000	Reserves of $167,000 includes $140,000 to be used for fiscal year 1968 pay increase costs of which $101,000 is for Office of Field Coordination and $39,000, by transfer for surplus property utilization; the remaining $27,000, for savings.
Salaries and expenses, Office of the Comptroller	6,748,000 (991,000)	26,000		233,000	259,000	Reserves of $259,000 includes $233,000 for fiscal year 1968 pay increase costs and $26,000 for savings.
Salaries and expenses, Office of Administration	2,427,000 (271,000)			65,000	65,000	Reserves of $65,000 will be used for fiscal year 1968 pay increase costs.
Salaries and expenses, Office of the General Counsel	1,935,000 (1,373,000)			106,000	106,000	Reserves of $106,000 will be used for fiscal year 1968 pay increase costs.
Surplus property utilization	1,158,000					The 1968 appropriation includes $39,000 to be transferred from the Office of Field Coordination for pay increase cost

[1] Includes proposed supplementals.
[2] Excludes portion of current reserves proposed for use in meeting increased pay and postal costs.
[3] Includes $40,000 unobligated balance brought forward July 1, 1967, for special study of administration of training programs.

SUMMARY OF STAFFING DETAIL, FISCAL YEARS 1967, 1968, 1969

	1967			1968			1969		
	Positions	Man-years	Employment	Positions	Man-years	Employment	Positions	Man-years	Employment
Food and Drug Administration	5,366	4,760	4,525	5,387	4,870	4,900	5,587	5,052	5,045
Office of Education	3,254	2,827	2,624	3,389	3,201	2,900	3,812	3,670	3,207
Public Health Service	43,113	39,686	38,739	45,360	43,976	41,270	47,927	47,051	43,131
Social and Rehabilitation Service	2,028	1,744	1,667	2,039	1,942	1,870	2,223	2,054	2,004
Social Security Administration	48,246	[1] 46,516	47,186	54,201	[1] 51,152	52,270	55,951	[1] 54,027	53,540
Office of the Secretary	2,646	2,434	2,210	2,981	2,726	2,830	3,454	3,222	3,173
Total, DHEW	104,653	97,967	[2] 96,951	113,357	107,867	106,040	118,954	115,076	[3] 110,100
End-of-year employment only:									
Overallocation						−540			−600
Budget Bureau ceiling						105,500			109,500
As shown in President's budget (full-time permanent positions)			95,900			105,400			108,800

[1] Excludes overtime equivalent as follows: 1967, 3,743 man-years; 1968, 4,414 man-years; 1969, 1,901 man-years.

[2] Includes figure of 841 for Freedmen's Hospital.

[3] 1969 end-of-year employment estimate assumes agencies will fill 73 percent of new positions.

	1967		1968		1969	
	Positions	Man-years	Positions	Man-years	Positions	Man-years
Food and Drug Administration:						
Salaries and expenses	5,080	4,505	5,101	4,597.0	5,261	4,746
Certification	266	245	266	263.0	306	296
Advances and reimbursements	20	10	20	10.0	20	10
Total	5,366	4,760	5,387	4,870.0	5,587	5,052
Office of Education:						
Salaries and expenses	2,527	2,249	2,545	2,422.0	2,918	2,755
Civil rights educational activities	92	70	89	93.0	124	118
Higher educational activities	260	204	253	226.0	253	258
School assistance in federally affected areas	60	45	58	46.0	58	46
Advances and reimbursements	89	65	224	217.0	224	217
Elementary and secondary educational activities					15	24
Education professions development activities						6
Expansion and improvement of vocational education						5
Libraries and community services						6
Educational improvement for the handicapped						15
Research and training						7
Subtotal, Office of Education	3,028	2,633	3,169	3,004.0	3,592	3,457
Allocations and allotments (net)	226	194	220	197.0	220	213
Total	3,254	2,827	3,389	3,201.0	3,812	3,670
Public Health Service:						
Office of the Surgeon General:						
Salaries and expenses	665	580	719	634.0	732	647
Comprehensive health planning and services	179	699	180	840.0	233	950
Service and supply fund	118	105	136	130.0	146	138
Advances and reimbursements	164	73	133	107.0	143	118
Total, Office of the Surgeon General	1,126	1,457	1,168	1,711.0	1,254	1,853
Health manpower:						
Health manpower education and utilization	723	643	762	752.0	813	821
Advances and reimbursements	19	16	68	63.	59	54
Total, health manpower	742	659	830	815.0	872	875
Disease prevention and environmental control:						
Chronic diseases	983	766	944	845.0	979	882
Communicable diseases	3,265	3,091	3,067	3,101.0	3,226	3,133
Air pollution	888	731	[1] 1,191	[2] 1,029	1,630	1,468
Urban and industrial health	1,136	952	1,228	1,093.0	1,462	1,364
Radiological health	814	786	799	781.0	994	961
Public Health Service management fund	171	146	184	168.0	0	0
Trust funds	5	4	5	4.0	5	4
Advances and reimbursements	903	555	914	751.0	888	781
Total, disease prevention and environmental control	8,165	7,032	8,332	7,772.0	9,184	8,593
Health services:						
Community health services	574	419	602	582.0	924	871
Patient care and special health services	6,296	5,918	6,855	6,697.0	6,940	6,866
Hospital construction activities	302	279	312	288.0	282	263
Indian health activities	6,237	5,541	6,724	6,224.0	7,151	6,781
Construction of Indian health facilities	0	144	0	168.0	0	316
Allocation to Bureau of Indian Affairs	44	40	44	43.0	44	41
Emergency health activities	181	170	175	171.0	175	171
Public Health Service management fund	97	90	117	100.0	0	0
Trust funds	0	2	0	2.0	0	2
Advances and reimbursements	277	228	302	265.0	326	311
Total, health services	14,008	12,831	15,131	14,540.0	15,842	15,622
National Institutes of Health:						
Biologics standards	333	285	324	283.0	329	287
National Cancer Institute	1,421	1,364	1,419	1,432.0	1,462	1,460
Allocation to Veterans' Administration	82	94	82	86.0	82	86
National Heart Institute	695	627	682	669.0	701	699
National Institute of Dental Research	310	292	322	308.0	329	315
National Institute of Arthritis and Metabolic Diseases	683	661	697	687.0	737	712
National Institute of Neurological Diseases and Blindness	776	729	793	801.0	830	850
National Institute of Allergy and Infectious Diseases	729	695	741	691.0	759	705
National Institute of General Medical Sciences	207	185	215	212.0	234	228

See footnotes at end of table.

	1967		1968		1969	
	Positions	Man-years	Positions	Man-years	Positions	Man-years
Public Health Service—Continued						
National Institutes of Health—Continued						
National Institute of Child Health and Human Development	430	356	478	407.0	573	521
Regional medical programs	114	91	145	137.0	198	175
Environmental health sciences	66	38	171	135.0	232	205
General research and services, NIH	302	273	338	324.0	371	360
National Institutes of Health management fund	4,433	4,378	4,489	4,323.0	4,652	4,425
Service and supply fund	510	464	718	700.0	789	772
Advances and reimbursements	32	53	4	4.0	4	4
Total, National Institutes of Health	11,123	10,585	11,618	11,199.0	12,282	11,804
National Institute of Mental Health:						
Mental health research and services	2,683	2,250	2,726	2,601.0	2,818	2,679
Allocation to St. Elizabeths Hospital	14	13	14	13.0	0	0
St. Elizabeths Hospital, salaries and expenses	4,102	3,796	4,072	3,973.0	4,124	4,145
Working capital fund, narcotic hospitals	44	44	33	39.0	33	34
Operation of commissaries, narcotic hospitals	10	10	10	10.0	10	10
Advances and reimbursements	0	19	0	13.0	0	15
Total, National Institute of Mental Health	6,853	6,132	6,855	6,649.0	6,985	6,883
All other Public Health Service:						
National Health Statistics	441	415	473	437.0	536	489
National Library of Medicine	397	344	536	477.0	546	493
Advances and reimbursements	21	17	63	56.0	23	30
Total, other Public Health Service	859	776	1,072	970.0	1,105	1,012
Total	42,876	39,472	45,006	43,656.0	47,524	46,642
Allocations and allotmedts (net)	237	214	354	320.0	403	409
Total, Public Health Service	43,113	39,686	45,360	43,976.0	47,927	47,051
Social and Rehabilitation Service:						
Working incentive activities			75	31.0	165	155
Rehabilitation research and training	4	5		5.0		
Social and Rehabilitation Service, salaries and expenses	1,777	1,479	1,797	1,681.0	1,997	1,802
Assistance to refugees in the United States	130	156	126	153.0	126	153
Advances and reimbursements	38	26	46	30.0	46	41
Total, President's budget	1,949	1,666	2,044	1,900.0	2,334	2,151
Allocations and allotments (net)	79	78	−5	42.0	−111	−97
Total, Social and Rehabilitation Service	2,028	1,744	2,039	1,942.0	2,223	2,054
Social Security Administration:						
Salaries and expenses	47,592	45,922	53,496	50,493.0	55,224	53,339
Operating fund, Bureau of Federal Credit Unions	491	441	512	478.0	534	507
Advances and reimbursements	163	153	193	181.0	193	181
Total, Social Security Administration	48,246	[3] 46,516	54,201	[3] 51,152.0	55,951	[3] 54,027
National Technical Institute for the Deaf	3	3	2	2.0	2	2
Model Secondary School for the Deaf, salaries and expenses			2	.5	2	2
Office of the Secretary:						
Salaries and expenses, Office of the Secretary	471	445	598	543.0	771	707
Salaries and expenses, Office of Field Coordination	404	369	431	365.0	496	439
Salaries and expenses, Office of the Comptroller	458	412	579	498.0	695	632
Salaries and expenses, Office of Administration	215	190	223	199.0	274	250
Surplus property utilization	105	96	105	97.0	105	99
Salaries and expenses, Office of the General Counsel	293	248	290	280.0	295	286
Educational broadcasting facilities	23	22	[4] 23	19.0	36	33
Higher education for international understanding					30	23
Working capital fund	603	578	667	648.0	681	673
Advances and reimbursements	52	52	47	59.0	49	58
Subtotal, President's budget	2,624	2,412	2,963	2,708	3,432	3,200
Net allocations and allotments	22	22	18	18.0	22	22
Total, Office of the Secretary	2,646	2,434	2,981	2,726.0	3,454	3,222

[1] Includes 106 positions for proposed supplemental.
[2] Includes 17 man-years for proposed supplemental.
[3] Excludes overtime equivalent as follows: 1967, 3,743 man-years; 1968, 4,414 man-years; 1969, 1,901 man-years.
[4] Includes proposed supplemental.

APPROPRIATIONS FOR WHICH LEGISLATION AUTHORIZES FUNDS TO REMAIN AVAILABLE BEYOND BUDGET YEAR

[Excludes direct construction and revolving funds]

Agency and account	Program	Length of availability
Public Health Service:		
Health manpower education and utilization.	Nursing educational opportunity grants.	2 years.
Construction of health educational facilities.	Construction of teaching facilities for medical, dental, and other health personnel.	Until expended.
Communicable disease activities	Community immunization grants	2 years.
Air pollution	Research relating to fuels and vehicles.	Until expended (sec. 104, Clean Air Act).
Hospital construction activities	Construction of hospital and medical facilities.	2 years; Guam, American Samoa, and the Virgin Islands, 3 years.
Regional medical programs	Grants for regional medical programs	2 years.
Grants for construction of health research facilities.	Grants for construction of health research facilities.	Until expended.
Community mental health resource support.	Construction grants	2 years.
National Library of Medicine	Grants for construction of medical library facilities.	Do.
	Grants for establishment of regional medical libraries.	Do.
Scientific activities overseas	Foreign currency program	Until expended. Authority contained in annual appropriation act.
Comprehensive health planning and services.	Grants to States for comprehensive State health planning.	2 years.
SPECIAL INSTITUTIONS		
[Excludes direct construction]		
National Technical Institute for the Deaf.	Grants and administration	Until expended. Authority contained in annual appropriation act.
Model Secondary School for the Deaf	Salaries and expenses and construction	Do.
OFFICE OF THE SECRETARY		
Office of the Secretary: Educational broadcasting facilities.	Educational broadcasting program	Until expended.

FUNDS TRANSFERRED TO INTERDEPARTMENTAL COMMITTEES, COMMISSIONS, COUNCILS, ETC.—FISCAL YEARS 1967–69

Activity and agency	1967 actual	1968 estimate	1969 estimate
Area coordinator program, Office of Federal Contract Compliance:			
Office of Education	$8,300		
Public Health Service	10,000		
Total	18,300		
Civil Service Commission, Interagency Board of Examiners:			
Food and Drug Administration	40,700		
Office of Education	5,500		
Public Health Service	158,400		
St. Elizabeths Hospital	10,300		
Social Security Administration	257,100		
Office of the Secretary	15,600		
Social and Rehabilitation Service	11,500		
Total	499,100	(1)	(1)
Commission on High Level Manpower:			
Social Security Administration		$32,500	
Public Health Service		50,000	
Food and Drug Administration		15,000	
Office of Education		137,500	
Social and Rehabilitation Service		15,000	
Total		250,000	
Committee on Government Patent Policy, Federal Council of Science and Technology: Public Health Service	20,000	5,000	
Federal Inquiry Center, General Services Administration:			
Office of Education	1,500		
Public Health Service	2,000		
Social and Rehabilitation Service	500		
Total	4,000		

See footnotes at end of table.

FUNDS TRANSFERRED TO INTERDEPARTMENTAL COMMITTEES, COMMISSIONS, COUNCILS, ETC.—FISCAL YEARS 1967–69—Continued

Activity and agency	1967 actual	1968 estimate	1969 estimate
Federal science and engineering exhibit, Civil Service Commission:			
Food and Drug Administration	$3,500	$3,100	$3,100
Public Health Service	3,500	3,100	3,100
Total	7,000	6,200	6,200
Interagency Committee on Civil Disorders:			
Social Security Administration		145,000	
Public Health Service		106,000	
Food and Drug Administration		16,000	
Office of Education		20,000	
Office of the Secretary		10,000	
Social and Rehabilitation Service		15,500	
Total		312,500	
Interagency Committee on Mexican-American Affairs:			
Social Security Administration		25,000	21,000
Public Health Service		30,000	27,000
Office of Education		20,000	18,000
Social and Rehabilitation Service		25,000	22,000
Total		100,000	88,000
National Advisory Commission on Health Manpower:			
Food and Drug Administration	9,100	2,500	
Office of Education	9,100		
Public Health Service	225,000	31,000	
Social Security Administration	35,800	11,000	
Social and Rehabilitation Service	21,000	5,500	
Total	300,000	50,000	
National Advisory Commission on Rural Poverty:			
Office of Education	15,000	7,350	
Public Health Service	20,000	9,800	
Social and Rehabilitation Service	15,000	7,350	
Total	50,000	24,500	
National Conference on Spanish-Speaking Problems:			
Office of Education	1,500		
Public Health Service	12,000		
Social and Rehabilitation Service	1,500		
Total	15,000		
National Council on Marine Resources and Engineering Development:			
Public Health Service		5,000	6,890
National Crime Commission (President's Committee on Law Enforcement and Administration of Justice): Social and Rehabilitation Service	117,521		
President's Commission on Income Maintenance Programs:			
Social Security Administration		100,000	350,000
Social and Rehabilitation Service		50,000	150,000
Total		150,000	500,000
President's Commission on White House Fellows:			
Office of Education	35,000	3,000	3,500
Social Security Administration		26,500	28,500
Public Health Service		20,500	22,500
Food and Drug Administration		3,000	3,500
Office of the Secretary		1,800	2,000
St. Elizabeths Hospital		1,800	2,000
Social and Rehabilitation Service		2,400	3,000
Total	35,000	59,000	65,000
President's Committee on Mental Retardation:			
Public Health Service	92,000		
Social Security Administration	41,000		
Social and Rehabilitation Service	25,000		
Total	158,000	(3)	(3)
President's Council on Recreation and Natural Beauty:			
Food and Drug Administration	3,000	2,000	
Office of Education	2,000	3,000	
Public Health Service	15,000	7,200	
Total	20,000	12,200	(3)

See footnotes at end of table.

FUNDS TRANSFERRED TO INTERDEPARTMENTAL COMMITTEES, COMMISSIONS, COUNCILS, ETC.—FISCAL YEARS 1967-69—Continued

Activity and agency	1967 actual	1968 estimate	1969 estimate
President's Council on Youth Opportunity:			
Office of Education	$5,000	$16,250	$17,000
Social and Rehabilitation Service	5,000	16,250	17,000
Total	10,000	32,500	34,000
President's Task Force on Older Americans:			
Social Security Administration		16,000	
Public Health Service		18,000	
Food and Drug Administration		5,100	
Office of Education		10,000	
Social and Rehabilitation Service		50,000	
Total		99,100	
Southwest traffic engineering study:			
Social Security Administration		600	
Public Health Service		600	
Food and Drug Administration		600	
Office of Education		1,600	
Office of the Secretary		800	
Social and Rehabilitation Service		800	
Total		5,000	
U.S. Civil Service Board of Examiners at Bureau of Standards: Food and Drug Administration	5,000		
World Conference on Education:			
Public Health Service		$46,000	
Food and Drug Administration		2,000	
Office of Education		98,000	
Office of the Secretary		1,000	
Social and Rehabilitation Service		3,000	
Total		150,000	
World list of future international meetings:			
Social and Rehabilitation Service		2,000	
Public Health Service		10,000	
Food and Drug Administration		2,000	
Office of Education		16,000	
Total		30,000	

[1] Transfer of the funds to Civil Service Commission is no longer permitted by Congress.
[2] Funded through direct appropriations.
[3] No advice has been received by the Department on 1969 requirements.

Report on Mental Retardation Activities of the Department of Health, Education, and Welfare
January 1968

Prepared by the Secretary's Committee on Mental Retardation, Office of the Assistant Secretary for Individual and Family Services

CONTENTS

Summary of Mental Retardation Activities 1967..... 259 - 262

Coordination of Mental Retardation Programs..... 263 - 264

Description of Agency Programs

Public Health Service..... 265 - 284

Office of Education..... 285 - 295

Social and Rehabilitation Service..... 296 - 331

Food and Drug Administration..... 332

Social Security Administration..... 333 - 335

Surplus Property Program..... 336 - 338

Appendix: Table I Obligations For Mental Retardation Programs By Agency Designation Fiscal Years 1956-1968

92 - 594 O - 68 - pt 2 - 18

SUMMARY OF MENTAL RETARDATION ACTIVITIES

On December 4, 1967, President Johnson signed into law the "Mental Retardation Amendments of 1967" (P.L. 90-170). Funds authorized by these amendments for FY 1968 total $95 million dollars. The 1968 Appropriations Act of The Department of Health, Education, and Welfare makes available over $400 million for mental retardation program activities in the current fiscal year. Of this amount $212,715,000 is to be used for income maintenance of persons who are mentally retarded.

The attached table indicates the amount of funds appropriated in prior fiscal years for the support of mental retardation programs. A description of of the mental retardation programs administered by each of the agencies of the Department is attached. Following is a brief summary of these activities:

Preventive Services

Preventive services are defined as those services rendered as a part of programs designed to reduce the incidence of mental retardation. The major programs in this area are administered by the Children's Bureau, Social and Rehabilitation Service. Maternity and Infant Care Projects support programs which provide necessary health care to prospective mothers in high risk populations. By December 1967, fifty-two such projects were in operation. Grants which support screening programs for phenylketonuria (PKU) and other metabolic diseases also are awarded by the Children's Bureau. As of December 1967 forty-one States had enacted laws related to PKU, most of them making screening for this disorder mandatory.

The Public Health Service carries on preventive services in relation to the health services provided beneficiaries of the Service.

Other Services

"Other services" are defined as those rendered to or for persons who are mentally retarded.

State health departments, crippled children's agencies and State welfare agencies use funds administered by the Children's Bureau for programs designed to: increase the health and welfare services available to the retarded, enlarge existing mental retardation clinics by adding clinic staff, increase

the number of clinics, begin evaluations of children in institutions, extend screening programs, provide treatment services for physically handicapped retarded youngsters, increase inservice training opportunities, and provide homemaker and other care services for the mentally retarded.

The mentally retarded receive a variety of services through the vocational rehabilitation program supported by the Rehabilitation Services Administration: medical diagnosis, physical restoration, counseling and testing during the rehabilitation process, assistance in job placement and follow-up to insure successful rehabilitation. Public Law 90-99, "Vocational Rehabilitation Act Amendments of 1967," will assist in the rehabilitation of additional mentally retarded persons to productive life.

The Division of Mental Retardation, Rehabilitation Services Administration, gives high priority to the support of projects which demonstrate new techniques of providing services to the mentally retarded: e.g., establishment of effective methods of referral; activities which facilitate care and management of the retarded; and improved methods of care, treatment and rehabilitation of the retarded. Major emphasis is given to projects which will result in the provision of the array of services needed for a continuum of care.

Public Law 90-247 "Elementary and Secondary Education Act Amendments of 1967," expands the opportunity for school districts to develop creative educational programs for the mentally retarded.

Training of Personnel

Training programs form an integral part of most of the mental retardation programs of the Department. These programs include support of professional preparation in the following areas: research training in the basic and clinical biological, medical and behavioral sciences; training of professional personnel for the provision of health, social and rehabilitative services for the mentally retarded; inservice training of workers in institutions for the mentally retarded; teachers and other education personnel related to the education of mentally retarded children. Also, the Student Work Experience and Training Program provides grants to enable insitutions to give qualified and interested students a chance to work with the retarded in the hope that the students will choose this area of work for their professional careers.

Finally the 1967 Amendments to the Mental Retardation Act authorizes funds for training professional personnel in physical education and recreation programs to enable them to work with the mentally retarded and other handicapped children.

Research

The Public Health Service estimates that more than $25 million will be devoted in fiscal year 1968 to the support of research related to mental retardation.

The Office of Education administers a program of grants for research and demonstration projects in the field of education of mentally retarded and other handicapped children, and projects related to the application and adaption of communications media to educational problems of the mentally retarded. Title V of Public Law 90-170 provides for grants for research or demonstration projects relating to physical education or recreation for mentally retarded and other handicapped children.

The Rehabilitation Services Administration supports selected demonstration projects that seek to coordinate community resources for the mentally retarded. Particular attenton is given to coordination between special education and vocational rehabilitation agencies. Rehabilitation Research and Training Centers for the mentally retarded, supported by the Rehabilitation Services Administration, provide for the diagnosis, evaluation, treatment and training, vocational counseling and placement of the mentally retarded.

Research grants administered by the Children's Bureau support projects directed toward the evaluation of programs and improving the development, management and effectiveness of maternal and child health and crippled children's services.

Construction

Title I of Public Law 88-164, "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963," authorizes three construction programs for the mentally retarded. "The Mental Retardation Amendments of 1967" extended two of these programs until June 30, 1970.

University-affiliated facilities for the mentally retarded will provide for training of physicians and other professional personnel vitally needed to work with the mentally retarded. Fourteen applications have been approved and funded under this program.

To date 175 projects for the construction of community facilities for the mentally retarded have been approved. The facilities constructed under this legislation will include a variety of services: diagnosis, treatment, education, training or care of the mentally retarded, including sheltered workshops.

Both the university-affiliated facility and the community facility construction programs are administered by the Rehabilitation Services Administration.

State Coordination

Public Law 89-97 authorizes funds for the implementation of the State mental retardation comprehensive plans which were supported under grants available in Public Law 88-156, "Maternal and Child Health and Mental Retardation Planning Amendments of 1963." This program has provided the States with an opportunity to plan for improved and expanded services for the mentally retarded.

Income Maintenance

The Social and Rehabilitation Service administers the five federally-supported public assistance programs. These programs assist children who are deprived of parental support or care, the needy aged, the medically indigent aged, the needy blind, and the permanently and totally disabled. Mental retardation itself is an eligibility factor only in the category of aid to the permanently and totally disabled.

The Social Security program, administered by the Social Security Administration, contributes to the maintenance of the mentally retarded through the payment of monthly benefits to eligible recipients.

COORDINATION OF MENTAL RETARDATION PROGRAMS

The mental retardation programs of the Department of Health, Education, and Welfare is a direct response to the Report of the President's Panel on Mental Retardation, issued in October 1962. This Panel, appointed by the late President Kennedy in 1961, set forth 95 recommendations that constitute a national plan to combat mental retardation.

These recommendations are directed to all Federal, State and local agencies that have a part in the national mental retardation program. However, one-half of the recommendations designate the Department as one of the responsible agents. Thus, it is obvious that the Department plays a major role in the formulation of a comprehensive mental retardation program that is responsive to the needs expressed by the President's Panel on Mental Retardation.

The administration of mental retardation programs cannot be confined to any one health, education, or welfare area or a single disciplinary group. Since the total program includes a wide range of activities designed to attack problems of mental retardation simultaneously from many vantage points, the responsibility for the various programs has been assigned to those units within the Department that can bring the best professional and technical knowledge and administrative experience to this important new undertaking.

The Department offers a variety of professional and technical services related to the improvement and extension of mental retardation programs. The services provided are offered to States, interested groups, and individuals. Coordination of these services in the Department is the responsibility of Assistant Secretary Lisle C. Carter, Jr. The Secretary's Committee on Mental Retardation operates under the general direction of the Assistant Secretary. Some of the areas in which the staff of the Secretary's Committee on Mental Retardation is involved in coordination are: the support of interdisciplinary training programs in mental retardation university-affiliated facilities; cooperation with the Department of Defense in the program which provides assistance to mentally retarded dependents of active duty members of the uniformed services; serving as a focal point for contact with the newly established President's Committee on Mental Retardation.

Representatives serve on the Secretary's Committee from each unit of the Department that has a mental retardation program. Mental retardation activities are thus administered as a unified, whole program which has as its objective combating mental retardation with every resource at our disposal.

Among the duties of the Committee is the responsibility for keeping in close touch with groups outside of the Federal Government concerned with mental retardation programs. Examples of these groups are the Joseph P. Kennedy, Jr., Foundation, the National Association for Retarded Children, the Council on Exceptional Children, and the American Association on Mental Deficiency.

The staff of the Secretary's Committee on Mental Retardation serves as a focal point for information on all aspects of the Department's mental retardation program. It also acts as a center for the referral of requests for professional and technical consultation to the appropriate agencies. This activity is carried on in cooperation with the Department's Regional Offices and agency representatives in Washington. A list of the Regional Offices and Directors will be found in Appendix D.

Specifically, the Secretary's Committee is responsible for the following activities:

a. Serving the Secretary in an advisory capacity in the consideration of Department-wide policies, programs, procedures, activities, and related matters.

b. Serving in an advisory capacity for the Department as a whole with respect to inter-Departmental programs and activities, and related matters.

c. Functions as a means for coordination and evaluation of the implementation of the recommendations made by the President's Panel on Mental Retardation and the President's Committee on Mental Retardation in the final reports to the President.

PUBLIC HEALTH SERVICE

Introduction

The Public Health Service, as the principal health agency of the Federal Government, is responsible for the conduct or support of a broad spectrum of services, research, manpower development, facilities construction, and planning for the prevention, diagnosis, treatment, or amelioration of mental retardation as a health problem. In addition, mental retardation has significant ramifications for a host of activities of the Public Health Service which are focused on broader targets or are concerned with disease categories and health problems inextricably related to mental retardation. This report attempts to highlight the most relevant of these activities.

The Public Health Service program activities described on the following pages are arranged according to their nature (training; research; construction; etc.) and also according to their purposes and most important potential contribution (fundamental research; prevention of organically-based mental retardation; treatment and other amelioration for mental retardates; etc.). While difficulties exist in differentiating the causes of individual cases of mental retardation according to whether they are organic or functional, a concerted effort has been made to classify relevant program activities focusing on "organic" or "functional" mental retardation where such a distinction helps us all understand where we are now and what health actions we need to take in the future to prevent or treat mental retardation.

Overall program coordination and direction of mental retardation activities within the Public Health Services is the responsibility of the Associate Surgeon General.

I. Preventive Services

A. Prevention of organically-based mental retardation

The prevention of mental retardation caused by organic factors is best accomplished by continuous, comprehensive, and excellent medical care of pregnant women and their offspring in the prenatal and postnatal periods. The Public Health Service, through its efforts to provide exemplary medical care to its legal beneficiaries, is reducing the incidence of organically-based mental retardation as well as the wide variety of other diseases and conditions in mothers and infants which the state of the art in medicine now makes at least partially controllable.

In the two Public Health Service general hospitals which operate obstetrical services, comprehensive prenatal and neonatal care is given specifically to reduce the incidence of mental retardation. Phenylketonuria (PKU) tests are performed on all newborn infants, and infants with a depressed Apgar score or who are prematurely born are evaluated for PKU or other evidence of brain damage.

Both the Division of Direct Health Services and the Division of Indian Health provide comprehensive medical care during prenatal, perinatal, and postnatal periods. In the Division of Direct Health Services, patients are referred to other agencies for genetic counseling, specific genetic studies, etc.

The Division of Indian Health has increased the number and frequency of maternal clinics for Indian mothers during the prenatal period and has also expanded its measles immunization program for Indian and Alaska Native children, to help prevent the measles encephalitis which has a high residual of brain damage of which mental retardation can be one of several adverse consequences.

The Division of Indian Health continues to develop its PKU blood screening program concurrently with the development of laboratory facilities by States in which their facilities are located. Individual Indian Health Area Offices cooperate with State and local health departments and regional offices in planning mental retardation programs made possible through Grants-In-Aid Funds from the Children's Bureau. Also, the Division is working with the Children's Bureau to determine the best utilization of the professionally trained nurse-midwife in the prevention of mental retardation through improved care of expectant mothers and newborn infants.

B. Prevention of functionally-based mental retardation

As a part of the ongoing comprehensive health program on one Indian reservation, a mental health project includes work with prevention, detection, and treatment planning for functional mental retardation. The Division of Indian Health is cooperatively working with Head Start Program throughout all of its seven areas.

II. Other Services

A. The Division of Foreign Quarantine

This Division has been working with other Federal agencies and voluntary groups to make the best possible arrangements for the reception and treatment of the mentally retarded coming to this country as immigrants.

The detection and diagnosis of mental retardation in aliens desiring to come to this country is a specific function of the Division of Foreign Quarantine. Since mental retardation is an excludable condition except for those eligible for waiver Public Health Service psychiatrists and psychologists review all cases of mental retardation discovered in visa applicants around the world.

For those mentally retarded aliens admitted to the United States, the Service is responsible for complete reports and review of arrangements for treatment in this country. A record is then kept covering the first five years of the individual's treatment in this country, which must be provided in institutions or special facilities approved by the Public Health Service. Semi-annual reports showing kind of treatment and progress made are required and kept on file at the Quarantine Station in New York.

B. The Public Health Service's Hospitals

The Public Health Service's hospitals, through their social service units, refer any mentally retarded persons for whom they have medical care responsibilities to appropriate community resources for diagnostic studies, evaluation, rehabilitation, custodial care, etc.

III. Professional Preparation

A. Research Training (National Institutes of Child Health and Human Development)

The rapid growth of opportunities and facilities for the conduct of research in mental retardation has significantly increased the demand for trained research workers. There is currently a critical need for more research workers, from all research fields, whose primary interests lie in areas related to mental retardation.

Growth of the training programs during Fiscal Years 1965 and 1966 has not been matched during FY 1967 which has been characterized by slower growth but of greater breadth and diversity. Particular programming effort has gone into stimulation of training programs in professional fields of extremely short supply. Epidemiology, social work and sociology have been singled out as in particular need for training stimulation.

The current training program is evenly balanced between training programs in the biomedical and the behavioral sciences. Approximately 58 predoctoral and 11 postdoctoral trainees are currently enrolled in the training programs. These numbers are small in relation to anticipated research needs and continued strong efforts to develop training programs will be required.

Thirteen training grants are currently being supported, providing training for sixty-nine trainees. The training programs are concentrated

in the areas of pediatrics, psychology, biochemistry, metabolism, and genetics. A training award to prepare social workers for research careers in mental retardation was made in FY 67. This is the first training award made by the Institute in the field of social work research training. It marks a significant advance in strengthening research in this field so closely concerned with mental retardation.

Fourteen investigators have been awarded postdoctoral and special fellowships designed to aid them in developing skills for the conduct of research in problems of mental subnormality. Eight of these investigators will receive their training in resources provided by the mental retardation research centers constructed under authority provided by P.L. 88-164, Title I, Part D.

The Research Career Program is designed to increase the number of stable, full-time career opportunities for scientists of superior potential and capability. Four outstanding scientists have received Research Career Development awards and are pursuing investigations on learning, brain lipids, bilirubin toxicity, and metabolic defects in mental retardation.

In addition to the above training efforts, which focus specifically on mental retardation, the National Institute of Child Health and Human Development currently supports fellowships, research career awards and training grants in areas highly relevant to mental retardation.

B. Training of Neurologists for Services and Research (National Institute of Neurological Diseases and Blindness)

While the training program of the National Institute of Neurological Diseases and Blindness is not specifically and exclusively directed towards mental retardation, it is directed toward the development of clinical neurologists and competent research scientists in the fields associated with the diseases of the nervous system. These discip;ines provide the basic tools required for any serious attack on the problem of organically-based mental retardation. Particularly important are the Institute programs for the training of pediatric neurologists, who are very often required to make the initial diagnosis of mental retardation. Training programs in speech pathology and audiology are fundamental to therapy in the mentally retarded and receive strong support from the Institute.

C. Education and Training Efforts by the Bureau of Health Services

Coping with mental retardation among its legal beneficiaries is only one of the many health responsibilities for which Bureau of Health Services personnel must be prepared; nevertheless, several aspects of the Bureau's training program are clearly relevant and important to the attack on mental retardation.

Post-graduate training programs in Public Health Service Hospitals include rotating internships, and residencies in internal medicine and obstetrics which involve maternal and pediatric clinical training and the diagnosis and treatment of mental retardation as it arises in the patient population. Research training is conducted in metabolism and endocrinology, disciplines basic to some forms of mental retardation.

The Division of Indian Health continues to provide both inservice and out-of-service training in maternal and child health nursing to ensure continuity of service from hospital to home and community. An average of 12 nurses are trained each year. Many of the Division's areas continue to develop and use coordinated teaching guides for hospital and public health nursing personnel, designed as aids in teaching good health practices to maternity patients and their families.

IV. Research and Development Activities

A. Research Related to Organically-Based Mental Retardation

1. National Institute of Child Health and Human Development

The greatest hope for mastery of the problem of mental retardation lies in its prevention, or when this is not possible, in the promotion of the individuals maximum skills through a wide range of habilitation and restorative procedures. The goals of the Mental Retardation Branch, NICHD then are the facilitation of research directed toward the identification, prevention, correction and amelioration of mental retardation.

The major thrust of biomedical research activity continues to be in the areas of inborn errors of metabolism and cytogenetics;however, new research efforts are being launched in the areas of human embryology and development and in psychopharmacology. Eleven additional fields of biomedical research are also represented in the total program.

Inborn Errors of Metabolism

Technological breakthroughs and innovations that permit mass screening programs for the detection of metabolic errors have expanded research interest and capability for the study of metabolic errors related to mental retardation. The promise of favorably altering the course of subnormal development in children with phenylketonuria and galactosemia and other metabolic disorders through dietary treatment has added impetus to this effort. This interest is evidenced by the fact that over 33% of the Institute's biomedical sciences research grant holdings are in the area of metabolic defects.

Studies are being supported to evaluate dietary treatment of such metabolic defects as maple syrup urine disease, hypervalinemia, homocystinuira and hyperglycinemia. Other types of inborn errors of metabolism appear on the threshold of discovery.

The discovery, by a grantee in Japan of a disturbance of folic acid metabolism associated with mental and physical retardation has opened up a promising and previously inadequately investigated avenue of research. This has resulted in the establishment of a program to screen mentally retarded infants for abnormalities in folic acid metabolism in order to gain more information regarding the frequency of such abnormalities, further definition of specific enzymatic defects, and attempted designation of heterozygous states, assuming that these abnormalities are genetically determined.

Cytogenetics

The Institute is supporting a number of research projects on the cytogenetics of mongolism and other chromosomal defects. These studies are attempting to correlate biochemical deviations with chromosomal anomalies and associated clinical manifestations. Through this so-called "mapping" of human chromosomes, scientists hope eventually to be able to determine which chromosomes are responsible for specific aspects of human development. Such knowledge would be a first step in the prevention of these abnormalities.

Evidence has been accumulating recently that chromosome defects do not occur by chance but may be due to specific environmental factors. Rubella or german measles, infectious hepatitis, irradiation, and endocrine aberrations in particular are suspected of causing chromosome aberrations. One group of NICHD-supported investigators examined 7,000 newborns in Denver, Colorado, and found that babies with abnormal numbers of sex chromosomes tended to appear in seasonal clusters. Instead of being distributed throughout the year, all the abnormal births occurred during a five month period in the spring and summer. In the first two years of the survey, they found an incidence of sex chromosome aberrations of 0.6 percent during one five-month period. No aberrations occurred in similar populations for a specified time either before or after this period. There was also an elevated incidence of Down's syndrome during this same five month period.

During the past two years, these investigators found another cluster of sex chromosome aberrations in a five month period. Similar clusterings have been reported by other groups of investigators in other cities. Their findings suggest that X chromosomes--the sex chromosomes--and autosome No. 21--the chromosome involved in mongolism--may both be susceptible to production of abnormalities due to some external factors. What this particular factor is remains a mystery. Researchers are currently looking into the possibility that a latent viral infection in the mother around the time of conception may be one factor involved.

The first case of an individual with complete monosomy for autosomal chromosome 21-22 was discovered by researchers working in the program of direct research conducted by NICHD's Diagnostic and Evaluation Clinic. Autosomal monosomy had previously been thought to be incompatible with extrauterine life. This condition was identified in a 4½ year old mentally retarded girl during developmental evaluation.

The investigators believe that the monosomy observed in this girl, in the presence of normal chromosome complements in her parents, was due to nondisjunction, asynapsis, or chromosome lag during gametogenesis in one of the parents, leading to a gamete with 21 autosomes and a sex chromosome but lacking one of the two small acrocentric chromosomes (21-22).

The NICHD scientists conclude that chromosome deletion is not always lethal but must depend on the particular aspect of development that the chromosome controls. In the case under study, they have not been able to l link specific abnormalities with the missing chromosome. Further studies are underway to determine the role of the missing chromosome.

Nutrition

There is a good deal of presumtive evidence (based mostly on animal studies) that protein-calorie deprivation may have an inhibiting effect on mental and social development. A major NICHD project in Guatemala, operated through the Institution for Nutrition in Central America and Panama, a unit of the Pan American Health Organization for Nutrition in Central America and Panama, a unit of the Pan American Health Organization, is testing this hypothesis. Guatemala is an area in which protein calorie deprivation is endemic, providing a natural test area for the relationships between such deprivation and intellectual and social development.

The core of the study involves matching a series of rural, isolated villages on a number of factors, and then providing a protein rich food supplement to half the villages. Careful biomedical, physiological, psychological and social examinations will be made of all children from birth through the age of six, of all pregnant women, and of various other sub-populations. While the major comparison will be between those populations who do and who do not receive adequate amounts of protein (through the supplementation program), careful design permits study of the relationships between a variety of other factors as well. These will include the effects of social status on intellectual and the relationship between certain types of intellectual and social development.

The study is now in its third year, and is just entering the major supplementation program. It is expected that it will continue until at least six years of continuous data on one cohort series have been gathered and analyzed, although major re-examinations will be made at periodic intervals. While the study does not relate to severe degrees of mental retardation, it should help provide information on the relationship between the malnourishing diet of half the children of the world and their resulting intellectual, social and physical development.

2. National Institute of Neurological Diseases and Blindness

The National Institute of Neurological Diseases and Blindness has a variety of research projects directed at the many facets of the neurological

disorders of infancy and childhood. Many of these projects deal with mental retardation where it appears as a symptom, complication, or sequela of a disorder of the central nervous system.

The National Institute of Neurological Diseases and Blindness is engaged in a collaborative project with fourteen cooperating institutions, investigating the prenatal, perinatal, and postnatal factors relating to the development of children. The "Collaborative Study in Cerebral Palsy and Other Neurological and Sensory Disorders in Infancy and Childhood" is following the offspring of more than 50,000 mothers from early preganancy through labor and delivery until the children are at least through the first year of school. The final baby has been born to this project and the first stages of analysis may now be completed. This project should yield an enormous amount of valuable information related to mental retardation.

The Institute is also supporting many other individual projects related to these areas, which will yield important insight into the normal development and functioning of the central nervous system as well as the factors leading to mental retardation during gestation, infancy, and childhood.

a. Prenatal Studies

Epidemiological and genetic studies are being carried out in an attempt to establish possible patterns of inheritance or other causative factors leading to neurological disease and mental retardation. These include inborn errors, chromosomal abonormalities, and congenital malformations.

Inherited diseases are among the leading causes of mental retardation and represent the "inborn errors of metabolism." These may be abnormalities of carbohydrate, protein, or lipid metabolism. The Institute has initiated a program of study of these diseases in order to understand their basic nature as well as their role in the resulting mental retardation.

Chromosomal abnormalities and congenital malformations continue to receive Institute-supported attention. Efforts are directed at establishing the causes of these abnormalities and, hopefully, developing methods of prevention. The possible role of physical agents as drugs and poisons is also receiving direct attention.

Intrauterine infections are important factors leading to severe destruction of the brain and major mental impairments. Special interest is directed at the role of viruses, including Rubella (German Measles) and Cytomegalic Inclusion Disease, and at the role of the fungus Toxoplasma gondii in producing neurological damage. Particularly important are efforts to produce a vaccine for Rubella (German Measles), which may cause congenital abnormalities in the offspring when the mother is infected during the first trimester of pregnancy. At the Laboratory of Perinatal Physiology in Puerto Rico, studies of preganant monkeys are bing carried out to see if this disease has the same effect in primates, and if so, whether this laboratory model can be used for a variety of tests.

b. Perinatal Factors

As noted above, the Collaborative Study has completed its pre-and perinatal phases. Data analysis will soon provide information relevant to the events of labor and delivery.

Regarding inborn metabolic errors, many States are now requiring tests in infancy for phenylketonuria, an example of this kind of disease. Many children will be examined in infancy and followed through childhood in order to relate early diagnosis to the effectiveness of therapy. Through research of this kind, it is hoped to discover how early these diseases do appear and when to begin treatment. There are more than 200 known metabolic abnormalities, of which no more than 6 may be amenable to present therapeutic approaches. Continued study is necessary to enlarge these treatment programs. The biochemistry of these diseases and the relationship of the biochemical activities to brain function are being studied. This may elucidate their role in the development of mental retardation.

c. Postnatal Studies

The examination of the brain-injured child is becoming more important. From a wide variety of causes, many children have minor degrees of brain injury which can markedly affect their development. Studies are under way linking the pathological patterns of brain damage to functional development. Again the Collaborative Study will be increasingly valuable in providing both normative data and incidence statistics relative to mental retardation.

Mental retardation is a potential sequela of meningitis or meningo-encephalitis. Institute programs are investigating the mechanisms involved as well as proper preventive and therapeutic approaches.

The early diagnosis of mental retardation is at times fraught with difficulties. The Institute continues support programs for the refinement of diagnostic techniques. The problem of minimal brain dysfunction is undergoing re-evaluation to assess the current status of and to apply advanced techniques to this difficult area.

Mental retardation is often a sequela of hydrocephalus and brain tumors in childhood. The development of appropriate surgical or pharmacological therapy remains an objective of the Institute.

The National Institute of Neurological Diseases and Blindness is directing its efforts at a number of other disease problems not specifically or necessarily involving mental retardation. However, the results of these studies may provide clues or answers to the various facets of mental retardation.

d. Epilepsy and related paroxysmal disorders

Epilepsy and the related paroxysmal disorders comprise a large disease category associated in many instances with mental retardation. The National Institute of Neurological Diseases and Blindness is planning a large-scale effort relating to epilepsy, including cooperative efforts with several clinics studying methods of diagnosis and treatment as well as basic research into the mechanisms of seizures.

e. Sclerosing disorders

Sclerosing disorders of the nervous system occur both in infancy and adulthood. Some of these diseases are lengthy and progressive, leaving the patient incapacitated and unable to care for himself. When these occur in infancy, mental retardation can result. Here, studies on the etiol etiological relationship of viral, immunological, chemical, or genetic factors are being carried out.

f. Basic studies of the neurological and sensory systems

Mental retardation involves malfunction of the nervous system. Therefore, the basic research relating to the structure and function of the central nervous system which is being carried out by the grantees of the National Institute of Neurological Diseases and Blindness may ultimately be important in understanding the processes involved in mental retardation, its prevention and therapy. Studies in a wide variety of disciplines are included: electro-physiology, neuroanatomy, neurochemistry, general physiology, cerebral bolood flow, and neurocontrol mechanisms, and studies on vision, hearing, and integrative activities of the nervous system relating to learning, memory, and behavior.

g. Disorders of communication

In addition to the basic studies mentioned above, many investigations are being carried out which relate to the integration of speech, hearing, and language. The Institute program is very large, embracing all facets of this wide field.

3. National Institute of Mental Health

The Institute's extramural grants program emphasizes basic and applied research in three major aspects of mental retardation: processes of learning, sociocultural influences, and psychiatric, or behavioral implications.

a. Processes of learning

Knowledge on processes of learning in retardation is sought to provide imporved diagnostic understanding and to help chart the way toward more

effective remedial techniques. Basic researches in learning include a variety of experiments dealing with the retardate's patterns of attentiveness, the effects of reward on learning, conditioned responses to meaningful events, learning by association, and differential abilities in dealing with varying materials.

Research is underway in the study of methods of increasing the attentive ability of retardates by varying the quality and timing of reward for attention. Other study is concerned with the effectiveness of social, verbal, visual, and other forms of rewarding reinforcement on behaviors in learning situations. The use of machines to dispense rewards for self-help skills such as toileting, dressing, and communication is being studied. Conditioning of responses holds promise as one approach to helping the retardate cope more effectively with everyday stresses. By a series of experiences in successful adaptation of a type of encounter, the retardate may be prepared to respond to subsequent natural encounters of the same type, even without having to stop and weigh the situation, so that conditioning may be carried out with more predictable results. Experiments are underway to clarify the characteristics of basic, classical conditioning with very young retarded and normal children. An approach applying programmed learning to reading skills being tested by one investigator. In comparing experimental classes of retardates using the programmed reading method with classes using current school methods, the investigator has found so far that the children receiving programmed instruction not only developed greater reading skills but gained also in attention span, frustration tolerance, social skills, and general vocabulary. Another project is extending the programmed teaching methods beyond reading to writing and arithmetic.

4. Bureau of Health Services

A pilot study by the Division of Indian Health in cooperation with the Bureau of Indian Affairs is in process which utilizes and interdisciplinary approach to identify both organically and functionally retarded children. The medical, psychological, and sociological screening of these children provides a diagnostic basis for determination of required medical treatment and specialized curriculum to meet individual learning needs. Other activities of the Bureau of Health Services include:

A study in process in the Phoenix Area designed to determine the cause and methods of prevention of prematurity among Indian infants (there being a high correlation between prematurity and mental retardation).

Research conducted in the Public Health Service hospitals on metabolism and the endocrine systems, disorders of which may lead to mental retardation.

92 - 594 O - 68 - pt 2 - 19

A special five-year study in conjunction with the National Institute of Dental Research, concerned with congenital malformations among Indian infants born in Division of Indian Health hospitals.

A five-year study on Alaska infant mortality and morbidity, completed in 1964, but extended through calendar year 1966 for the purpose of continued study and follow-up.

B. Research concerning Functional mental retardation

1. National Institute of Mental Health

a. Sociocultural influences

Several projects deal with the environmental circumstances of retardates. The concern is with the impact of the environment on the retardate's mental ability and extends to his ability to adapt to environmental circumstances in his normal community.

One demonstration aims to find out the extent to which diagnosed educable mentally retarded children can be helped to participate in group activities for normal children. Other observations are directed toward learning those characteristics which a child must have in order to interact successfully with his normal peers, the social group work leardership skills which are required, the kind of satisfactions or frustrations he and his parents experience, and the administrative rearrangements an agency must make to accommodate such children.

In a State which recently opened a new institution for the retarded, study is being made of the opportunity to assess the consequences of remaining within the natural cultural milieu compared with those of entering an institution. Comparisons are being made between cohort groups that are admitted against cohorts that are not on demographic, psychological, and medical indices. The results should help clarify the influence of natural clultural experiences as related to the influence of the institutional culture on the adaption skills of the retarded person.

A number of investigators are making experimental explorations into the impact of cultural deprivation on subsequent emotional and intellectual development. Deprivations associated with social problems such as poverty, inadequate schooling, and community disorganization are found to be major factors in the development or exacerbation of mental retardation. Some investigators, for example, are attempting to determine whether foster home care will overcome the retarded behavior of children reared in institutions from infancy, while others are contrasting the effects on intellectual development of various types of home and community environments.

b. Psychiatric implications

The behavioral skills of retarded children are receiving increasing attention. Preoccupation with intellectual deficit has often occluded the

lectual potential of the normal child but also on how to aid the mentally handicapped child. Basic study of the cognitive processes in children provides information essential to investigators developing methods for more effectively teaching the mentally retarded. A study on language disorders in aphasia has led to ideas for identifying and assisting the child who may be labeled "retarded" but is in fact suffering from a learning problem.

2. National Institute of Child Health and Human Development

Prevention of Functional Retardation

A major thrust of the Institutes program in functional retardation is related to prevention and treatment through environmental enrichment for preschool-age children. Many studies have demonstrated that preschool education can improve I. Q. scores of children but that these gains are not sustained as the child grows older. One investigator was able to overcome some of this slippage by giving instruction and lesson kits to mothers of retarded children. The mothers were especially guided toward reinforcing the child's progress through praise and encouragement. Some success was achieved through this technique, but it was found that while the incidence of praise increased, most mothers could not resist nagging their own offspring. This year, the mothers are teaching children other than their own and the incidence of nagging has almost literally disappeared. Now the children choose the mother to teach the lesson they select and appear to enjoy learning more.

The researchers involved in this program are confident that parent-child teaching and training may be one answer to breaking the self-perpetuating cycle of cultural deprivation. They feel that the application of the findings in this study will not only help remediate current learning deficits of these children but prevent further deficits from occurring through the improved mother-child interactions.

One of the chief difficulties encountered in work with deprived children is their lack of motivation. Much of the research in remedial instruction programs is therefore directed toward improving motivation and incentive techniques.

In one such study, children attending remedial instruction courses are given incentive points for doing homework and for grades earned in regular school classes. These points can then be traded in for such things as daily snacks, field trips, picnics, toys or clothing when enough are accumulated. During the first year of this program, the pupils from a sixth grade remedial classroom showed significant academic progress with the grade average for the entire group being raised from D to C.

Utilizing a similar incentive program, these same researchers ran a remedial classroom for junior high school drop-outs who were members of the local Neighborhood Youth Corps. These students were motivated to achieve by

fact that the ability of the retardate to handle life situations is influenced markedly by his behavioral characteristics. Researches are being conducted to determine the optimum manner of relating to a retardate, to discover the role of reinforcement in bringing about more effective reactions, and to discover how to identify unnoticed personality assets and to predict behavior characteristics later in life.

Other projects are designed to test methods of helping the retardate acquire effective behavioral adjustment to life. These involve multi-disciplinary assistance in non-residential settings, special techniques for children whose retardation is complicated by blindness, reduction of the untoward effects of custodial experiences, the use of volunteers in modifying behavior patterns, and the application learning theory principles in the development of increased self-sufficiency.

c. Other research relevant to functional mental retardation

Intramural studies being carried out principally by psychologists in the National Institute of Mental Health include: investigation of the ways in which pre-school children develop the concepts which make possible an understanding of the world around them and the learning of complex relationships; study of the impact on culturally deprived infants of intellectual stimulation during the period of early verbal development; and the development of methods of observing and analyzing the behavior of three-and four-day old babies with the objective, among others, of learning to identify early and mild mental retardation.

The Institute also provides grant support for a number of areas of research which, although not directly focused on mental retardation, provide research findings which stimulate the development of new methods of diagnosis, care, and treatment applicable to the retarded. Research on closely related disorders in childhood contributes to understanding the environmental causes of mental retardation. The developmental research program provides data on the physiological, psychological, and social growth of the normal child, against which deviations in the mentally retarded child can be better understood and measured.

Studies of the diagnosis and treatment of childhood autism and other childhood behavior disorders contribute knowledge which helps to discriminate between those children with intellectual deficits and those suffering from emotional difficulties. Because certain psychopathological states as childhood autism result in a gross intellectual deficit, research being conducted on this problem is helping to provide the means to differentiate accurately between retardation and emotional illness.

The National Institute of Mental Health also supports a number of studies on basic problems of learning, perception, cognition, emotion, motivation, personality, and language, all of which have relevance to understanding and treating mental retardation. For example, studies of the child's intellectual function in school yield information not only on how to enhance the intel-

being paid for each problem worked correctly in class. Pre- and post-achievement tests in this group showed considerably higher grade achievement levels than those obtained by Neighborhood Youth Corps children working at regular jobs and not attending classes.

Intrafamily relationships are of paramount importance in the socialization of children and in the acquisition of communication and language skills. Studies supported by this Institute indicate that in deprived families there is limited verbal interaction between parent and child. The style of communication in such homes is poor preparation for the school setting or for daily problem-solving which the child will have to face. Some language development and communication is indispensable to learning. Some researchers are therefore studying the processes involved in learning and communication in order to be able to modify and advance the retarded child's skills.

Studies of intersensory integration

Since learning depends greatly on sensory and motor input, these systems must be sound to assure an effective learning experience. In school, many children are slow learners because of sensory and motor deficits. For example, children with cerebral palsy, having poor motor coordination, may not do well in school, and some of the mental retardation associated with cerebral palsy may actually be impaired learning ability due to poor motor coordination.

While completely deaf, blind or mute children have their handicaps recognized and, hopefully, compensated for in the school environment, those with partial or subtle impairments of sight, hearing and speech are not always recognized. Often their learning difficulties are simply attributed to limited intellectual ability or to a lack of effort. With better diagnostic and remedial instruction techniques, these children can be saved a lot of misery and be helped to achieve their full intellectual potential.

Investigators in New York City have developed a series of tests aimed at helping to recognize partial imairments affecting learning. These tests check the child's auditory-visual, visual-touch, and visual-motor activities and their ability to integrate these important sensory-motor activities.

Through these tests, the group of investigators have shown that reading disabilities often relect an interference with auditory-visual interaction, although this may not be the sole factor in their disability. They note that this type of sensory integration in its more complex and general form may be one process underlying adaptive behavior and thus I.Q. They found that individuals who can perceive and integrate many sensations, such as touch, vision, and hearing, are very likely to be the more "intelligent" ones.

This continuing research is based on the principle that each sensory system in the body interacts with and is modified by other sensory systems and that even the simplest sensory functions are continuously modified by activity in the other senses. The researchers believe that, in humans, integration of sensory systems is a developmental process which follows a definite age and growth curve.

d. Other Public Health Service mental retardation research activities

Two Branches and one Laboratory have been organized to carry out direct research activities in mental retardation. These include a Children's Diagnostic and Study Branch, a Laboratory of Biomedical Sciences, and a Behavioral Biology Branch.

The Children's Diagnostic and Study Branch is operational and is located at the National Naval Medical Center. The purpose of this Outpatient Clinic is to provide a program of clinical research and a source of case material for basic research in the biomedical and behavioral aspects of mental retardation. Currently, two new patients are being evaluated each week by a multidisciplinary team. The Clinic team is interested in studies on learning. A small nursery school is associated with the Clinic and will provide an ideal setting for studies of learning, motivation, and teaching procedures. Specific studies are being carried out on improving attending behavior in preschool retardates; behavioral assessment in a free-play situation; and operant conditioning audiometric techniques.

A Laboratory of Biomedical Sciences has been collaborating with other Institutes on specific projects. Construction is proceeding to renovate space for biomedical and behavioral research laboratories at the National Naval Medical Center, adjacent to the Children's Diagnostic and Study Branch to facilitate collaboration between clinicians and laboratory investigators. This facility will be ready for occupancy early in 1967. The Biomedical Sciences Laboratory will combine the disciplines of genetics, developmental enzymology, and intermediary metabolism in studies centering around an investigation of the inborn errors of metabolism.

V. Construction

A. Mental Retardation Research Centers

Research and research training in mental retardation and related aspects of human development present unique demands in terms of facilities and resources. Recognition of these needs led, in 1963, to legislation authorizing construction grants for facilities in which biological, medical, social, and behavioral research relating to human development could be conducted to assist in finding the causes and means of prevention of mental retardation and, for finding means of ameliorating its effects.

Acceptance of applications for construction grant awards under the Act authorizing the Mental Retardation Research Centers closed on July 1, 1967. During the authorized four years of the Mental Retardation Research Center Construction Grant Award Program a total of twelve centers were awarded to outstanding scientific institutions.

The facilities constructed through the Mental Retardation Research Center Program will provide research facilities in particular environments where a cohesive program of research and research training can be accomplished. Most of the centers are large complex facilities in settings where a broad spectrum of research on mental retardation can best be carried out. A small number of specialized centers which have a concentrated scientific focus on a particular aspect of mental retardation are also supported by the program.

Centers awarded under the Mental Retardation Research Center Program and expected date for completion of construction are given below:

Institution	Estimated Construction Completion Date
University of Chicago, Chicago, Ill.	March 1967
University of Washington, Seattle, Wash.	
Unit Ia	Feb. 1968
Ib	Nov. 1968
Ic	Feb. 1969
George Peabody College for Teachers Nashville, Tenn.	March 1968
Children's Hospital, Cincinnati, Ohio	April 1968
University of Colorado Medical Center Denver, Colo.	April 1968
Albert Einstein College of Medicine, New York, N. Y.	June 1968
University of Kansas, Lawrence, Kansas	
Lawrence, Kansas unit	Dec. 1968
Kansas City unit	June 1969
Parsons unit	Aug. 1969
University of California at Los Angeles Los Angeles, Calif.	May 1969
University of North Carolina, Chapel Hill, N.C.	Sept. 1969
Fernald State School, Waltham, Mass.	Dec. 1969
Children's Hospital Medical Center, Boston, Mass.	March 1970
University of Wisconsin, Madison, Wisconsin	Jan. 1971

B. Community Mental Health Centers

Public Law 88-164 authorized in 1963 appropriations to the NIMH to finance up to two-thirds of the cost of construction of Community Mental Health Centers. These centers in which the mentally retarded are eligible to receive treatment and services, serve as the nucleus of the national mental

health program. Working in unison with other facets of the national programs in mental retardation and mental health, the NIMH assists States and communities achieve comprehensive treatment in the community for all who need it.

Institute data reveal, for example, that nationally, an estimated 4 million children under the age of 14 are in need of some kind of psychiatric help because of emotional difficulties. Other estimates are that from 10 to 20 percent of school children show symptoms indicative of pathology which require at least preventive mental health services.

Since the passage of the Community Mental Health Centers Act, the NIMH has supported the development of hundreds of Community Mental Health Centers throughout the Nation. The services and programs of many of these centers extend to and include mentally retarded persons. Thirty percent of the centers funded so far are located in cities of a half million or more persons; 35 percent are in cities of 50,000 to 500,000; and 35 percent are cities of 50,000 or less, including 28 percent of the total that will serve geographic areas covering some 351 predominantly rural counties.

VI. Other Activities

A. Partnership for Health

The amendments of 1967 extend and expand the present program which includes the provision of health services for the mentally retarded.

The "Partnership for Health Act of 1966" removed almost all of the categorical limitations, giving the States much more flexibility in the use of Federal health grant funds. Project grants, which support targeted attacks on new or special health problems and stimulate development of new health services, were made available for the whole range of health activity.

The 1967 Amendments continue the concept of a statutory framework for the revitalization and expansion of Federal-State-local cooperative efforts to make maximum use of national health resources. The amendments also strengthen State and local capacity and initiative modifying existing patterns of Federal financial assistance to States. This revision of the Federal health grant structure will make Federal grant funds available to States, and through them to local communities on a flexible basis, thus enabling these groups to focus on the needs of individuals and on families in their area. Communities will be better able to provide services for maintenance of good health as well as for rehabilitation following disease. Through the support of training and the interchange of Federal and State health personnel, competency and strength necessary for planning and administration of comprehensive health services can be improved .

The 1967 Amendments retain all the innovative provisions of the "1966 Partnership for Health Act," extends them for two years, through June 30, 1970, and authorizes larger expenditures. In addition, new and expanded authorities were provided for health services research and development and for improvement of clinical laboratories.

B. Collection and Dissemination of Information

Since 1964 a mental retardation information activity has been operated as part of the National Clearinghouse for Mental Health Information. Because knowledge about mental retardation comes from many scientific disciplines and professions, this service will improve both research and practice and thus have a decided effect on the prevention and treatment of mental retardation.

To maintain this service, the National Clearinghouse for Mental Health Information, under contract with the American Association on Mental Deficiency, collects current literature on mental retardation, writes informative abstracts, indexes the literature in depth, compiles annotated bibliographies on special topics, and prepares critical reviews. Since 1964, a total of 4,900 current articles, books, and monographs have been collected, abstracted, and indexed. To provide a more extensive coverage of information for retrieval purposes, an additional 3,500 indexed abstracts of documents published from 1957 through 1963 were recently added to this system.

Special annotated bibliographies have been prepared on: (1) Programmed Instruction with the Retarded; (2) Literature for Parents; (3) Application on the Stanford-Binet and Wechsler Intelligence Scales with the Mentally Retarded; (4) Nursing and Mental Retardation; (5) Family Care and Adoption of Retarded Children; (6) Psychotherapy with the Mentally Retarded; (7) Recreation for the Retarded; (8) Counseling Parents of the Mentally Retarded; (9) Sheltered Workshops for the Mentally Retarded; (10) Films on Mental Retardation; (11) Psychopharmacological Therapy with the Mentally Retarded; (12) Electroencephalographic Studies Relating to Mental Retardation; (13) Hydrocephalus; (14) Mental Retardation and Religion.

Review articles and critiques have been prepared on: (1) Mental Retardation; Definition, Classification, and Prevalence; (2) Research on Linguistic Problems of the Mentally Retarded; (3) Attendant Personnel: Their Selection, Training, and Role; (4) Research on Personality Disorders and Characteristics of the Mentally Retarded; (5) Effects of Severely Mentally Retarded Children on Family Relationships; (6) Factor Analysis and Structure of Intellect Applied to Mental Retardation; (7) Counseling Parents of the Mentally Retarded; (8) Genetic Aspects of Mental Retardation; (9) Instrumental Learning in Mental Retardates; (10) Vocational Rehabilitation of the Mentally Retarded: The Sheltered Workshop; (11) Relationships Between Educational Programs for the Mentally Retarded and the Culturally Deprived; (12) A Decade of Research on the Education of the Mentally Retarded.

The abstracts, annotated bibliographies, and reviews appear in the quarterly journal Mental Retardation Abstracts, which is distributed gratis to approximately 5,500 individuals engaged in research and practice in mental retardation and is also for sale by the Superintendent of Documents.

C. Institutional and Case Statistics

1. Inpatient Facilities: Information is obtained from all inpatient mental retardation facilities, both publicly and privately owned, on the numbers of patients in various movement categories, as well as such patient characteristics as age, sex, medical classification, measured intelligence level for first admissions, and for resident patients. Also, from the public institutions for the mentally retarded, information is obtained on the personnel employed, by occupation, and the amount of maintenance expenditures for patients.

2. Outpatient Psychiatric Clinics: Information is obtained on the number of terminated patients diagnosed with mental retardation, by age, sex, and degree of deficiency (mild, moderate, severe), whether treated or not treated. Administrative and staff information (man-hours of professional staff by discipline) is also secured for clinics restricted to patients with mental retardation.

3. Annual administrative data, man-hours, type of services provided, estimated caseload, and weekly census are reported for day-night units and those with a consultant psychiatrist primarily serving mental deficients.

4. Maryland Psychiatric Case Register: Data are routinely collected on demographic patient characteristics, type of service, referral service, and disposition of all patients diagnosed as mentally retarded in all psychiatric clinics and public and private institutions for the mentally retarded.

OFFICE OF EDUCATION

Introduction

As a result of programs authorized during the past few years, there is a promise of a richer future for mentally retarded children and new hope for their parents and teachers. The 90th Congress added new dimensions to the efforts to help the mentally retarded and provided valuable tools to carry out the objectives of the Office of Education.

One of the most important steps taken by the Office of Education was to streamline the activities of educating the handicapped by establishing on January 12, 1967, the Bureau of Education for the Handicapped. The Bureau is responsible for programs and projects relating to the education, training, and research of handicapped children and youth. These children are the mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or otherwise health impaired and require special education. The Bureau of Education for the Handicapped is composed of the Office of the Associate Commissioner, the Division of Educational Services, the Division of Training Programs, and the Division of Research.

The Office of the Associate Commissioner is responsible for program planning, administration, evaluation, and also provides an informational service on the handicapped for the Nation's educational community. The Associate Commissioner and his staff work in cooperation with the National Advisory Committee on Handicapped Children, State Educational Agencies, higher educational institutions, public and non-profit organizations, and professional associations, to develop and stimulate innovative educational programs for handicapped children and youth.

This Bureau is directly concerned with helping handicapped children become independent and self-sufficient through programs designed to (1) increase the number of qualified professional personnel; (2) improve educational services in preschool and school programs; (3) stimulate acquisition and utilization of modern educational equipment and teaching materials; (4) encourage research and the use of successfully tested research and advanced educational techniques.

Each of the divisions provides an important element in the functions rendered by the Bureau in making up a total program of service for the mentally retarded. The following pages describe these services for mentally retarded children on a divisional basis.

I. Division of Educational Services

1. Purpose

The purpose of the Division of Educational Services is to bring direct support to handicapped children through services at the classroom and intermediate levels. The Division's activities are designed to provide support to State, regional, and local programs to assist in developing and maintaining leadership in the education of handicapped children.

2. Historical Development

Public Law 85-905 was passed by Congress in 1958 to provide entertainment films for the deaf. This Captioned Films for the Deaf Law has subsequently been amended by P.L. 87-715 in 1962 and P.L. 89-258 in 1965 to allow for training, research, production and distribution of educational material for use of deaf children. In December 1967, this authority was again expanded to include educational services to all kinds of handicapped children through the 1967 amendments to the Elementary and Secondary Education Act.

Public Law 89-313 was passed by Congress in November 1965 extending the benefits of the Elementary and Secondary Education Act to handicapped children in State-supported programs.

During recent years as local facilities for the handicapped have increased, State schools have found the composition of their resident populations changing from the mildly handicapped to large percentages of children who are severely mentally retarded and those who have serious handicaps in addition to mental retardation. Model and pilot programs for these types of children have been conducted under P.L. 89-313 in many States.

These moneys have enabled programs to develop for children that have not previously been considered capable of responding to educational or rehabilitative services. The results in many instances have been encouraging and special educators and staff in residential institutions have raised their levels of expectations for such children.

The 1966 amendments to the Elementary and Secondary Education Act provided under Title VI a program of support to local education agencies through a Federal-State program. This law authorized $50.0 million for fiscal year 1968. The appropriations for 1967 were $2.5 million, and for fiscal year 1968, $14.25 million. Moneys allotted under P.L. 89-313 for handicapped children were $15.917 million, fiscal year 1966, $15.065 million, fiscal year 1967, and $24.747 million, fiscal year 1968. In fiscal year 1967, 46,645 mentally retarded youngsters were assisted under this program at an expenditure of $8,473,118.

3. Impact on Mental Retardation

Programs will have a significant and far reaching impact upon education and rehabilitation of mentally retarded individuals. Through such direct support programs Title VI (aid to local programs) P.L. 89-313 (aid to State programs), more extensive and comprehensive programs will develop which will include the utilization of the latest teaching techniques and educational technology. Media Services and Captioned Films for the Deaf with expanded responsibility should provide for an opportunity for State and local programs to take advantage of educational materials, media, and equipment especially designed to meet the needs of the handicapped.

4. Future Goals

The goals of the Division of Educational Services are to:

a. Provide significant support moneys to both State-supported and local educational programs to assure quality education for all handicapped children.

b. Provide intermediate services such as comprehensive educational diagnostic resource centers on a regional base to provide services for handicapped children and their families. In addition to direct service to children, these centers will provide consultative services to State and local educational agencies to assure the latest available information from research with respect to the learning process.

c. Provide wherever needed comprehensive regional programs for severely multiply handicapped children such as deaf-blind children.

d. Provide through media services the research, production, and distribution of specially designed materials and programs for educational technology for handicapped children. To provide training in the use of media for teachers of the handicapped.

e. Provide through Instructional Material Centers educational management and information systems.

5. Current Activities

It is anticipated that during fiscal year 1968 the combined resources of Title VI and the P.L. 89-313 amendment to Title I will enable State and local school systems to employ more than 3,000 new staff members to help them meet the special educational and related needs of mentally retarded children. Project activities involving mentally retarded children of preschool, elementary, and secondary school age under these programs will include: curriculum enrichment, expansion, and improvement; summer school programs; preschool and school readiness programs; physical education and recreation; prevocational and vocational training; inservice training of teachers; and improved diagnostic services.

A series of regional meetings are planned to help orient State and local officials to Federal programs administered by the Division. Leaders in the field of education of the handicapped will discuss ways in which the new and expanded Federal resources can be utilized to implement exemplary administrative and program practices and the latest findings of research. Efforts will be made also to increase the level of coordination and cooperation among State and local agencies serving mentally retarded children.

II. Division of Training

1. Purpose

The purpose of the Division of Training Programs is to initiate, maintain, and improve programs for the preparation of professional leadership and teaching personnel to educate handicapped children. Divisional programs which are designed to implement this purpose are two-fold in their attack, in that they must provide: (1) classroom and administrative personnel for State and local special education programs; and (2) personnel for higher education institutions responsible for preparing administrative and classroom personnel.

2. Need

As more States legislate mandatory education for handicapped children the major problem faced in implementing such legislation is an acute shortage of qualified personnel. Current estimates indicate a need for approximately 300,000 teachers to meet the educational needs of handicapped children. However, only 70,000 teachers are now available, with the prospect of an additional 21,000 to be trained by 1969. Of the 70,000 teachers available now, approximately one-fourth are not fully qualified. If general turnover rates applicable to the profession are applied, approximately 10% of the special education teachers will leave the field each year. At current rates of preparing professional personnel, sixteen years would be needed to close the gap between supply and demand.

As a result of the teacher shortage, approximately three-fourths of the more than five million handicapped children of school age are not receiving the special educational services they require. Too, many of the programs established are actually of minimal quality, because they have been started with less than fully qualified personnel. Needless to say, this current deficit, as in the past, not only retards the systematic growth of special education, but simultaneously requires the majority of our nation's handicapped children to accept an educational program inappropriate to their needs.

3. History

In 1958, Public Law 85-926 was passed by Congress authorizing an appropriation of $1 million per year for the preparation of professional

personnel in the education of the mentally retarded. This initial piece of legislation was directed at preparing college and university personnel to staff the then existing programs, and much needed new programs for preparing personnel to work with the handicapped in State and local school systems. Between academic years 1959-60 and 1963-64, 692 graduate fellowships were granted to 484 individuals. The majority of these individuals did become college and university professors while others became State and local special education leadership personnel.

On October 31, 1963, P.L. 88-164 was signed into law. Section 301 of this act amended P.L. 85-926 to: (1) expand the program to include not just the area of mental retardation, but also the areas of the visually handicapped, deaf, crippled and other health impaired, speech and hearing impaired, and the emotionally disturbed; (2) allow for the preparation of teachers and other specialists in addition to leadership personnel at the graduate level; (3) extension downward into the senior year undergraduate levels; and (4) increase the monies authorized for these purposes. Since P.L. 85-926 was passed in 1958, approximately 12,453 fellowships and traineeships have been awarded to individuals preparing to work with mentally handicapped children.

An internal study, conducted in February of 1964, of 245 former P.L. 85-926 fellowship recipients revealed that over 90 percent of them were engaged in the field of special education, including the mentally retarded, and about 70 percent were engaged primarily in the field of mental retardation. Sixty-eight of the 245 former fellows indicated that they were currently employed by a college or university, 80 were employed in an administrative or supervisory capacity (19 of these were employed by State educational agencies), and 54 returned to the classroom as teachers of the mentally retarded.

On August 4, 1965, P.L. 85-926 was further amended with the passage of P.L. 89-105 which expanded and extended the program until June 1969. This amendment authorized appropriations of $29.5 million for fiscal year 1967; $34 million for fiscal year 1968; and $37.5 million for fiscal year 1969. These funds are, and will be, used as stipends for students and to support colleges, universities, and State education agencies with the cost of instruction. Table I graphically depicts the expansion of the fellowship and traineeship program under P.L. 85-926.

Table I - Awards made in the area of mental retardation since the passage of P.L. 85-926 (Fiscal Years 1960 through 1967)

Fiscal Year	No. of Trainee. & Fellowships	No. of Hi. Edu. Inst. Partici.	No. of State Edu. Age. Par.	TOT. Amt. obligated
1960	177	16	23	$ 985,222
1961	164	18	41	993,433
1962	160	20	46	997,000
1963	163	19	48	996,433
1964	2,357	108	50	6,419,332
1965	2,506	153	50	6,569,815
1966	3,110	162	52	7,658,002
1967	3,816	177	53	8,891,072
1968**				

**Appropriations will be approximately equivalent to FY '67 (awards not available at time of this report)

To be sure, the number of individuals being trained in mental retardation under this grant program is, in and of itself, very significant. It is felt by many, however, that the improvement and expansion of the many teacher-training programs in mental retardation throughout the Nation -- resulting directly and indirectly from the grant program -- will, in the long-run, be of even greater significance. Evidence suggests that the support grants which accompany traineeships and fellowships have enabled a great many of the currently participating colleges and universities to add staff, expand the course offerings, and better supervise the observation and student teaching experiences of the students. The total number of students benefitting from these program improvements at the various colleges and universities will, in most instances, far exceed the number of students who are on a fellowship or traineeship.

It is readily apparent that the "old" P.L. 85-926 program, and its amendment, P.L. 88-164, has, without question, enabled a great number of colleges and universities to develop and/or expand their teacher-training programs in mental retardation. A current analysis of the more than 220 institutions requesting funds in the area of mental retardation indicates that more than 150 of them have on their faculties former Public Law 85-926 fellows.

To be sure, it will be a number of years before there will be a great reduction in the gap between the number of trained teachers and "leadership personnel" in the area of mental retardation who are needed and the number who are available; however, Public Law 85-926 -- prior to and since the amendments by Section 301 of Public Law 88-164 -- has provided the necessary beginnings in our efforts to close this gap.

4. Regional Conferences

During fiscal year 1967, the Unit on Education of the Mentally Retarded, Division of Training Programs, held four regional conferences to discuss various aspects of the U.S. Office of Education program in mental retardation under Public Law 85-926, as amended. The four regional conferences were co-sponsored by the Southern Regional Education Board, University of Connecticut, Northern Illinois University and the University of Utah. National coverage was provided and all institutions of higher learning that had submitted applications in mental retardation since the initiation of the traineeship and fellowship program were invited to participate. Two hundred and twenty-five persons participated in these conferences, representing a total of one hundred and fifty-five different college and university programs.

The content of each conference was very similar and primarily focused on the following major elements:

a. Changes in the Manual for the Preparation of Professional Personnel in the Education of Handicapped Children for Fiscal Year 1968 (Award Year 1968-69).

b. The rationale for, and format of, the new application forms to be used in requesting funds for support of teacher education programs in mental retardation under Public Law 85-926, as amended.

c. The evaluation criteria used by past panels of consultants in mental retardation to review requests in mental retardation. Specific criteria discussed related to staff requirements and qualifications, course content, practicum opportunities, geographic need, and administrative commitment.

The favorable results of the above meetings have indicated their great value in precipitating both greater understanding and cooperation between the Division of Training Programs, BEH, and professionals in the field. Every effort will be made to continue them.

5. Special Study Institutes

One of the most unique forms of funding in the area of mental retardation under Public Law 85-926, as amended, is the Special Study Institute. Five of these institutes were funded for the 1967-68 academic year to up-date professional personnel in mental retardation. These self-contained institutes are short term, concentrated educational events. They are separate from the regular program of the sponsoring institution of higher learning and specifically directed towards improving college professional personnel active in educating teachers of the mentally retarded. In effect, the institutes are in-service education programs for teacher educators in mental retardation.

92 - 594 O - 68 - pt 2 - 20

The institutes were scattered geographically, so that a national effort could be made in working with college teacher educators in mental retardation. As a result, the following five universities were each awarded an institute to provide a continuing education program for those seeking professional improvement:

The University of Oregon
The University of Texas
The University of Minnesota
Yeshiva University
The University of Illinois

The need for these institutes arose because of the rapid expansion of special classes for the mentally retarded, and the collateral expansion of college teacher education programs to cope with the large demand. As a result, teacher preparation programs in mental retardation proliferated, due to the impetus of increased public interest and the funding made available by national and State agencies. Further, there were more programs and positions in special education than there were experienced and qualified persons to staff them. As a result of this pressure, colleges employed staff members who had less than adequate preparation to conduct specialized teacher education programs in mental retardation. These problems will increase as student enrollments and the demand for teachers continue.

Many educators working in the field of special education have had little opportunity for extensive observation of other programs. Few have had the chance to consult with their peers in other institutions on problems and possible solutions in their disciplines. The institutes provided the avenue for interaction by college faculty involved in the preparation of teachers of the mentally retarded. It is a superior mechanism which affords an opportunity for intensive consideration of the common problems confronting teacher educators in mental retardation. It also offers a study and evaluation of programs which are designed to meet these problems, and serves as a stimulus for creative thinking.

The institute also provides enrichment for professors new to the field of special education as well as for those who lack recent graduate study, or who are isolated from major research programs in the field of the handicapped. Specifically, it offers the following opportunities:

-- for an intensive up-dating experience in the field of mental retardation for teachers of professional education courses.

-- for an interaction with a mutual group focusing on promising new techniques, trends, and resources in teaching "methods and curriculum" courses in the field.

-- for a critique of issues related to teacher training.

The long range goal of these institutes will be to effect changes in teacher training programs in mental retardation that will increase the effectiveness of the efforts put forth by special educators, and lead to a more proficient classroom teacher of the mentally retarded.

6. Program Development Grant Conference

A two-day conference was sponsored during the month of May by the Division of Training Programs for professional personnel from institutions of higher education which had been awarded new program development grants for Fiscal Year 1967 (academic year 1967-68). Nine new institutions with programs in the area of mental retardation participated, in addition to ten institutions which had received program development grants in the area during the preceding Fiscal Year. The major foci of the conference were discussions relating to procedures for the initiation of programs and the evolution of guidelines for action at specific stages of program development.

A similar conference is planned for the spring of 1968 for recipients of program development grants for Fiscal Year 1968.

7. New Program to be Supported

The Bureau of Education for the Handicapped, through the Division of Training Programs, will provide funds for the support of "core" special education personnel in five university-affiliated facilities for the mentally retarded. These special educators will be responsible for instructing medical students, physicians, and other related medical personnel as well as students majoring in special education. They will also be responsible for effectively integrating the special education component into the over-all training program of the university-affiliated facility.

8. Significant Changes in the Fellowship and Traineeship Program - FY 1968

For the academic year 1968-69 the following major changes will occur in the grant program under Public Law 85-926, as amended:

a. Junior year traineeships ($300 each) to allow for the recruitment of outstanding sophomore students into the field of education of the handicapped.

b. A reduction in the amount of stipend for senior year traineeships to $800 in order to more adequately reflect the needs of senior year students and to allow for a greater number of awards.

c. An increase in the stipend for master's level fellowships to $2,200 and an increase in the post-master's level fellowship stipend to $3,200.

III. Division of Research

1. Purpose

The purpose of the Division of Research is to promote and support research and demonstration activities which show promise of leading to improved educational programs for handicapped children.

2. History

The research and demonstration program for handicapped children was initiated during Fiscal Year 1964 with an appropriation of $1,000,000 authorized under Title III, Section 302 of Public Law 88-164. Two million dollars were appropriated for the second fiscal year of operation. During that time the enabling legislation was amended by P.L. 89-105 which authorized increased funds and the use of funds for the construction of a comprehensive research and demonstration center for handicapped children. Funds increased to $6 million in Fiscal Year 1966, $8.1 million in Fiscal Year 1967, and $11.1 million for Fiscal Year 1968. The enactment of Public Law 90-247 extended the authority through 1970 -- $14 million for FY 1969 and $18 million for FY 1970. Amendments in P.L. 90-247 also provide authority to support the training of research specialists, to make contracts as well as grants, and to engage in intramural research activities.

3. Impact on the Problem of Mental Retardation

It is always difficult to assess the direct impact of research activities since the lag between the discovery of new knowledge and the change in educational practice obscures the picture. In this particular instance, it is too early to expect significant results. The initial level of funding was too low to permit work of much significance. Activities initiated during the first year of adequate funding, 1966, have not yet been completed. One observable measure of impact, however, can be noted. During the first two fiscal years of operation, considerable difficulty was encountered in finding enough good projects to make use of the limited funds which were available. At the present time, even with $11.1 million, applications far exceed the amount of funds available.

4. Future goals

The history of research on handicapped children suggests that minimal gains are obtained by spreading research monies too thinly. Many of the most important problems in education require a massive effort if solutions are to be found in time to help today's children. The Division of Research proposes to support the establishment of R&D Centers to focus on the more difficult problems of evaluation, communication, instructional procedures, etc. Through the combined efforts of R&D Centers and programmatic research on specific major educational problems it can be expected that new models of instruction will be available within a few years.

At the same time, systems of dissemination will be evolved which will facilitate the acceptance of these new models by local school administrators. The new systems of dissemination will be built upon the foundation of instructional materials centers already developed.

As more funds for research become available, engineering technology will more and more become a part of research supported by this Division. This development has been made possible by the amendment permitting the use of contracts as well as grants for research and development activities. Engineering technology, programmed instruction, and the "systems approach" to education will occupy a major place in the Division's activities in the years to come.

5. Current Activities

The Division currently supports a wide range of activities relating to the education of mentally retarded children. One of the most visible of these is the network of instructional materials centers for handicapped children. Although serving teachers of all the handicapped, these centers have a major commitment to mental retardation. The instructional materials centers, 14 in all, are scattered across the country to serve specified regions. The primary objective of each center is to keep teachers of handicapped children aware of new developments in educational materials. The centers are evaluating existing materials as to their relevance to the handicapp and assisting in the development of new materials. Since the 14 centers are connected as a network any information located at any center is immediately relayed to all other centers.

The Comprehensive Research and Demonstration Center for Handicapped Children, now under construction at Teachers College, Columbia University, similarly has a major emphasis on the problems of the retarded although at the same time relating to the educational problems of many categories of handicapped children. This center represents a major investment of research funds, both for construction and operation, in an attempt to develop an intense effort in this area of education.

Other research activities now under way are attacking the problems of teaching and learning with the mentally retarded. One such project has suggested that time spent in learning to learn can make a significant difference in the learning performance of retarded children. Other projects are developing and testing new curricula for the retarded.

SOCIAL AND REHABILITATION SERVICE

Introduction

The Social and Rehabilitation Service (SRS) was established August 15, 1967, by the Secretary of Health, Education, and Welfare to join under a single leadership the Department's income support programs for needy Americans and the social and rehabilitation programs that many families and individuals need.

The reorganization is designed to provide a stronger emphasis on rehabilitation in social and welfare programs.

Key features of the new organization are:

-- The uniting in a single agency of the various HEW services that deal with special groups -- the aged, the handicapped, and families, especially children.

-- The separation of the administration of income-maintenance programs for needy persons from rehabilitation and social service programs.

-- Decentralization of certain authority to the Department's nine Regional Offices and the appointment of a single Social and Rehabilitation Service Regional Commissioner in each region to make it easier for States and communities to do business with the Federal Government.

SRS includes the programs formerly administered by four separte units of the Department: the Administration on Aging; Vocational Rehabilitation Administration; Welfare Administration; and the Division of Mental Retardation of the Public Health Service.

The five major components of the new agency are: the Administration on Aging; Assistance Payments Administration; Children's Bureau; Medical Services Administration; and the Rehabilitation Services Administration.

All of these component agencies have major responsibilities in the area of mental retardation except for the Assistance Payments Administration. The reorganization has placed new responsibilities for the mentally retarded on the Administration on Aging, the Children's Bureau, and the Rehabilitation Services Administration, which are now concerned with the provision of social and rehabilitative services to various categories of public assistance recipients. The Rehabilitation Services Administration also includes the Division of Mental Retardation, transferred from the Public Health Service.

Also located in SRS is the newly established Office of Research and Demonstrations. This office administers a program of grants to States and to public and private, nonprofit agencies to pay part of the cost for research, demonstrations, and the establishment of special facilities and services contributing to the field of rehabilitation.

New legislation has reaffirmed and expanded the Nation's commitment to programs on behalf of the mentally retarded. This includes the Mental Retardation Amendments of 1967, the Vocational Rehabilitation Amendments of 1967, and various aspects of the Social Security Amendments of 1967.

The reports which follow describe in detail the responsibilities and activities of the component agencies of the Social and Rehabilitation Service and the provisions of the new legislation with respect to programs for the mentally retarded.

The Administration on Aging

1. Title III Programs

Title III of the Older Americans Act of 1965 provides for the Administration on Aging to stimulate the establishment of a single agency in each State to be responsible for the coordination of all State activities and programs in aging. Once the governor has designated such an agency and the State plan has been approved, allotments are made to the State. The State, in turn, makes grants to public and nonprofit private agencies for (1) community planning and demonstration of programs in aging; (2) for demonstration of new programs or activities beneficial to older people; (3) training special personnel for such programs; and (4) establishment of new or expansion of existing programs, including senior centers.

Under a title III grant, the Boulder River Junior Chamber of Commerce, in Boulder, Montana, is operating a project called "Senior Citizens Conducting Programs for the Mentally Retarded Aged." Six older people are being trained to provide services to over 100 mentally retarded aged at the Montana State Training School and Hospital. The project was initiated because existing services and programs at the Training School were focused on younger residents and the older population was being neglected. The project will provide personal attention and interaction with other adults who have experience with older people. It is hoped that this will increase the social adjustment of mentally retarded older persons and perhaps lead to an ability for them to care for younger patients.

2. The Foster Grandparent Program

The Administration on Aging also administers the Foster Grandparent Program under contract with the Office of Economic Opportunity. The

program recruits, trains and employs low-income men and women over 60 years of age to serve as foster grandparents to children in institutional and community settings. "Grandparents" provide two hours of individual attention to each of two children daily, and usually work five days a week.

In December 1967, there were 63 projects in 38 States and Puerto Rico. About 8,000 children -- 5,500 of whom are mentally retarded -- in 155 institutional and community settings are served by 3,927 foster grandparents. Over 120 communities are affected by the program and many more have expressed interest in developing a project.

Foster Grandparents are not intended to relieve institutional staff of routine care tasks. Rather, their work is entirely child-related, on a one to one basis, and aimed at providing personal attention to deprived and neglected children.

Evaluation by a private firm of ten projects across the nation 6 months after initiation of the projects indicated that 70 percent of the children receiving such services (including children not retarded) had improved socially and emotionally or in physical condition.

In one project for retarded children, seven children achieved the level of functioning that enabled them to enter Head Start classes; four were admitted to special education classes; one boy thought to be retarded was enrolled in summer Head Start and then registered for a regular classroom program. In another project, "Grandparents" are working within a public school, enabling retarded children to attend regular classes.

Grandparents are forming a link between the community and the institution, bringing the outside in to the children and bringing to the community a new attitude on the subject of mental retardation.

Further information may be obtained from the Commissioner on Aging, Administration on Aging, Department of Health, Education, and Welfare, Washington, D.C. 20201.

Children's Bureau

1. Introduction

The concern of the Children's Bureau for mentally retarded children and their families stems initially from its responsibility under the Basic Act of 1912 to "investigate and report on all matters pertaining to the welfare of children and child life." In the first 6 years of its existence, three of the major studies produced by the Bureau dealt with mental retardation.

The passage of the Social Security Act in 1935 and the assignment to the Bureau of the added responsibility of administering Federal grants for maternal and child health, crippled children, and child welfare services, emphasized the principle that all of the people, through the Federal Government, share with the State and local governments responsibility for helping to provide community services that children need to have for a good start in life. The Social Security Act also afforded the Bureau an opportunity to help the States develop demonstrations and special programs in areas where there were gaps in services.

As recently as 1954, maternal and child health activities in the Children's Bureau on behalf of mentally retarded children and their families were extremely limited. Many local public health nurses were reporting suspected mentally retarded children in their caseloads, but for the most part, they had few or no resources for establishing a diagnosis. By age groups, the greatest gap in available services was in relation to infants and preschool children. It appeared that many of the services that were lacking could best be provided through program emphasis within the framework of the maternal and child health program. The basic interests of this program--that is, preventive health services, child health supervision, growth and development and the fostering of good parent-child relationships--are also the basic interests of a program for mentally retarded children.

It was on this basis and to achieve these goals that the Congress, for fiscal year 1957, increased the Children's Bureau's annual maternal and child health appropriation and earmarked $1 million specifically for special projects serving this group of children. The Appropriations Committee also expressed the hope that an additional million dollars of the increase, which was to be distributed to the States on a regular formula basis, would be used to implement services for the mentally retarded. The enactment of P.L. 88-156 in 1963 increased the authorization and has resulted in increased appropriations both for special projects for mentally retarded children and in the amount of regular formula funds designated for this purpose. P.L. 89-97, "Social Security Amendments of 1965," made further improvements, including the provision of grants for the training of professional health personnel to work with crippled children, particularly the mentally retarded and those with multiple handicaps.

P.L. 89-97 also made available project grants to provide comprehensive health care and services for children and youth of preschool or school age, particularly in areas with concentration of low-income families. The appropriation for the fiscal year 1966 for this program was $15 million, for fiscal year 1967, $35 million, and for fiscal year 1968, $37 million.

Mentally retarded children are also aided by the Children's Bureau's program of child welfare services whose objective is to assure that each child with this problem receives the care, protection, and services that

can enable him to realize his full potential. Grant-in-aid child welfare funds authorized by the Social Security Act were used early in scattered instances in behalf of retarded children, for child welfare services, including foster care, and for child welfare workers who gave some service to this special group of children. In 1957, special child welfare staff was employed in the Federal program. The years since, as part of the Bureau's overall effort to reach out to special groups of children, have seen substantially increased child welfare services extended to the mentally retarded. Although programs for the mentally retarded have developed markedly, a considerable need for service to this group remains.

A further impetus to improving care of retarded children was provided by the Child Welfare Research and Demonstration Grants Program authorized by the Social Security Amendments of 1960 and by the Maternal and Child Health and Crippled Children's Services Research Projects authorized by the 1963 amendments. Some of the program research conducted under both of these programs pertains to mentally retarded children.

The Child Health Act of 1967, which is included in P.L. 90-248, the "Social Security Amendments of 1967," makes provision for the following: (1) Increased authorizations for child health under Title V; (2) services for reducing infant mortality and otherwise promoting the health of mothers and children; (3) family planning services; (4) continuation of the programs of maternity and infant care project grants and of comprehensive grants for the health of preschool and school-age children; (5) new dental health service projects; (6) emphasis on early identification of health defects of children; and (7) broadening the scope of research and training authorizations. Reducing the incidence of mental retardation and improving care to mentally retarded children are among the objectives of these provisions.

2. Preventive Services

a. Maternity and Infant Care Projects

The report of the President's Panel on Mental Retardation emphasized the interrelationships of lack of prenatal care, prematurity, and mental retardation. A recent major emphasis in Children's Bureau programs has been the Maternity and Infant Care Projects, authorized by P.L. 88-156, "Maternal and Child Health and Mental Retardation Planning Amendments of 1963." This law provides for a new authorization for project grants to meet up to 75 percent of the cost of projects for the provision of necessary health care to prospective mothers who have, or who are likely to have, conditions associated with childbearing which increase the hazards to the health of the mothers or their infants, and whom the State or local health department determines will not receive necessary health care because they are from low-income families or for other reasons beyond their control. In addition, the legislation provides for medical and hospital care for premature infants and other infants at risk. Late in fiscal year 1964, $5 million was appropriated for this program, and eight projects were approved. For fiscal year

1965, $15 million was appropriated; for fiscal year 1966, $30 million; for fiscal year 1967, $30 million; and for fiscal year 1968, $30 million. By the end of December 1967, 52 projects were in operation.

P.L. 90-248 extends the program of maternity and infant care projects until June 30, 1972, after which they become a special part of each State health services plan. The new legislation continues the intent to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing, and in addition calls for services for helping to reduce infant and maternal mortality. It also adds authority for projects for intensive care of infants and for family planning services.

b. Phenylketonuria and Other Metabolic Diseases

A second major emphasis in prevention within the past few years has been in relation to phenylketonuria (PKU). This inborn error of metabolism has in the past been responsible for one percent of the population in our State institutions for the mentally retarded. By detecting families with the condition and by placing young infants with the condition on a special diet, mental retardation can usually be prevented. The Children's Bureau had been working with State health departments in developing and trying out various screening and detection programs, developing the necessary laboratory facilities, and assisting States in providing the special diet and follow-up programs for these families. When the Guthrie inhibition assay method for screening newborn babies was developed, the Children's Bureau supported field trials of this test. More than 400,000 newborn babies in 29 States were screened, and 39 cases of PKU were found, an incidence of almost one in 10,000.

The Children's Bureau is now urging that all States have a program for screening infants for PKU. Although such a program may be initiated without a legislative requirement, in many States laws have been enacted on this subject. As of the end of December 1967, 41 States had such laws, most of them making screening for PKU mandatory. The 41 States are:

Alabama	Illinois	Minnesota	Ohio
Alaska	Indiana	Missouri	Oregon
Arkansas	Iowa	Montana	Pennsylvania
California	Kansas	Nebraska	Rhode Island
Colorado	Kentucky	Nevada	South Carolina
Connecticut	Louisiana	New Hampshire	Texas
Florida	Maine	New Jersey	Utah
Georgia	Maryland	New Mexico	Virginia
Hawaii	Massachusetts	New York	Washington
Idaho	Michigan	Oklahoma	West Virginia
			Wisconsin

As more children with PKU are found, the problems relating to treatment services are receiving increased attention. Funds have been granted for planning a 5-year collaborative study of treated phenylketonuric children, for purposes of increasing knowledge of methods of treatment of children with this disease. A grant has also been made to develop a reference and standard service for phenylalanine determinations needed in screening and treatment. In April 1966, an important meeting was funded by the Children's Bureau to discuss PKU screening and treatment problems, pathogenesis of the disease, and other relevant topics. The proceedings of this Conference have been published under the title, "Phenylketonuria and Allied Metabolic Diseases." "Recommended Guidelines for PKU Programs" have also been prepared to make known the Children's Bureau recommendations for a comprehensive PKU program.

Interest is also increasing in metabolic diseases other than PKU that lead to mental retardation. The Children's Bureau is currently supporting a study of the clinical application of screening tests to detect galactosemia, maple syrup urine disease, and histidinemia. Also, support is being given to studies of new approaches to broader screening methods; for example, support is being given to a study which would make available a battery of automated tests for screening metabolic diseases. In addition, field trials are being conducted of a simple method to determine elevations of 10 different amino acids, for detection of metabolic disorders.

The concept of regional centers for treatment of PKU and other metabolic diseases has been developed, and during 1966, a grant for one such center was approved.

c. Lead Poisoning

In the area of prevention, increasing attention was paid to lead poisoning. Despite present-day manufacture and use of lead-free paint, many children become mentally retarded or suffer other damage from ingestion of chips of lead-containing paint from walls and woodwork in old, dilapidated housing. A publication "Lead Poisoning in Children," addressed to public health workers, was prepared, suggesting a program of prevention, casefinding, follow-up of cases, and other measures to cope with this problem.

3. Other Services

a. Casefinding and Screening

The Children's Bureau has, from the beginning of its work in funding programs for retarded children, emphasized the importance of early detection and casefinding. Preference to young children as new cases has been encouraged in the clinics supported by Children's Bureau funds. In recent years training, particularly for nurses, has emphasized the skills necessary for early detection. "A Developmental Approach to Casefinding with Special Reference to Cerebral Palsy, Mental Retardation, and Related

Disorders," written by a nurse, was published in 1967 to provide a tool for developing such competency.

b. Clinical Services

Support of clinical services for mentally retarded children is one of the most important uses for Children's Bureau mental retardation funds. The services provided include diagnosis, evaluation of a child's capacity for growth, the development of a treatment and management plan, interpretation of findings to parents and follow-up care and supervision. As of the end of November 1966, of the almost 200 mental retardation clinics in the country, the staff and services of 135 were supported in whole or in part by Children's Bureau funds. The Children's Bureau-supported clinics served approximately 40,000 children in fiscal year 1966. Somewhat over one-third of the children new to the program were under 5 years of age. During fiscal year 1967, the number of Children's Bureau-supported clinics increased to 150, serving approximately 43,000 children. The total number of mental retardation clinics in the United States rose to over 200.

The Children and Youth projects authorized by P.L. 89-97 offer an opportunity for providing increased services to mentally retarded children in the areas served by the projects. As of the end of December 1967, 54 Children and Youth projects were in operation. These projects provide comprehensive health services for children especially those living in areas with concentrations of low income families.

c. Crippled Children's Services

Since enactment of the Social Security Act in 1935, the Federal Government, through the Children's Bureau, has assisted the States in providing services to crippled children. Although exact data are not available, it is known that relatively few mentally retarded children were cared for in these programs prior to 1963. The enactment of P.L. 88-156, providing for increased funds for the crippled children's program and for the earmarking of some of the funds specifically for mentally retarded children, has resulted in more attention being paid to physically handicapped retarded children. In some States, the definition of crippling conditions is being broadened to include conditions for which services had not hitherto been given. Some children who would formerly have been turned away are now being given service.

An important use of the expanded funds available for mentally retarded crippled children is in providing services for institutionalized children; for example, orthopedic services not hitherto available to these children. In addition, the Children's Bureau staff itself has provided some consultation to the institutions, particularly in the fields of nutrition and physical therapy and to some extent in nursing.

A recent development has been a broadening of the scope of services to give more attention to children who are both physically handicapped and mentally retarded, children who have several physical handicaps, and children with serious learning disorders. Some mental retardation clinics are showing increased interest in serving those children and a number of special clinics, financed by Children's Bureau funds, have been set up.

In 1966, over 20,000 children with diagnoses of various forms of mental retardation received medical services in the Crippled Children's program. The 1967 amendments to the Social Security Act require that State plans for Crippled Children's services provide for more vigorous efforts to screen and treat children with disabling conditions. This provision should result in an increase in the number of mentally retarded children identified and treated.

d. Cytogenetic and Biochemical Laboratory Programs

A new use to which some of the Children's Bureau funds earmarked for mental retardation are being put is in the area of cytogenetic and biochemical laboratory services. Project grants have been approved which establish such programs as extensions of clinical services at hospitals or medical schools. Projects include chromosome analysis and diagnosis of various medical conditions which may be genetic and result in mental retardation. On the basis of these analyses, counseling may also be given to parents seeking advice on genetic questions. The biochemical laboratories may also do continuing monitoring of patients with metabolic diseases. Training in medical genetics is also an important aspect of many of these projects. By the end of December 1967, 20 such projects had been approved. In March 1966 a group of experts in this field was called in to discuss and make recommendations on present and future Bureau programs in this area.

e. Dental Programs

Programs for the dental care of handicapped children, including the mentally retarded, have been encouraged in the past; but dental care will be given new support as a result of the 1967 Social Security Amendments. These amendments authorize support of up to 75 percent of the cost of projects to provide comprehensive dental health services for children from low-income families.

f. Child Welfare Services

The Children's Bureau administers child welfare services funds authorized by the Social Security Act as amended, for the purpose of cooperating with State public welfare agencies in establishing, extending and strengthening child welfare services. These funds are allocated to States on a formula basis. Child welfare services which can benefit the mentally retarded include

parent counseling, homemaker services, day care services, foster family care, small group care, adoption services, services to unmarried mothers, protective services, and certain institutional pre-admission and aftercare services.

At the present time, all State public welfare programs provide some child welfare services for mentally retarded children. By conservative provisional estimates of the Children's Bureau, 42,500 mentally retarded children receive services from public child welfare agencies.

Following are examples of developments related to the extension and improvement of child welfare services for mentally retarded children and their families:

Two State public welfare agencies have authorized mental retardation specialist positions for the purpose of strengthening the agencies' services for the retarded.

One State, on the basis of its experience in providing the range of child welfare services through a special unit for the retarded in one locality, is now extending increased child welfare services to the retarded and their families in other areas of the State. Another State, similarly, has initiated a project for the purpose of providing comprehensive child welfare services to the retarded and their families.

Several States report that with the support of a child welfare worker and assistance provided through this service in utilizing other community resources, parents often are able to keep their retarded children at home and keep their families intact.

Homemaker services are increasingly provided through State child welfare services programs for families of retarded children. As a result of expansion in both the number and size of homemaker services programs operated by public welfare agencies, these programs are meeting a wider variety of need. Approximately 400 public welfare agencies now--as compared to around 95 in 1964--operate their own homemaker services programs. The majority of these provide services which are an integral part of the child welfare services program. Through homemaker services, an overburdened mother can be relieved of the constant and full responsibility for the day-to-day care of her retarded child. Frequently, she acquires new skills which help her in better home management and in her special problems with child care.

Several State public welfare agencies are developing day care services for mentally retarded children. In one State, the number of licensed daytime-activity centers has more than tripled in about a three-year period, from 21 to 70. The State child welfare agency

licenses these centers. Another State child welfare agency administers a program of special State grants to assist in the development of local day care centers for the retarded. With concern for quality in their programs of day care for the retarded, some States have given special attention to the development of standards and to training of day care personnel. Day care programs offer both constructive experiences for some retarded children and necessary relief for their parents. This service often may be the key factor in determining whether a child can remain with his family.

Most States provide some foster family care for retarded children. In all, it is estimated provisionally that 13,200 of the retarded children receiving public child welfare services are in foster family care.

Some children who must be cared for outside their own homes can profit from close interpersonal relationships and respond to the stimulation of foster family life. Short-term foster care at intervals or during periods of crisis may enable a retarded child's family to provide adequately for him at home for the most part. For other retarded children, foster family care permits long-term benefits of family life and community living. Foster family care would be the plan of choice for many children who have been placed inappropriately in large residential facilities. In fact, some States are giving attention to the "exchange" of children between institutional and child welfare services programs to assure more appropriate services for particular children.

The experience of several States illustrates that retarded children can profit from adoption and that adoptive placement is feasible for many of these children. Adding impetus to the development of this service was a two-day conference of 30 representatives of public and voluntary child welfare agencies from 7 southeastern States which was convened by Children's Bureau staff of Region IV on adoption of retarded children.

Child welfare services also may have preventive aspects in relation to mental retardation. For example, day care or foster care for children from certain deprived homes may be preventive services.

Homemaker service may be preventive in nature when brought into play with some expectant mothers who need relief from the physical demands of caring for other children. Protective services can reduce child abuse as a cause of mental retardation. Services to unmarried expectant mothers can assure utilization of proper prenatal services.

Child welfare workers also are in a key position with regard to early casefinding, assistance with obtaining proper diagnosis, and providing continuity of planning and services consistent with the individual retarded child's need.

In spite of the efforts and potential of child welfare services which have been cited, numbers of retarded children and their families need and could profit from child welfare services not now available. Professionally skilled staff, new programs, and extension of those in existence are needed. The growing emphasis on community services as a means of combating mental retardation will place increasing demands on child welfare agencies. Many States, however, have been unable to finance these special programs because of other pressing priorities which are also consistent with implementing the 1962 Public Welfare Amendments on use of State and Federal child welfare services funds.

The emphasis of the "Social Security Amendments of 1967" upon provision of child welfare services to AFDC families constitutes still an additional priority for child welfare services agencies and will require furthere mustering of resources. At the same time it perhaps will bring increased attention to the special needs of the estimated 114,000 AFDC children who are already mentally retarded and to the depriving family conditions in which mental retardation is often rooted. (The estimate was reached by applying data from a late 1961 study to the current caseload of AFDC children.)

g. Program Aids

The Children's Bureau has assisted in the production and circulation of films on mental retardation and has also operated an exchange of educational materials as a service to the mental retardation clinics. Since November of 1961, through this exchange, more than 400 items have been distributed to each of the mental retardation clinics in the country. Special publications have been developed which have been in great demand. In addition, pertinent articles appearing in various professional journals have been reprinted and distributed. During the calendar year 1967, more than 24,000 individual copies of publications were distributed in response to requests.

4. Professional Preparation

a. Training for Health Services

Training activities for health services in the field of mental retardation, assisted by Children's Bureau funds, have encompassed many approaches: Grants for fellowships; support of and participation in institutes, conferences, and other short-term training sessions; consultation on course curriculums; arrangements for clinical experience in mental retardation clinics; distribution of informational materials to professional workers; and recently, support of the university-affiliated centers being constructed under authority of P.L. 88-164, Title I, Part B.

The following points up the wide range of disciplines involved in training activities and illustrates the variety of training approaches.

92 - 594 O - 68 - pt 2 - 21

During fiscal year 1965, the Children's Bureau funded 27 pediatric fellowships in mental retardation; in fiscal year 1966, 39; and in fiscal year 1967, 26 such fellowships were funded. In nursing, assistance was given in fiscal year 1967 to 10 university schools of nursing for their graduate programs in maternal and child nursing, including mental retardation; in these programs special attention is given to the nursing role in casefinding, prevention and intervention. In addition, 4 university schools of nursing were given grants for continuing education courses for nurses in mental retardation. State agencies also sponsored short-term, intensive educational programs in mental retardation for staff nurses. The Fourth National Workshop for Nurses in Mental Retardation sponsored by the Children's Bureau, held in Miami in 1967, was attended by 60 nurses.

During 1966, 35 nutritionists attended a one-week workshop on nutritional services in mental retardation, sponsored by the Washington State Health Department, the University of Washington, and the Children's Bureau. The Children's Bureau also funded an Institute on Nutrition and the Inherited Diseases of Man held in May 1966 at the University of Minnesota Continuing Education Center.

In the 1966-67 academic year, 45 pre-masters social work students received their training in 19 Children's Bureau-supported mental retardation clinics from 20 graduate schools of social work; some of these students received stipends through training projects supported by the Children's Bureau. Additional students were placed in Children's Bureau-supported programs where they could have experience with Mental Retardation cases. A small number of post-masters social work students, who are receiving stipends through Children's Bureau projects, received exposure to mental retardation in their field placements.

Training of dentists to work with mentally retarded children was stimulated, as was the training of psychologists. During 1966, three symposia for professional physical therapists on the Child with Central Nervous System Deficit were supported by Children's Bureau funds at the University of Pennsylvania, Western Reserve, and Stanford Universities. A new development beginning in 1966 has been the initiation of projects for the training of occupational therapists. Two special project grants were made, to the University of Florida and to Boston University's Sargent College, to enhance the professional education of occupational therapists to work with handicapped children. Also, two one-week seminars on perceptual-motor dysfunction were attended by nearly 500 occupational therapists involved in the evaluation and training of children with learning and motor disabilities; the proceedings of the seminars were published and widely distributed.

Children's Bureau special project funds support academic training in speech pathology and audiology in 5 universities, both for faculty and for stipends to 31 students seeking an M.A. or Ph.D. degree. Another university training program in communicative disorders supports faculty in pediatrics and otolaryngology as well as in audiology and speech pathology. A clinical fellowship program in pediatric-audiology has been expanded from 1 to 3 universities. All these training programs include a mental retardation component.

Medical genetics represents a new field of training which was begun in fiscal year 1965 and extended in subsequent fiscal years. Training programs, as part of the cytogenetic and biochemical laboratories, were set up for physicians and biochemists to specialize in aspects of medical genetics, particularly in cytogenetics, metabolic disease, and endocrinology.

The 1965 amendments to the Social Security Act made additional provision for grants for training purposes to be administered by the Children's Bureau. The amendments authorized appropriations for grants to be made to public or other nonprofit institutions of higher learning "for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps." The amounts appropriated for this program, $4 million in fiscal year 1967 and $7 million in fiscal year 1968, were used primarily to support training in the university-affiliated centers for diagnosis and treatment of the mentally retarded.

The new Section 511 of the Social Security Act as amended in 1967 replaces and expands the training authority to include all personnel involved in providing health care and related services to mothers and children, with special attention to undergraduate training.

b. Training for Child Welfare Services

States are urged to use Children's Bureau child welfare services funds for tuition and maintenance grants for child welfare staff educational leave. All States have structures for a staff development program, including orientation, inservice training, and educational leave. These programs contribute to the overall increase of child welfare staff which is better able to serve the mentally retarded.

The 1962 Public Welfare Amendments provided a new avenue for augmenting the supply of trained child welfare workers by establishing grants for child welfare training projects. This program provides grants to public and other nonprofit institutions of higher learning for special projects for training personnel in the field of child welfare, including traineeships to students.

Training for child welfare services to the mentally retarded is included in this program. For example, five projects currently have approval under this program for providing social work field instruction units in mental retardation settings.

While complete facts from schools of social work are not compiled on the current school year, during the 1966-67 school year, 14 students receiving child welfare traineeships through this program were in mental retardation settings for their field instruction. For that year also, schools of social work reported that at least 74 child welfare-related mental

retardation agencies were providing field experience for as many as 185 students from 42 schools of social work.

In one State, a project for the training of foster parents of the mentally retarded is being supported by a child welfare training grant.

5. Research

The Children's Bureau Clearinghouse, which maintains an inventory of current research relating to children, recently revised its publication, "Research Relating to Mentally Retarded Children"; this is a listing of the mental retardation studies reported to the Clearinghouse during the period 1949-1965, including references to published reports.

Two research grant programs administered by the Children's Bureau can be used for program research assisting mentally retarded children:

a. Child Welfare Research and Demonstration Grants Program

The Child Welfare Research and Demonstration Grants Program, authorized by the Social Security Amendments of 1960, provides financial support for special research or demonstration projects in child welfare which are of regional or national significance, and for special demonstrations of new methods or facilities which show promise of substantial contribution to the advancement of child welfare.

Since community support is vital to improvement of child welfare services, an important function of several projects is to develop support through interpretation and communication of the problems that many children face, ranging from shattered families to mental retardation.

Projects relating to mental retardation which have been completed include: (1) a demonstration to test the feasibility and value of foster home care for deprived mentally retarded children; (2) a demonstration, training, and service project designed to test the feasibility of training and using unskilled personnel as aides to professional personnel in caring for retarded children in the areas of homemaking and child care, physical medicine and nursing care, speech therapy, play activity, and auxiliary maternal care; (3) a study of specialized foster home care for deprived mentally retarded children; and (4) a study of existing laws and their administration applicable to children suffering from mental disorders, including their commitment, care, and guardianship.

A grant was made to Howard University for a Project to determine how much a day-care program, plus parent education activities, can accomplish to offset intellectual and social disadvantages encountered by environmentally deprived children on entering public school. The research component of the Project was carried out by the Children's Bureau. Recently, the entire Project was transferred to George Washington University.

During fiscal year 1968, the Child Welfare Research and Demonstration Grants Program will be supporting 12 projects with mental retardation elements or components. Two new studies were begun relating to work with infants and preschoolers who are prone to become mentally retarded with reasons other than genetic or congenital factors. As the vast majority of mentally retarded children appear to have functional retardation an increased effort has been launched to develop feasible programs of prevention. A study with the Family Service Association of Nassau County is aiding the cognitive growth and development of preschool children using a special day-care program combined with work with parents. At the University of Florida a special study is focusing on using child development aides who teach mothers how to stimulate and motivate their infants and toddlers without the necessity of placing them in a day-care group program.

b. Maternal and Child Health and Crippled Children's Services

The purpose of this research grant program, authorized by the Maternal and Child Health and Mental Retardation Planning Amendments of 1963, is to support studies that show promise of making a substantial contribution to the advancement of health programs for mothers and children. Programs for mentally retarded children may be included in these studies.

In the area of mental retardation, projects have been funded which will study ways to improve amounts and quality of prenatal care. These are an effort to reduce the occurrence of prematurity and as a means of preventing mental retardation due to these causes. Several projects supported in various schools of medicine have as their objective an evaluation of methods for screening children for metabolic and other inherited diseases which can lead to mental retardation. They also seek to develop procedures for screening preschool children for neurological damage and psychological deviancy.

In one project, a major step may be achieved in alleviating the critical shortage of trained professional psychologists. This project will test, in selected mental retardation clinics throughout the country, a plan for utilizing nonprofessional personnel.

Another major study that has been funded proposes to uncover every case of mental retardation in a well-defined population. The prevalence of mental retardation and its relation to social, economic, and demographic characteristics of the individual and his household will be investigated in the hope of uncovering etiological relationships.

The final report of a study entitled "Medical Needs of Children in Institutions for the Mentally Retarded" makes clear that some State institutions are failing to provide the necessary services to meet the health and medical needs of the mentally retarded child. Suggestions are made to correct this long-study problem using the financial resources of

the State and the medical personnel in the local community.

The Retarded Infants Service of New York has completed its report entitled "Feasibility of Training and Using Unskilled Personnel as Aides to Professional Personnel in Caring for Retarded Children." This study is a pioneering effort in using aides in a variety of service programs concerned with mentally retarded children and has wide applicability.

During fiscal year 1968, the Maternal and Child Health and Crippled Children's Services Research Grants Program will be supporting 22 projects with mental retardation elements or components. One new study will examine intensively the sequelae of infants and toddlers with congenital rubella and another study will follow up low birth-weight infants.

The 'Social Security Amendments of 1967' provide that after June 30, 1968, special emphasis shall be given to research projects which will study need for, feasibility, costs and effectiveness of use of health personnel with varying levels of training.

Medical Services Administration

As the responsible agency for the general oversight and setting of standards for the provision of medical assistance services under Title XIX, the Medical Services Administration provides guidance to State agencies in the administration of Federal-State programs and evaluations of health and medical care programs.

The Mental Health Workgroup, Program Planning and Development Division, has responsibility for the mental retardation activities in conjunction with the Medical Assistance Program.

The mentally retarded who meet a State's eligibility requirements for the Medical Assistance Program, may receive the same benefits in terms of medical care, as any other recipient. The amount and scope of medical services depend on the individual State plan.

Rehabilitation Services Administration

1. Introduction

The Rehabilitation Services Administration is responsible for a broad range of programs designed both for the provision of diagnostic, treatment, and rehabilitation services for the mentally retarded and for the support of special facilities and activities to expand and improve national resources for serving the mentally retarded. These programs include the State-Federal vocational rehabilitation program, as well as special project grants for the expansion and innovation of vocational rehabilitation services; the improvement of State residential institutions and sheltered workshops for the

mentally retarded; the planning and construction of rehabilitation facilities, sheltered workshops, special comprehensive community facilities and university-affiliated facilities for the mentally retarded; and training for professional, supportive and technical personnel already engaged or preparing to engage in occupations in the care and rehabilitation of the mentally retarded.

These diverse activities are unified by the common goal and objective of assisting mentally retarded individuals to achieve and maintain the maximum personal, social, and economic competence of which they are capable.

2. Services

a. Vocational Rehabilitation Services

Under the public rehabilitation program, grants are made to State vocational rehabilitation agencies to assist them in providing rehabilitation services to mentally and physically disabled individuals who have substantial employment handicaps and who can reasonably be expected to be rehabilitated into gainful employment. Among the services provided by State vocational rehabilitation agencies are comprehensive medical, psychosocial and vocational evaluation; physical restoration; counseling; adjustment, prevocational and vocational training; maintenance and transportation during the rehabilitation process; placement in suitable employment; and follow-up to ensure successful rehabilitation.

Of the 173,594 disabled people rehabilitated through the State-Federal program in fiscal year 1967, approximately 18,000 were characterized by the primary disability of mental retardation. This group comprised 10.3 percent of the total number of rehabilitants in all disability categories, a significant rise from the comparable figure of 9.3 percent for fiscal year 1966. Looking ahead, it is projected that about 24,000 retardates will be rehabilitated through the public program in fiscal year 1968, and 27,000 mentally retarded in fiscal year 1969.

There are many ways in which State vocational rehabilitation agencies have been organizing and developing their services for the mentally retarded. Basic to the vocational rehabilitation effort has been the growing reliance on counselors and other vocational rehabilitation staff who work only with retarded clients. This specialized staff may be assigned to local vocational rehabilitation offices, schools, institutions, sheltered workshops, or other facilities serving the mentally retarded. By concentrating their attention on the mentally retarded clients, these counselors are successfully developing rehabilitation plans based on the special problems of the retarded and are able to be broadly responsive to the needs of both the client and his family.

As special vocational rehabilitation programs and facilities for the retarded continue to be developed and expanded, the number of specialized counselors within State vocational rehabilitation agencies continues to increase.

The specialized vocational rehabilitation staff working with the mentally retarded has been particularly effective in the development of cooperative vocational rehabilitation-school programs designed to assist the retarded young person to make a satisfying transition from school to work. These cooperative school programs are found in many communities throughout the country and have greatly strengthened both special education and vocational rehabilitation efforts with the mentally retarded. The cooperative program structure varies from State to State. In Texas, for example, a Statewide program ensures that an in-school progression from elementary to high school special education experience is available in most school districts within the State with the rehabilitation agency assuming prime responsibility for the vocational aspects of the secondary school programming. In California, a similar program has been developed by the vocational rehabilitation agency and twenty-eight independent school districts in the State. In South Carolina, special in-school rehabilitation facilities have been established to provide a full range of vocational rehabilitation services on the school campus. In Wisconsin, community resources such as sheltered workshops are used for vocational evaluation and occupational training. Still other patterns are found in other States.

Most cooperative arrangements have brought about the development of vocationally oriented curricula within the schools. All of them, however, provide for a comprehensive evaluation of the retarded young person's vocational rehabilitation potential; the provision of personal adjustment and pre-vocational training; counseling; on-the-job training and work experience; job placement, follow-up and related vocational rehabilitation case services.

The number of retarded young people enrolled in cooperative vocational rehabilitation work-study programs is increasing steadily as new programs are developed. An estimated 6,000 are enrolled in Florida; 3,800 in Texas; 3,600 in Georgia; and 3,000 in California. These cooperative programs have proven themselves effective in reducing the school drop-out rate of retarded youngsters and have provided a technique for continuous service to youngsters during the school years when they are best able to benefit from them.

Another emphasis of State vocational rehabilitation agencies has been the establishment of rehabilitation facilities, such as comprehensive rehabilitation centers, evaluation centers, occupational training centers, workshops, half-way houses, and other specialized facilities serving the mentally retarded. Some of these rehabilitation centers are located in State vocational rehabilitation agencies, by the State agency in cooperation with other public agencies, or by other public or private agencies.

State vocational rehabilitation agencies may assist in the establishment of rehabilitation facilities in a variety of ways. They may alter, expand or renovate existing buildings; purchase necessary equipment; and for certain types of facilities, provide initial staffing support for a period of one year. In some cases, State agencies provide direct grants to the facilities from State appropriated funds. In other cases, local facilities and workshops are supported by means of private contributions which may be used for Federal matching.

During fiscal year 1967, sheltered workshops primarily serving the mentally retarded were established in California, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland and Texas. School campus rehabilitation units were established in Alabama, California, Florida, Michigan, South Carolina and Tennessee, and comprehensive rehabilitation facilities were established at residential institutions for the mentally retarded in Arkansas, Maine and Pennsylvania.

b. Vocational Rehabilitation Service Project Grants

Special project grants for the innovation and expansion of vocational rehabilitation services have also been utilized to extend and improve State rehabilitation agency efforts with the mentally retarded. Innovation grants provide the means for State agencies to develop new programs and techniques in order to adapt to changing needs while expansion grants are designed specifically to increase the number of people rehabilitated by the State agency.

Under the innovation program in Maine, for example, a project is enabling the vocational rehabilitation agency to develop employment opportunities for the mentally retarded in both the Federal and State governments. A project in Minnesota has developed a series of audio-visual aids for use in work preparation of retarded clients and a project in Pennsylvania is providing for the application of a closed circuit relay television system within the rehabilitation facility at a residential institution. In Montana, a rehabilitation facility for both residents and non-residents of the State training school has been supported.

The expansion grant program has supported the growth of sheltered workshop and facility resources for the mentally retarded in Alaska, Indiana, Louisiana, Pennsylvania, and Wisconsin. An expansion project in North Carolina has brought special services to the mentally retarded public offender incarcerated within the State prison system and a project in Washington has enabled a sheltered workshop to expand its operation into a box manufacturing plant.

Within an extensive program of workshop improvement, the Rehabilitation Services Administration administers Workshop Improvement grants designed to upgrade the services of sheltered workshops by supporting such activities as the employment of additional staff, technical consultation, staff development, and the purchase or rental of equipment.

During fiscal year 1967, 15 Workshop Improvement grants totaling $400,215 were awarded to sheltered workshops affiliated with local associations for retarded children. In addition, Workshop Improvement grants have been awarded to two residential institutions for the mentally retarded to improve their sheltered workshop programs. As a result of the workshop improvement program, the number of State vocational rehabilitation agency clients at workshops receiving grants has increased by 106 percent.

Other workshop improvement activities are: (1) a program of technical assistance consultation by means of which contracts may be made with State vocational rehabilitation agencies or with other expert consultants to provide workshops with special consultation services; and (2) projects to share in the cost of providing training services for handicapped individuals in public or other nonprofit workshops and rehabilitation facilities. Federal financial participation in the Training Services grant program may assist in the cost of such services as training in occupational skills, work evaluation, work testing, provision of occupational tools and equipment necessary for training purposes and job tryouts.

During fiscal year 1967, Training Services grants totaling $2,000,000 were awarded to 13 workshops serving the mentally retarded as well as other disabled persons.

c. Other State Agency Activities

State vocational rehabilitation agencies have also been actively participating in other special projects and programs for the training and job placement of the mentally retarded.

Under a jointly sponsored Rehabilitation Services Administration-U.S. Civil Service Commission program for Federal employment of the mentally retarded, State vocational rehabilitation agencies have been certifying retardates as qualified for existing vacancies in Federal installations. With more than 30 Federal departments cooperating in the program, State rehabilitation agencies have succeeded in placing approximately 3,800 retardates in over 45 different types of jobs at Federal installations across the country since the beginning of the program.

Another significant step toward increasing the number of mentally retarded in competitive employment was taken in the fall of 1965 when a project was launched by the Institute of Industrial Launderers under a contract with the Bureau of Apprenticeship and Training, U.S. Department of Labor. Known as Project Manpower, it is providing 800 retardates with on-the-job training for employment in the industrial laundry industry. State vocational rehabilitation agencies are collaborating in this program by evaluating, screening and referring mentally retarded clients for the training opportunities established under Project Manpower.

In a second effort of this kind, begun in February 1966, by the National Association for Retarded Children, 1,500 mentally retarded persons are scheduled to be placed in on-the-job training leading to competitive employment. This Promotional Contract, and a subsequent one providing an additional 2,000 slots, is opening a broad spectrum of jobs in private industry. Woolworth Company, Sky Chef, Federal Mart, Howard Johnson, Sears Roebuck, Montgomery Ward, Marriott Corporation, and the Hotel Corporation of America are some of the industries participating in the program.

Recent legislation has provided rehabilitation agencies with additional resources and techniques for serving the retarded.

Special provisions in the 1965 Vocational Rehabilitation Amendments (P.L. 89-333), for example, assisted States in meeting the cost of providing vocational rehabilitation services to handicapped individuals in order to determine whether they can reasonably be expected to engage in gainful employment. In the case of the mentally retarded, such services may be extended over a period of 18 months. Previously, State rehabilitation agencies were expected to determine after an initial diagnostic evaluation, but prior to the rendering of any services, whether a handicapped person could reasonably be expected to become employable after his rehabilitation program had been completed. This provision permits State rehabilitation agencies to work with an increased number of more severely retarded clients, and provide them with extended evaluative services in order to determine their real potential for ultimate employment.

Partially as a result of this new opportunity, State rehabilitation agencies are better able to give special attention to developing services for retarded persons with multiple disabilities. Special programs for the mentally retarded blind, for example, are currently being explored in a number of States.

An additional resource for aiding in the rehabilitation of the retarded is the "Social Security Amendments of 1965" (P.L. 89-97) which permit payment from Social Security Trust Funds for rehabilitation services to selected categories of disability beneficiaries. These supplemental funds will be especially helpful to State vocational rehabilitation agencies in serving the Disabled Children Over Age 18 group, which contains many of the more severely retarded with no past record of employment.

Under the "Military Medical Benefits Amendments of 1966" (P.L. 89-614) State rehabilitation agencies are cooperating in the provision of rehabilitation services to moderately or severely mentally retarded dependents of military personnel on active duty.

The 1967 Vocational Rehabilitation Amendments (P.L. 90-99) provide that State plans for vocational rehabilitation must be amended by July 1, 1969, to ensure that no residence requirement will be imposed on eligible

clients. This means that any mentally retarded individual present in a State may be evaluated for vocational rehabilitation without regard to how long he may have resided in that State.

The rehabilitation of the mentally retarded is a major concern of the State agencies and this concern is evidenced both in programs directed specifically at serving the retarded and in programs in which the retarded are served in addition to other special groups of individuals. Projects for groups, such as selective service rejectees, welfare clients, public offenders and the economically disadvantaged have demonstrated a high incidence of mental retardation and have resulted in considerable service to the mentally retarded. By participating in multi-service centers, concerted services projects, pilot neighborhood activities and similar efforts, State rehabilitation agencies are extending their services in order to reach and rehabilitate greater numbers of retarded persons living in both rural and urban poverty.

d. Social Services within Public Welfare Agencies

The Rehabilitation Services Administration is also responsible for the promotion and maintenance of standards for social services provided by State and local public welfare agencies on behalf of disabled public assistance recipients. Such services are directed toward strengthening individual and family life and helping needy individuals attain the maximum economic and personal independence of which they are capable. Among the disabled clients within the Aid to the Blind and Aid to the Permanently and Totally Disabled categories are an estimated 115,000 mentally retarded adults.

While there are many special problems and conditions which are of concern to the public assistance programs, mental retardation has particular significance as a frequent cause of economic dependency. Many of these retarded persons cannot live in the community unless special protective services are provided in their behalf. These social services are particularly essential when family members through incapacity or death can no longer provide a protective environment.

Homemaker services, group work services, foster family care, group and volunteer services, and use of additional specialists, such as teachers, psychologists, and counselors, can make special contributions towards meeting the needs of the mentally retarded. Public welfare agencies are responsible for participating with the total community in developing diagnostic, treatment, training and employment services, for the mentally retarded, and for developing basic social services to support, encourage, and sustain the mentally retarded in areas of family and social functioning.

The various State public welfare agencies may elect to provide as a minimum the following services: (a) those providing protection for the individual, (b) those which help the client remain in or return to the

community, and (c) those services appropriate for self-support. Other services--to persons with potentials for self-care, to those estranged from family, and to those who are former and potential public assistance applicants and recipients--may be provided in addition. Special programs providing homemakers, volunteers and group services may also be furnished in addition to the minimum services. When the States elect to provide these services, Federal matching in the amount of 75 percent is available to meet such costs. About two-thirds of the States have elected to provide at least the minimum services and a further expansion of social service is being encouraged.

e. Mental Retardation Hospital Improvement

The Mental Retardation Hospital Improvement grant program is designed to assist State institutions for the mentally retarded to improve their care, treatment, and rehabilitation service. The program is specifically focused on the demonstration of improved methods of service and care, as opposed to research exploration or the development of new knowledge.

Each State institution for the mentally retarded is eligible to apply for a maximum of $100,000 per year for a period of up to ten years. While an individual project grant application is required, an institution may apply for concurrent grants, or a series of consecutive grants, so that a programmatic approach to use of the program in improvement of services is both possible and encouraged. Projects are planned in response to the high priority needs of the institution and are directed toward the ultimate improvement of resident care throughout the entire institution.

An analysis of the current Hospital Improvement projects shows that a majority of the projects is focused on specialized services for residents who will require long-term care and treatment. A number of these projects involve retardates functioning at the severe and profound levels of retardation; some involve multiply handicapped residents; and a few are concerned with aged residents. Demonstration projects for these more severely retarded and dependent residents are emphasizing personal development by means of self-care training, socialization experiences, intensive medical diagnosis and treatment, and opportunity for improved speech.

A number of projects have focused on special program areas, such as prevocational training for adolescents, and programs of treatment, training, and social habilitation. Other projects provide a diversified range of improved services, such as placement preparation, speech therapy, medical-physical diagnosis and treatment, recreation services, social-vocational habilitation, diagnostic study with improved records and program planning, and use of the unit system, all of which enhance the development of an institution-community continuum of services.

The Mental Retardation Hospital Improvement project grant program was initiated in 1964 as an extension of the Mental Health project grant

program. By the end of 1967 approximately 100 State institutions for the mentally retarded had received awards. This means that approximately 68 percent of the eligible institutions are included in the program. All but five States had at least one grant for an institution for the retarded.

Although the program has been in operation for less than four years, it is already clear that many of the severely and profoundly retarded residents are benefiting. Some are able to participate in more advanced developmental programs of the institution, and others are returning to their families and communities. There is evidence that the success of the patients is changing staff attitudes and "de-institutionalizing" staff attitudes and behavior. For many institutions the projects are stimulating improved institution-community program coordination, and making possible a more effective use of nearby community, university and college resources.

Major emphasis in this program during the next year will be placed both on the extension of coverage to those institutions not yet involved in the program and on the development of long-term collaborative efforts by the staffs of the institutions receiving grants, their State mental retardation agencies, and the Rehabilitation Services Administration. Such collaboration is being developed so that project experience in solving problems of mental retardation institutional care may be assessed and shared in order to ensure that improved methods and techniques can be widely disseminated.

The coordination of institutional programs with community service programs and State-wide comprehensive planning activities remains an important objective of the Mental Retardation Hospital Improvement program.

f. Community Services

Although Community Service projects are administered in the Office of Comprehensive Health Planning of the Public Health Service, the Division of Mental Retardation within the Rehabilitation Services Administration actively stimulates such projects and encourages their submission for competitive evaluation and support.

High priority is given to project proposals which will result in expanded or improved services for the retarded at either the community or the regional level. Grants are available for projects devoted to: (1) the establishment of effective methods of referral; (2) the coordination of existing agency programs with other activities facilitating the care and management of the retarded; (3) programs of patient care services; and (4) the demonstration of new techniques of providing services. In addition, major emphasis is given to projects which, by supplementing the existing services of community agencies, will make possible the community services necessary for a full continuum of care. An example of this type of project is the development of outpatient services by a residential institution to serve the community in collaboration with other health agencies.

Examples of community service projects are numerous and varied. One type of demonstration project, currently being supported in several States, is organizing and initiating a county-wide system of Daytime Development Centers, where an extensive program of care, training, and/or education is provided for the mentally retarded persons whose needs are not otherwise being met. The activities of the Centers are assisting the retardates in becoming more self-sufficient, and are providing some relief during the daytime hours for their families. Family counseling is also part of the program.

Another type of project is demonstrating new techniques of providing services in a diagnostic and evaluation clinic which meets one day per month for the examination of 8 to 10 children and a second day each month for staff discussion. Continuity and follow-up is provided by one full-time social worker and one full-time clerical person. The cost for this type of diagnosis is approximately one-fifth of that of conventional diagnostic and evaluation clinics.

Another demonstration project is applying laboratory-derived principles in modifying the personal, social, educational, and occupational behavior of moderately and severely retarded, institutionalized girls. The primary technique in this project is the systematic, controlled rewarding of desired behavior.

A project with national implication is one in which the narrative standards for residential facilities, as promulgated by the American Association on Mental Deficiency in 1961, are being updated and converted to a rating device which could be used for establishing a "base line" for the assessment of institutions. Also being supported is the planning for a national accreditation body to be concerned with the accreditation of residential facilities for the retarded.

3. Professional Preparation

a. Training Grant Programs

The Rehabilitation Services Administration also supports a variety of training grant programs designed to increase both the supply and competence of professional and subprofessional personnel qualified to provide rehabilitative, health and other services to the mentally retarded. Included within the training activity are: (1) grants to educational institutions to employ faculty or otherwise expand or improve their instructional resources (teaching grants); (2) grants to educational institutions for traineeships (stipends) to students; (3) grants to State residential institutions for the mentally retarded and State vocational rehabilitation agencies for inservice staff training; (4) contracts with educational institutions and other agencies to support short-term training programs; and (5) grants to public and private nonprofit agencies and organizations for a program of student work experience and training in mental retardation.

Under the Vocational Rehabilitation Act during fiscal year 1967 there were 36 long-term teaching grants supported at 33 different institutions or organizations, including 31 universities. There were also 6 short-term training grants during this same period. The long-term grants supported the professional education of specialists in social work, speech pathology and audiology, rehabilitation counseling and physical therapy with 283 traineeships awarded in these areas including 4 traineeships awarded by the Research and Training Center at the University of Oregon. The short-term grants, with an emphasis on vocational rehabilitation aspects of mental retardation, are basically offered to meet the additional in-service training needs of professionals in the field. Vocational rehabilitation training grants in mental retardation for fiscal year 1967 totaled $1,930,706. It is estimated that in fiscal year 1968 approximately the same amount as in 1967 will be utilized in financial support for long-term training and traineeships in mental retardation.

Rehabilitation Services Administration activities in fiscal year 1968 in the field of professional preparation include:

---Increase in numbers of students in graduate training programs in psychology, social work, rehabilitation counseling, physical therapy, speech pathology and audiology receiving specialized training in the rehabilitation of the mentally retarded through supervised field work in mental retardation settings;

---Improvement in curriculum content and teaching methods in training projects through support of field teachers, the development of case material and other teaching aids, the encouragement of research in the rehabilitation of the mentally retarded, and training courses dealing with the scope, nature and place of content on mental retardation in the curriculum. The Parsons State Hospital and Training center, for example, is producing teaching films to be used in training rehabilitation personnel to serve mentally retarded persons and an institute on "Mental Retardation: A New Dimension in the Curriculum" was held for representatives of all Schools of Social Work in the Spring of 1967;

---Upgrading of personnel now serving the mentally retarded through short-term training courses of great variety in length, subject matter, intensity, depth and frequency. Included will be professional personnel in all relevant fields, sheltered workshop executives, floor supervisors and others in positions with management responsibilities;

---Encouragement of a comprehensive, inter-disciplinary approach to providing care and rehabilitation of the mentally retarded through training courses focused on inter-disciplinary program planning and operation of rehabilitation services;

---Stimulation of training programs for assistant or aide positions in such fields as physical therapy, occupational therapy, social work and of educational objectives, curriculum development and preparation of teaching materials;

---Support of training programs for volunteers in rehabilitation of the mentally retarded, not only for assistance to professional personnel engaged in services to individuals or groups, but also for lay leadership in community planning and program development;

---Development of training programs to prepare executives and other management personnel in rehabilitation facility administration, including workshops offering sheltered employment, vocational evaluation or occupational adjustment services;

---Extension and development of training in rehabilitative medicine to include orientation to mental retardation at the undergraduate level and at the residency level in physical medicine and rehabilitation.

Based upon 1967 obligations, long-term training grants in mental retardation supported by the Rehabilitation Services Administration will include:

Multi-Disciplinary Programs

California Department of Mental Hygiene, California State College, Columbia University, Devereaux Foundation, University of Colorado Medical Center, New York Academy of Sciences, University of Oregon, University of Wisconsin, University of Washington.

Field Instruction Units

Rehabilitation Counseling

California State College, University of Florida, Michigan State University, New York Medical College, University of Oregon, Southern Illinois University, State University of New York at Buffalo, West Virginia University, University of Wisconsin.

Social Work

Boston College--Simmons College, University of California (Berkeley), University of California (Los Angeles), University of Connecticut, University of Denver, Florida State University, University of Georgia, University of Hawaii, Howard University, Louisiana State University, University of Louisville, University of Michigan, Our Lady of the Lake College, University of Puerto Rico, New York University, University of Pittsburgh, Rutgers State University, State University of New York Research Foundation,

92 - 594 O - 68 - pt 2 - 22

Syracuse University, University of Texas, Tulane University, University of Utah, University of Washington, University of Wisconsin (Madison), University of Wisconsin (Milwaukee).

Speech Pathology and Audiology

University of Georgia, Michigan State University

Physical Therapy

Ithaca College, University of Oklahoma

Medicine

University of Mississippi, University of Rochester

Medical Genetics

University of California

Dentistry

Long Island Jewish Hospital, Montana State Board of Health

Medical Technology

St. Mary's Junior College, University of Wisconsin

Psychology

University of Alabama, Memphis State University, University of Mississippi, University of South Carolina

Nursing

California Board of Nursing Education, University of Tennessee

Program Management

Florida State University

Short term training in mental retardation is being conducted by University of Alabama, Boston College, California State College, Columbia University, Denver Board for the Mentally Retarded and Seriously Handicapped, Inc., University of Indiana, National Recreation and Park Association, University of Minnesota, New York Academy of Science, University of North Carolina, University of Southern California, University of Wisconsin.

The long-term multi-disciplinary training programs at the University of Wisconsin and the University of Oregon are now operating within Social Rehabilitation Service Research and Training Centers. Long-term traineeships at these Centers are supported by Rehabilitation Services Administration funds and 4 such traineeships were awarded by the Research and Training Center at the University of Oregon in Fiscal year 1967. Although the underlying content and intent of the multi-disciplinary courses supported under the Vocational Rehabilitation Act are geared to vocational rehabilitation, the programs will serve many other professional disciplines either in their own professional grouping or in courses serving several professional disciplines.

The grant to the New York Academy of Science is for support of a series of two-day courses to train specialists in different fields in the concept and techniques of the interdisciplinary "workshop" conference. Such conferences are designed to provide an exchange of ideas and discussion in depth by scientists with different backgrounds and training but a common interest in mental retardation.

Individual traineeship grants have also been awarded to 65 post-resident, graduate, and post-graduate nursing students to pursue professional careers in mental retardation in such fields as medicine, dentistry, psychology, social work, nursing recreational therapy, speech therapy, and music therapy.

b. Hospital Inservice Training

The Rehabilitation Services Administration is especially concerned with improving the quality of service within institutions for the mentally retarded. Hospital Inservice Training grants have been designed to provide a continuing means for increasing the effectiveness of employees in State training schools and other State residential institutions for the mentally retarded.

One hundred and five of the eligible State residential facilities in 45 States and 2 territories are receiving a total of $2,182,000 through the Hospital Inservice Training program and are translating the rapidly expanding body of knowledge about practices in the care of the mentally retarded into more effective services.

Hospital inservice training has been broadly defined to include: preservice training, job-related training, inservice training, continuing education, special training and technical training needed to introduce new methods, and training to make better employees.

Because personnel such as attendants, houseparents, psychiatric aides, and others in the personnel category comprise over 84 percent of those rendering direct care to institutionalized retardates, the first major area

of grant support was extended to these personnel. Grant support is available for inservice training of all professional, subprofessional, and technical personnel who have direct responsibilities for resident care and training.

Every State residential facility for the mentally retarded is eligible to participate in this program. The maximum grant to a single institution may not exceed $25,000 in any one year. These grants can be made for a period of up to seven years and are renewable.

There are four general types of training supported by inservice training grants to institutions for the mentally retarded: (a) orientation and initial on-the-job training for employees; (b) refresher, continuation, and other special job-related training courses; (c) continuation training for technical and professional staff to keep them informed of new developments in their fields which can be translated into more effective patient service; and (d) special instructor training for staff with inservice training responsibilities aimed at providing a cadre of personnel to continue and extend the institutional training program.

The personnel categories involved as trainees in these programs have been, in order of descending frequency, aides, attendants, charge aides, supervisors, practical nurses, and registered nurses.

The content of the training programs includes general instruction in the areas of mental retardation; child growth and development; nursing care skills; patient-staff relations; human behavior; intra-staff relations; supervisory skills; communications skills; psycho-pathology; and adjunctive therapy skills.

Consultation is given to the institutions which have received grants to assist them in making the best use of training opportunities. Technical information and professional consultation is being provided to the remaining State institutions for the mentally retarded in order to enable them to qualify for similar grants.

Student Work Experience and Training

A program of Student Work Experience and Training (SWEAT) projects provides students with both employment and training during summer months and other vacation periods, while working directly with mentally retarded children and adults.

The program is open to high school seniors, college, and graduate students and generally offers to these young people experience in all phases of work with the mentally retarded.

Sixty-two projects, in which approximately 700 students are participating, are being supported. It is hoped that, as a result of this experience, many of these students will be attracted to careers in mental retardation.

4. Construction

a. Community Facilities for the Mentally Retarded

The community facilities construction program authorized under Title I, Part C of the "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963" (P.L. 88-164) provides Federal grants to States to assist in the construction of specially designed public or other nonprofit facilities for the diagnosis, treatment, education, training, or custodial care of the mentally retarded, including sheltered workshops which are part of a facility providing comprehensive services. The program is administered at the State level by an officially designated State agency. Participation in the program requires the development of a State plan for the construction of community facilities for the mentally retarded based on an inventory of needed additional services and facilities. Construction projects are approved in accordance with the provisions of the State plan.

All States are participating in the program. As of November 1967, 175 projects have been approved including 20 facilities which were completed and in operation. These facilities will provide care and treatment for approximately 23,000 additional retarded persons not now being served. The estimated total cost of these projects is over $117 million with an estimated Federal share of over $32 million.

The program is having a widespread impact on community efforts to meet the needs of the retarded. Public and voluntary agencies are demonstrating increased interest in participating in the construction program, and community leaders and professional personnel are combing efforts to stimulate sponsorship of needed facilities. Accomplishments to date, however, have only slightly touched on the need for additional services and facilities. State plans indicate that services should be provided for more than one million additional retarded individuals.

The "Mental Retardation Amendments of 1967" (P.L. 90-170) have extended the construction program of community mental retardation facilities through fiscal year 1970. These Amendments also provide initial staffing assistance to aid community facilities in the critical early years of their operation when it is necessary both to initiate the new services and to mobilize essential community, regional and State support. To encourage the initiation of these new service programs, the Amendments provide for a period of 4 years and 3 months of Federal financial assistance on a gradually decreasing scale.

b. Construction of Rehabilitation Facilities and Workshops

The "Vocational Rehabilitation Amendments of 1965" (P.L. 89-333) authorized a program for the construction of rehabilitation facilities and workshops, including State and individual project planning for rehabilitation facilities

and workshops; the construction of rehabilitation facilities and sheltered workshops; and initial staffing support for newly constructed rehabilitation facilities and workshops. Special provisions are made to permit the inclusion of residential facilities within projects for the construction of workshops for the mentally retarded.

State Planning grants for workshops and rehabilitation facilities encompass: (1) the development of a State Workshop and Rehabilitation Facilities Plan, and (2) a continuing program for assessing needs and evaluating activities for establishment, construction, utilization, development, and improvement of workshops and rehabilitation facilities.

Project Development grants pay part of the cost of organized, identifiable activities necessary for the planning and development of specific local construction projects for rehabilitation facilities or workshops. These projects are oriented particularly towards assisting local citizens groups with limited financial resources to engage consultants and secure other types of help to develop a sound project proposal.

During fiscal year 1967, thirteen Project Development Grants, having a national average of $7,300, were made to applicants planning a specific construction project providing services to the mentally retarded.

Construction grants assist in the costs of the new construction of rehabilitation facilities and workshops; the acquisition, expansion and alteration of existing facility and workshop buildings; initial equipment for the completed project.

Twenty-two construction grants totaling $3,000,000 were awarded during fiscal year 1967. Seventeen projects were for the construction of workshops, four were for the construction of comprehensive rehabilitation centers, and one was for the construction of a comprehensive speech and hearing rehabilitation center. Most of these projects are multi-disability in nature and serve the mentally retarded as well as other disability groups. A workshop serving only the retarded was constructed, however, at the Travis State School in Texas under this program.

c. University-Affiliated Facilities for the Mentally Retarded

The University-Affiliated Facilities for the Mentally Retarded program assists universities or affiliated facilities for the mentally retarded in the construction of special clinical facilities capable of demonstrating exemplary care, treatment, education and habilitation of the mentally retarded. In University-Affiliated clinical facilities comprehensive services are provided; specialized personnel are trained; or new techniques of specialized service are demonstrated.

The primary purpose of this program is to provide facilities for the clinical training of physicians and other professional and technical personnel in the field of mental retardation. Among the professional disciplines represented in these facilities are medical personnel, dentists, nurses, speech and hearing therapists, nutritionists, physical therapists, occupational therapists, rehabilitation specialists, special educators, psychologists,

social workers, recreational specialists and chaplains. Each facility is encouraged to conduct a comprehensive multidisciplinary training program so that each discipline involved in the care and rehabilitation of the mentally retarded may be fully familiar with the contributions of the other disciplines.

The Mental Retardation Amendments of 1967 (P.L. 90-170) extended the university-affiliated construction program until June 1970. The present law was also amended to provide grants for the construction of university-affiliated facilities which include programs for persons with other neurological handicapping conditions related to mental retardation.

Because of the complexity of the university-affiliated program, individual planning grants are available. Such individual grants may not exceed $25,000 nor more than 75 percent of the planning costs.

Examples of approved projects for the construction of university-affiliated for the mentally retarded are: Children's Rehabilitation Institute, Reisterstown, Maryland; University of Colorado, Denver Colorado; Walter E. Fernald State School, Waltham, Massachusetts; Children's Hospital Medical Center, Boston, Massachusetts; Georgetown University, Washington, D. C.; University of California Neuropsychiatric Institute, Los Angeles, California; University of Alabama Medical Center, Birmingham and Tuscaloosa, Alabama; Indiana University Medical Center, Indianapolis and Bloomington, Indiana; University of N. C., Chapel Hill, North Carolina; University of Tennessee, Memphis, Tennessee; New York Medical College, New York, New York; Georgia Department of Public Health, Atlanta and Athens, Georgia; University of Oregon, Portland and Eugene, Oregon; and University of Miami, Miami, Florida.

5. Planning

a. Mental Retardation Planning and Coordination

State planning for comprehensive coordinated services to the mentally retarded was begun in 1964 under P.L. 88-156 and is now supported under P.L. 89-97 in the form of continued planning, the development of mechanisms for the coordination of programs of State agencies dealing with the mentally retarded, and the mobilization of community support.

Under the current planning and impremementation program, $2.75 million was authorized for each of 2 years. By the end of the year, approximately $4.25 million of the $5.5 million appropriated had been awarded to 53 of the 54 eligible States. Although the implementation programs vary greatly from State to State, progress is evident in all areas. For example, stress has been placed on community planning in Colorado, North Carolina, Florida and Nebraska. The division of a State into regions for better assessment

and projection of programming is being emphasized in Illinois, Indiana, Connecticut, and Wisconsin. Special projects with primary attention to implementation objectives have been undertaken in Texas, New York, Michigan and Montana.

b. Vocational Rehabilitation Planning

The Vocational Rehabilitation Amendments of 1965 authorized a program of grants to States to plan for the orderly development of comprehensive vocational rebilitation services, including services provided by private, non-profit agencies. These plans, which will involve careful consideration of the rehabilitation needs of the mentally retarded, have the objectives of making vocational rehabilitation services available by 1975 to all handicapped individuals who need them. Fifty-two comprehensive Statewide planning projects are now being undertaken by State vocational rehabilitation agencies and other designated agencies throughout the country.

State Planning Grants for Workshops and Rehabilitation Facilities provide for the coordination orderly development of the total State-Federal facilities effort. Initial State Workshop and Rehabilitation Facility Plans have been completed in the 49 States receiving grants. These States received continuation grants for a second year during which the plans are being updated and refined. Upon completion of the continuation grants in June of 1968, this program will become a part of the State vocational rehabilitation agency operation, thus assuring a permanent program in each State agency for assessing needs and evaluating activities for establishment, construction, utilization, development, and improvement of workshops and rehabilitation facilities.

6. Films and Publications

The Rehabilitation Services Administration continues to distribute a documentary film, "Handle with Care," stressing the value of a fixed community point of referral upon which the families of the mentally retarded can depend for continuing lifetime guidance and assistance in obtaining appropriate services. The film has been placed in State health departments and medical school film libraries for wider distribution.

A second film, "Teaching the Mentally Retarded--A Postive Approach," a documentary dealing with behavior shaping, was placed in circulation during 1967. It is aimed at child-care workers and attendants as well as students who are preparing to work with the mentally retarded.

Numerous publications have been prepared and placed in circulation. One in particular, "A Modern Plan for Modern Services," states the basic philosophy of the Division of Mental Retardation in 6 major points. Briefly stated, these points emphasize: (1) utilization of generic community agencies in lieu of establishing specialized services, (2) provision of basic training in mental retardation for every category of service personnel, (3) definition for utilization of specialized services and agencies, (4) placement of a

mental retardation specialist in every generic agency, (5) development of standards for service and training and (6) coordination within the community.

Under consideration and in various stages of production are several other publications and another film.

FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration is concerned with the prevention of mental retardation which might result from drugs or hazardous substances. This concern extends to consumers in all age groups, but especially the reproductive age and the vulnerable periods of embryonic, fetal and infant life. Immature mechanisms of detoxification make the premature or newborn age group especially vulnerable to serious toxicity including brain damage from drug dosage levels which may have proven safe in older infants. The statutory mission of the Food and Drug Administration includes developing and enforcing valid criteria for drug testing, identification and proper labeling of products hazardous to the public in use or misuse, and keeping from the market foods, food additives, pesticides, drugs, devices or cosmetics considered either unsafe or misbranded.

In particular, the Office of New Drugs, in the Bureau of Medicine, monitors the investigational use of new drugs in early testing phases. Thorough animal experimentation is required before a new drug may be tested on humans, and frequent reporting of the actions of the new drugs is part of the overall surveillance program of the Bureau.

The Food and Drug Administration is concerned as well with the treatment of mental retardation insofar as special diets and drugs are known to be efficacious for this purpose, but also takes regulatory action against drugs or devices which are represented to be useful in the prevention or treatment of retardation but are not in fact effective for such purposes.

Surveillance activities of the Food and Drug Administration encompass any untoward effect of chemicals used in foods, drugs, cosmetics and household chemicals. In the acquisition of these data, close liaison has been established with many hospitals in the nation, with the American Medical Association, the World Health Organization, the pharmaceutical industry, and other health, education and welfare agencies. The evaluation, cataloging and retrieval of this information, for ready consudmer protection, is being undertaken by advanced data processing methods.

SOCIAL SECURITY ADMINISTATION

Purpose

The social security program today is the basic method in the United States of assuring income to individuals and families who suffer a loss of earnings when workers retire, become disabled, or die and, since July 1, 1966, health insurance protection to persons 65 and over.

Historical Development

In 1935, when the original social security law was passed, the program was to have provided only retirement benefits to aged workers. In 1939, benefits for dependents and survivors were added and benefits became payable in 1940. Protection against long-term total disability-not only for disabled workers, but also for adult sons or daughters (who became disabled before age 18) of disabled, retired, or deceased workers-was provided by the 1956 Amendments. In 1965, health insurance benefits for the aged were added. Since 1949, there have been six general benefit increases in recognition of the fact that prices and wages have gone up.

Economic Impact

Significant numbers of the mentally retarded are among social security beneficiaries, particularly among dependents who have been continuously disabled since childhood. The problem of mental deficiency is a major factor in more than 65 percent of the beneficiary group having disabilities which began in childhood. It is the primary diagnosis in about half of all childhood disability cases. In fiscal year 1967 an estimated 143,650 adult mentally retarded beneficiaries received $93,600,000 in social security benefits. The number of mentally retarded children under age 18 who receive payments as dependents of retired, disabled, or deceased workers is unknown, since their benefits are payable without regard to disability.

Under social security's "Childhood Disability" provisions,, lifetime monthly payments can be made to a person age 18 or over who has been disabled by mental retardation--or other impariments--since childhood. The social security law has special importance for the parents of a mentally retarded child because, in many cases, the monthly benefits enable the retarded childhood disability beneficiary to be cared for at home instead of in an institution. Furthermore, as more and more retarded people outlive their parents on whom they have always been dependent (about half of the childhood disability beneficiaries are over 35 and 25 percent of them are over 45), the program presents a source ot comfort for fathers and mothers who know that financial help will be forthcoming, even after their death.

If the parents are dead, a relative who has demonstrated a continuing interest in the beneficiary's welfare, a welfare agency, or a legal guardian may be chosen as representative payee to handle the benefit funds and plan for using them in behalf of the beneficiary. A representative payee receives social security benefits in trust for the beneficiary and, as a trustee, is held held accountable for the way in which he uses the benefits. The Social Security Administration recently annotated records to identify beneficiaries disabled since childhood who are under representative payment to institutions for the mentally retarded. This will give future access to an enumeration, by State, of this beneficiary group.

Health insurance benefits under the social security law are available to any individual, including a mentally retard individual who is 65 or over and who meets certain necessary conditions. Therefore, a mentally retarded individual 65 years of age who has contracted an illness or suffered an inquiry is, like any other person in this age group, protected under the health insurance program. However, the health insurance for the aged program specifically prohibits reimbursement under the law for expenses incurred for custodial care, i.e., personal care designed primarily to aid an individual in meeting the activities of daily living and which does not require the continuing attention of trained medical or paramedical personnel. Therefore, an aged mentally retarded person whose only deficiency is mental retardation requiring general institutional care, e.g., vocational training, help in the activities of daily living, and so forth would not be receiving the type of care covered under the medicare program.

Activities and Achievements

All district offices of the Social Security Administration maintain a referral service to other programs and services of both public and private agencies and organizations. Giving information about these programs and agencies is an essential part of the Social Security Administration's service to the public. Disabled persons applying for disability benefits under social security are promptly referred to the Rehabilitation Services Administration to the end that the maximum number may be rehabilitated into productive activity or to a level of self-care. Information and referral service is also provided to non-beneficiaries or applicants who inquire about services at social security district office.

SSA has participated in the program for employment of the mentally retarded since its inception and has experienced first-hand the excellent work the mentally retarded can perform in positions geared to their handicap. A total of 62 are on duty at the present time as follows: 24 in Centeral Headquarters offices, 18 in payment centers, and 20 in district offices. Added to the general clerical duties of retardates in central office has been the clerical function in connection with the card reading machines in the control of claims folders. All are performing in a highly satisfactory manner and 7 have done well enough to be promoted to GS-2.

In the area of public information, the Social Security Administration developed a pamphlet entitled, "Social Security: What it Means for the Parents of a Mentally Retarded Child." This pamphlet describes the conditions under which a mentally retarded child may be eligible for social security benefits. It explains to the parents or guardian how these benefits should be applied for. Some 225,000 copies have been distributed and the pamphlet is now undergoing revision to reflect the 1967 amendment changes.

A new exhibit, "Childhood Disability and Social Security," had its premier showing at the convention of the American Orthopsychiatric Association, in Washington, D.C., in March 1967. Other meetings at which it has already been shown or is scheduled to be shown include the American Association of Mental Deficiency, the American Osteopathic Association, and the Southeastern Association on Mental Deficiency.

Plans are being made for the development of a film (originally scheduled for 1967) about the value of social security benefits to the mentally retarded child and his family. The film will be one of a series being produced in color for television featuring social security beneficiaries whose "stories" have dramatic human interest appeal. The film would portray "A Day in the Life of a Mentally Retarded Child and His Family."

The Social Security Administration conducted a nationwide survey in the fall of 1967 which will supply basic information about institutionalized adults, including the mentally retarded in institutional care. The 1967 survey of institutionalized adults examined the socio-economic characteristics of mentally retarded persons (as well as other disable persons) over age 18 in institutions such as homes and schools for the mentally or physically handicapped, mental hospitals, chronic diseases and other long-term hospitals. This survey focused on the types of care they receive, the cost of care, and sources of payment, the economic resources of the patient and his family, and his family relationships.

The 1966 survey of disabled adults (non-institutionalized) will also provide a wide range of data on financial, medical and family arrangements of disabled adults who are mentally retarded.

SURPLUS PROPERTY PROGRAM

The Division of Surplus Property Utilization, within the Office of the Assistant Secretary for Administration, carries out the responsibilities of the Department under the Federal Property and Administrative Services Act of 1949, which makes available for health and educational pruposes surplus Federal real and personal properties. The properties which become available under this program are those that have been determined by the General Services Administration as no longer having any further Federal utilization.

Surplus personal properties are screened to determine those types which may be needed and usable by eligible institutions throughout the country in conducting health and educational programs. Properties determined to have utilization for these purposes are allocated by the Department of Health, Education, and Welfare for transfer to State agencies for Surplus Property which have been established in all States. It is the function of these State agencies to secure the properties, warehouse them, and make them available to eligible donees for health and educational uses. The only cost to the eligible donees are the handling and service charges which are assessed by the State agencies.

In the case of real properties which have been determined to be surplus to Federal needs, notices of their availability are sent to potential eligible applicants either by the State agencies or the Regional Representative for Surplus Property located in each of our nine Regional Offices. Real properties available for removal from their site for relocation are conveyed by agreement of sale with restrictions as to the use of the facilities which run for a period of 5 years. These properties are conveyed with a 95 percent public benefit allowance discount from their fair market value. Land or land and buildings together with other improvements are conveyed by deed which contain restrictions as to use for a period of 30 years. These properties are conveyed with public benefit discount allowances ranging from 50 to 100 percent of fair market value. The only other costs to eligible transferees are "out of pocket" Federal cost, i.e., appraisals, surveys, etc.

Schools for the mentally retarded are eligible to acquire surplus real and personal property. In the case of personal property, such a school must be operated primarily to provide specialized instruction to students of limited mental capacity. It must be tax-supported or non-profit and exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954. It must operate on a full-time basis with a staff of qualified instructors for the equivalent of a minimum school year prescribed for public school instruction of the mentally retarded. It must also demonstrate that the facility meets the health and safety standards of the local governmental body. In the case of real property, the applicant must be a State or political subdivision thereof, or instrumentality, a tax-supported educational or public health institution, or a non-profit educational or public health institution that has been held to be exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of

1954. Its proposed program of use must be for a fundamentally educational or public health purpose; i.e., devoted to academic, vocational or professional instruction, or organized and operated to promote and protect the public health.

Types of personal property available would range anywhere from a nail to an electronic computer. Many items of surplus personal property have never been used before. Real properties would consist of all types of buildings which are removable, land with or without structures, and other improvements such as utility lines, sewer and water systems, etc.

Pamphlets giving more detailed information as to eligibility of organizations for both surplus real and personal properties, as well as additional information in connection with the surplus property utilization program, along with a directory of the State agencies for Surplus Property and the nine regional offices of the Department, may be obtained from the Division of Surplus Property Utilization, U.S. Department of Health, Education, and Welfare, Washington, D.C., 20201.

The following are examples of real properties conveyed under the program for use in aiding the mentally retarded. Frequently, these facilities are put to a joint use, namely, for the training of the mentally retarded as well as the physically handicapped. Other conveyances have been made for hospital use where, as a part of the total program, portions of the facility are used for the treatment and training of the mentally retarded.

The State of Missouri passed legislation authorizing the State Department of Education to establish and operate State schools for mentally retarded in any county or in a district comprised of two or more counties. One of the first of these schools has been established on the 4.95 acres of land and 9 buildings we conveyed for this purpose at the surplus O'Reilly General Hospital, Springfield, Missouri. The facility is a day school for a maximum enrollment of 90 children.

The State of Florida has undertaken the establishment of a System of Sunland Training Centers throughout the State for the training of its mentally retarded children. Present plans call for 10 of these Centers having capacity of approximately 1,000 resident students each. One of these Centers, serving the northwest section of the State, has been established at Marianna, Florida, on 372.67 acres of land and 65 buildings, formerly the Graham Air Force Station, through our surplus property utilization program. Most of the personal property for the operation of this facility was conveyed with the real estate.

Other States also have programs for the mentally retarded, using Federal surplus real property. The Department conveyed 34.39 acres of land and 47 buildings, formerly the Lufkin Air Force Base, Lufkin, Texas, to the Texas State Hospital and Special Schools for a resident unit to accommodate between 1,000 and 1,500 retarded children. Louisiana received 537 acres with modest improvements at the Belle Chasse Navy Ammunition Depot, New Orleans, as a

site for a State unit serving this area for day treatment and resident training and care of mentally retarded. The State of Kansas has renovated the Winters Veterans Administration Hospital, also an intact transfer comprising 225 acres and 195 buildings, for the treatment and care of some 300-400 mentally retarded children.

The Warren City School District, Warren, Ohio, has initiated a novel program for learning incentive for slow learning pupils of intelligence quotients between 50 and 79. Through our program, the School District obtained 76.4 acres of land and 10 buildings from the Youngstown Family Housing Annex, Trumbull County, Ohio. There are farm ponds, vocational shops, and programs for conservation and horticulture. An experiment in providing summer garden plots for these pupils was significantly successful.

The State of Georgia obtained the former Veterans Administration Domiciliary in Thomasville, consisting of 207 acres of land and 131 buildings, with a bed capacity of 400 to 800, for the care and rehabilitation of the mentally ill and retarded. Another site of nearly 200 acres at the former U.S. Penitentiary Honor Farm near Atlanta has been conveyed for a Regional Mental Hospital for the rehabilitation and training of the mentally ill and retarded. The State of Ohio received the former Veterans Administration Hospital at Broadview Heights, near Columbus, which will initially accommodate 250 mentally retarded, with a future capacity of 600. This will greatly alleviate the critical situation in this area where, in this one county alone, there is a waiting list of 2,200 mentally retarded requiring treatment.

Smaller areas, such as former Post Office buildings and sites, Nike Sites, have been converted into schools and training centers. The former Post Office at Carlisle, Pennsylvania, is now a school, operated by the Cumberland County Association for Retarded Children; Lake County, Ohio, has converted the former Post Office at Willoughby into a school for the retarded; and portions of Nike Sites at Needham, Massachusetts, and King County, Washington, are now used in the care and training of the mentally retarded.

These are but a few examples of where Federal property, both large and small, which are no longer required for Government use, are serving the country in the care of its mentally retarded.

Through June 30, 1967, 4,821 acres and 718 buildings have been transferred to institutions for use in programs serving the mentally retarded. These properties originally cost the Government $35,592,829, and had a fair market value of $13,339,701 at time of transfer.

TABLE I.—DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OBLIGATIONS FOR MENTAL RETARDATION PROGRAMS BY AGENCY DESIGNATION, FISCAL YEARS 1956–1969

[In thousands of dollars]

Agency and appropriation	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968 (estimated)	1969 (estimated)
OFFICE OF EDUCATION														
Elementary and secondary education activities											20,963	[1] 27,512	[1] 37,996	[1] 54,000
Educational improvement for the handicapped					985	993	997	996	6,753	7,235	8,977	10,024	9,958	11,248
Research and training		648	1,171	981	743	459	397	508	422	408	255	165	100	90
Total, Office of Education		648	1,171	981	1,728	1,452	1,394	1,504	7,175	7,643	30,195	37,701	48,054	65,338
SOCIAL AND REHABILITATION SERVICE														
Vocational rehabilitation:														
Grants to States	375	575	850	1,225	1,798	2,266	2,800	3,900	5,500	7,500	13,764	22,855	32,400	43,700
Research and demonstration projects	99	138	459	545	944	1,071	1,174	1,287	2,287	3,090	3,133	2,556	2,544	2,507
Training and traineeships									878	1,213	1,501	1,700	1,760	1,760
Special rehabilitation research and training centers										385	500	645	950	1,250
Innovation grants											225	56	65	71
Expansion grants											86	419	450	500
Research and training (special foreign currency program)									175	93	80	563	400	400
Workshop improvement grants											283	1,302	2,060	2,167
Rehabilitation facilities and workshop construction grant program											325	1,000	632	640
Mental retardation									2,011	9,712	37,862	49,486	32,363	42,056
Maternal and child welfare:														
Grants to States	88	584	889	1,300	1,300	1,434	1,610	2,519	12,858	23,029	44,000	52,409	58,805	68,055
Salaries and expenses	3	45	77	77	98	92	80	99	330	737	851	982	1,025	1,025
Public assistance:														
Grants to States [2]	12,000	14,000	16,000	19,000	21,000	24,000	28,000	33,000	38,000	44,000	51,000	79,500	[3] 103,000	118,200
Salaries and expenses	7	9	8	9	10	15	20	20	25	44	55	60	65	70
Total, Social and Rehabilitation Service	12,572	15,351	18,283	22,156	25,150	28,878	33,684	40,825	62,064	89,803	153,665	213,533	236,519	282,401
SOCIAL SECURITY ADMINISTRATION														
Estimated benefits payments from the trust funds		1,200	8,800	19,300	29,300	39,300	51,600	62,800	63,700	70,900	84,500	93,600	107,250	131,300
Trust fund obligations incurred to adjudicate claims of beneficiaries		700	1,200	1,600	1,900	1,400	1,700	1,600	1,600	1,900	1,800	1,600	2,400	2,700
Total, Social Security Administration		1,900	10,000	20,900	31,200	40,700	53,300	64,400	65,300	72,800	86,300	95,200	109,650	134,000

See footnotes at end of table, p. 334.

TABLE I.—DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—Continued

OBLIGATIONS FOR MENTAL RETARDATION PROGRAMS BY AGENCY DESIGNATION, FISCAL YEARS 1956–1969

[In thousands of dollars]

Agency and appropriation	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968 (estimated)	1969 (estimated)
PUBLIC HEALTH SERVICE														
National Institute of Neurological Diseases and Blindness	919	2,507	3,841	5,938	8,947	11,455	12,822	14,887	20,376	22,636	22,028	19,473	22,153	22,869
National Institute of Child Health and Human Development									5,991	7,279	8,500	6,105	6,568	9,558
Hospital construction activities					1,841	3,650	4,704	3,552	[1]					
Chronic diseases and dental services					2	12	260	630	[1]					
Grants for construction of health research facilities										14,745	6,234	6,026		
Mental health research and services	923	1,630	1,947	2,356	2,808	3,947	5,275	5,743	5,433	9,066	11,636	8,279	1,556	[6] 1,627
National health statistics									10	11	19	21	21	6
Planning and services													4,071	3,475
Total, Public Health Service	1,842	4,137	5,788	8,294	13,598	19,064	23,061	24,812	31,810	53,737	48,417	39,904	34,369	37,535
OFFICE OF THE SECRETARY														
Office of General Counsel (legal services)									22	42	42	44	46	37
Intradepartment coordination [7]								(150)	(39)	(198)	(238)	(105)	(105)	(110)
President's Committee on Mental Retardation												[8] (316)	577	580
Total, Office of the Secretary									22	42	42	44	623	617
Total, services and grants	2,407	6,127	9,234	12,422	19,466	25,379	30,119	34,121	63,046	107,181	181,264	211,622	216,500	267,621
Total, income maintenance	12,007	15,909	26,008	39,909	52,210	64,715	81,320	97,420	103,325	116,844	137,355	174,260	212,715	252,270
Grand total, all funds	14,414	22,036	35,242	52,331	71,676	90,094	111,439	131,541	166,371	224,025	318,619	386,382	429,215	519,891

[1] Includes 50 percent of funds appropriated for title VI, Elementary and Secondary Education Act; specific estimates of obligations for mental retardation activities are unobtainable.

[2] 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.

[3] Includes funds from proposed supplemental for public assistance grants for 1968.

[4] All construction funds beginning in 1964 are shown under mental retardation which includes construction under title I, pts. B and C, Public Law 88-164.

[5] Beginning in 1964, not shown as line item.

[6] Includes $52,000 for a National Institute of Mental Health clearing house for information projects grant for the publication "Mental Retardation Abstracts."

[7] Shown as nonadd items since they were derived from funds available to other agencies for mental retardation activities.

[8] Beginning in 1968 this item is included in direct funding as a line item.

ACTIVITIES IN AGING
OF
THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

1967

(Report compiled by the Administration on Aging)

Activities for older Americans during 1967 were outlined early in the year by President Johnson in one of his first messages to the 90th Congress. As the Secretary of HEW said at the time, "This message outlines the most sweeping program for older Americans ever recommended by a United States President." The message called for 37 actions--both administrative and legislative--to deal effectively with the present and future needs of older people. The areas covered included improvements in social security and old-age assistance, needed changes in medicare, other improvements in nursing and health care, employment opportunities, improved housing and community services, and opportunities for participation by older people.

During 1967, the Congress passed several pieces of legislation incorporating many of the President's recommendations. New legislation affecting the Department of Health, Education, and Welfare's programs for older people included:

-- The passage of the Older Americans Act Amendments of 1967, which reaffirmed the objectives of the Older Americans Act of 1965, extended the life of its programs and increased funding levels;

-- The Social Security Amendment of 1967 which will bring increased benefits to about 23.7 million older people by March, 1968;

-- The Partnership for Health Amendments of 1967 which continues, at increased funding levels, the Federal-State cooperation in health planning to bring comprehensive services to all age groups.

The new authority to assist older people given to the Department of Health, Education and Welfare by this legislation, together with the efforts of the Department to strengthen ongoing activities, provided older people with many new opportunities in 1967.

SOCIAL AND REHABILITATION SERVICE

During 1967, a major reorganization within the Department of Health, Education, and Welfare paved the way for a strengthening and coordination of programs of particular importance to older people. As a result of this reorganization, the Social and Rehabilitation Service was established to coordinate the functions of the Administration on Aging, the Welfare Administration, the Vocational Rehabilitation Administration, and the Mental Retardation Division of the Bureau of Health Services, Public Health Service.

The Service represents a major new approach to bringing needed services to our citizens in a coordinated manner by joining under a single roof both the income support programs for needy Americans and the social service and rehabilitation programs that many families and individuals need. Each separate program, while maintaining its own administrative integrity, can utilize the services and expertise of every other part of the Service. Joint planning and joint action should result in stronger overall programs.

In addition to new program strength, the States, communities and voluntary, private groups will now find it easier to deal with the Federal Government in solving the problems of the old, the young, and the disabled. In the face of the growing size of the Federal Government, the greatest concern today is to cut down the barriers between agencies, public and private, and thus reach the people who need services faster and more effectively. The Social and Rehabilitation Service will help to do this. In addition, this consolidation will make things easier on the average citizen seeking information on programs in his community. Rather than having to go to four different agencies to get the information he needs, he will be able to turn to one central source.

The Social and Rehabilitation Service provides a wide range of services aimed at rehabilitation in the broadest sense of that word--giving people opportunities to become self-supporting and self-sufficient, where possible; releasing and fostering their energies and talents; enhancing their capacity to cope with the world and to be responsible and participating citizens; and enabling them to live their lives with some measure of dignity. Rehabilitation services such as these are most important to older Americans, whose rehabilitation often pays the maximum return on public funds invested in enabling them to resume independent living and achieves social and personal gains that are beyond measurement in dollars and cents.

With the lines of interagency coordination strengthened at the community level, a unified and comprehensive approach to the needs of all older people will be facilitated. State commissions on aging can draw on a pool of specialists in various areas in the regional offices who have a direct responsibility to help them in any way possible. A much broader range of services is thus available from one central source.

The Administration on Aging

The unanimous passage of the Older Americans Act Amendments of 1967 was a highlight of the year for the Administration on Aging. These extended the Older Americans Act of 1965 and increased its funding levels. They thus increased AoA's planning ability and the resources available to older people under its grant programs.

Under AoA's direction, 46 jurisdictions had approved plans to carry out statewide programs of community services for older people by the end of 1967. State commissions on aging are providing the central focus and leadership for all aging programs in the State and are mobilizing and coordinating State resources to meet the needs of the older population. Research and demonstration projects are paving the way to more effective provision of services and to the establishment of new roles and meaningful activities for older persons. Training programs are providing leadership with knowledge of the problems and rewards of aging and with fresh program ideas.

The Administration on Aging, in 1967, worked toward improving the material needs of older persons--for adequate income, good housing, improved health--through the grant programs of the Older Americans Act, and through its activities with other Federal agencies with responsibilities in these areas. But it focused, too, on the non-material needs of the older population: the need for a place and role in society; and the need to continue to offer abilities to the country and to participate in everything the country has to offer. As President Johnson said in his message on older Americans on January 23, 1967:

> "Our goal is not merely to prolong our citizens' lives, but to enrich them."

New responsibilities were given AoA as a result of the organization of the Social and Rehabilitation Service in August, 1967. This report reflects both AoA's activities and services under the Older Americans Act and its responsibilities for services to public assistance recipients. In discharging its new responsibilities, AoA will give particular emphasis in the coming year to cooperative relationships between the State agencies administering the public assistance programs, and the State agencies administering title III of the Older Americans Act in order to strengthen the services available to all older people.

Grant Programs Under the Older Americans Act

1. Title III - Grants to States for Community Planning, Services, and Training

Title III of the Older Americans Act provides for allotments to the States for (1) community planning and coordination of programs in aging; (2) demonstration of new programs or activities beneficial to older people; (3) training of special personnel to carry out such programs and (4) establishment of new or expansion of existing programs including senior centers. The grants are intended to strengthen State and community services to the aging and to stimulate new interest and commitment on the part of the States and communities to their older residents.

In order to participate in the title III programs, the governor of each State must designate a single State agency to coordinate programs for the aging throughout the State and a State plan for the aged must be approved. The State, in turn, makes grants to local public and nonprofit, private agencies.

Four more State plans were approved during 1967 for a total of 47 States with approved plans. Forty-six States now have operational programs. During 1967, over 400 new projects were funded. In total over 640 projects have been funded since the program began.

Over 500,000 older persons have been or are being served directly by title III programs. The impact of these programs is being felt at the local community level where the older person finds new services and activities and at the State level where there is increasing concern for the State's older population.

2. Title IV - Research and Demonstration Grants

The title IV grant program of the Older Americans Act authorizes grants for research on patterns and conditions of living of older people, for demonstration and development of new approaches and programs in meeting the needs of older people, and for achieving or improving coordination of community services.

In 1967, 22 new grants and contracts were awarded under title IV bringing the total to 58 grants and contracts. During 1968, approximately 48 additional new grant awards will be made.

The objectives of the programs are to analyze, develop and demonstrate:

-- various ways of administering and delivering a full range of services in an effective and efficient manner wherever older people live;

-- new roles and menaingful activities for older persons;

-- improved patterns of retirement and preparation for it;

-- opportunities for employment and sources of supplemental income for older persons;

-- housing and living arrangements conducive to the well-being of older persons;

-- means of preventing personal disability among older persons and, when needed, providing rehabilitative procedures.

3. Title V - Grants for Training

Title V of the Older Americans Act authorizes grants for training professional, technical and lay personnel to plan for and serve older people in programs related to the broad purposes of the Act.

During 1967 and 1968, 29 new grants were awarded, for a total of 42 grants since operations began. Almost 3,000 persons had received short- and long-term training by the end of the year.

The Administration on Aging training program is focusing on areas within which there is desperate need for personnel and for which existing support is inadequate or lacking. Training in several professions is being offered for the first time. Priorities in training are as follows:

-- Broad planning and administration in aging for work at Federal, State and local levels;

-- Planning, administrative, and management training in the field of retirement housing, villages, and homes for the aged;

-- Planning, administration, and program supervision for personnel of multiservice centers for older people;

-- Training for specialists in aging within such professions as recreation, religion, adult education, architecture, and retirement preparation;

-- Preparation of faculty personnel and preparation of specialist in aging within established professions;

-- Leadership training for members of State and community committees on aging and for older adults who wish to become active in their communities;

-- Training for semi-professional and technical personnel to serve under professional direction as library and recreation aides; aides in housing projects, senior centers, homes for the aged, and institutions; in homemaking and meal services, and in other ways.

Services Under the Older Americans Act

1. Senior Centers

The largest number (227) of title III grants since the start of the program has been awarded to senior centers. The center is available to older people who wish to participate in a varied program under leadership of trained personnel. For the individual older person, it offers meaningful relationships, a chance to learn new skills, a chance for community service and a community role.

The specific services most often found in a senior center are: information and referral, personal counseling, recreational facilities, educational opportunities, volunteer programs, and health and employment services. The Administration on Aging has been encouraging the development of multipurpose senior centers which provide a central location for this range of services and activities.

The largest proportion of title IV grants was also for demonstration in senior centers--of how to create a variety of centrally located services and encourage full participation, especially by those outside of community life. In Chicago, for example, a "senior center on wheels" takes activities and services into the homes and neighborhood of formerly isolated older persons; a mobile van also transports these persons from their homes to health, social, and recreational services.

2. Comprehensive Community Planning

About 145 title III grants went for planning and development of services for older persons at the community level. Many communities are unaware of the actual needs of older persons, particularly those individuals who have become isolated. Most planning and development grants have made it possible for communities to structure a planning body which is sensitive to the urgency of determining where the older persons are, what the most pressing needs are and what resources can be mobilized to meet these needs. Older persons themselves are involved in the planning and implementation of programs which enable the elderly to maintain independent living. Some examples of planning programs undertaken include:

-- A project in Utah in which university personnel are developing standardized data gathering procedures is permitting a number of communities in the State to survey the needs of older persons through personal interviews in which standard forms are used. The responses are fed into a computer system. As a result, the State will have accurate and consistent data to strengthen planning at both the State and community levels.

-- In Texas, the Agricultural Extension Service has expanded its program of establishing local committees on aging, and providing leadership in the development of local programs of services and activities for older persons. Seventy-five percent of the counties of the State now have local committees organized or are beginning organizational procedures. Ninety percent of all persons over 56 in the State live in these 189 counties. Over 200 county extension agents have been actively involved with local committees in the planning and initiating of activities and services to meet local needs. The extension agents have played an advisory role successfully encouraging initiative and leadership from the committee members.

The State agencies on aging continue to strengthen their administrative roles and to carry out effectively their responsibility for comprehensiveness and coordination of services. In Michigan, for example, cooperation between the Commission on Aging and the State Department of Public Health led to a multiphasic, health-screening program for rural communities and senior centers. Cooperation with the State Department of Education resulted in new educational opportunities for older people.

The development and demonstration of comprehensive, coordinated services was also a priority in the title IV grant program during 1967 and accounted for 21 percent of title IV grants. Studies are determining such things as: preferences and sources of help used by older people; services available, inter-relationships among agencies providing services; effectiveness of different patterns of services. These are all for the purpose of combining fragmented resources into a model of coordinated health, welfare and community services which meet the many needs of older people and are accessible to them.

-- A title IV project in St. Paul, Minnesota, for example, is demonstrating how cooperation between the State agency on aging and an educational television station can lead to a statewide program of services and activities. Weekly programs for, about, and by older persons are coordinated with a field staff of six older persons who work with 42 planning committees and over 500 golden age clubs throughout the State.

3. Volunteer and Social Employment

The Administration on Aging supports programs offering paid employment opportunities or which refer older people to employment opportunities. This approach is combined with the development of volunteer service opportunities for those who do not need additional income, but who wish to continue to offer their services and abilities to the community.

About 115 title III projects have an employment "component": employment training or counseling, placement services, or direct employment of older persons in the project. One such project features a complete employment agency for older persons, receiving an average of 83 applicants a month with placements running from 39 to 56 a month--from hourly workers to business executives.

About 330 title III projects--including center projects--have reported some volunteer activity for older persons, including recruitment and training of older persons to provide services to other older persons and to the community--to hospitals, schools, private organizations in a variety of roles. Over 14,500 elderly volunteer are serving in title III projects.

Demonstration of new voluntary and social roles for older people comprised 11 percent of title IV projects. Included are creation and demonstration of the role of library aide,

and other community service roles. Other social service functions which might be performed by older people are: home health aide, recreation leader, employment counselor, social work aide and others.

The Foster Grandparent Program (p. 16) is an example of a highly successful volunteer program of mutual benefit to the "grandparents" and the children. It has proven the older person to be a valuable resource in providing badly needed services.

4. Recreation and Retirement Preparation

The person retiring at age 65 has about 45,000 hours not needed for sleeping, grooming or eating. Yet the concept of "retirement" is new in American history and the elements of "successful retirement" are not yet known. Choices, however, are essential and the AoA programs are committed to providing a range of alternatives for a rewarding retirement, and to stimulating education for retirement.

Over 300 title III projects, including center projects, contain a recreation or life-enrichment component ranging from social gatherings to adult education courses. One project, for example, offers a pre-retirement training course prepared by a 74-year-old-retired community leader and designed to train 30 other leaders in the methodology of conducting programs for preretirees.

About 10 percent of title IV projects were in retirement planning and preparation, including research in retirement adjustment patterns, role changes and evaluation of different methods of pre-retirement counseling.

Another 5 percent of title IV projects were for development and demonstration of rewarding use of recreation and leisure.

5. Consumer Education

The Administration on Aging has been active in the field of consumer education during the past year through its title III and IV grant programs and through direct relations with the President's Committee on Consumer Information.

In October 1967, the Administration on Aging participated in a conference on Consumer Problems of Older People, held by the Hudson Guild-Fulton Center. The conference was part

of a continuing consumer education program conducted by the Center under an Older Americans Act title III grant. The objectives of the program were to draw together various disciplines concerned with consumer problems of the elderly; to involve business and local agencies; to interest older people themselves; and to make recommendations to government agencies on encouraging comprehensive consumer programs. Speakers, panels and workshops discussed various aspects of the consumer problem and focused attention on consumer action for the coming year.

During September and October of 1967, Project Moneywise-Senior, a pilot program in consumer education, was conducted in Boston, Massachusetts, by the Bureau of Federal Credit Unions, Social Security Administration. The program was sponsored by the Massachusetts Commission on Aging and the Consumers Council of the Bay State.

The agenda of the four-week consumer education program included: an overview of the effects of poverty on the elderly, marketing and shopping weaknesses of the older poor, recognition of fraudulent practices, financial counseling and budgeting, use of credit, and discussions of available public services.

On the basis of the experience gained in this project, the Administration on Aging will prepare, in 1968, a model consumer education program for older people to be distributed to all State agencies on aging.

6. Nutrition

Many older people, because of lack of adequate income, lack of transportation to shopping facilities, or lack of motivation to prepare meals on the part of those living alone suffer from severe dietary deficiencies.

Under title III, 70 projects have a nutritional aspect--meals or nutrition education.

Several title IV projects are demonstrating nutritional services to older people, such as: a central meal distribution system for senior centers in a large urban area; a system of neighborhood eating clubs; a food and nutrition program which will also increase opportunities for companionship.

In recognition of the nutritional problems of older people, a major new demonstration program in nutritional services was initiated under title IV of the Older Americans Act

during 1967. The Administration on Aging is cooperating with the Public Health Service and other agencies concerned with nutrition to develop new approaches and information about food services to be presented through this program. The purpose of the food and nutrition project is to gain new knowledge of the dietary needs of older persons and to develop a flexible program of providing an adequate diet through facilitating the purchase of food, assistance in meal planning, education in nutrition, and the development of group dining programs. Approaches to be demonstrated include: central dining facilities operated by senior centers, dining clubs and other organizations; a program of cooperative purchasing of food for meal preparations at home; and a program of delivered meals for the homebound.

7. Training of Personnel

As part of the employment and volunteer training under title III grants, older people are trained to help other older persons in problems of aging. Over 1,500 persons have been trained in this capacity.

Under title V, over one-half of the projects funded by the Administration on Aging by December, 1967, were for short-term training; about one-quarter were for long-term, career preparation courses; and another 20 percent were for development by universities of curricula in aging.

Within the career preparation courses, over half were for preparation for community organization and administration, one-fourth for senior center directors, and the remainder for retirement housing managers and mixed courses.

The impact of title V is just beginning to be measured: in new ideas stemming from trained people, in the implementation of better center programs and program planning, and in changed attitudes and outlooks of young and older trainees on the needs and the roles of the aging and aged.

The Older Americans Act Amendments of 1967 expanded authorizations for the training grant program in fiscal year 1968. This will provide for a substantial increase in the number of training programs and trained personnel. The amendments also authorized the Secretary of Health, Education,

and Welfare to undertake a study and evaluation of the existing and foreseeable need for trained personnel in various programs and services related to the objectives of the Older Americans Act and to report his findings to the President on or before March 31, 1968.

The Senate report on the Amendments, in noting the need for this study, stated: "The comprehensiveness of legislative programs for older people has created a tremendous need for a pool of professional and technical personnel possessing knowledge about the consequences of aging and equipped to administer the newly developing programs, to serve older people directly, and to train others for the many new career opportunities in the field. According to expert testimony received by the committee, this pool of manpower is currently nonexistent, for so great is the number of job openings that every available trained person is already employed. To improve the situation, an immediate all-out effort on the part of Government and educational institutions is required."

The Administration on Aging began preparations for the study in July of 1967. Projections were made on the numbers of older people in 1970 and 1980, their incomes, life expectancies, participation in the labor force and other aspects of the older population. To accomplish the study, two grants to national professional organizations and one contract to a survey organization have been awarded.

8. Other Services

Other titles III and IV projects included a variety of services: homemaker, foster care, friendly visitors, information and referral, transportation and special services. For example:

-- Under title III, a demonstration of unlimited transportation on regularly scheduled city buses for a small monthly fee for those over 65 and those over 60 who are social security beneficiaries or are disabled. The project stimulated inquiries from cities across the country and other such projects have been initiated as a result.

-- Under title IV, a study of the involvement of older persons in traffic accidents and of the practice of different States in issuing licenses to older drivers in order to develop fair standards for licensing and insuring older drivers.

Service Responsibilities to Public Assistance Recipients

Public assistance provides for needy older people: (1) cash to buy food, clothing, shelter, and other necessities; (2) payments to hospitals, physicians and others for medical care; and (3) social services to help them achieve as much personal and economic independence as possible.

Under the Social and Rehabilitation Service the first area is the responsibility of the Assistance Payments Administration (see p. 29). Payments for medical care are the responsibility of the Medical Services Administration (see p. 27). Public social services to eligible older persons covered under the provisions of titles I, XVI, and XIX of the Social Security Act and certain other related responsibilities are now part of the administrative functions of the Administration on Aging. These include services for recipients of old-age assistance and medical assistance to the aged and services for former recipients and potential applicants who are aged persons.

The broad range of services to be provided are designed to improve, restore, or retain the older individual's capacities for personal and social functioning. Direct services provided include: the activities of caseworkers who provide counseling and guidance or secure other services or facilities to meet the needs of individuals and families; and the activities of other social work staff such as medical and psychiatric social workers and volunteers who work directly with the individual. Enabling services provided include consultation on social, legal, educational, medical, psychiatric, psychological, or other problems of the older person. Complementary services provided include homemaker services, foster family care for adults, volunteer services, and social rehabilitation services.

Responsibilities to public assistance recipients also include cooperation with communities in developing resources to serve low income groups and the development of alternative plans of care for older people who would otherwise require care in mental institutions.

Under the provision of titles I and XVI of the Social Security Act, 1967 Amendments, States administering the public assistance programs for the aged may elect to purchase services from other public and private agencies, as specified by the Secretary, DHEW. This new action by the Congress will give States the opportunity to develop more flexibility in the provision of services to the aged.

As of December 31, 1967, 36 States and other areas provided prescribed and specified social services to the aged under the provision of titles I and XVI of the Social Security Act (1962 Amendments). Those States which have not elected to provide social services to the aged under the 1962 Public Welfare Amendments for 75 percent Federal Financial Participation are being encouraged to do so.

During this period, there were increases in the number of cases receiving such services over the previous year -- from 257,000 cases as of March 31, 1966, to 266,000 cases as of March 1967.

At the present time, 21 State Departments of Public Welfare have a State level Specialist on Aging, or a special unit composed of such specialists, carrying responsibilities for program planning and program development for social services in the public assistance program. States having such specialists are: Maine, Rhode Island, Vermont, New York, Pennsylvania, District of Columbia, Maryland, North Carolina, Alabama, Florida, Mississippi, Illinois, Kansas, Minnesota, Colorado, New Mexico, Oklahoma, Texas, Utah, California, and Washington.

Training opportunities for State and local specialists on aging should be expanded and State training opportunities for supervisory and casework staff working with the aged reviewed and strengthened where indicated.

A number of significant service activities have been developed in States. In Maryland, a study of shelter costs for older people living on low incomes has been reported; in New York, the Bureau of Social Services has prepared criteria and guidelines to promote development of its service program; Pennsylvania reports a study to determine the extent to which community resources are actually available to a selected group of white and Negro aged in Philadelphia neighborhood. In an effort to improve substandard housing, a survey of rental units of Old Age Assistance recipients in four areas of Pennsylvania -- two with housing codes and two without -- was also made.

Of the 339 units surveyed by December 1966, 75.2 percent had at least one deficiency. Follow-up action with landlords to encourage them to repair such deficiencies has been undertaken by staff of the agency.

Training activities to strengthen social services provided to the aged were undertaken in Virginia, Oklahoma, Kansas and Texas. New program efforts were undertaken in several States: personal care services to the aged in Washington; Foster family care for adults in Florida; transportation services in Chicago, Illinois; and use of AFDC mothers as home-health aides for the aged in Lincoln, Nebraska.

Action in specific service areas is outlined below:

1. Homemaker Services

   Since 1963, homemaker services in public welfare have more than tripled. At that time, there were homemaker services available to the aged in 93 public welfare agencies. At the present time, at least 440 public welfare departments throughout the country provide homemaker services to their clients, including the aged. All but 12 States and 2 other areas have at least one homemaker service program in public welfare. A new development has been the establishment of State level homemaker service programs in the State. At this time, 6 States have employed such specialists: New Jersey, Delaware, Colorado, Nevada, California, and Michigan.

2. Volunteers

Public Welfare Agency utilization of citizens in volunteer service is uneven. The 54 State agencies have more than 3,000 county departments of public welfare administering the public assistance program with approximately 6,500 State or local board members, many of whom can be utilized as resources in the program.

In New York, Michigan, Wisconsin, and Minnesota, where there are coordinators of volunteer program services on the State agency staff, this has resulted in statewide volunteer services. The Cook County (Chicago), Cuyahoga County (Cleveland), District of Columbia, Milwaukee, Salt Lake City, and San Francisco Departments of Public Welfare each have a variety of volunteer services for the benefit of welfare recipients. Elsewhere such services are sporadic, unorganized and often serve only a one-time purpose. Hope for a greater use of volunteer citizen's abilities lies in the requirement of Public Law 92-248 (the Harris Amendment) that States, by July 1, 1969, will use "non-paid or partially paid volunteers in a social service volunteer program -- and in assisting any advisory committees established by the State."

3. Housing

During 1967, a plan for increasing cooperation between housing and public welfare agencies was developed by means of staff liaison between the Social and Rehabilitation Service and other Federal housing (HUD, USDA, FHA, and PHS) programs. Information was made available and exchanged on policies affecting the housing of welfare recipients, including the aged. To bring about improvement in housing and expand housing resources guidelines developed for:

(a) Relocation adjustment payments and relocation social services required by older public assistance recipients.

(b) Cooperation between the Farmers Home Administration of the Department of Agriculture and public welfare agencies to improve housing of aged recipients in rural areas.

(c) Public welfare's role in Model Cities planning, particularly as it affected older recipients.

(d) Welfare rents in public housing, as they affect older public assistance recipients.

(e) State experience in programs to improve housing of older public assistance recipients.

Administration on Aging staff participated in the D/HEW-HUD task force on improving housing of public assistance recipients.

92 - 594 O - 68 - pt 2 - 24

States must increase the opportunities for aged recipients to secure adequate and decent housing at rentals they can afford, through direct action to increase shelter allowances in the assistance payments, and through cooperation with local housing authorities and those State and local agencies responsible for housing standards and housing code enforcement.

4. Institutional Care

Standards for Social Care Institutions (intermediate care facilities), were prepared for issue to the States. These are non-medical institutions which provide maintenance and some care and services to the elderly. They provide group living accomodations for older persons who do not need medical care, but do need a protective environment.

The 1965 Amendments to the Social Security Act also made possible, for the first time, Federal sharing in payments to needy aged persons in institutions for mental diseases and tuberculosis. The Administration on Aging has responsibility for community services to aged and their families included in the program services related to after-care and prevention provided through titles I and XVI.

5. Demonstration Projects

During 1967 several new demonstration projects for the aged served by public assistance programs were initiated and financed under Section 1115 of the Social Security Act. The following illustrate the types of service demonstrations conducted under the auspices of State Departments of Public Welfare:

-- A demonstration of the value of a multi-disciplined team of caseworkers, case aides and homemakers, operating under professional social work direction, in providing protective services to the aged. This is a 3-year project carried out by the D.C. Department of Public Welfare and three rural county Departments of Public Welfare in Colorado. A unique feature of this demonstration will be the use of consultants from the medical, psychiatric, legal and nursing professions by the team members on an "as needed" basis.

-- A demonstration project to provide social services to the aged in seven rural counties in Mississippi, by the State Department of Public Welfare. The project will be supervised by the State Specialist on Aging, and will demonstrate what is involved in undertaking such services as a regular program of the State.

-- A demonstration project initiated by the Arkansas State Department of Public Welfare to screen aged patients in nursing homes to determine whether they need to stay in such institutions, or might return to their communities.

The Foster Grandparent Program

The Foster Grandparent Program, which is administered by the Administration on Aging under contract with the Office of Economic Opportunity, recruits, trains and employs low-income men and women over 60 years of age to serve as foster grandparents to children in institutional and community settings. "Grandparents" provide 2 hours of individual attention daily to each of 2 children and usually work 4 hours a day, 5 days a week. Their salary is equal to the Federal minimum hourly wage, and in most cases transportation is provided.

The program expanded from 37 grants in 1966 to 63 project grants in 38 States and Puerto Rico in December 1967. About 8,000 children in 155 institutional and community settings are served by 3,927 foster grandparents in over 120 communities. As knowledge of the program expands, more communities are expressing an interest in developing a foster grandparent project. During the past 6 months, over 100 additional communities and institutions have asked for information to assist them in developing a project.

Foster grandparents serve a variety of dependent, neglected and otherwise needy children in many institutional and community settings. These settings include institutions for the mentally retarded, dependent and neglected, the emotionally disturbed, and physically handicapped; day care centers; foundling hospitals and pediatric wards of general hospitals. Some experimental programs are continuing in which foster grandparents serve children in correctional settings, special classes for the retarded, and in Headstart homes.

Foster Grandparents is a double-edged program from which two needy groups gain. It provides the grandparent with the dignity of a much needed income while making a meaningful contribution to the community and adds the ingredients of love and understanding to the lives of the children.

This program has proved that older people are eager to help themselves through employment when the opportunity is available to them. There have been more than 8 applications for each available foster grandparent position. Some projects with a full complement of foster grandparents have more eligible applicants on the waiting list than positions authorized. For example, one project with 114 foster grandparents authorized has over 450 on the waiting list.

Local financial support of the program is also increasing. In Iowa, 25 foster grandparents are employed through State funds. In Illinois, 68 foster grandparents have been employed with State funds. Within one year, the total cost of the project in New York will be provided from local funds. The States of Pennsylvania and Iowa are considering the possibility of expanding the program throughout their States. This further confirms the viability of the program and the enthusiastic support of the organizations and institutions involved.

Activities with Other Federal Agencies

The Administration on Aging maintains formal and informal liaison with all Federal agencies which have programs affecting the aging, including agencies represented on the President's Council on Aging. Through these activities, it attempts to stimulate more effective use of existing resources and the planning of new programs to fill areas of gap in services.

During 1967, the Administration on Aging worked with the Department of Housing and Urban Development to assure continued consideration of older people in programs such as neighborhood facilities and the Model Cities programs. A joint State letter with the Bureau of Outdoor Recreation was issued to State agencies to encourage recreation programs for older people and the preparation of a pamphlet on outdoor recreation planning was begun. The Administration on Aging consulted with the Census Bureau, on items of special interest to the aging to be included in the census questionnaires; encouraged special tabulation and analysis of aspects of the older worker problems by the Department of Labor; maintained contact with the Department of Transportation on consideration of older people in the planning of that Department; and continued to administer the Foster Grandparent Program in cooperation with the Office of Economic Opportunity. AoA also provided technical assistance to various congressional committees concerned with developments in aging.

Activities with Private, Voluntary and Religious Organizations

The Administration on Aging maintains contact with private citizens through the Advisory Committee on Older Americans, a group of 15 public experts in the field of aging. Through this mechanism, representatives from all interested segments of society furnish the Secretary of Health, Education and Welfare and the Commissioner on Aging with recommendations based on their own experience.

Consultation and technical assistance to voluntary and religious organizations and groups is carried on by the Administration on Aging staff in both the Washington office and in the field. Close working relationships are maintained with those groups which represent older people or have aging divisions such as: the National Council of Senior Citizens, the National Council on the Aging, the American Association of Retired Persons, the American Public Welfare Association, the National Farmers Union, and the Gerontological Society.

Special efforts have been made to enlist the cooperation of organizations whose community affiliates represent a source of leadership for local programs for older people. The YWCA, the YMCA, health and welfare councils, and the service clubs are sponsoring or cooperating in many projects under the Older Americans Act. The Girl Scouts of America celebrated Senior Citizens Month in 1967 with special programs featuring youngsters and older people working together for a common objective.

Working relationships continued in 1967, with the American Library Association, the Adult Education Association, and the National Recreation and Park Association, all of whom are working toward increased educational and recreational opportunities for older people.

The interest and concern of religious organizations for the needs of older people have increased greatly in the past few years and the Administration on Aging is continuing to further the movement. There is a discernible trend towards broader based, better integrated and coordinated programs in both the national denominational structure and in the local parish, with much more emphasis on services to people in their own homes; on opportunities for educational and creative pursuits; and on volunteer opportunities.

Religious organizations were included among the recipients of project grants under the Older Americans Act in 1967. Nine representatives of major faiths are serving voluntarily and at their own expense on an advisory panel to consult and advise the Commissioner on Aging in the preparation of materials and other activities relating to religious organizations.

Information Activities

During 1967, the Administration on Aging handled nearly 12,000 inquiries from members of Congress, from public and private organizations and from members of the public, including older people themselves. These individuals and organizations requested a variety of information ranging from how to start and maintain programs for older people to personal questions involving family relationships.

The Administration on Aging started a new series this year entitled "Designs for Action for Older Americans." These publications provide brief descriptions of successful programs being carried out by communities and organizations throughout the United States. They contain sufficient information to permit local communities and agencies to determine whether similar programs can be undertaken locally.

Another series of documents entitled "Federal Financial Assistance for Projects in Aging" describes Federal grant programs which offer support to communities and agencies in developing programs for older people. At the end of 1967, six of these had been published and another seven were in process.

A periodic summary of major Federal legislation concerning older people in a series entitled "Highlights of Legislation on Aging" was also issued. Another AoA series, "Useful Facts," provides a coordinated, analytical approach to pertinent data on the characteristics and conditions of the older population. Twenty-six issues were distributed in 1967.

The Administration on Aging also publishes a monthly newsmagazine, Aging, which reports on programs and activities on aging from Federal, State and local levels, and goes to over 16,000 individuals and organizations in the United States and overseas.

In cooperation with the President's Council on Aging, the Administration on Aging conducts the annual observance of Senior Citizens Month. During the 1967 observance of Senior Citizens Month, news media across the country cooperated by reporting on both the needs of older people and some of the accomplishments of programs being conducted under the Older Americans Act. Over a million pieces of material were distributed to individuals, organizations and news media for the 1967 observance.

The Older Americans Act Amendments of 1967

On July 1, 1967, the President signed the Older Americans Act Amendments of 1967, after unanimous passage by the Congress.

The Amendments (P. L..90-42) authorized increased appropriations for the State grants program (Title III) for fiscal year 1968 and 1969. For the three succeeding fiscal years, the Congress will determine amounts to be authorized. The authorizations will enable the continued support of projects already funded and will permit the States to fund additional community projects.

The Amendments also increased authorizations for fiscal year 1968 and 1969 for the research, demonstration, and training grant programs (Titles IV and V). Congress will determine amounts to be authorized for fiscal years 1970 through 1972. These sums provide for the continuation of projects already funded, and permit the Administration on Aging to undertake more comprehensive research and demonstration into methods of providing services for older people, to permit orderly development of a pilot program of nutritional services in senior citizens centers, and to provide for a substantial increase in the number of personnel to be trained for work in programs and services for older people.

The Amendments authorized additional funds to be used for administration of State plans. States may now use $25,000 or 10 percent of their total allotment, whichever is greater, for this purpose, instead of the $15,000 or 10 percent formerly authorized. This enables the States to improve their overall administration to (1) provide additional consultation and technical assistance to community project grantees receiving Title III funds and (2) to carry out more effectively their responsibility for coordination and stimulation of more comprehensive programs for their older citizens on the State and local level.

The Amendments provide for a study of the need for trained personnel in the field of aging, and of the availability and adequacy of the educational and training resources for people preparing to work in the field. The Secretary of Health, Education, and Welfare is authorized to undertake this study and to present a report to the President and to the Congress on or before March 31, 1968. The Secretary is to report his findings and his recommendations as to the specific proposals, including legislative proposals, he deems will assist in assuring that the need for trained personnel will be met.

The Amendments also provide that any funds which a State notifies the Secretary of Health, Education, and Welfare will not be required to carry out its State plan, if it has one, must be reallotted to other States that need and can use them.

Rehabilitation Services Administration

The objective of the Aging program of Rehabilitation Services Administration is to rehabilitate as many older handicapped persons as possible into gainful employment. This is accomplished through activities of the State-Federal rehabilitation program administered by the Rehabilitation Services Administration.

National Health Survey estimates indicate that 7.8 million persons (not retired) aged 45 and have one or more chronic conditions partially or totally limiting their major activity.1/

The Rehabilitation Services Administration calculates that 2 million of then--including 130,000 persons 65 years of age or older--would need vocational rehabilitation services in order to return to work.

The remaining 5.8 million cannot be rehabilitated into employment, but many could, in varying degrees, be returned to self care and independence through appropriate services.

Of the 173,594 persons rehabilitated in fiscal year 1967, it is estimated there were 47,000 aged 45 and beyond.

Progress in Rehabilitation of the Aging Disabled

As a result of modern rehabilitation services, there are many thousands of handicapped middle-aged and older persons employed in every occupation and performing jobs as efficiently and reliably as workers who have no handicap.

Since 1945, when 7,344 disabled persons 45 years of age and older were rehabilitated, there has been a steady increase in the number of aging handicapped individuals rehabilitated into employment. For example in FY 1966, 41,300 persons were rehabilitated, over 5 times the 1945 figure. It is estimated that a total of 47,000 persons aged 45 and beyond will be rehabilitated during FY 1967; it is projected that a possible 53,000 will be rehabilitated in FY 1968, and a possible 60,300 in FY 1969.

State Vocational Agencies: Rehabilitated persons 45 years of age or over at acceptance - fiscal years 1965 - 1969:

Fiscal Year	All Rehabilitants	45 years of age and over
1965	134,859	36,656
1966	154,279	41,300
1967	173,594	47,000
1968	200,000	53,000
1969	230,000	60,300

1/ Chronic conditions and activity limitation - US - July 1961 - June 1963 Series 10, No. 17 - May 1965 US DHEW

Research and Demonstration Projects Serving the Aged

A wide diversity of problems is found among older disabled people. In order to obtain more knowledge about these problems, the Rehabilitation Service Administration is helping to support reserach and demonstration projects relating to this older group. Since 1954, financial assistance amounting to over $7 million for these projects has been provided. Usually, the sponsors of such projects contribute an additional dollar for every two dollars of Federal grant funds, and to date grantees have invested nearly $3 million of their own funds in these research and demonstration activities.

In 1964, vocational rehabilitation research and demonstration projects grants amounting to $1,511,000 were supported. All of these projects were developing new methods and techniques for dealing with the problems of disability among older disabled individuals. For example, a project in New York City pioneered in demonstrating that disabled older workers could be retrained and placed in employment. 197 handicapped men over 60 years of age were placed in competitive industrial employment. The oldest individual placed was over 80. The results of this project were so successful that similar projects were established in Kansas City and St. Louis, Missouri; St. Paul and Mankato, Minnesota; Milwaukee, Wisconsin; Miami, Florida; Gadsden, Alabama; Dallas, Texas; Philadephia, Pennsylvania; the Virgin Islands and in 1964, a project was approved for operation in Chicago, Illinois. On two occasions representatives of these projects attend conferences in New York City at which the training and placing of older handicapped workers in employment was discussed.

A 5-year project completed in 1967 was designed to evaluate response to regular employment of selected disabled men and women over 60 years of age in Coney Island, New York. This project used many innovative approaches to problems faced by the aging, and its results should prove valuable.

A number of projects are seeking to assist older people confined to institutions and nursing homes to become as self-sufficient as possible. For some, this would mean a resumption of a normal place in community life.

In the State of Washington, an RSA sponsored project to rehabilitate the chronically ill confined to nursing homes was very successful. An elderly woman unable to respond, walk or feed herself was committed by her family to a mental hospital and remained for 18 months. She was released to a nursing home and after six weeks of intensive treatment by the staff was able to respond, feed herself, and walk. She was subsequently returned home and her family was delighted and amazed at her progress.

The University of Michigan and the Illinois Public Aid Commission developed special staff training techniques and rehabilitation methods applicable in public and private nursing homes.

At Highland View Hospital, Cleveland, Ohio, a project successfully demonstrated that rehabilitation is possible for long-term hospital cases disabled by severe chronic diseases.

All of the research and demonstration projects have a common goal--finding new techniques and methods for restoring maximum functional or earning capacity to older disabled people.

Training

Since it is anticipated that a higher proportion of older disabled persons will require rehabilitation services, more of the training resources of the Rehabilitation Services Administration are being devoted to increasing the proficiency of rehabilitation personnel in relation to the older disabled person. Special institutes in geriatric rehabilitation in a number of our universities are also being supported.

For example, the Department of Physical Medicine and Rehabilitation of the New York Medical College Metropolitan Hospital Center conducted a two-week course on the principles and practices of geriatric rehabilitation for registered nurses, occupational therapists, physical therapists and social workers.

In March 1967, the Rehabilitation Services Administration co-sponsored with the Division of Chronic Diseases, PHS, the American Orthopoedic Association and the Orthopoedic Research and Education Foundation, a seminar on Orthopoedics and Gerontology, in Washington, D. C.

In October 1967, the Administration sponsored a Regional Institute on Rehabilitation of the Aging in cooperation with Northeastern University at Boston.

In the past, workshops have been held in California, Arizona, Oregon, Utah, Texas, Mississippi and West Virginia in order to bring together community agencies for a cooperative attack on problems of service to the aging. Future plans call for such workshops to be held in additional States for this same purpose.

Accomplishments

Research

Although many economists and labor experts agree that the older worker has valuable skills and talents which can be utilized, unfortunately many employers and a large portion of the general public are not

convinced of his ability, much less the ability of the older handicapped worker, to produce in competitive employment.

The Rehabilitation Service Administration is attempting to counteract this point of view through a research projects designed to present facts on the older disabled worker's productivity. For example, projects have been conducted in Florida, Colorado, Massachusetts, Michigan, Texas and New York geared to train and place the older handicapped worker into competitive industrial employment.

The New York project previously referred to, a 5-year project, is evaluating results of a community-operated vocational rehabilitation program. Results of these studies, plus results obtained from other RSA supported projects, will provide tangible evidence regarding the adjustment and performance of the older handicapped worker on the job.

A number of research and demonstration projects are designed to assist older people confined to nursing homes to become as self-sufficient as possible and to train nursing home personnel in modern rehabilitation techniques that can be applied to older persons under their care.

Jobs for the Blind

The Rehabilitation Service Administration puts forth sustained efforts to open greater job opportunities for the blind including the expansion of vending stand opportunities under the Randolph-Sheppard Act. The majority of blind persons rehabilitated are over 45 years of age, and over half of the vending stand operators fall into this age group.

Jobs for the Deaf

As the inroads of automation have their impact upon the employment of the large numbers of older deaf workers in skilled and semi-skilled occupations, efforts should be increased to emphasize retraining and re-employment.

Social Security Disability Applicants

The Social Security Disability Insurance program serves as an important referral source of older disabled persons for State vocational rehabilitation services. Over the past several years, more than one-half million persons have applied annually for disability benefits and have been considered for rehabilitation services. The number of disabled workers receiving social security disability benefits reached 1 million in 1966. In recent years, the median age of such beneficiaries has been 57. The 1967 Amendments to the Social Security Act provide reduced disability benefit payments to a new group of persons age 50 and over,

viz., to totally disabled widows, divorced survivors and widowers. It is estimated that 65,000 of such persons will become eligible for reduced disability benefits between the time of legislative enactment and the remainder of fiscal year 1968.

To make it possible for more persons who apply for social security disability benefits to receive State vocational rehabilitation services, the 1965 Amendments to the Social Security Act authorized the use of OASDI trust funds to pay the cost of such services to selected disability beneficiaries. The money is to be used in such a way that the saving from the amount of benefits that would otherwise have to be paid and the contributions to the trust funds paid on the earnings of beneficiaries who return to work would exceed, or at best equal the money paid from trust funds for rehabilitation costs. An estimated $16 million will be available from trust funds in fiscal year 1968, and a slight increase in available funds is expected for use by all State agencies in fiscal year 1969.

Future plans

Administration on Aging

State and local communities will be greatly assisted in their efforts to provide services for the aging through provisions of the Vocational Rehabilitation Amendments of 1965 and 1967 and the Older Americans Act of 1965, strengthened by 1967 Amendments. To aid in implementing these provisions, and to insure that full consideration will be given to the rehabilitation needs of the aging, a joint communication from the Commissioner of Rehabilitation Services Administration and the Commissioner on Aging was issued to State vocational rehabilitation agencies and State commissions on aging urging closer cooperation and collarboration in planning program activities and services for the aging.

Research and Demonstration

In order to make progress in rehabilitating older disabled people it is necessary to have factual data. Such data is obtained primarily from research through which methods and procedures for various types of rehabilitation services are discovered, developed, and adapted for use.

RSA plans to continue emphasis on research projects and conduct demonstrations throughout the country which will illustrate the techniques or findings of research projects. Such demonstrations will serve to illustrate that with proper evaluation, training, and placement many older people can return to work, or with other assistance achieve greater independence.

Training of Personnel

There is an urgent need to orient hospital, nursing home and other institutional personnel in modern methods of rehabilitative care and techniques. There is also the need to stimulate and expand training programs in rehabilitation for physicians, occupational therapists, physical therapists, rehabilitation counselors, speech and hearing therapists, and other specialists concerned with rehabilitation of the disabled.

Community Resources

It is of the utmost importance to establish services in the community for post-institutional care of the aged who are ill, services to sustain disabled individuals after restorative medical care and prevent or reduce the need for institutionalizing persons who could be maintained in their homes. There is also a need to promote job opportunities for the aged disabled among local employers, to establish recreational programs, friendly visitor programs and other projects.

As our aging population increases, the demand for various types of services become greater, necessitating plans for expanded programs operations and increased financial assistance to make program expansion possible.

The Rehabilitation Services Administration will continue to put forth sustained efforts to provide improved services for more aging disabled people in order that they may be able to be vocationally rehabilitated and/or help themselves realize their full potential.

Medical Services Administration

The Medical Services Administration administers grants to States for medical assistance programs serving public assistance recipients and other medically needy people.

Medical Assistance for the Aged (MAA)

In States that do not have Medicaid programs in operation, this program pays for basic medical care for people over age 65 who have enough income for their basic living costs but need help with medical expenses. In September 1967, payments for medical care under MAA totalled $5,173,000. In the 12-month period from July 1, 1966 to June 30, 1967, hospital care and nursing home costs accounted for approximately 88.5 percent of the total MAA expenditure. The remaining 11.5 percent covered physicians' care, prescribed drugs, and other services.

In December 1965, 47 States and areas operated MAA programs, serving 280,000 people. In September 1967, the MAA program was in effect in only 10 States, Guam, and the District of Columbia. This decrease reflects the shift to the broader Medicaid program in many States, commented on below.

The 1965 Social Security Amendments, that provided for hospital and voluntary medical insurance for people over 65 under the Social Security program, reduced the need for the MAA program. The need is bring further reduced as more States establish the single medical assistance program (Medicaid) that was also established by the 1965 Amendments. In States that do not have Medicaid, the Medical Assistance Program for the Aged is still needed to provide medical assistance to the medically needy aged, including the payment of deductibles and premiums, that are not covered by Medicare.

Medicaid

This program began January 1, 1966, and by 1970 will be the only way for States to receive Federal funds for vendor payments for medical care for welfare recipients. In adopting a Medicaid program, a State must provide high quality medical care and services to all people receiving federally aided public assistance. By 1975, the program must be extended to certain children and adults who do not qualify for public assistance but do need help with medical expenses.

By December 1, 1967, 40 jurisdictions had approved Medicaid programs. They were: California, Connecticut, Delaware, Georgia, Guam, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Texas, Utah, Vermont, Virgin Islands, Washington, West Virginia, Wisconsin, and Wyoming. All of these except Delaware, Georgia, Missouri, Ohio, and Texas had formerly operated MAA programs.

The remaining jurisdictions are being encouraged and helped to establish Medicaid plans to benefit not only the needy aged but all people who cannot afford adequate medical care.

Institutional Care

The 1965 amendments to the Social Security Act made possible for the first time, Federal sharing in payments to needy aged people in institutions for the mentally ill and tuberculosis. By the end of 1967, twenty-eight jurisdictions had adopted the provision with respect to institutions for mental diseases. These States are receiving Federal funds toward the treatment and care of approximately 70,000 patients 65 years of age and over. Many of the twenty-eight States are utilizing the Federal funds to improve services to the aging mental patient by increasing staff in the mental hospitals. Twenty-one jurisdictions have adopted the provision for tuberculosis institutions.

The Assistance Payments Administration

Administration of public assistance grants to States for nearly 3 million aged, blind, or disabled was formerly the responsibility of the Bureau of Family Services, Welfare Administration, and is now the job of the Assistance Payments Administration, Social and Rehabilitation Service. These grants provide the cash to buy food, clothing and other necessities.

The program served about 2,065,000 persons 65 and over in September, 1967. This is a marked decline from the all-time high of 2,810,000 in September 1950 despite the steady increase in the number of aged people in the older population. It is due to the increased number of persons receiving Old Age Survivors and Disability Insurance (OASDI). About 1.1 million older persons are receiving both Old Age Assistance and Social Security payments. They represent 53 percent of all Old Age Assistance recipients.

All 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have Old Age Assistance programs. The national average in September 1967 was about $68 for maintenance. Medical care, in nearly all States, is provided under the Medical Assistance Program.

According to a 1965 study, the median age of old-age assistance recipients was nearly 77 years. This was an increase of about 2 years over the median age in 1953. The proportion of those living alone in their own homes increased from 27 percent in 1953 to 35 percent in 1965. During the same period, however, the proportion requiring help from others rose from 18 percent to 27 percent, including a rise from 5 percent to 9 percent for those living in institutions. In 1965, recipients were older, less mobile, and were increasingly the victims of chronic illness.

A new Federal matching formula, effective January 1, 1968, makes it possible for States to disregard up to $7.50 a month -- rather than $5 -- of any income. This will permit States to disregard more of the Social Security benefit increase.

Another amendment, effective January 1, 1968, permits the Federal Government to share with the States in the cost of repairs made to the homes of older persons receiving assistance. The purpose is to enable the individual to continue to live in his own home. The limit is $500 for the repair of any home.

OFFICE OF EDUCATION

Title III of the Elementary and Secondary Education Act (Public Law 89-10) provides nonmatching grants to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs to serve as models for regular school programs. This program gives special consideration to projects that are truly innovative as well as being of high quality and responsive to local needs.

Under the provisions of Title I of the Library Services and Construction Act (as amended by P.L. 89-511) the Division of Library Services provides information and advice on programs oriented to the aging which are conducted by State library agencies; assists training institutions with programs designed to give librarians special skills needed to meet the special library needs of older persons; maintains liaison with other Federal agencies and organizations concerned with the aging; assists in conferences of professional and lay leaders concerned with library-sponsored activities for older people; and provides grants for the improvement of public library services. One example of a special program supported by Federal funds to assist the aging is a program in Vermont to train older persons for work in community libraries. California granted funds to the Los Angeles Public Library for a three-year project for library service to shut-ins in the inner city. The St. Louis public library is bringing books and other library services directly to the aged living in hotels, apartments, and rooming houses.

The Division of Adult Education administers programs for the training of adults in basic education, community service and continuing education, and civil defense education and provides information and consultative services for these programs -- all of which include older persons. For example, in fiscal year 1967, approximately 26 percent of the total enrollment in basic education classes was age 45 or older. Under Title I of the Higher Education Act (P.L. 89-329) there were 18 programs in 12 States dealing with problems of the aging and focusing generally on (1) increasing the intellectual and community involvement of these older persons, (2) broadening their economic knowledge and/or employment opportunities, and (3) making available to them the best possible health information and medical treatment.

Vocational education training programs provide training and retraining for persons of all ages in occupations in health, technical trades and industry, office, distribution and marketing, home economics, and agriculture. These programs serve the increasing numbers of older persons who need to learn basic skills, or to improve old skills, or to develop new skills in order to advance employment opportunities. Agencies and institutions developing these programs are encouraged to employ older qualified persons as teachers in vocational training programs.

92 - 594 O - 68 - pt 2 - 25

Programs under the Manpower Development and Training Act have focused attention on the development of institutional training projects specifically for the older worker. Pilot projects have been developed using a multi-occupational training approach which provides a greater variety of training opportunities. These programs offer basic education, prevocational opportunities, counseling specifically for this age group and a variety of occupational training.

FOOD AND DRUG ADMINISTRATION

All of the activities of the Food and Drug Administration are designed to protect consumers, and therefore, have a significant impact on the health and well-being of the aging. There are nearly 60 million Americans aged 45 and over, representing about 30 percent of the Nation's population. Since the aging are more reliant as a group upon drugs than the rest of the population and drug activities constitute about one-half of FDA's programs, it is safe to estimate that one-third of the Agency's resources are devoted in one way or another to the protection of the aging.

A year ago FDA asked the Consumer Specialists in its 17 District Offices to direct special attention to health education of the elderly. They were to develop, as part of an overall national effort, effective local and State programs. FDA would sponsor these programs on its own, or with the help of other Federal and local agencies. Included in this new program to bring senior citizens up-to-date on foods, drugs, cosmetics, medical devices, and certain hazardous substances was a series of regional conferences (conducted in cooperation with the Administration on Aging) directed at professional groups and organizations concerned with the problems of the elderly. Forty-four conferences were conducted in 1967, reaching an audience of 7,549. These conferences were restricted to professionals and leaders working with the aging. Limited FDA resources and personnel depend on these leaders to carry the life protection message to individuals with whom they come in contact.

In addition to the conferences, the Consumer Specialists also spoke to 50 local senior citizen centers or clubs, for a total audience of 7,900. FDA exhibits were shown at several State or local health fairs, in libraries, and in public buildings in an effort to reach the largest possible audience.

The Special Consultant on Consumer Affairs to the Commissioner of FDA spoke at the Baltimore and Boston District Aging Conferences and at the Wisconsin State Medical Society annual convention. The theme of the medical meeting was "The High Cost of Quackery in Lives and Money," a topic of concern to the FDA and of special concern to the elderly who are particularly susceptible to frauds, quackery and misrepresentation.

PUBLIC HEALTH SERVICE

Bureau of Health Manpower

Division of Allied Health Manpower

The Division supports four project grants in the field of aging, at Tulane University, the University of Michigan, Boston University, and Johns Hopkins University. Each of these grants provides for faculty and curriculum growth in the area of chronic disease as well as aging. At Tulane work is being done on teaching rehabilitation of the aged. The University of Michigan project emphasis is on adult health and aging, while the Johns Hopkins project centers on chronic disease. The grant to Boston University is for a gerontology program in the school of nursing.

Through the traineeship mechanism, the Division supports students pursuing full-time graduate training in public health with majors in adult health and aging and gerontology. Also included is support for short-term courses relating to geriatric medicine and gerontology. In addition to these courses, various long and short-term training programs of benefit to the aging and aged are being supported. Some of these are for the training of nurses, pharmacists, physical and occupational therapists, dietary consultants, social workers, and nursing home administrators. Others provide for training of health officers and voluntary health agency officials who, for example, may serve as consultants to nursing homes and extended care facilities.

Bureau of Disease Prevention and Environmental Control

National Center for Air Pollution Control

The National Center for Air Pollution Control is continuing its support for studies of the effects of air pollution on chronic respiratory and chronic nonspecific respiratory diseases, of which there is a high prevalence among the aging and aged. Program project grant authority was authorized in the Clean Air Act to provide for the support of State pollution control programs and other projects to demonstrate effective air pollution control measures at the community level. The aged represent a population group more likely to suffer ill effects from exposure to air pollution, and the aged will benefit greatly from the research, abatement, and training activities being conducted and supported by this Center.

National Center for Urban and Industrial Health

Aging programs in the National Center for Urban and Industrial Health include research conducted or supported by the Occupational Health Program which is concerned primarily with the pathophysiologic

response of man to his environment. In this connection, clinical studies are being made in which age is the most important non-occupational variable. Among the projects now being supported are investigations of chronic chest diseases in bituminous coal miners, health hazards in uranium mining and milling, and the effect of a hot environment on the elderly. Other research projects supported by the Program include a study of hearing loss in industry due to noise, and of the aging lung.

The injury control program is supporting several research projects basic to the health and well-being of older people. Included are studies which provide for the screening of women for osteoporosis, bone disease, evaluation of a new diagnostic device used to measure osteoporotic change, and methods of maintaining bone strength and improving bone mending, all of which will contribute to improved preventive or control measures. In addition, experimental research has been programmed in the injury control program's research laboratory on various types of motor and perceptual impairments in driving among the aged. Consultation is also given to State health departments, other Federal agencies, and other public and voluntary groups concerned with the development of accident prevention programs for services and public education. The program also assists the agency involved with the development of materials relating to accidents and the aged, and provides courses in the "Public Health Aspects of Accident Prevention," which include material relevant to the problems of older people. These courses are conducted by health departments, universities, and schools of public health. Similar seminars are being developed for selected practitioners in the field of public health and for personnel in schools of nursing and public health. Close liaison is maintained with experimental groups in gerontology.

The Environmental Sanitation Program provides consultation to groups planning special services for the aging and aged. General consultation in housing hygiene is given to Federal, State, and local and private agencies.

National Center for Radiological Health

A major portion of the research efforts of the National Center for Radiological Health is concerned with the long-term effects of low levels of radiation exposure. Primary interests relate to the study of long-term effects as a function of radiation dose with the ultimate aim of providing better scientific bases for population radiation standards as well as gaining more fundamental knowledge related to the mechanisms of cause-effect relationships and methods by which radiation damage may be diagnosed early, prevented, mitigated or treated.

The primary approach is to study the relationship between radiation dose and the incidence of disease and disability in human population groups, i.e., epidemiologic studies, with supportive and complementary experimental studies using animals and various biological systems. Nonspecific life-span shortening and acceleration of aging are among the most important consequences of the long-term somatic effects of radiation exposure in population groups. Consequently, much of the research, directly or indirectly, relates to the problem of "aging" and the closely interrelated problem of radiation carcinogenesis.

The major epidemiologic study effort as related directly to aging concerns the studies of the Atomic Bomb Casualty Commission in which life-span studies are being done on the incidence of disease and disability among the survivors of Hiroshima and Nagasaki. A major study parameter is whether nonspecific life-span shortening or accelerated aging relatable to exposure from the atom bomb will be found in the survivors.

Bureau of Health Services

Division of Medical Care Administration

Major activities of the Division which are of most immediate benefit to aging persons are those directed (a) at carrying out its responsibilities for the professional aspects of the Medicare program, and (b) at the problem of providing health protection and preventive services to the elderly who are in apparent good health.

A. Medicare

The passage of Medicare was an important step forward in meeting the health needs of the sick aged in the population. The Division was particularly active in the areas of standards development, certification of health service providers, and assistance to providers enabling them to meet Medicare standards.

Although the majority of hospitals and home health agencies were certified in 1966, more than 400 hospitals and 700 home health agencies were added during the past year, bringing the number of hospitals certified to participate in Medicare to 6,800 and the number of home health agencies to 1,850. Approximately 4,200 extended care facilities and 2,500 independent laboratories have also been certified.

Home health services can be an important source of care for aging persons confronted with health problems. To encourage the growth of home health agencies, the Division supported seven regional home care training centers to promote the development and utilization of home health services by the Nation's physicians and other health professionals. Educators representing 39 medical schools from 29 States were convened to discuss a teaching program stressing the team approach in home health care. Extensive consultation by representatives of PHS, AoA and OEO was given in 16 demonstration projects funded by OEO to train older poor Americans as home health aides. A compilation and analysis of data developed from the projects, and recommendations for future training programs are being prepared. More than 5,000 Physician's Kits (a collection of booklets, articles and monographs on the roles of various health professionals in home care programs) were distributed, on request, throughout the country to individual physicians, hospitals, health departments, nurses' organizations, etc.

In the certification of extended care facilities, Division staff concentrated on clarifying the concept of an extended care facility and explaining the requirements for participation in Medicare. There were seminars to help professional and other staff in nursing homes to improve their skills. A prototype seminar was developed, and widely demonstrated, for nursing home administrators in order to help them work more effectively. Seminars were held in New Jersey, Ohio, Florida, and other States. The Division encouraged five statewide or community demonstrations involving cooperative relationships between hospitals and nursing homes.

Recognizing the need for group practice in organizing health care services within a community for Medicare beneficiaries as well as in health protection programs for the aged, the Division established a Group Practice Section to encourage and promote the growth of group practice programs.

The Group Practice Section served as the focal point for the National Conference on Group Practice held October 19-21, 1967, at the University of Chicago. The Conference, called by Secretary Gardner and sponsored by the Public Health Service, brought together 150 experts from health professions, insurance industry, labor, management and government for the express purpose of seeking ways to promote the group practice of medicine. Proceedings of the Conference were printed and distributed early in 1968 by the Division and contained recommendations for action by private organizations and the Federal government.

A film entitled, "At the Crossroads," directed at the medical profession and community leaders, was produced in 1967. The film probed problems in delivering health care, and how communities can organize to solve these problems. Film strip and slide presentations were prepared on how communities can establish Information and Referral Service Centers, and home health care programs. An exhibit was prepared to promote the growth of group practice among the medical profession and community leaders.

B. Health protection and preventive services

The provision of therapeutic services for the aged is only part of a comprehensive health program for the aged. Another vitally important facet of such a program is the provision of preventive services to protect the health of the majority of the elderly who are in apparent good health.

A new method of providing adult health assessment combines automated and functional testing with self-administered history. In the opinion of experts, such use of automation in a health protection center can permit optimum utilization of the time of physicians and other health workers, and can make it possible to conduct health assessment of large numbers of adults in an economic and effective manner.

The methodology for providing automated laboratory and related individual health screening has been successfully demonstrated in a prepaid health plan at the Kaiser-Permanente Health Foundation with Public Health Service support. Four service programs currently are underway in various organizational settings for the community at large. The City of Milwaukee Health Department began offering services in July 1967; Tulane University (New Orleans) in August 1967; the Brookdale Hospital Center (Brooklyn) is expected to become operative in early 1968; and the program developed under the auspices of the Rhode Island State Health Department is expected to offer health screening by the end of 1968.

Tests and measurements provided in the screening programs include: screening tests for cardiac function (electrocardiogram), chest x-ray, ocular tension (tonometry), hearing (audiometry), pulmonary function (spirometry), cervical cytology (Pap smear), retinal photography, visual acuity, and a number of laboratory tests including 12 blood chemistries, hematology, and urinalysis. In addition, questions concerning the past medical history, present symptoms, health habits, family history, and social history are self-administered.

A working conference brought together representatives from each of the four prototype projects, outside experts and consultants, and concerned personnel from the Public Health Service. Their group purpose was to define a framework for evaluation, considering what specific information is needed to judge performance of an "adult health protection center," by what criteria "success" may be defined, and what answers might be expected from these programs within the next few years. The recommendations emanating from this conference provided a valuable basis for developing specific procedures for implementation of the first stages of the evaluation plan.

In anticipation of a future need for information on which to base refinement of the methodology, a contract was negotiated with the University of Southern California to develop a research design for a project identifying health characteristics of various strata of the population.

A conference was called by the University of Rhode Island, supported through a contract with the Public Health Service, which brought together approximately 100 representatives of New England agencies concerned with adult health. This conference, geared at imparting current knowledge about aging and adult health protection programs, was intended to stimulate the development of adult health protection programs in other localities in the New England area.

During the past year three programs for aged, which offered health screening examinations utilizing traditional methods without automated laboratory procedures and computerization, were successfully completed. They were carried out in North Carolina, New Mexico, and Connecticut. Two of the three have been continued by the local health departments concerned. These programs successfully demonstrated: (1) that health maintenance services could be efficiently provided in a variety of geographic settings and to various socio-economic groups, and (2) that they were a needed addition to health services in a community. A similar new contract has been negotiated with a local health department in New Jersey for the establishment of a well oldster conference.

It is becoming increasingly evident that the delivery of effective and appropriate health and health-related services is being compromised by shortages in the supply of health personnel, as well as the paucity of

teaching programs and resources necessary to train health professionals oriented to comprehensive health care. While these inadequacies affect the health status of the population in general, they are of critical significance to the adult health segment of the population, for it is this population group which is affected most by illness and disability.

Reports such as those of the Millis Commission and of the Ad Hoc Committee on Family Practice reveal that extant graduate training in medicine does not generally provide physicians with an orientation in comprehensive patient care. Efforts have been directed at stimulating interest in the development of undergraduate medical curricula which provide orientation in comprehensive patient management. Contracts were negotiated with three medical schools--the School of Medicine of the University of Missouri, the School of Medicine of Tufts University, and the Mount Sinai School of Medicine of the University of New York -- each of which will develop a "blueprint" for a teaching program in comprehensive patient care.

A program has been developed at Meharry Medical College through which clinical experience is provided for dental and medical students in a community adult health maintenance program. At the University of Pennsylvania School of Social Work, a program now in its second year is providing supervised field experience for students in work with the aged. The Pennsylvania project has been most successful in generating interest among both faculty and students in this area, and serves as a demonstration to other schools.

For practicing physicians and other health professionals, graduate and continuing education courses are required to orient them to the unique health needs of the aged, and to alert them to new knowledge in this field. It is evident, however, that there is a paucity of adequately funded and well-organized activities for this purpose.

Support has been provided for the development of centers for continuing education in applied gerontology as components of university-based centers of continuing education. Such centers have already been developed at the University of Oklahoma and the University of Georgia; two additional centers are in the developmental stages at Boston University and the University of Nebraska.

The Gerontological Society, through contract support, has produced an impressive curriculum in gerontology to be used as resource material in the development of short-term institutes and workshops for health practitioners who serve the aged.

The Jewish Hospital of St. Louis, supported by a contract, conducted a study to evaluate the effectiveness of the program being carried out by the Gerontological Society. The final report underscored the fact that the supportive resource materials for professional training activities developed and distributed by the Gerontological Society serves as a valuable adjunct to sorely needed continuing educational activities of health professionals who work with the aged.

A method of providing personal health counseling which will motivate older adults to take positive action to protect their health is currently being developed and tested. In most cases, such positive action takes the form of visiting the physician even in the absence of distressing symptoms. Whether or not this action has occurred after counseling is a primary criterion for evaluating success of the method.

During 1967, three health counseling projects supported by the Public Health Service in cooperation with the Social Security Administration became operative--in Milwaukee (Wisconsin), Peoria (Illinois), and New Orleans (Louisiana). All of these contracts are utilizing a similar population sample, individuals over 62 years of age or older who are new applicants for Social Security benefits. Each project is designed to secure information regarding common health maintenance practices held among a group of adults who are a high risk for chronic diseases. Such data will prove valuable in planning services for the older person, and evaluation of the findings is due in 1968. Preliminary data, however, indicate an increase in adequate health maintenance routines after counseling is provided. Three new contracts were developed in Fresno (California), Buffalo (New York), and Holyoke (Massachusetts).

A number of study and evaluation activities in health services were undertaken in 1967. A project was developed on a contract with Washington University in St. Louis, calling for a national survey of physicians' attitudes toward aging and care of the aged, and the impact of these attitudes on the services rendered. The data have been collected and are under analysis; the final report is expected in the Spring of 1968.

An illustrated publication entitled "Office Evaluation of the Aging Patient: Disease Detection in Persons Over 45" was aimed at encouraging physicians to use a series of high-yield diagnostic tests and laboratory procedures as an integral part of regular health appraisal of adults. To gain knowledge about the reaction of the medical profession, the

publication was mailed to a 2-percent stratified sample of all general practitioners along with a questionnaire. With no follow-up, almost 40 percent of the questionnaires were completed and returned. Sixty percent of the respondents indicated that the publication influenced their thinking; more than 75 percent recommended that the publication be sent to all general practitioners.

A contract was awarded to Community Studies, Inc., of Kansas City, Missouri, for the purpose of developing the design and methodology for a study to determine the effect of changing socioeconomic forces on the utilization and provision of health services for the aged. The effect of Medicare was a prime factor to be taken into consideration. Research grant support was ultimately awarded to the investigation, and this grant research has continued. A first round of data collection has been completed in five midwestern communities on a sample of persons over 60, physicians, and facilities offering health services to provide baseline data on use and provision of health services and expectations for Medicare. Information on experiences under Medicare will be collected in a second round of data collection to be carried out in 1968. Papers on preliminary findings have been presented at such meetings as the American Public Health Association and the Midwest Sociological Society.

Division of Hospital and Medical Facilities

A primary objective of the Division of Hospital and Medical Facilities is to stimulate the construction of facilities needed to build up an efficient, well-coordinated network of services for the acute care, long-term care, and rehabilitation of all persons, including the aged and aging. Since the enactment of the Hill-Burton program, the Division has provided assistance for the construction of 69,000 long-term care beds in chronic disease hospitals, nursing homes, and units of general hospitals.

The need for construction of long-term care facilities continues at a high level. As the aging population continues to increase, the demand for adequate nursing home care for them must be met. In addition, the enactment of the Medicare program partially removes the economic barriers to care of the aged. State agencies report that 357,500 long-term care beds, including extended care facility beds, must be constructed, modernized, or replaced. 66.8 million dollars was available in 1968 for the construction of long-term care facilities. If continued, this level of financial assistance would stimulate the construction of approximately 11,200 long-term care beds per year.

The aging and aged will benefit also from the construction or modernization of other health facilities under the Hill-Burton program. Hospitals, diagnostic and treatment centers, public health centers, and rehabilitation facilities are used by the aging as well as other segments of the population. Funds available for these facilities totaled 200.4 million in 1968.

In addition, the following services provided by the Division contribute to improved health care of the aged and others throughout the Nation: (1) technical and professional consultation regarding all aspects of facility planning, design, and construction, which is available to States, public agencies, and nonprofit organizations; and (2) guide material relating to the planning, design, equipping, and construction of health facilities, which is being developed and distributed.

National Institutes of Health

National Institute of Child Health and Human Development

In its five years as the focal point of aging research at the National Institutes of Health, the National Institute of Child Health and Human Development has shaped a four-point program for advancing research on aging. The program consists of research grants, training grants and awards, direct research, and contract operations.

Through its direct and contract operations, the Institute has provided services that national and international scientific groups concerned with aging require--bibliographic services, a directory of human and organizational resources in aging research, and the support of conferences and symposia on various topics important in aging research.

Each area of aging research--biological, psychological, medical, and social--needs the active interest of scientists to solve problems in that area. Until recently, research in aging attracted few investigators. As a quantitative illustration of this, there were only 59 research proposals in aging from a total of 11,000 reviewed by NIH in fiscal year 1967. The task of the Institute is to increase interest in research in aging by all appropriate means and make available funds and mechanisms for support of such research.

Because training for future research is important, planning for future training is being emphasized by the Institute. A contract has been let to the Gerontological Society to survey research training needs in gerontology. The desired information has been gathered by conferences of scientists and educators interested in aging, questionnaires to individuals and institutions involved in training, and interviews at selected training sites. A preliminary draft of the Society's report outlines present manpower problems and suggests means of overcoming them. The final report is now being prepared by the Society.

A directory that would provide information on persons and institutions interested in the field of aging throughout the world has been badly needed. Such a document--a Directory of International Resources in Gerontology--is being prepared under a contract with the Gerontological Society. The directory will

consist of lists and descriptions of personnel involved in gerontological research, institutions with major commitments to research in aging and training for such research, scientific and professional organizations concerned with research and training for research in areas relevant to the problems of aging, and resources of value in aging research.

The directory will be prepared for publication in fiscal year 1969. It will facilitate (1) the coordination of gerontological research by putting investigators with similar interests in contact with each other, (2) the stimulation of cross-national research, (3) the broadening of the base of information about training opportunities, and (4) the rapid identification of universities, institutions, and individuals who could participate in enlarged programs of training and research in gerontology. The publication will be widely publicized and distributed throughout the world to interested investigators, associations, and institutions. It is anticipated that the directory will be revised frequently, as the field of gerontology changes and grows.

The ability to maintain effective coverage of the scientific literature in the field of aging is an important aid in the development of new knowledge. The Institute has supported the preparation and publication of bibliographic aids that facilitate the maintenance of such coverage by scientists. One of these is "Current Publications in Gerontology and Geriatrics" which consists of about 3,000 citations annually and is published in the Journal of Gerontology. This bibliographic information has been published in that journal for many years and provides a readily accessible source of information on research on aging. The Institute has also supported the publication of the abstract journal, Gerontology and Geriatrics, which is prepared by the Excerpta Medica Foundation. About 3,000 journals, in addition to books, reports, and other appropriate publications related to the basic and clinical sciences in gerontology and geriatrics, are reviewed and abstracted in this journal.

For even more effective utilization of the world's literature on aging, NICHD has developed an Aging Information Center which is about to become fully operational. The personnel of this Center will scan the world literature relevant to aging, identify appropriate papers, abstract them, and present them to the scientific public through abstract journals. In addition, the abstracts will be stored in a computerized system that will permit retrieval of information in appropriate form to guide many aspects of research in aging.

Several recent Institute-supported conferences have been on retirement. Little is known about the retirement and post-retirement phases of life, partly because the presence of large numbers of people in this period of life is a recent phenomenon. To advance research effort in this area, the Institute began a series of conferences on retirement, bringing together experts in aging, medicine, social sciences, and administration for an analysis of this period and its problems. Four conferences have been held. From a related conference on how living arrangements affect adults and the elderly, a book, Patterns of Living and Housing of Middle-Aged and Older People, has been published. The proceedings of the first retirement conference are now being prepared for publication.

Large-scale longitudinal studies of humans provide an important means for studying physiological, psychological, medical, and social aspects of aging. A conference in 1967 to bring together investigators working on the major longitudinal studies in this country was supported by contract at Duke University. The conference provided the opportunity for a discussion of the similarities and differences of the goals, populations and methodology involved in the different studies.

In a longitudinal study at the Institute's Gerontology Research Center in Baltimore, 600 men ranging in age from the late teens to nearly 100 years old have volunteered to undergo examinations every 18 months for the rest of their lives. Begun in 1957, this study has contributed data about the chemical, physical, and mental states of these men and how they, as individuals, are changing. Eventually, the experiment is designed to include 2,000 people, with equal numbers of men and women of all age groups. Generations within families will be studied for hereditary influences on the aging process.

Many phases of this longitudinal study are aimed at distinguishing between a normal decline in body functions with age and the effects of disease, since a distinct feature of aging is an increased vulnerability to disease. For instance, this longitudinal study has demonstrated a decline in glucose tolerance with age that would classify about half the older patients as diabetic by usual diagnostic standards. But whether this is a normal decline in function or is actually caused by the disease diabetes mellitus is open to question. Hopefully, extending these studies will give greater insight into the relationship of diabetes and old age.

At the Lovelace Foundation for Medical Research in Albuquerque, New Mexico, another longitudinal study is using commercial and military pilots aged 20 to 60 as test subjects. The study population

92 - 594 O - 68 - pt 2 - 26

will eventually include 500 persons. Every five years these men are evaluated to see what effect time has on respiration, cardiovascular function, renal function, and function of the nervous system. In addition, three other longitudinal studies, involving a total of over 2,000 persons, are being supported at Duke University, Brown University, and the Age Center of New England in Boston.

Learning research is a target area of the Duke study, as well as of the Institute aging program as a whole. Two conferences on learning and age have been held as a guide to program development--one at Duke and the other in Bethesda. Investigators at Duke are probing the reasons for the verbal learning deficit found in adults and the elderly. They are testing the effect of drugs on controlling the extreme anxiety that often interferes with learning in adults and are studying the cardiovascular events which bear on learning ability. These include the decline in cardiovascular function which usually precedes decline in mental function, and the observed phenomenon that the stage of the heart's working cycle affects speed of response. The effect of aging on short-term memory deficits may be largely responsible for changes in awareness, judgement, and emotion with age.

Recently, the Institute's Adult Development and Aging Advisory Committee met to discuss learning and aging. The state of this research field was discussed and preliminary steps taken to formulate and promote a strong research program in this area.

At the Gerontology Research Center in Baltimore, conditions are being devised which decrease the verbal learning deficit in older subjects. Conditions already developed by the investigators are enabling the subjects to read aloud while learning and permitting subjects an active response during learning.

Learning ability has been studied at the Center since 1960 using the paired-associate technique where new associations (e.g., between letters and numbers) are learned, similar to learning vocabulary in a foreign language or learning a code. Each item to be learned consists of a stimulus and a response. First, the participant is instructed to give a response when the stimulus is presented alone. This is followed by the entire item, stimulus and response, to confirm or disconfirm the participant's response.

The investigators hypothesized that, for the old person, the probability of responding correctly is related to learning; i.e., the higher the proportion of correct responses, the better the aged subject would learn.

To test this hypothesis, they used prompting; i.e., the stimulus was first presented together with the response, then the stimulus appeared alone. The participant had just seen the response with its stimulus and was quite likely to say the response when he saw the stimulus alone. The investigators found that the high percentage of correct responses during this type of prompted learning decreased the learning deficit in older subjects.

It has been shownthat learning performance is improved in old persons who respond frequently during the learning situation. This year, the investigators tested the possibility that overt responses serve as auditory stimuli which improve the likelihood of the response being retained. The study was designed to test learning performance under three different input conditions: visual only, visual with passive auditory (given by the experimenter), and visual with active auditory (given by the participant). They found that adding an auditory input to the visual input did facilitate short-term retention for the old. There appeared to be some small additional effect of active responding over and above the effect of auditory input. Why should learning and short-term retention improve for the old person when he says the material aloud or when the material is presented aloud? Evidence from several psychology laboratories indicates that material presented visually in short-term retention is converted to an auditory storage, and, if auditory storage does not occur, at least under some conditions, all the material is forgotten in a fraction of a second. The principal investigator of the Gerontology Research Center study, Dr. David Arenberg, believes the old have difficulty converting visual input to auditory storage. Therefore, any aspect of the learning situation that facilitates this conversion to auditory storage, such as active responding or auditory presentation, should be particularly beneficial to the old person's learning and retention. All of the results of this study are consistent with this view.

A great deal of grant-supported research as well as direct research deals with the identification, characterization, and control of the basic processes and mecnanisms which underlie the aging phenomenon.

In the past year, data collected in the longitudinal study at the Gerontology Research Center showed that performance of two organ systems declined more with age than performance of components of the systems. For the pulmonary system, changes in the vital capacity of the lungs (VC) (i.e., the greatest volume of air the lungs can expel after a maximum inspiration) have been recorded over a six-year period in young and old subjects in the longitudinal study. Average decline in function was the same for all age groups. However, on the task of using the pulmonary components to demonstrate maximum breathing capapcity of the lungs (MBC), older subjects showed a significant decline in performance not evident among younger men. MBC, the greatest amount of air that

can be voluntarily breathed during a 10-30-second period, is a reliable test of the ventilatory capacity of the lungs.

Changes in muscular system performance with age were analyzed by comparing young and old subjects with each other rather than with their own previous performances. The complex task performed was rotary crank-turning with the arms; the component tested was muscle strength of the arm and shoulder. Subjects were from the longitudinal study and ranged from 20-89 years old. The average composite strength score for the arm and shoulder declined from 150 in 20- to 69-year-olds to 130 for men in their seventies and 105 for men in their eighties. However, cranking ability began to decline at age 40 and declined progressively through age 89.

In both organ systems, the need for coordination ability to perform the more complex task seems to have put the older person at a disadvantage which would have not been predicted from the measurement of the potential (VC or strength) of the lungs or arms These studies point to a principle that will be tested further at the Gerontology Research Center: that the overall change in a system may be greater than the sum of the changes in the individual components of the system.

In other studies of body function, Dr. Richard Hausknecht, at Mt. Sinai Hospital in New York, discovered recently that postmenopausal females, both normal and those with endometrial carcinoma, secreted significant amounts of estrogens. However, the major estrogenic compound secreted was estrone, with little or no estradiol-17-beta being secreted. This is a reversal of the situation in normally menstruating females, where estradiol-17-beta is the primary estrogen, and relatively little estrone is secreted. This finding suggests that urinary estrogens in postmenopausal females may be metabolic byproducts of secreted steroids other than estrogens, possibly from the adrenal glands. Data thus far from this study suggest that the adrenals are the major source of steroids appearing in the urine of postmenopausal females as estrogen conjugates, and may play a relatively more important role in these females than in normally menstruating ones.

The information obtained from this study may be significant regarding treatment of neoplasms such as breast and endometrial carcinoma, frequently thought to be estrogen-dependent tumors and thus dependent on ovarian function. These data suggest such cancers may instead be influenced by other glands, whose products are eventually converted into estrogens.

An understanding of the basic biology of the human body is a major goal of aging research. The aim of Dr. Karl Meyer's study at

Yeshiva University Medical School in New York City is to explain the biological roles of the main groups of the mucopolysaccharides (complex sugar molecules with attached amino sugar and uronic acid groups) of connective tissue.

Some of the most striking events in the maturation and aging of the skeleton are alterations in the quantity and distribution of the mucopolysaccharides. The relative concentration of keratosulfate increases, while other mucopolysaccharides decrease. This research is trying to determine the structure and function of keratosulfate and other mucopolysaccharides, as well as their possible relationships to some inheritable diseases; e.g., Marfan's syndrome (characterized by skeletal abnormalities) and Hurler's syndrome (characterized by dwarfism and mental retardation).

The studies in this laboratory have led to the following data: (1) Keratosulfates are a family of similar but distinctly different compounds. (2) All keratosulfates are bound to specific proteins by strong chemical bonds. The nature of these bonds has been determined. (3) Keratosulfate is highly increased in tissues of patients with Marfan's syndrome, and it lacks the crosslinkages present in normal skeletal keratosulfate. (4) The structure of a portion of the keratosulfate molecule in old human rib cartilage recently has been determined. Finding the basic structure of various aging cells and tissues might open the way to altering these molecular structures to prevent or reverse detrimental changes in them with age.

Many of the investigations of basic processes and mechanisms are carried out in a variety of animal species, each chosen because of its particular suitability for the phenomenon under analysis. Basic mechanisms operating at the genetic, biochemical, or organelle, cell, and tissue levels tend to be highly similar in diverse forms of life. Thus, using a wide range of both invertebrates and vertebrates as laboratory animals has yielded significant results. One such result is the discovery that synthetases (enzymes which couple specific amino acids with their corresponding transfer or soluble ribonucleic acids) are differentially distributed in different organs of the same animal. This provides an exciting possibility for understanding the basis of cellular differentiation as well as of aging.

Dr. Morris Ross, a grantee at the Institute for Cancer Research in Philadelphia, studying the effects of diet on life span, on liver and kidney function, and on tumor incidence in the rat, has found that:

1) When the experimental dietary regimen, consisting of diets varying in their proportions of proteins, carbohydrates, and fats, was begun at weaning (21 days in the rat), significant extensions in life span were observed for rats fed a diet with a protein/carbohydrate ratio of 1/5, and whose intake was restricted. When the diet was offered

to mature rats in limited amounts, life expectancy was significantly increased. However, mature rats eating all they liked of the experimental diets showed a decrease in life expectancy.

2) A restricted intake of protein, carbohydrate, or both reduced the incidence of progressive glumerulonephrosis (PGN), a major kidney disease in rats. Carbohydrate restriction produced the best reduction in PGN. PGN reduction was not directly related to the level of protein intake.

3) Activities of several liver enzymes were correlated with various diets: e.g., the activity of alkaline phosphatase, which plays an important role in bone formation and carbohydrate metabolism, correlated directly with rate of change in body weight, regardless of protein, carbohydrate, or fat content of the diet.

4) Calorie and protein intake modify tumor incidence patterns in the male rat. Total tumor risk was directly and exponentially related to caloric intake, but time differences for development of each of the incidence patterns were related inversely to caloric intake. Within each dietary group, rats of heavier weight had greater tumor risks than lighter rats. Altering protein intake altered the type of cancers that predominated. Lowest incidence, greatest delay in time of occurrence, absence of malignant epithelial tumors, and greatest life expectancy were observed in underfed rats, whose intakes of protein, carbohydrate, and total calories were low.

How does the individual adjust to the biological changes of altered appearance, less vigor, slowed mental and physical functions, and expectation of death which he encounters with age? Social, cultural, and personality factors that contribute to good adjustment to aging are important areas of study. One study, at the Langley Porter Neuropsychiatric Institute in San Francisco, is comparing aging individuals of three subcultural communities of San Francisco: Mexican-American, Japanese-American, and Anglo-American. From the findings of such studies will hopefully come conclusions of which psychological and social effects of aging are unique to certain cultures and which may be universal.

Social adjustment is also being studied at Brown University, where changing consumption patterns of the aged are being analyzed. How old people spend their money is in part a reflection of their adjustment to the impact of aging. Data on income, savings, and expenditures for basic necessities in 1950 are compared with those for 1960-61, for example. The consumer behavior patterns of the aged in the 1960's are also compared with a younger segment of the population.

Growth of a developmental psychology that will define the molding factors of human personality and permit their control is essential.

Without satisfactory psychological and social adaptations to the later years of life, freedom from disease and economic worry will be of little value in making an extended life meaningful either to the individual or to society.

Generally, a behavioral science of the adult years is yet to be developed. The farther along on the age scale, the sparser are the data, the more primitive the theories that guide investigation, and the smaller the repertory of techniques for collection of data.

Little scientific research has been done which is adequate to describe the relationships between early and late human life. We know a fair amount about some relationships between infancy and childhood, or childhood and late adolescence, but such early data are seldom compared to the ultimate goal: a happy, well-adjusted, and productive adult.

To maximize talents and minimize inabilities at various ages, methods for measuring adult psychological capacities must be improved. Most present measurements were designed for either young or impaired persons. In many cases, loss of various abilities could be compensated for if they were better understood. Increased knowledge of changes in perception and movement with age should lead to engineering of a better environment for the elderly.

A milestone in the first five years of aging research at the Institute is the completion of the new Gerontology Research Center building at Baltimore. The Center is linked to the Baltimore City Hospital's chronic disease building where for more than a quarter of a century much of the intramural Federal research in aging has been carried out under increasingly crowded conditions. Activation of this new facility is scheduled to begin in March and, when fully operational, it will be the most comprehensive gerontology research facility in the country.

With facilities such as this and with a steady expansion of other resources--grants, contracts, and conferences--the Institute looks forward to a significant era in which aging research will at last come of age.

National Institute of Mental Health

Persons over 65 years of age constitute less than 10 percent of the population, yet they make up 24 percent of all first admissions to State mental hospitals and they occupy 30 percent of all public mental hospital beds.

Many of the mental health problems common to other age groups are common as well to the aged, but in addition this group is vulnerable to specific difficulties associated with the aging process. Although some of the mental impairment of the aged is a concomitant of physical aging, the psychological reaction to this physical process forms the basis for excess impairment. The high incidence of depression, suicide, withdrawal, and regressive responses on the part of older people provides a crucial area for attention by the National Institute of Mental Health. The handicaps imposed by nonacceptance and loss of status in a youth-oriented society accelerate the psychopathological reactions occurring within older persons. Congressional legislation (such as Medicare and the Older Americans Act) of the past few years is designed both to provide steps toward the solution of the problem and to call national attention to its magnitude.

Through the Section on the Mental Health of the Aging in the Office of the Director of the Division of Special Mental Health Programs, all of the relevant efforts and resources of the Institute are concentrated on this special program area. In general, the Section has concentrated on stimulating and encouraging: (1) the recognition and incorporation of specific mental health considerations in those programs for the aging where mental health aspects

have been unrecognized or unacknowledged; (2) appropriate provision for older people in those mental health programs where the aging have been neglected; (3) services and research in areas where new programs and more information are needed. Extramural basic and applied research grants, training and manpower programs, Hospital Improvement Projects, and intramural research have all been involved in some aspect of the development of the program on aging.

One of the first major programs to receive NIMH support was a Regional Center of Research on Aging, which was established at Duke University in 1957 with grants from NIMH and the National Heart Institute. Since that time, 44 senior investigators in varied disciplines have conducted research projects under the aegis of the Center dealing with subjects connected with the aging process, such as changes that take place in the brain and the effects of various emotional states on body processes of elderly people.

An active program of research in the mental health aspects of aging is being supported through the Extramural Research Division of the Institute. During fiscal year 1967, investigators supported by NIMH studied a range of factors related to the aging process and the mental health needs of the aged. Among the problems dealt with were the biological mechanisms of the aging process, the course and treatment of psychiatric illness in the aged, and the social, psychological, and cultural influences related to satisfactory adjustment in later life. Several studies were concerned with testing out and demonstrating new methods of assisting older individuals to maintain the best possible functioning.

For the past ten years, a group of investigators have been studying the incidence and manifestations of mental illness among elderly people in a large city. The three books and numerous articles that have appeared to date provide authoritative psychiatric, physical, sociological, anthropological, and psychological data based on close study of 600 elderly residents of the community and 534

elderly persons admitted for the first time to a psychiatric ward. The findings suggest that American society poses a series of adaptive tasks for the elderly and that these are more easily accomplished if the aging individual can sustain a relatively high level of involvement with others. Succesful aging seems to be related to the ability to reevaluate one's life so that one comes to seek wisdom - rather than escape - during new-found leisure. While better-educated oldsters seem to have an easier time mastering this ability, it can be found among older people in all socioeconomic groups. Elderly persons who have voluntarily withdrawn from certain social relationships maintain a higher morale than those who have been forced to withdraw because of physical illness, widowhood, or other deprivations.

Another group of researchers have begun to study a random sample of aged individuals enrolled in a medical care program connected with a metropolitan welfare department. The investigators will attempt to learn what health needs, particularly what mental health needs, are not being met among these low-income aged people, and, eventually, how the aging process affects the ability of these people to function in the community - and how this ability can be enhanced.

Other projects dealing with the normal biological, psychological, and social components of the aging process include experimental studies of perception and memory, the relationship between sociocultural patterns of living and the adjustment of women to the menopause, the effect of late remarriage on the mental health of people over 60, racial attitudes of older adults, and characteristics of the healthy aged. In one of the latter studies, many centenarians, despite handicaps, were found to have adjusted to declines and to have remained physically active and mentally alert. Among their characteristics were a willingness to help others, a keen sense of humor, inventiveness, and the ability to make decisions and to accept change.

The Institute has long been interested in what types of housing can meet the needs of elderly people and how a given type can influence an elderly person's satisfaction and adjustment. One project is studying the effects of special, noninstitutionalized housing for healthy elderly persons on the West Coast. In the first phase of the work, the investigators made an extensive survey of the apartments, houses, and hotel units being built for elderly persons of low or middle income. The investigators are now studying the effects of the different kinds of housing upon the mental, emotional, and physical well-being of the residents. They are also studying such questions as the consequences of older people (a) being segregated from young people, and (b) living geographically remote from relatives.

Another investigation of the same general subject is studying 1,700 elderly persons residing in various types of housing - some for older people only, some for people of diverse ages, some in the city, some in the suburbs. The investigators are learning what the aged themselves feel is important in housing, the kind of housing that would best meet the expressed needs, the extent to which these needs actually influence satisfaction with their present housing, and the effect of socioeconomic variables.

Investigators elsewhere are measuring the effects of the availability of social and medical services in various housing arrangements for the aged, and identifying some of the characteristics of those aged who choose these types of group-living arrangements rather than remain in a larger, more heterogeneous community. Residents of eight different group-housing settings for the elderly - including public, nonprofit, and commercial developments - are being compared with one another and with people outside of such developments.

One of the major problems that plague managers of public housing is the need to provide services in such fields as health - mental and physical - social welfare, and recreation. The Community Service Society of New York City is attempting to meet this problem by giving

special training to mature women and placing them in public housing developments as information and referral sources for elderly residents. One of these senior advisory service workers has been placed in each of four housing projects, each with 300-500 persons aged 60 or more. A fifth project is used as a control. The elderly, readily responding to the program, have made the offices of the service workers places for meeting, discussing their problems, and seeking information and help. The New York City Housing Authority has responded very favorably and offered full cooperation in expanding the program.

Since our society largely excludes the aged from the world of work, we need to learn more about reactions to retirement and about ways of establishing new work patterns for older people. Two groups supported by the Institute are currently studying variables - such as morale, role alteration, and uses of leisure time - that affect adjustment to retirement. Another project has dealt with the importance of work in assisting elderly individuals to function adequately in the community. One hundred and twenty-five people, aged 55 to 86, with impaired social functioning, were employed in a sheltered workshop. Many persons found that this experience increased their independence and improved their morale; for a few it even resulted in regular employment. Dependent aged persons, who were advanced in years or in poor health, gained some degree of satisfaction from participating in the program. Aging, depressed persons, who enrolled in the workshop as a means of combating emotional regression, benefited from the personal counseling that was available and were able to move toward engagement in other community activities.

The feasibility of retraining older persons for productive employment in community services has been demonstrated by a widely influential project of the Senior Citizens Center, Nashville, Tennessee. Of the 68 persons trained during the three years of the project, all but five have remained actively engaged in various service programs. Activities include working with school dropouts, tutoring high school students, assisting with social and recreational activities in the State mental

and Veterans Administration hospitals, participating in a program of crafts for homebound individuals, directing a crafts program in a low-cost housing project, and establishing senior citizens centers in communities without such facilities. This project was so well accepted by the community that local sources have supported and expanded it since the end of NIMH support.

A pioneering demonstration project in a rural community, lacking the resources found in urban centers, has also had marked success. Elderly persons were called upon to analyze and serve the needs of the entire community. They undertook such projects as community beautification, the formation of a taxicab company, planning with the county for OEO funds, and the development of various home-care services. The community benefited, and the elderly volunteers, knowing they had achieved a definite role, reported significantly better morale.

In addition to examining the normal processes of aging and of ways to meet the accompanying problems of reasonably healthy older people, NIMH is interested in the special problems of those elderly persons who are mentally or physically impaired.

Improved methods of finding and helping impaired older persons are being devised in several demonstration centers, and special attention is being given to preventing unnecessary institutionalization. In one city, a multidisciplinary team examined 112 individuals over the age of 65 who had been referred to the county court for proceedings leading to commitment in a State hospital. In about 75 percent of the cases, the team suggested an alternative to such commitment. Available community resources were mobilized to provide appropriate medical and psychiatric treatment.

For those aged who require institutional care, grantees are seeking ways to prevent further physical

and psychological deterioration. One home for the aged tackled the problem by establishing a sheltered workshop, with scheduled hours and production standards, that provided gainful employment. Participants in this workshop showed so much improvement, in terms of functioning as well as in feelings of self-esteem and well-being, that the institution has continued the operation even though the NIMH grant has ended. Now, under another grant, the program has been expanded to include residents whose physical handicaps and brain damage do not permit them to leave that part of the institution where they live. Subworkshops have been established in the various living quarters, and special bedside facilities have been designed for nonambulatory patients.

The extent and nature of mental impairment among residents of homes for the aged - there are 250 such homes on the Eastern seaboard - are being studied in order to learn how the levels of care in these institutions can be improved. Preliminary findings show that nearly two-thirds of the residents manifested some symptoms of mental impairment and that almost one-third displayed signs of depression severe enough to justify the services of a psychiatrist. In only a small percentage of the cases did the personnel of the homes studied recognize the severity of the condition.

Another investigator is determining the effects of individualized treatment on mentally impaired persons in a home for the aged. Such persons, the investigator believes, are more disabled functionally than is warranted by the extent of the damage to their brains. If the factors - physical, psychological, and social - responsible for this "excess disability" can be identified and treated, a good deal of improvement should result.

Some cases of apparent mental deterioration have turned out to be caused by undetected physical disabilities such as loss of sight or hearing. Investigators at a State hospital in Minnesota made a systematic study of the effect of hearing loss upon psychological functioning. Older patients were given a thorough

examination by an audiologist, and, in feasible cases, correction and rehabilitative programs were undertaken. These included surgery, provision of hearing aids, and cleansing of the auditory canal. Patients whose hearing improved showed significant improvement in their general behavior. The program has now been adopted by the State, and a Hearing Center has been established to serve all the hospitals in the State system.

To improve the care of geriatric patients, one research group is studying the effects of several different milieu therapy programs upon older mental patients while they are hospitalized and after they have been discharged to various aftercare settings; another is investigating the use of psychoactive drugs in the treatment of geriatric patients; a third is studying the terminal phase of life and the care of the dying.

In the interest of providing basic information, useful at first mainly in research but with a potential effect on treatment and prevention programs, the sleep patterns of patients with chronic brain syndrome are being studied, as are the biochemical bases of senile dementia. So that all researchers and clinicians concerned with mental impairments in the aged can speak the same language, another investigator is developing a standardized form for assessing psychopathology in geriatric patients.

Through its Hospital Improvement Program, the Institute is working to raise the level of care for elderly patients in State mental hospitals. As of the end of fiscal year 1967, 17 projects directed specifically toward aiding geriatric State hospital populations were being supported.

Close attention is paid in HIP programs to milieu therapy and to remotivation programs. Attempts are made to involve families and friends of the patient and to bring about stronger relations between the hospital and agencies in the community. Several projects include preadmission screening and referral programs; others incorporate supportive follow-up services. Some projects address themselves to specific segments of the geriatric

population, such as severely debilitated patients requiring considerable nursing care, chronic patients who have been long institutionalized, recent geriatric admissions, and patients showing the best chance of living independently outside the hospital.

At one State hospital, HIP funds were used to establish a Geriatric Treatment Center to provide intensive care for all patients with the potential for independent living. During a two-year period more than half of the newly admitted patients were accepted for treatment on the project. Of this group of 200, almost 90 percent could be discharged to alternative care facilities within 90 days after admission to the Center. The program is now housed in a new building designed to serve as a model for geriatric care. To existing programs - which include rehabilitation, therapeutic recreation, family counseling, and geriatric outpatient services - a community visiting service and a day-care program are being added.

The improvement program at another State hospital is concerned with the most severely disabled patients, who require large amounts of staff nursing time. By directing staff energies toward rehabilitation and focusing attention on the physical, social, and psychological needs of the patients, this program has reduced the physical dependence of these patients and increased their participation in social and recreational activities.

A Community Placement Center was established at another hospital to provide an intensive treatment and planning unit for geriatric patients and others considered difficult to place in the community. It has programs to encourage patients to return and to educate them for community living. Housing 50 patients at a time, the Center has returned double that number to the community in a year's time.

A program in Texas is demonstrating how even a remote hospital, lacking adequate staff and resources, can stimulate elderly patients to care for themselves and take interest in their surroundings. A group of 90 women,

mobile and in moderately good health, were moved to a renovated, partitioned ward with mirrors. They were told that they were ladies and were expected to behave as such. Lessons were given in self-grooming, and the patients were required to bathe themselves and to buy or make their own clothes instead of having them issued. The response to the pleasant surroundings and to the expectation of self-reliance was dramatic. For example, the women began planning and participating in activities and being more friendly and cooperative. Because of its success, the program has been enlarged to include a men's ward.

In dealing with the mental health problems of the aging, manpower, of course, is critical. Besides the more general training programs of the Institute, a number of programs directed entirely or in large part toward providing more and better-trained personnel for working with the aged are supported. One grant finances a two-year advanced residency training program in geriatric psychiatry. Another supports a program to increase the number of clinically skilled psychiatric nurses who are interested particularly in the geropsychiatric aspects of their work. It is a one-year program for psychiatric nurses who already have a master's degree. Most of the other training programs in this field are for social workers.

Social work schools throughout the country are increasingly responding to the need for manpower for services to the aged. Their graduate curricula include seminars and courses dealing with geriatric problems and theory, as well as training and experience in group work and casework services to the aged in a variety of settings. The 14 schools with special training programs supported by the Institute provide students with a broad range of field experience that includes recreational and group work programs, community centers, hospitals, public housing development, Golden Age clubs, homes for the aged, general hospital comprehensive care programs, nursing homes, and social service departments of medical schools. Field training also includes experience with such groups

92 - 594 O - 68 - pt 2 - 27

as retired workers, elderly people with physical and mental disabilities, and persons who are poor as well as old.

Specialized services for the aged as part of the program of comprehensive community mental health centers are being developed, particularly in areas having a sizable proportion of elderly people. For example, in California, where many older people have chosen to reside, the San Luis Obispo Community Mental Health Center has an active program for the elderly that includes medical, social, rehabilitative, and financial planning. In collaboration with the Department of Public Welfare, the Center provides consultation to all nursing homes and physicians in the county. The program's goal is to support and maintain general health at the maximum level, to prevent emotional problems, and to maintain satisfying and meaningful functioning in the community. Prescreening and alternative community services are used to prevent unnecessary admissions to the State hospital 150 miles away. For those who do go to the hospital, the Center coordinates appropriate aftercare services; it becomes involved in the planning for the patient's return while he is still hospitalized. Home visits are made to older persons living in the remote areas of the county to familiarize them with the services available at the Center and to encourage their utilization.

Today, there are some 20 million Americans above the age of 65 and some 12,000 above the age of 100. By the year 2000, it is estimated that 65 million of our people will be over 65. The mental health aspects of aging are, therefore, among the most important areas of scientific inquiry supported by the National Institute of Mental Health. While medical science has increased the prospects of longevity, the complexities of modern life - urbanization, automation, the exponential growth in knowledge and technology - pose problems of adaptation for older persons far greater than those of earlier times and simpler societies. The National Institute of Mental Health, in pursuit of its research mission in the public health problems of aging, is providing support to a wide range

of scientists and clinicians to enable them to direct their skills to the problems - of physical, intellectual, emotional, and social functioning - faced by older persons. Through research endeavors, clinical studies, community demonstrations, and training programs, improved abilities to care for, treat, and rehabilitate are being developed that will permit a far larger proportion of the aged to maintain meaningful and rewarding roles in American life.

Office of the Surgeon General

Comprehensive Health Planning and Services

As of July 1, 1967, the Office of Comprehensive Health Planning became responsible for 16 formula and project grant programs previously carried in nine separate appropriations. Various types of aging programs were supported by these grants as follows, and it is expected that similar projects will be supported in future years:

1. Service action program for heart, cancer, stroke and related illness;

2. A study of the role of a geriatric facility in the development of evaluation and referral services for the chronically ill and aged;

3. A study of the method for the prevention of dependency in later years; and

4. Home nursing care for the chronically ill and aged.

The non-categorical nature of the formula and project grants provides the States and communities with a flexible means of supporting improvement in the delivery of health services. The single formula grant is designed to meet the specific health needs of each State, according to priorities established by that State. Project grants are now intended to: (1) provide services to meet health needs of limited geographic scope or of specialized regional or national significance, and (2) develop new and innovative public health services. The comprehensive public health service projects (as an example), now being planned for areas with particularly high incidence of health problems, will provide a full continuum of service, including prevention, diagnosis, treatment, chronic care, and rehabilitation. The aged would certainly be covered under such a program.

SOCIAL SECURITY ADMINISTRATION

Objective

The Social Security Administration is responsible for administering the social security program which provides old-age, survivors, and disability insurance protection for over 90 percent of the workers and their families in the United States. It also provides hospital insurance protection for virtually all individuals in the United States who are age 65 or older, as well as voluntary supplementary medical insurance coverage elected by about 93 percent of those age 65 or over.

Benefits to Older Persons

Cash Benefits: Monthly benefits are paid: (1) To insured workers between the ages of 62 and 72 who have substantially retired from gainful employment and beginning at age 72 without regard to work status; benefits are also paid to wives of beneficiaries at or after age 62 and to widows of insured workers when they reach age 60. Children of retired, deceased, or disabled workers are also eligible for benefits when they are under age 18, and after age 18 if they have a severe disability which began before that age and which has made it impossible for them to work and support themselves. For those children continuing to attend school at age 18 and above, monthly benefits are payable up to age 22. Benefits are paid to mothers (irrespective of age) when they have such children in their care, except for the students age 18 and over; (2) to insured workers up to 65 years of age who have worked a specified period of time in covered employment and have a medically determinable disability which can be expected to last for a continuous period of not less than 12 calendar months and so severe that it prevents them from engaging in any substantial gainful activity; (3) to certain individuals age 72 and over who are not insured under the social security program; and (4) to certain disabled individuals at age 50 who qualify as widows, widowers, or divorced wives of insured workers. The latter category of payments was enacted into law by the first session of the 90th Congress (P.L. 90-248) and is effective March 1968. In addition, two major changes in P.L. 90-248 extended existing entitlement to benefits by: (1) Liberalizing the insured requirement for disabled workers under age 31; and (2) establishing the same insured requirement for dependents of female workers as those for male workers. These provisions are also effective March 1968, and are initially estimated to benefit 275,000 individuals.

Of the 23.7 million beneficiaries receiving monthly old-age, survivors, and disability insurance benefits at the end of December 1967, about 18.2 million were age 62 or over. About 90 percent of all persons now 65 and over are either receiving old-age and survivors insurance benefits or would be eligible for benefits on retirement. This proportion will grow until practically all aged persons are protected. The number of disabled workers and their dependents receiving benefits at the end of December 1967 totaled 2.1 million.

The 1967 Amendments to the Social Security Act increased the monthly benefit amounts by 13 percent, effective February 1968, and increased the minimum monthly benefit from $44.00 to $55.00. The estimated effect of the benefit increase on average benefits for selected categories of OASDI beneficiaries in current pay status in February 1968 is shown below:

Benefit Category	Average Benefit Payment Before Increase	Average Benefit Payment After Increase
1. Retired worker without dependents	$82	$94
2. Retired worker and his aged wife	145	165
3. Aged widow	75	86

For families with benefits computed on the basis of earnings after 1950, the averages are higher. Among these families the average benefits for February 1968 before and after the amendments were as follows:

Benefit Category	Estimated Average Before Increase	Benefit Payment After Increase
1. Retired worker without dependents	$89	$101
2. Retired worker and his aged wife	152	173
3. Aged widow	84	96

These average benefits are expected to increase over time, since the percentage of benefits based on earnings after 1950 is higher for current awards than for all benefits currently being paid. Also, the maximum earnings base which can be used in calculation of benefits has been increased from $6,600 to $7,800 effective January 1, 1968, as a result of the 1967 amendments.

The 1967 amendments also increased the monthly benefit amounts paid to certain people age 72 or older who qualify for uninsured (Prouty) benefits. Beginning with February 1968, the payment to a single person under this provision is increased from $35 to $40 a month and for a couple from $52.50 to $60.00 a month.

Health Insurance Benefits: Nearly all of the 19.5 million persons aged 65 and over in the United States (as of January 1, 1968) are afforded basic protection against the costs of inpatient hospital services, outpatient diagnostic services, post-hospital home health services and post-hospital extended care facilities under the hospital insurance program established by the 1965 Amendments to the Social Security Act. In addition, an average

of about 18.3 million persons aged 65 and over are expected to be enrolled during fiscal year 1968 in the voluntary supplemental medical insurance program, which covers physicians and related services. Both programs provide for payment of these costs subject to certain deductible and co-insurance amounts.

Medicare payments to hospitals, extended care facilities and home health agencies are expected to total an estimated $3.4 billion in 1968 (the first full year of all phases of the hospital program) and $3.9 billion in 1969. Supplemental medical insurance payments for 1968 and 1969 are estimated to amount to $1.5 billion and $1.7 billion, respectively.

Services to Aged Individuals and to Community Groups

The social security program is nationally administered. Local communities are served by over 640 district offices and over 3,500 branch offices, service centers, resident stations, and contact stations.

Social security district offices give information to the public and answer inquiries about the benefits available to those who meet the conditions specified under the insurance provisions of the Social Security Act. Old-age, survivors, and disability insurance claims for benefits are received, developed, and initially adjudicated in the district offices. Help is given in securing the factual information needed to determine eligibility for benefits and persons filing claims are advised as to their rights. For those adult beneficiaries determined by SSA to be incapable of management of their benefit funds, usually based on the evidence of a physician's statement, a person other than the beneficiary is selected to receive the checks, and is held accountable for their use in the best interests of the beneficiary.

District offices keep current information about community resources and make referrals to meet the service needs of persons seeking help to other agencies when appropriate. The district office manager and staff also participate with local groups in planning for community services.

The Social Security Administration cooperates in many ways with other Federal, State, and local programs, especially with community agencies which can offer services not provided by the social security insurance programs.

The modes of cooperative endeavors between the SSA and other agencies include both the experimental and the continuing efforts to meet selected problems and needs. Illustrative of these activities are:

1. Joint projects of PHS and SSA wherein applicants to SSA in a few selected communities are offered a health counseling service by a PHS counselor separate from the district office operations, to help the aged person find health resources and maintenance in the event he has none or is neglectful of his health. In other communities social security is not directly involved, but with a fully developed comprehensive health service program available to a group such as found in a housing center project, the Social Security Administration can make immediate referrals of persons seeking health care with assurance it

can be provided. In such a project it is essential that SSA staff keep fully informed on the nature of the project and what services are available to people who are referred to it; and

2. Cooperation with the Center for Community Planning in the Department of Health, Education, and Welfare and the Department of Housing and Urban Development in implementing model cities legislation. The objective is development of a coordinated and comprehensive attack on the problems which affect blighted neighborhoods in our larger cities. The Department of Health, Education, and Welfare will have a community liaison representative in, or responsible for, each of the 63 cities which have been selected to receive model cities planning grants. In 56 of these cities the local social security district office manager will be the Department of Health, Education, and Welfare's community liaison representative. Among his many responsibilities will be: Funneling city requests for help to the regional coordinator; keeping informed of city programs and needs; working closely with the city planning teams; and passing information on to the regional offices and to Washington, D.C.

Social Security joins with other responsible organizations of the community in gathering adequate information on the numbers of aged, disabled, and dependent children of survivors, for purposes of community planning for the continued development of health, vocational, and welfare services. With the advent of medicare and medicaid there has been increased interest in community analysis of resources such as hospitals, extended care facilities, home care, and other health services. At the same time there is need for corollary information on the numbers of SSA beneficiaries in different categories, and data which might give clues to both incidence and trends in critical problems of people. With widespread gaps in health resources such as nursing services, and with the need for community planning recognized through passage of new grant programs to State and local communities for planning, SSA is an active member of the team in many areas.

The following are examples of SSA cooperation and collaboration with other agencies toward the objectives of having more services available to beneficiaries and all others in the community who need the services.

1. At the Federal level more services are being developed through interagency planning committees directed by:

   a. Department of Agriculture for rural health projects in selected areas.

   b. Public Health Service for health maintenance projects for the aged.

   c. Social and Rehabilitation Service for development of protective services projects to meet the needs of incapable aged beneficiaries.

   d. HUD for development of experimental information and service through the Neighborhood Service Program.

e. PHS on programs for the education of agency personnel in local communities on potentials in home care and combined health services and in communities without facilities for such programs.

2. At the State level the assistance to State health departments to fulfill medicare requirements and to promote full potential for care of the aged in institutions, outpatient, and home care models with:

   a. Participation in experimental training programs for community service personnel on the problems and needs of the aged and chronically ill.

   b. Consultation to State personnel, e.g. when used for planning and promotion of health services as related to medical care.

3. At the local level interagency community planning and development of resources such as:

   a. Surveys and analysis of health and welfare facilities and services.

   b. Collaboration on information and referral centers, providing a contact service for persons having questions or concern about SSA benefits.

   c. Experimental centers of information or service under special arrangements, such as in the Federal Office Building, to help the public obtain information on Federal services. One of these is functioning in Atlanta and half of the public inquiries in the Federal Office Building are related to SSA.

   d. Demonstrations of vocational training to provide the unskilled and lesser employed person in certain rural deprived areas selected in conjunction with regional and State staff.

   e. Close cooperation with Public Welfare and service agencies providing special help to handicapped or other groups such as the mentally retarded.

Research on Economic Security for the Aged

The Social Security Administration research and statistical program provides information derived from the operations of the Social Security Administration system, from population surveys and from studies of related public and private income maintenance programs that is useful for continuous evaluation of the effectiveness of the social security program in providing economic security for the aged, including protection against the costs of hospital and medical care. Data are developed and published regularly in the Social Security Bulletin and its Annual Statistical Supplement, in special published reports and in various other ways to meet user requests.

Indicative of the types of information made available and of interest to officials and groups planning programs for the aged are: Continuously

reported data on claims and benefit payments to retired workers and their dependents; the findings of surveys of the aged population, including OASDI beneficiaries, which provide information as to the level of economic security that social security benefits support (information obtained on income includes sources of income of individuals and families, level and types of assets owned, special demands on income such as medical expenditures, etc.); special studies that show the changing share of the total national output going to the aged, what measures of income adequacy are most appropriate and meaningful, the relations between individual and family income over the life cycle; continuing statistical series that are concerned with the totality of public and private income maintenance protections and the relative weight of the social security program in that totality; research to measure the impacts on both public and private health and medical care; identify and define gaps and unmet needs under the health insurance program, and examine and evaluate the economic consequences of the health insurance program. Social Security Administration research draws heavily upon basic data in the social security system, data from the population survey program, and upon data from Census, BLS, and other statistical sources.

Funds for Programs on Aging

(In thousands - existing legislation)

	1965	1966	1967	1968 Estimate	1969 Estimate
General fund appropriations:					
Food and Drug Administration	15,206	18,512	20,302	22,000	23,000
Office of Education (vocational education, library services, research, supplementary centers and services, community services, adult basic education, and administrative costs)	17,758	22,140	22,175	23,435	24,135
Public Health Service:					
Bureau of Health Manpower	2,214	1,528	790	672	566
Bureau of Health Service	51,150	54,139	56,955	62,167	59,390
Bureau of Disease Prevention and Environmental control	3,155	3,737	5,084	8,114	14,857
National Institutes of Health	4,320	5,764	7,270	7,488	7,861
National Institutes of Mental Health	2,630	4,780	3,967	4,129	4,027
Office of the Surgeon General	51,000	55,300	46,787	45,000	45,000
Total, PHS	114,469	125,248	120,853	127,570	131,701
Social and Rehabilitation Service:					
Vocational rehabilitation services and facilities, training and research, and demonstrations	27,865	40,653	61,020	73,915	88,685
Grants to States for public assistance:					
Age 45 to 64	252,900	293,700	435,000	551,100	640,400
Age 65 and over	1,711,700	1,903,900	1,872,900	2,084,000	2,152,200

	1965	1966	1967	1968 Estimate	1969 Estimate
Administration on Aging (Grants to States for community planning, services, and training; grants for research, demonstration, and training; and technical consultation services)	587	7,341	9,327	18,450	27,821
Total, SRS.....	1,993,052	2,245,594	2,378,247	2,727,465	2,909,106
Total, general fund appropriations.....	2,140,485	2,411,494	2,541,577	2,900,470	3,087,942
Federal Old-Age Survivors, Disability, Hospital, and Medical Insurance Trust Funds:					
Social Security Administration:					
Disability insurance payments:					
Age 45 to 64....	988,000	1,202,000	1,297,000	1,476,000	1,760,000
Dependents age 65 and over	8,000	8,000	9,000	10,000	11,000
Retirement/survivors insurance payments:					
Age 45 to 64.....	1,500,000	1,748,000	1,846,000	2,002,000	2,314,000
Age 65 and over..	12,108,000	14,129,000	14,855,000	16,352,000	18,692,000
Hospital insurance payments:					
Age 65 and over..	---	---	2,508,000	3,369,000	3,865,000
Supplementary medical insurance payments:					
Age 65 and over..	---	---	664,000	1,473,000	1,656,000
Total, Federal Old-Age, Survivors, Disability, Hospital and Medical Insurance Trust Funds.	14,604,000	17,087,000	21,179,000	24,682,000	28,298,000

	1965	1966	1967	1968 Estimate	1969 Estimate
Total, Department of Health, Education, and Welfare.....	16,744,485	19,498,494	23,720,577	27,582,470	31,385,942

JUVENILE DELINQUENCY

INTRODUCTION

The complex problem of juvenile delinquency is of increasing national concern, both because of its monetary cost, estimated at more than $20 billion a year, and because of the inestimable loss to society in the damaged lives of troubled youth. The number of delinquency cases among youngsters between the ages of 10 and 17 has been increasing faster than the number of youth in this age group. Recent studies indicate that one out of five boys in the age range of 10-17 will appear in juvenile court. This is a nationwide average; in some deteriorated urban areas, as many as nine out of ten of the juveniles have had juvenile court contact.

To attack this crucial problem, a number of units within the Department of Health, Education, and Welfare are seeking new solutions through demonstration and training programs, and are strengthening state and local efforts through consultation and dissemination of current information about successful community experiences.

While there are many diverse programs and strategies for tackling the problem of delinquency within the Department, there are also many common threads that appear in the attached unit reports. There is a consensus that the key areas of intervention to prevent delinquency are education, youth employment, neighborhood services, courts and corrections, group services, legal services, and youth involvement. Inter-departmental activities emphasizing exchange of ideas and materials, and joint conferences and committees have strengthened and coordinated on-going programs and new developments.

Individual reports describing the work of the following units in the Department are contained in this overview:

1. Public Health Service - NIMH
2. Social and Rehabilitation Service
    a. Office of Juvenile Delinquency and Youth Development
    b. Children's Bureau - Division of Juvenile Delinquency Services
    c. Rehabilitation Services Administration
3. Office of Education

SPECIAL REPORT
CRIME AND DELINQUENCY

Introduction

Antisocial behavior, ranging from truancy and petty thievery to multiple homicide, has become a major problem in our society. Its monetary cost to the Nation - including the loss of law enforcement, administration of justice, and correctional efforts - has been estimated at more than $20 billion a year. The psychological costs, which defy measurement in terms of dollars and cents, affect in numerous ways the lives of countless innocent people.

The number of offenders under correctional supervision at any given time approximates 1.3 million, with close to 30 percent of them in jails, prisons, and reformatories. Delinquency cases among persons between the ages of 10 and 17 have been increasing at a considerably faster rate than the number of youngsters themselves. Recent studies indicate that one out of five boys within this age range will appear at some point before the juvenile court. In some deteriorated urban areas, as many as 9 out of every 10 juveniles have had some contact with juvenile authorities.

Although the 15 to 17 age group represents only 5.4 percent of the population, it accounts for 12.8 percent of all arrests - the highest arrest rate in the United States. The problem in the years ahead, should the present situation continue, is dramatically suggested by the fact that 23 percent of the population is 10 or under.

Delinquency and criminal behavior stem from a complex interaction of psychological, social, and other factors. The precise nature of this interaction is poorly understood, but such behavior, it is generally agreed, is symptomatic of underlying social and emotional dysfunctioning.

Prepared January 1968 as background information for the Director of the National Institute of Mental Health, Public Health Service, U. S. Department of Health, Education, and Welfare, in connection with fiscal year 1969 appropriation hearings.

The National Institute of Mental Health has a specific mandate to be concerned with the prevention and control of law-violating behavior. Further, the Institute's role in this area arises naturally from its primary function as a research organization dealing with the phenomena of human behavior, especially problem behavior.

The Center for Studies of Crime and Delinquency serves as the Institute's focal point for activities directed toward understanding and doing something about this particular type of problem behavior. Included in the efforts of the Center are basic research on the causes and nature of crime and delinquency; the development and better coordination of community resources directed at delinquency prevention and control; a search for suitable alternatives to incarceration; the development of better rehabilitation techniques for use with offenders in institutions; the development of more effective ways of training and using professional and nonprofessional mental health, correctional, and related personnel; and the provision and improvement of services and facilities for mentally ill offenders. The Center works also for the more effective communication of new knowledge through publications, conferences, and direct consultation with States and communities.

More than 160 research, demonstration, and training projects directly related to the effort against crime and delinquency are being supported by the Institute.

Research and Demonstration Projects

The work reported in this section is representative of Institute-supported approaches to fill major gaps in our knowledge about the prevention and control of crime and delinquency and, where appropriate, to test the validity of these findings.

Several studies using different techniques are trying to answer such basic questions as where and under what circumstances criminal or delinquent behavior occurs,

and who participates in it, for what reasons, and how frequently. One investigation, for example, seeks to determine the incidence, frequency, and type of delinquent acts committed by a group of 14,000 boys in a large metropolitan area. All the boys were born in 1945, entered schools in the area under study before the age of ten, and remained in that area through their 18th birthday. The investigators are determining how delinquency evolves by age and the severity of offenses, and they are comparing the delinquents with non-delinquents in respect to such variables as school history, intelligence, race, and residential area. Preliminary findings indicate that approximately one-third of the group are listed officially as having committed delinquent acts, a number of these having been very minor violations. One highly important result of this study, it is expected, will be information about those points where intervention will most effectively prevent further or more serious delinquency among different classes of delinquents.

Another investigator has begun to measure detected and undetected delinquent activity among a representative sample of American boys and girls ranging in age from 13 to 16 years. His purpose is to obtain information about the nature and circumstances of the delinquent acts, and to place these acts in a psychological, sociological, economic, and cultural context. The results should contribute much to our understanding of delinquency and of the development of mental health in children. One significant contribution is expected to be the establishment of national norms for delinquent behavior, which should increase our ability to determine where efforts at prevention are especially needed.

With two-thirds of the total corrections caseload under probation or parole supervision at any given time, the central question is no longer whether to handle offenders in the community, but how to do so safely and successfully. While it is necessary to confine dangerous offenders in order to protect the community, recent studies have demonstrated that intensive community treatment is an economical and desirable alternative to incarceration.

92 - 594 O - 68 - pt 2 - 28

In one of the most influential of these studies, approximately 600 youngsters from 13 to 18 years of age were referred to the agency administering the grant - the California Youth Authority - as first commitments from the juvenile court. All the youngsters except those who had been convicted of serious assaults were then randomly assigned to an intensive community treatment program and to the regular correctional institution. A follow-up after three years shows that intensive community treatment was markedly more successful and cost much less than institutionalization. Reports indicate that only 28 percent of the community-based group have been subject to parole revocation, as against 52 percent of the institutional group. Savings in construction costs alone have amounted to $8 million.

A study of the effects of variation in the intensity with which probation officers supervise offenders leads to another significant finding. The degree of supervision seems to make little difference in the rate of violation, which indicates that the role of the probation and parole officer may need to be redefined. Under the new role, the investigator suggests, the officers should act as a mediator between the offender and the community, and should encourage the community to absorb the offender as one of its members.

Also concerned with the potentialities of treatment within the community is a study whose subjects are young male felons who have been referred for pre-sentence investigation. These are classified into three groups on the basis of probation success probabilities and then randomly assigned to an experimental or a control group. These groups differ in regard to (1) frequency of worker-client contact, (2) theoretical orientation of the caseworkers, (3) nature of the treatment unit supervision, and (4) availability of psychiatric consultation. Evaluation is based on the incidence of arrests, convictions, and revocations during probation, and on the degree to which the offenders attain an acceptable level of social functioning.

Another project has brought together various lay and professional groups to study how existing programs for youth can be made most effective. The aim is to help develop a unified community approach to youth problems.

The so-called typological approach to the treatment and control of delinquency is being taken by another group of Institute-supported studies. In such an approach, the investigators seek to learn what kinds of treatment programs, in what kinds of settings, administered by what kinds of treatment agents, are most effective with different kinds of delinquents.

The study mentioned earlier that demonstrated the effectiveness of community treatment placed delinquents in one of three major groups according to their degree of social maturity - low, middle, or high. The investigator reports that each group needed quite different methods of treatment and control. The very immature, somewhat infantile clients received a great deal of support and guidance; the middle-maturity subjects, who were guided more by the power of authority than by a sense of right and wrong, received firm and consistent management; high maturity subjects, whose behavior represented a struggle with internal values and inhibitions, received a more insight-oriented and exploring form of therapy.

Another investigator is using this same type of classification to assign young institutionalized delinquents to residential units offering a variety of treatment modes. The results could have immediate practical implications for treating institutionalized delinquents - including the provision of more effective methods without significantly augmenting the size of the staff.

More clues to the causes, prevention, and treatment of violent behavior, as expressed in the commission of such crimes as assault and murder, and to the early detection of individuals prone to violence, are being sought as well. One investigator is developing a typology of violence according to the purpose the violent behavior seems designed to serve. Essentially, his study is

developing and testing a classification framework for violent acts and for violence-prone individuals. The study population consists of 335 recurrently violent offenders. The results of this research may be important both for prevention and treatment, for the findings should enable program planners to focus attention on certain kinds of situations that precipitate violence, and also on the kinds of persons who are violence-prone. And, if the study confirms that violent individuals are not psychologically alike, treatment programs could more effectively be tailored to meet the individual needs of the offender.

On the average, the likelihood of a serious personal attack on any American in a given year is about 1 in 550. However, studies suggest that the risk of serious attack from spouses, other family members, friends, or acquaintances is almost twice as great as it is from strangers. Other data indicate that while some injury may occur in two-thirds of all attacks, the risk is about 1 in 3000 that a given injury will be serious enough to require hospitalization. The injury inflicted by family members or acquaintances is likely to be more severe than that inflicted by strangers.

An Institute-supported study of 52 psychotic murderers who had been admitted to a State hospital gave particular attention to men who had killed their wives. It found a number of factors believed to be of importance in determining the homicidal potential of the marital setting. These included repeated verbal threats, threatening use of weapons, presence of alcoholism, expressions of jealousy, ideas of infidelity and persecution, and breakdown of communication between husband and wife.

Other investigators with backing from NIMH have looked into the early lives of children for a better understanding of how a pattern of aggressive behavior may develop. One investigator found that the parents of aggressive boys tended to punish aggression directed toward themselves and to encourage aggression expressed outside the home. Consequently, the boys used indirect rather than direct forms of aggression against the parents but showed little or no hesitancy in aggressing directly against persons outside the home.

Subsequent laboratory research by the same investigator provided strong evidence that aggressive behavior by adults heightens aggressive reactions in the children who observe it. When a parent punishes a child physically for hitting playmates, the investigator explains, the intended outcome is self-restraint on the part of the child in dealing with others. Incidental to this intended outcome, however, is a certain amount of learning that occurs because a child tends to imitate parental behavior. In the case of physical punishment, the reasoning goes, the child is provided with a model for aggression which may guide his behavior in later social interactions. In an effort to determine the extent to which this "transmission of aggression" from adult model to children occurs, the investigator designed a set of experiments in which one group of children observed an adult displaying physical and verbal aggression toward a large inflated doll, and a second group observed the same adult behaving in a very subdued, inhibited manner. Children in a control group were exposed to neither model. The children were then mildly frustrated and tested for the amount of aggressive behavior they displayed. Those who had been exposed to the aggressive model were found to exhibit about twice as much aggression toward the doll as the children in the other two groups. The children exposed to the subdued, nonaggressive model expressed significantly less aggression than the control children.

More recently, the investigator found that adults acting aggressively in a moving picture and on television were as effective as real-life models in heightening children's aggressive responses to subsequent frustration. Further, aggressive models were found to be highly influential in shaping the form as well as the extent of the children's aggressive behavior. The research group suggests that what a child sees on television may substantially influence behavior and should not be ignored in conceptualizations of personality development.

Because the fields of law and mental health are both concerned with deviant behavior, the Institute has supported several projects to clarify the relationship between them. The main objective of one current study is to improve psychiatric clinical services to courts, particularly by

developing and testing psychiatric criteria and diagnostic procedures for the evaluation of patients referred by the courts on the question of pre-trial competency. The research group, composed of psychiatrists, psychologists, lawyers, and supporting personnel, is examining court procedures, the role of court personnel, the specific nature of the problems handled, and the personalities of defendants and witnesses who appear in court concerning the issue of competency to stand trial. Since the law on this subject is basically similar throughout the United States, the mental health criteria and diagnostic procedures developed and demonstrated by the investigators are expected to be widely applicable.

Another study has explored the laws, administration, and procedures, both civil and criminal, as they relate to the mentally disordered offender. The investigators have tried to describe and document civil procedures governing admissions to, and discharges from, mental hospitals in representative areas throughout the United States. This project is expected to influence not only the treatment of the mentally ill offender, but also the training and philosophy of lawyers, psychiatrists, public officials, and others involved in this important problem.

Manpower and Training

Of the approximately 121,000 people employed in the field of correction, only 20 percent have treatment and rehabilitation as their primary function. These are the probation and parole officers working in the community and the educators, social workers, psychologists, and psychiatrists working in institutions. The other 80 percent are mainly concerned with custody and maintenance. Correctional agencies and programs across the country face acute shortages of qualified manpower, especially in positions concerned with treatment and rehabilitation. Many thousands of such personnel will be needed in the next decade.

To help remedy this critical shortage, the National Institute of Mental Health has provided support for the training of mental health professionals - such as psychiatrists, psychologists, and social workers - and of other

professionals who have to deal frequently with the problem of deviant behavior - among them sociologists, juvenile court judges, prosecuting attorneys, and parole and probation personnel. Support has also been provided for the training of nonprofessionals - including ex-offenders - to enable them to perform various service roles in the correctional field. For it is quite evident that we cannot hope to meet the manpower shortage with professionals alone.

One of the more significant projects is a so-called New Careers study, which represents part of a growing trend toward involving persons with social problems in the solution of those problems, and to develop offenders themselves for work against delinquency and crime. Twenty-five selected offenders were exposed to a training and rehabilitation program that placed emphasis on self-understanding and social development. Later, upon parole, they were assigned to work with research and action groups in crime and delinquency prevention programs. Assessment measures include (1) their effectiveness on the job; (2) the adequacy and nature of their particular contributions to the work; and (3) their ability to maintain themselves in the community. The Joint Commission on Correctional Manpower and Training has shown great interest in this study, whose results should improve our knowledge of how most effectively to develop and use nonprofessionals to meet the need for mental health manpower.

Another important effort in the manpower field is a project, undertaken recently with a grant from the Institute, to develop a Center for Training in Differential Treatment of Delinquents. Trainees include correctional administrators, planning and research personnel, treatment supervisors and staff, prevention workers, and graduate students in various fields. Instruction and practical experience are given in differentiating one type of delinquent from another, and in implementing the most effective treatment for each type.

Hospital Improvement and Inservice Training Programs

Ten projects for improving therapeutic and rehabilitative services in mental hospitals having maximum security units

and programs for mentally ill offenders are in operation. They include inservice training programs aimed for the most part at increasing the competence of psychiatric technicians and ward nurses to treat and manage this especially difficult group of patients. In one of the hospitals assisted through HIP grants, almost 20 percent of the population has been charged with criminal homicides, and another 20 percent with serious assaults.

Other Program Efforts

In April of last year, staff members of the Center for Studies of Crime and Delinquency participated in a three-day "Conference on Dangerous Behavior" in Baltimore. The conferees addressed issues regarding the definition of dangerous and violent behavior, explored the relationship of mental disturbance to crimes of violence, examined some of the methodological problems involved in the measurement and prediction of violent behavior, and considered the role of mental health professionals in the solution of this problem. A month later, in collaboration with the Institute's Division of Extramural Research Programs, the Center conducted a two-day workshop on "Individual Violent Behavior." The participants were a small group of researchers from various disciplines who are interested in this critical problem. The Workshop assessed the current state of knowledge concerning individual violence, focused upon some of the more pressing research and program needs, and considered the role to be played by the National Institute of Mental Health.

The proceedings of a conference to bring together and assess knowledge in the field of typology were recently published as an NIMH monograph under the title, Typological Approaches and Delinquency Control: A Status Report.

A paper on The Mentally Disordered Offender, originally prepared for the President's Crime Commission, is being revised and expanded for publication as another Institute monograph.

The proceedings of a national conference on "The Use of the Offender as a Correctional Manpower Resource: Its Implementation" have also been published and been widely welcomed. The Center supported the conference by offering both consultation and financial aid.

The Center staff has been active in providing consultation and other assistance in the field of mental health and the law. Some of its efforts have been directed toward a study of juvenile court philosophies, facilities, practices, and policies as they affect the treatment and rehabilitation of deviant youth. Another critical area receiving considerable attention relates to the pre-trial or pre-charge diversion of certain mentally disordered persons from the criminal process. Such programs were strongly recommended in a paper on The Mentally Disordered Offender, prepared by a member of the Center staff. Such a recommendation has been strongly endorsed by the President's Commission on Law Enforcement and Administration of Justice.

In this same general field of law and mental health, plans are underway for an in-depth study and survey of mentally disordered offenders. Likewise, efforts are being made to encourage and assist community mental health centers to develop and to provide mental health services to various law enforcement, judicial, correctional and related agencies. With the increasing thrust toward community treatment for delinquents and offenders, the need for mental health facilities and services will undoubtedly grow. Research programs are also planned to learn more about what happens to certain special categories of mentally disordered law-violators - such as sexual psychopaths, persons committed as incompetent to stand trial, and those acquitted by reason of insanity - committed for indeterminate periods to mental hospitals.

The staff of the Center for Studies of Crime and Delinquency has worked closely with the President's Commission on Law Enforcement and Administration of Justice. It has also prepared special papers for the President's Crime Commission for the District of Columbia,

served in various consultative roles, brought in other consultants, and given assistance in writing parts of the Commission's final report. There has also been continuing contact with the Joint Commission on Correctional Manpower and Training, with Center staff serving in a consultative capacity on various occasions.

Following the introduction of the two major Administration bills relating to delinquency and crime - "The Juvenile Delinquency Prevention Act of 1967," and "The Safe Streets and Crime Control Act of 1967" - conferences were held in Washington, D.C. on each piece of legislation. The bills were also the subject of study and discussion at the Governors' Conference on Juvenile Delinquency held in Chicago last April. Center staff attended all three conferences and were involved in various aspects of planning and participation.

In view of the rapid increase of published material on crime and delinquency throughout the world, the compilation of bibliographical references is an indispensable aid to all who are involved in research, teaching, law enforcement, and correctional work. This need is being served by the International Bibliography on Crime and Delinquency, which is prepared under contract by the Information Center of Crime and Delinquency of the National Council on Crime and Delinquency and published by the National Clearinghouse for Mental Health Information. This bibliography and the Current Projects in the Prevention, Control, and Treatment of Crime and Delinquency were originally prepared under an NIMH grant and published several times a year. The two publications are now combined and are printed by the U.S. Government Printing Office.

Currently, the National Clearinghouse for Mental Health Information contains about 9000 abstracts or citations in the area of crime and delinquency. These include (a) informative abstracts of the professional literature; (b) reports of current action programs and project demonstrations; and (c) reports of research in progress.

Under the terms of a new grant to the National Council on Crime and Delinquency, projects listed in the Crime and Delinquency Abstracts will be screened and final summaries will be developed. This additional material will be added to the information already accumulated about crime and delinquency projects and abstracts of the world's literature in this area. Such information will be readily available to all interested programs, agencies, and individuals. The information derived from this study will also form the basis for subsequent monographs describing and assessing the national effort to prevent, control, and treat criminal and delinquent behavior.

SOCIAL AND REHABILITATION SERVICE
REHABILITATION SERVICES ADMINISTRATION

In its efforts to provide vocational rehabilitation services to the juvenile delinquent, the Rehabilition Services Administration is effectively demonstrating the flexibility and versatility of the public rehabilitation program. As a rehabilitation agency, its primary orientation is correctional. Its preventative potentials, however, are finding expression in diverse programs being developed throughout the country.

For a client to be eligible to receive vocational rehabilitation services, a physical or mental disability must exist. Included within the definition of physical and mental disability are those behavioral disorders characterized by deviant social behavior or impaired ability to carry out relationships with family and community. Studies have shown that within delinquent populations,a relatively small number have physical disabilities. A much greater number have mental disabilities, often in the form of mild mental retardation. There is a very sizable group, however, whose disability is essentially behavioral and the public rehabilitation program is broadly extending vocational rehabilitation services to this group of disabled young people.

The fact that most of the services which public offenders are receiving under the vocational rehabilitation program are part of the regular activities of the State vocational rehabilitation agencies is one of the fundamental strengths of the public rehabilitation program's involvement in corrections, since services need not be dependent on the duration of a grant period and their continuity is insured. State rehabilitation agencies have been steadily organizing programs and services for the juvenile delinquent and other public offenders in three general ways. Some agencies have emphasized the establishment of special rehabilitation units within correctional institutions. Others have concentrated on assigning vocational rehabilitation counselors to institutional programs and have designated counselors with special correctional caseloads at the local State vocational rehabilitation agency offices. Still others have been particularly active in the development of cooperative programs in liaison with court, probation, parole, and police agencies.

Under the Basic Support program, and related grant programs, a number of State agencies are providing comprehensive rehabilitation services to incarcerated youthful offenders. An effective device has been the establishment of institutional rehabilitation units, which offer a full range of vocational rehabilitation services and show great promise of contributing to a reduction in the recidivist rate. The Georgia Division of Vocational Rehabilitation, for example, has developed a unit of this type at the Georgia Industrial Institute. This program offers vocational rehabilitation services concurrent with and subsequent to incarceration and encompasses such functions as screening, vocational appraisal, pre-vocational

evaluation, physical restoration, prevocational training, specific vocational training, counseling and guidance, job placement and follow-up. Similar institutional programs for young offenders are found or are being developed in about 25 other States throughout the country.

Many rehabilitation counselors have been assigned full time to correctional institutions, and others regularly visit them. The Texas Division of Vocational Rehabilitation, for example, has assigned counselors to each of the 14 State institutions. Currently all State prisoners are being screened and, if eligible, served before release. Whenever it is feasible, State vocational rehabilitation agencies are planning and preparing for the full-time assignment of counselors to correctional institutions. In other States institutions are served by a vocational rehabilitation counselor from the local office of the State agency on a less-than-full-time basis. Another technique for serving offenders and delinquent groups involves a close coordination between the State vocational rehabilitation agency and court, parole, and other correctional agencies. In Texas, counselors have been assigned to the Dallas, Fort Worth, and Abilene juvenile courts to work with both juvenile and adult offenders referred by the local courts. A family court project in Rhode Island is providing psychiatric treatment, physical restoration services, guidance, counseling, vocational testing, and vocational training to adolescents coming into contact with the law.

Under a Rehabilitation Services Administration innovation grant, courts in Birmingham and Montgomery, Alabama may refer disabled juvenile offenders to the Alabama Division of Vocational Rehabilitation for rehabilitation services. A Rehabilitation Services Administration expansion grant has enabled the District of Columbia Department of Vocational Rehabilitation to develop a new program for court-referred youth to provide the courts with an evaluation of rehabilitative potential and to facilitate a conditional parole as an alternative to imprisonment. In association with the Denver Juvenile Court, the Colorado Division of Vocational Rehabilitation has established a residential treatment center with an innovative treatment program for delinquent youth of junior high school age.

Although State vocational rehabilitation agencies have been involved in corrections for a relatively short time, they have already begun to seek improvements in their methodology and have attempted to serve particularly difficult cases. The Tennessee Division of Vocational Rehabilitation, for example, is experimenting with token reinforcement payments in its rehabilitation unit at the Jordonia Training Schools for juvenile offenders. Similarly, a program at the Rhode Island Training School for Boys involves the utilization of behavioral conditioning techniques within an institutional system of rewards and punishments. The Arkansas Rehabilitation Service has added counselor aides to its staff to assist the offender during the difficult transition period after his release from prison.

Research and Demonstration

Social Rehabilitation Service research and demonstration authority has supported the establishment of correctional rehabilitation units at selected institutions throughout the country. Other research has been supported to develop: (1) a treatment center within a residential school in New York for emotionally disturbed youth adjudged to be juvenile delinquent;(2) a prevocational curriculum in Illinois for slow learners considered delinquency prone; (3) a study in Oklahoma of the rehabilitation needs of the juvenile delinquent; (4) a comprehensive program within a rehabilitation facility in Minnesota for parolees from a State reformatory; (5) a study in South Carolina of the effectiveness of intensive rehabilitation services for public offenders; (6) a rehabilitation program for municipal public offenders in Louisiana; (7) a study in Washington of the influence of identification opportunities on the behavior of adolescent delinquent boys; (8) a study in the District of Columbia to determine essential features of a rehabilitation program for young handicapped inmates of a correctional facility, and (9) a study in New York to evaluate the effectiveness of various types of treatment programs for the rehabilition of emotionally handicapped and delinquent youth. An extensive correctional service program has also been established under the research and demonstration program in eight Federal jurisdictions. These projects are in Atlanta, Chicago, Denver, Pittsburgh, San Antonio, Seattle, Springfield (Ill.), and Tampa. They have been designed to demonstrate and test different ways of developing vocational rehabilitation programs for State and local offenders. Under its International Rehabilitation Activities program, Social Rehabilitation Services has supported a study sponsored by the Ministry of Social Welfare in Israel concerning the influence of group psychotherapy on the work adjustment of delinquent adolescents. This project is designed to measure attitudinal changes in different psychosocial and vocational areas which occur during the institutional process.

Training

Under its training grant authority, Rehabilitation Services Administration has been supporting conferences which bring together professionals from both the correctional and rehabilitation fields to explore ways of working more closely together. Recent conferences have been the "Midwest Institute of Correctional Manpower and Training," Topeka, Kansas, "Institute for Meeting Manpower Needs for Correctional Rehabilitation in the South," Atlanta, Georgia, "Rehabilitation of Clients with Behavioral Disorders," Norman, Oklahoma, "Effective Approaches to the Rehabilitation of the Disabled Public Offender," Andover, Massachusetts and "The Juvenile Court and Vocational Rehabilitation" Boston, Massachusetts.

Social workers and rehabilitation counselors being trained for correctional work are also supported by the Vocational Rehabilitation Administration

training grant authority. Social work programs with correctional emphasis have been established at Bryn Mawr College, University of Washington, University of Denver, State University of New York at Buffalo, University of Illinois, University of Louisville, and University of Missouri. Similarly, vocational rehabilitation counselors receive some correctional experience in the programs at University of Alabama, State University of New York at Buffalo, Columbia University, University of Georgia, University of Missouri, Southern Illinois University, Syracuse University, and University of Tennessee.

Funds have been made available from fiscal year 1968 funds, for a short-term training course for consultants from State Departments of Correction and State vocational rehabilitation agencies' personnel. The focus of the course will be on the rehabilitation of Juvenile delinquents.

Correctional Rehabilitation Study Act of 1965

The shortage of skilled personnel in the field of correctional rehabilitation is a critical one. The Correctional Rehabilitation Study Act of 1965 amended the Vocational Rehabilitation Act to make special project grants available for conducting a program of research and study of the personnel practices and needs in the field, and of the educational and training resources for persons already working or preparing to enter the correctional rehabilitation professions. A grant has been made to the Joint Commission on Correctional Manpower and Training which is currently undertaking a study of the entire correctional manpower problem.

Preventive Rehabilitation Programs in Schools

Research has shown that within the youthful offender population there is a sizable proportion of young people who would qualify for special education classes. In virtually every State, special education-vocational rehabilitation cooperative programs have been developed to provide curricular and vocational training experience appropriate for young people in special classes and to insure their securing stable and suitable employment at the termination of their schooling. Programs of this type have spread rapidly thoughout the country, and Rehabilitation Social Administration and the Office of Education are jointly encouraging the the establishment of new programs and the improvement of existing ones.

It is hoped that a further expansion of this effort will present the the predelinquent who has limited mental ability with an alternative to school dropout and delinquent behavior.

SOCIAL AND REHABILITATION SERVICE
Office of Juvenile Delinquency and Youth Development

Grants-Contracts for Demonstration and Evaluation Projects

In the initial years of the Juvenile Delinquency and Youth Offenses Control act, the congressional mandate to develop a fresh approach to the perplexing problems of juvenile delinquency was implemented through the development of a series of broad-scaled, comprehensive demonstration programs. Based upon the assumption that a good deal of delinquent behavior is caused by the current arrangements of society, these projects were aimed primarily at changes in social situations affecting delinquent or potentially delinquent youth. Concentrating on the deprived inner city areas which have the highest delinquency rates, these pioneering projects mobilized community resources to attack the conditions which brought about delinquency. They emphasized prevention as well as control, and recognizing the interrelatedness of youth problems, they include intensive efforts and coordination on the part of educational, employment, health, welfare, law enforcement, correctional, neighborhood organizations and other agencies concerned with youth problems. Many of the hallmarks of these juvenile delinquency programs have become official policies and programs in such Federal efforts as the Anti-Poverty Program, the Urban Development Demonstration City Program, Labor Department Youth Employment Programs and Educational Programs.

As it became clear that the Office of Economic Opportunity was developing a larger program and utilizing many concepts similar to those developed in the Juvenile Delinquency Program, the responsibility for financing these projects was transferred to the Anti-Poverty Program. By the end of fiscal year 1966 the transfer of all comprehensive projects was successfully completed, and the Office of Economic Opportunity assumed the funding of the youth delinquency programs. The only exception to this was the comprehensive delinquency program in the District of Columbia, where the Office of Juvenile Delinquency and Youth Development maintained a statutory responsibility.

Although fiscal responsibility for these programs has been transferred to the Office of Economic Opportunity, the Office of Juvenile Delinquency and Youth Development maintains contact with these projects so the Nation may have the benefit of the new knowledge which has been produced in the field of juvenile delinquency.

With the transfer of these projects, a program of special demonstration grants was established in fiscal year 1965. Spread throughout the Nation, in rural areas small towns and suburban communities, as well as the slums of our large cities, these short-term projects capitalize upon the techniques and approaches developed in the comprehensive programs. They concentrate upon delinquents, youth who are in danger of becoming delinquent, and youth who have not been served effectively by social, educational or treatment agencies. But their major objective remains unchanged: the development of innovations which have the potential for wider adaptation and which deal with the social

conditions that foster delinquency and anti-social behavior.

In fiscal year 1967, 26 Special Demonstration Grants were awarded. Of these, 20 were for the continuation of the projects begun in fiscal year 1966. The remaining grants represent new projects. Among these continuation grants were:

In Puerto Rico, adjudicated delinquent boys are randomly selected for participation in a community-based treatment program as an alternative to being committed to a correctional institution. Using a program of paid work and guided group interaction, butressed by remedial education, vocational placement and after-care, the youth are being helped to understand their past delinquencies and to prepare for the world of work.

In Denver, Colorado, a group work program involving 60 glue sniffing adolescents has resulted in 1) improvement in school attendance and academic achievement, 2) reduction in the number of Juvenile Court filings and commitments, and 3) development of valuable information concerning the problem of glue-sniffing.

In North Philadelphia, Pennsylvania, a police-community relations project provides the opportunity for the police and community to confront each other, share their concerns, learn from each other, and change their attitude and practices with regard to one another. A training grant was awarded simultaneously to prepare police officers and administrators as well as community residents for their new role in the community relations program.

In an institutional setting, the Institute for Behavioral Research, Inc. was awarded a grant to follow-up on an earlier experiment at the National Training School for Boys. This corrections program, based on principles of operant conditioning and learning theory, offers rewards to boys for socially acceptable, and constructive behavior. Based on indications thus far, this approach is much more successful with boys than traditional institutional practices; as a result the program is playing an important role in generating significant changes throughout the institution. A great deal of interest has been shown in this program throughout the Nation. The Federal Bureau of Prisons, which also supports the project, is disseminating knowledge of the techniques to other institutions.

In Columbus, Ohio, disadvantaged youth--many of them referred by probation departments and other official agencies--have been given the responsibility for operating a community youth center. The project is based on the premise that the most effective method of curbing anti-social behavior is to give the youth themselves a major share of the responsibility for planning and operating programs of prevention and control. The youth themselves select the center's staff members and plan its program, which includes remedial education, employment services, social action, and recreation.

92 - 594 O - 68 - pt 2 - 29

In Enfield, Connecticut, a Juvenile Review Board, composed of lay people and professionals with an interest in and close contact with juveniles in the community, has been established to serve as an intermediate resource to the Police Department for the disposition of youthful offenders. The goal of the project is to lessen and/or even eliminate the need for referral to an outside judicial system. With the help of a consulting psychiatrist, the Board functions as a resource through which problems of youth can be defined and positive approaches to remedial action taken. Existing community agencies are being utilized to provide medical, vocational, recreational, educational and social services, and efforts are being made to alter and/or institute new community services.

On the Lower East Side of New York City, the relative effects of two different methods of providing social services to adolescents--through a professionally administered service center as compared to an adolescent administered center--are being explored. The project continues to examine the effect of the adolescent administered center upon the social action programs of older adolescent and young adult action groups in the area.

In Contra Costa County, California, middle-class youth are being given the opportunity to work closely with adults of their community in developing a system of informal controls to prevent delinquency. Early findings from the project have shown that delinquency in suburban areas is due in part to a sense of alienation from the community in general, and from a sense of frustration and lack of meaningful dialogue with parents and others in the adult society. Activities of the youth include the development of community-wide recreation and community service programs, and participation in the decision-making process of the official agencies which affect youth. Additionally, attempts are being made to promote increased dialogue between the adult community and the youth, while at the same time, to assist adults in the development of realistic plans for the future of youth who are involved in delinquent behavior.

These projects which were refunded during fiscal year 1967 will be completed during fiscal year 1968, and their final reports and evaluations are expected to produce valuable insights which can guide the efforts of other communities in the Nation.

Six new projects were funded in fiscal year 1967. They include:

A project in the sparsely settled Upper Peninsula of Michigan, conducted by the Marquette County Probate Court is aimed at resocializing delinquent and neglected children whose behavioral or situational problems are serious enough to indicate institutionalization. Multiple forms of intervention are being used, including group, family and individual services and community organizations. This environmental manipulation

approach requires the probation worker to assume an active role in opening opportunities for the youth in the social system and in helping them make beneficial use of the opportunities. The project is also exploring the feasibility of using subprofessionals as aides to the probation workers. Additionally, the project utilizes the direct involvement of the client in the rehabilitation process as well as in the on-going development of the program.

In Providence, Rhode Island, the Department of Social Welfare is conducting an experimental remedial program involving 300 boys and girls in state training schools. The project is exploring which methods of remediation produce significant improvements in reading and is attempting to prepare students to meet success when they return to normal school situations. There have been improved community relations between the institute and the public schools as a result of the project. For example, educators are more aware of problems of socially deviant youth. Also, teachers and school administrators have been trained to improve the school environment to which these youths are returned. In addition, a guide has been developed for use by other correctional institutes on remedial reading.

In New York City, the Puerto Rican Community Development Project employs non-professional workers to provide necessary linkages between the family courts and the Puerto Rican community in the city, i.e., Manhattan, Bronx and Brooklyn. A court worker who is an employee of the Puerto Rican Community Development Project, performs two functions: 1) assists the Probation Officer in obtaining and evaluating family environment and other information pertaining to Puerto Rican children brought to the attention of the court, and 2) acts as liaison between the court and "block workers," and the court and the community. Some of the non-professionals have been performing foster care functions for children in the Puerto Rican community as a result of this project.

Grants and Contracts for Training Personnel

This phase of the program authorizes grants and contracts for the purpose of training personnel employed or preparing for employment in programs for the prevention and control of juvenile delinquency or youth offenses. Through fiscal year 1967, programs supported by these grants trained over 35,500 personnel.

Functional Category	Number of Trainees
COMMUNITY LEADERSHIP	2,600
CORRECTIONAL INSTITUTIONS	3,300
EDUCATION	9,000
EMPLOYMENT	200
HEALTH	550
JUDICIAL-LEGAL-PROBATION	5,400
PAROLE	800
POLICE	2,500
RECREATION	350
SOCIAL WELFARE	4,850
NON-PROFESSIONAL AIDES	250
YOUTH	750
COLLEGE STUDENTS, VOLUNTEERS	1,550
MISCELLANEOUS (Including Multi-service Organizations, National Organizations, Organized Religion)	3,415
TOTAL	35,500

Indirectly, by establishing Training Centers and Curriculum Development projects which are developing knowledge that is being fed systematically into a variety of curricula, this program will have contributed to the training of thousands of additional personnel by upgrading the quality of the knowledge transmitted to them.

In fiscal year 1967, 35 Training Grants were awarded. Of these, seven were Training Centers, 14 Curriculum Development and 14 Workshops, Institutes, Seminars, etc. (WISE) Grants.

Training Centers

The Training Centers established by the Office of Juvenile Delinquency and Youth Development have proven to be effective mechanisms for involving the relevant expertise of universities in studying the problems of delinquency and in training a variety of levels of personnel to work with problem youth. Several Federal departments have replicated the Training Centers for use in their own programs.

Each of the Training Centers has had a significant impact on the existing curricula and traditional courses within their respective universities. The Training Center at the University of Minnesota, for example, produced a video taped course for teacher education which is being used by the College of Education. At Howard University an interdisciplinary graduate program in youth work developed out of the activities of the Training Center. The staff at the Training Center at Southern Illinois University developed model courses in corrections which have been introduced into a number of departments.

A variety of innovative techniques and methods of instruction have continued to develop from the activities of the Training Centers. For example, the Training Center at Howard University has attracted national attention for its pioneering program of training problem youth for new careers in the human services. Southern Illinois University has established an accredited student teacher training program within institutions of the Illinois Youth Commission.

All of the Centers have worked with community leadership to press for the development of new programs for delinquent youth. Boston University developed a police-community relations program in which significant elements of the community were brought together around the problems of youth. The University of Hawaii has been instrumental in the establishment of a statewide task force on youth and corrections. The University of Minnesota has assumed the initiative for developing programs for volunteers in the community.

In addition to their direct involvement in training programs, the Training Centers have provided consultative services to community agencies, City and State officials. Organizations such as the National Council on Crime and Delinquency, the Council of State Governments, and the Council on Social Work Education have utilized the training resources of the Centers. In addition, Federal agencies such as the Department of Labor, the Office of Law Enforcement Assistance, and the Office of Economic Opportunity have also taken advantage of the kinds of training programs developed by the Centers.

The experiences of the Training Centers have helped to develop new alternatives and approaches to training and related curriculum material. Additionally, they have emphasized areas of experimentation and knowledge development which predicate their continuity and expansion.

The Training Centers reveal:

1. The capability of universities to broaden the scope of their training.

2. The ability of Training Centers to develop new curriculum materials and refine and test those which have been developed over the past years.

3. The increased ability of the Training Centers to respond to requests for training programs and technical assistance on problems such as probation services, handling of youth by courts, working with youthful gangs, etc. Additional support will enable them to meet these requests and assume a leadership role in their region.

Curriculum Development

Curriculum Development grants are designed to overcome the dearth of useful materials available for training purposes, to update existing materials and to translate the knowledge based on research into practical guides for agency workers. Through curriculum grants, a variety of new materials has been produced: training manuals, syllabi, guidelines for designing programs, reference books and visual aids. In 1967, 95 documents were completed. A highlighting of the significant materials developed in 1967 follows:

1. Guidelines for the training of indigenous workers as non-professionals.

2. National Policy Guidelines on Manpower and Training in the field of Criminal Justice.

3. Curricula and training materials concerning the work problems of deprived delinquent youth.

4. Materials for use in police-community relations programs.

5. New curricula in community organization for use in graduate schools of social work.

6. Manuals on group counselling in correctional settings.

7. Resource materials for agencies interested in utilizing the performing arts.

8. Materials to assist probation officers to make more effective use of community resources.

9. Materials on the Juvenile Court for use in training future lawyers. Areas of emphasis in curriculum development to be completed by the end of fiscal year 1968 include:

   a. The development of materials dealing with youth involvement and youth culture.

   b. Citizenship and leadership training for both adjudicated and pre-delinquent youth.

   c. The development of training materials in the area of non-judicial handling of juvenile delinquents as an alternative to official adjudication by the courts.

   d. Development of materials to provide for a comprehensive correction training program for personnel involved in the system from arrest through release.

   e. The development of a series of teaching methods drawing upon materials from the demonstration programs funded by the Office of Juvenile Delinquency and Youth Development designed to meet the basic curriculum needs in the training of social workers.

   f. Development of materials that will enable local police departments to better understand the causes of problems which lead to unlawful behavior.

   g. Annotated case records from social work field placement experiences in non-traditional settings, as well as a detailed and specific view of the organization and activities of the program as a blueprint for other training institutions.

   h. The development of a series of teaching methods, drawing upon materials from the demonstration programs funded by the Office of Juvenile Delinquency and Youth Development designed to meet the basic curriculum needs in the training of social workers from a generic point of view.

Short-Term Workshops

Short-term workshops reach all levels of school personnel, welfare workers, law enforcement officers, civic leaders, judges, volunteers, clergymen, and citizens with an interest in delinquency. They stress an interdisciplinary and interagency orientation and the communication of new techniques and information. These programs are intended to assist trainees to examine the adequacy of existing services, to plan needed changes and to initiate new service. Also, these short-term training programs have proved to be effective means of disseminating the knowledge gained from curriculum development projects. Examples of these training efforts include:

1. Police Training Workshops: Designed to improve their work with juveniles, the training has focused on such areas as police-community relations, the social and legal aspects of delinquency, and the responsibility of the police to the child and to the community. As the result of the efforts of one project, several police jurisdictions of one county are combining their resources in working with the problem of juvenile delinquency.

2. Workshops were conducted with teachers of Indian children focusing on the problems of these children and how these problems could lead to delinquent behavior without skillful intervention by understanding adults.

3. A unique series of workshops and institutes have enabled the labor union leadership of one State to develop a viable role for unions in opening up training and employment opportunities for deprived and delinquent youth.

4. The first national conference on amphetamine abuse was held in February 1966. The objectives of the conference were: to help participants with problems of disseminating information on the growing abuse of amphetamines, especially among young adults; to explore possible ways of setting up a long-term method of collecting data about and working toward the control of these drugs; to identify effective ways to communicate about amphetamines; and to focus national attention on the problem.

   As a result of the conference, a continuing Institute on Non-Narcotic Drug abuse will be conducted, focusing on drug abuse in secondary schools and colleges. Additionally, a national conference on the training of personnel in community action programs produced important materials emphasizing the gaps that currently exist in these programs.

Program Assessment and Dissemination of Information

In fiscal year 1967, the OJD/YD has continued the Congressional mandate to collect, evaluate, publish, and disseminate information and materials related to the programs funded by the Office during the past six years. The major task of assessment will come in fiscal year 1968 with most of the Office's 200 demonstration and training projects nearing completion. The overall goal has been to document the significance of delinquency control programs supported by the Office.

Systematic program analysis began in September 1965 with an inventory of grant products. Examples of these tasks include:

a. Maintaining and monitoring systematic files and lists of products.

b. Classification of products. (Over 1,000 documents resulting from Office of Juvenile Delinquency and Youth Development funded project activities have been classified according to a substantive area code which represents a categorical description of the types of materials on file.)

In-depth analytic reports have been published and are being utilized along with other data to answer basic questions relative to the Office's total program efforts. These documents also serve as means of widely disseminating the new knowledge gained from OJD/YD funded projects, as well as of collating information and findings concerning new approaches to dealing with the problems of juvenile delinquency (prevention, treatment and control) and youth development. Some of these publications include:

1. The Sentencing and Parole Process
2. Personal Characteristics and Parole Outcome
3. The Alcoholic Offender
4. Learning in Action
5. Neighborhood Legal Services: New Dimensions in the Law
6. Neighborhood Service Centers
7. The Extension of Legal Services to the Poor
8. Pros and Cons: New Roles for Nonprofessionals in Corrections
9. The Handling of Juveniles from Offense to Disposition - (3 volumes)
10. Helping Youth - A Study of Six Delinquency Prevention Programs
11. A Community Mental Health Approach to Drug Addiction.

The Office has also published four documents that relate to critical issues in juvenile delinquency control. In this case, the material was drawn not only from the experiences of the OJD/YD funded programs, but also from the field as a whole. The papers have been useful, not only in formulating Office policy and program direction, but in the assessment of delinquency and crime made by the President's Commission on Law Enforcement and the Administration of Justice.

The documents are entitled:

The Culture of Youth
Reentry of the Offender into the Community
Alternatives to Incarceration
Non-metropolitan Delinquency

Another vehicle for dissemination of knowledge has been the production of two movies filmed on the site of projects funded by the Office. The films entitled "The Quiet Summer", "The Image Changers", and "Look Further Than Tomorrow" focus on the involvement of youth and adults in crime and delinquency prevention in the community.

Materials have been made available and special reports prepared for grantees, universities, national organizations and other Federal agencies, such as the Office of Economic Opportunity, the Office of Education, the Labor Department and the Law Enforcement Assistance Agency. Detailed descriptions of more than 100 projects were prepared for the Crime Commission for use in a study of the policies and program direction of Federal agencies concerned with juvenile delinquency. To facilitate the efforts of the Office to provide grantees with a constant flow of information from grant activities, the Information Center of the National Council on Crime and Delinquency provides copies of Office of Juvenile Delinquency and Youth Development materials upon request. The Center publishes bi-monthly newsletters to provide grantees with current information on grant activities and accomplishments.

Staff responsibility for fiscal 1968 involve two major components:

1. A Monitoring Unit has been established to continue technical assistance to 51 current grants funded by the Office of Juvenile Delinquency and Youth Development. These projects focus on innovative solutions to delinquency control and are located in urban, rural, and suburban areas across the Nation.

2. An Assessment Unit has been developed to evaluate, coordinate and disseminate research documents evolving from the six year experimental delinquency control program.

This comprehensive program assessment plan has been established as a major priority for fiscal year 1968. The purpose of the assessment is to prepare a history of the development of the program, the evolvement of its philosophy, its operation related to that philosophy, its accomplishments and failures, its impact and its contribution in the development of new knowledge in the field of juvenile delinquency (prevention, treatment, and control) and youth development.

Areas to be covered include:

-- The role of the University - its relationship and impact on the community.

-- Comprehensive Demonstration Projects as a means of developing and identifying new roles and functions for community organizations.

-- Changing concepts and relationships of the police and the community.

-- Changing institutional patterns (e.g., Corrections) - the relationship to:

  -- Alternatives to incarceration
  -- Community based corrections programs
  -- Problems of labelling
  -- Probation and parole - changing functions

-- Social Work and Social Work Education - a means of developing new methods of social service delivery.

The above and many other areas of concern will be assessed in relation to:

-- Organizational structure and behavior.

-- Delinquency prevention, treatment and control.

-- Community competence and social change.

-- Organizational change (i.e., modifications of existing services), and

-- Institutional change (i.e., establishment of new services)as a method of developing new techniques and knowledge.

Both specific content areas and broader programmatic areas will be assessed. Example of specific content areas are:

  -- Gangs
  -- Social Alienation
  -- Attitudes of Youth
  -- Youth Involvement
  -- Substance Abuse
  -- Methods of Delinquency Treatment and Prevention

Examples of the broader programmatic areas are:

  -- Education
  -- Youth Employment
  -- Development of New Careers for Youth
  -- Training Programs
  -- Research and Evaluation

These areas will draw extensively upon the learnings from projects funded by the Office. It will focus on the lessons learned (e.g., successes and failures) in each of the specific areas. The nature of such an assessment will result in presenting these new learnings on a variety of levels.

In order to carry out this assessment, the following plan is in the process of implementation:

-- Staff of the Assessment Unit is being utilized both to conduct in-depth studies in selected programmatic areas and to serve as resource personnel

to persons contracted to conduct specific studies.

-- Former staff members, and members of the Demonstration and Training Panels, all of whom have consultative status for fiscal year 1968, act as advisory members in their area of expertise.

-- Special contracts are being made with individuals and/or research organizations having specialized knowledge in the field of delinquency control to conduct studies in areas not covered by either staff or consultants.

Thus, the Assessment will present a clear picture of the new developments, trends, problems and gaps in particular programmatic areas related to the delinquency control field.

Additionally, these comprehensive research documents will serve as a guide to ongoing delinquency programs.

Washington Metropolitan Area Demonstration and Evaluation Project

Section 9 of the Public Law 88-368 authorized $5,000,000 to be appropriated, and to remain available until expended, for a special project in the Washington Metropolitan Area. The purpose of this project is to demonstrate to the Nation the effectiveness of a large-scale, well-rounded program for the prevention and control of juvenile delinquency and youth offenses.

In fiscal year 1965, the United Planning Organization launched a number of action projects in starting the three-year delinquency prevention and control program. In doing this, effective liaison has been achieved with a number of organizations that significantly affect the lives of children in the community.

During the first year of the project, the program supported by this Office was essentially a broad-based effort focused in the Cardozo area of Washington intent on correcting the social and economic causes of community and individual disorganization which led to anti-social behavior of youth. These programs included such activities as legal services to the indigent, Neighborhood Development Centers, pre-school programs, housing programs, etc. With the introduction of the Office of Economic Opportunity, which has now assumed financial responsibility for funding these programs, it has become increasingly possible for the UPO to direct its OJD funds to programs more specifically geared to a delinquency control and correction effort.

The Neighborhood Legal Services Program has encouraged disadvantaged Cardozo residents to seek legal redress to housing, welfare and other problems confronting them.

The three residences in the Youth Community Facilities Program provide alternatives to institutionalization hitherto not available to the respective institutions and agencies dealing with the youthful offenders served by each house.

The Court Reporter Program for Cardozo residents, which makes transcripts of court proceedings available upon the request of defendants, seems to have had an impact upon the atmosphere and dignity of the court. Although no casual link can be conclusively drawn, there have clearly been more appeals by indigent defendants than were made during a similar period in 1965, and, thus, seemingly supports the original thesis that if transcripts were made available to defendants in the Court of General Sessions, more appeals would be made, and possibly the cause of justice would be enhanced.

The Incentive Payments Program for Youthful Misdemeanants offers pre-vocational work experience, remedial education, counseling, placement and follow-up programs for misdemeanants, for whom there have previously

been few rehabilitative opportunities.

The Roving Leaders Program reaches out and befriends and serves previously unattached and alienated youth.

The Group Foster Homes Program provides a series of residences for children who otherwise would be placed in the overcrowded Junior Village.

The Neighborhood Development Youth Program provides an opportunity for youth, previously voiceless in the decision-making process which mold their socio-economic lives, to speak out on problems affecting their lives. The program provides a mechanism by which youth throughout the city can organize, plan, present, and lobby for solutions to the problems that plague them, in their respective neighborhoods, as well as in the wider urban community.

In fiscal 1968 many of these programs will become a vital part of the on-going poverty efforts in the District of Columbia.

JUVENILE DELINQUENCY PROGRAM

CHILDREN'S BUREAU

The Children's Bureau was created by Act of Congress in 1912 and initiated studies in the field of juvenile delinquency in 1914. Subsequent to a Bureau review of procedures and programs on juvenile delinquency, a Juvenile Delinquency Branch was established in the Division of Social Services in 1952, to be followed by the present Division of Juvenile Delinquency Service authorized by the Secretary of Health, Education, and Welfare as the result of a supplemental appropriation by Congress in 1954 to enable an expansion of the Bureau's services in the field of delinquency.

The Division was required to provide technical assistance to public and voluntary agencies and to develop standards, guides, and methods relating to various types of services and care for delinquent children. The fields covered include police work with juveniles; court and probation services; institutional care for delinquent children, including training schools, forestry camps, and detention care; legal aspects of delinquency, including legislation; community coordination and planning for the prevention, control, and treatment of delinquency; group work with delinquent children and potential delinquent gangs; and training programs for personnel, professionals, and nonprofessionals working with delinquent youth.

The Bureau, through its Division of Research, has obtained a more precise national picture on the total volume of juvenile delinquency, from 1,800 juvenile court statistical reports utilized as the base of a representative sampling of data of 500 juvenile courts. Juvenile Court Statistics are compiled and released by the Bureau annually. The Division of Social Services, through its expanded grant-in-aid program to States for child welfare services and its consultative services, continued its effort to safeguard children and young people who seemed prone to commit delinquency acts.

Regional child welfare staff consult with citizen groups, public welfare administrators, legislators, and legislative commissions on community need and direct requests for technical assistance to the Division of Juvenile Delinquency Service.

The mandate implicit in two decisions of the Supreme Court of the United States regarding due process in the administration of justice to juveniles will clearly motivate States to re-examine their juvenile court statutes. The critical observations of the President's Commission on the present status of juvenile courts will reinforce this examination. In the one case of Kent v. U.S., 383 U.S. 541 (March 1966) which was not decided on constitutional grounds, the right of hearing preliminary to waiver to criminal court was upheld, while in the second case, In re Gault, 387 U.S. 1, (May 1967) Standards, and Guides promulgated by the Division over the years received recognition by citation in the decision, which held that a juvenile has a constitutional right to counsel, right to confrontation of witnesses, privilege against self-incrimination and right to notice of the charges. In declaring that ". . . neither the Fourteenth Amendment nor the Bill of Rights is for adults alone," the Supreme Court of the United States forced States to evaluate the procedural regularity of their juvenile hearings. That States are doing just that is evidenced by recent requests for consultation to this Division.

In the Courts and Probation area of service of the Division, the scope of the concern and interest in juvenile delinquency and the administration of justice displayed by the decisions of the United States Supreme Court, the Report of the President's Commission, and the introduction of legislation in the nature of the 1967 Juvenile Delinquency Prevention Act has been reflected in increased requests for professional assistance from judges and staff.

As United States correspondent to the United Nations, the Director, during the year, met twice with the other United Nations Correspondents. He also conferred with officials of the Social Defence Section of the United Nations on four separate occasions. The purpose of these meetings has centered around agenda items for the annual meeting of the Social Welfare Commission, and discussions relating to the Fourth United Nations Congress on the Prevention of Crime and Treatment of Offenders to be held in Tokyo, Japan in 1970.

During the past year the Director has held many consultations with international visitors--from Uruguay, Norway, Peru, Turkey, Indonesia, Japan, Israel, Switzerland, New Zealand, and the United Nations.

Staff participated with the Division of Social Services in establishing the format for a pilot project to be administered by the Child Welfare League of America, and funded by the Office of Education for the training of child care staff in eight metropolitan communities.

Workshops for probation officers, detention workers, police officers, and institutional workers were conducted by Division staff.

A staff member participated in the training of foreign police officers for the Agency for International Development throughout the year. Some 500 police officers from foreign countries participated in these seminars. He acted also as an advisor to the Office of Juvenile Delinquency and Youth Development in the production of a film on Police Community Relations.

A comprehensive study of delinquency prevention resources in Honolulu, Hawaii requested through the Oahu Committee on Children and Youth was made by a staff member, resulting in a commendatory letter of appreciation to the Secretary from the Mayor of Honolulu.

Surveys of law enforcement programs for children and youth were made in Sioux City, Iowa; Roanoke, Virginia; Sangamon County, Illinois; and Chattanooga, Tennessee. Current police practices regarding specialized services for children were discussed at training sessions of the Agency for International Development, with police officers from Guatemala, Jamaica, Sierra Leone, and Vietnam, and with chiefs of police throughout the United States.

A study of the Division of Youth Services and the Youth Service Board of Massachusetts and a study and assessment of Maryland's Program and Facilities for the Treatment and Control of Juvenile Delinquency involved total staff. Detention consultation included not only new studies in St. Louis County and Northern Minnesota; Tarrant County, Fort Worth, Texas; Trumbull County, Ohio; Hamilton County, Tennessee, but included consultation which implemented previous studies in Rhode Island, Michigan, and Massachusetts. Extensive written evaluations with recommendations of floor plan of a local holdover facility in Carbon County, Utah, and a study of Juvenile Detention Needs in Rock County, Wisconsin were completed. In the Court and Probation field a major portion of staff time was devoted to community and State studies, plus consultation. Studies of court and probation services were completed in Maryland, Virginia, Illinois, and Tennessee. Preliminary planning with Volusia County, Florida for a study of community services for children has been completed. Cooperation has been sustained on the special juvenile court statistical project funded by the Children's Bureau, in Eugene, Oregon. The project title is An Improved System For Processing And Reporting Juvenile Court Statistics, which deploys the use of optical scan sheets and data processing equipment to store and retrieve needed statistical information with speed and accuracy.

In the Institutions field, studies have been made of the New York State juvenile institutions and the Lakeside Center for Boys in Missouri, in addition to the participation in total staff studies in other States.

92 - 594 O - 68 - pt 2 - 30

Three position papers were published on camp architecture, staffing philosophy, and management, by the Center for Delinquency Control, Southern Illinois University. Architectural plans were reviewed for a number of camp, training school, diagnostic, and security type institutions for delinquent children. A two-day workshop on institutions was led by a staff member at the Annual D.C. Welfare Department Conference on Juvenile Delinquency. An article on Volunteers was completed for publication in Children, as was also a guide for establishing group counseling programs for youth. Consultation has been furnished to the Joint Commission on Correctional Manpower and Training whose Task Force V will be devoted to the study of the use of volunteers in a correctional setting.

Publications of the Division were:

"Are We Aiming Too Low In Recruitment." by George H. Shepard in POLICE CHIEF, January 1967.

"Juveniles Who Commit Noncriminal Acts: Why Treat In A Correctional System." by William H. Sheridan in FEDERAL PROBATION, March 1967.

"New Directions for the Juvenile Court." by William H. Sheridan in FEDERAL PROBATION, June 1967.

Speech published:

"The Constitutional Rights of Children Before the Court" by Alice B. Freer, in Proceedings, Southern Conference on Corrections, Tallahassee, Florida, February 23, 1967.

JUVENILE DELINQUENCY

Office of Education

The 1966-67 school year marked the beginning of a new grant program administered by the U.S. Office of Education on behalf of children in institutions for juvenile delinquents. This was authorized by the 1966 amendments to Title I of the Elementary and Secondary Education Act of 1965 (P.L. 89-750).

Grants are available to State agencies for those institutions in which they operate a school program and to local educational agencies for other public and private non-profit institutions for delinquents. Grants are based on applications which must describe the special educational needs of the youth in the institution, and propose a project designed to meet the most crucial of these needs. While the U.S. Office of Education administers the provisions of the Act, and provides program leadership, it is the State departments of education that are authorized by Title I to approve project applications.

The entry of the official education agency of the national government into the administration of a grant program in the field of juvenile delinquency implies a recognition on a national scale of the importance of education in the amelioration of one of the nation's most urgent and prevasive problems. Delinquency represents serious failures of families, schools, communities and society at large, as well as of the institutionalized children who find themselves unable to "make it" in the free world and are on the threshold of crime. The domestic anguish, the increasing sense of widespread insecurity, and the disruption to all aspects

of American life caused by delinquency and crime are immeasurable. The condition of overcowded juvenile facilities and the acute shortage of qualified service staff presents an appalling picture of enlarging concentrations of delinquents whose needs are not being met. Consequently, further hardening of attitudes and increasing inadequacies develop among many of the juveniles who are but a short step from entering the criminal sub-culture found in prisons.

The role of education, then, is to address itself to the problem of juvenile delinquency with full awareness of its complexity which extends beyond the individual child during the limited time he is compelled to sit in a classroom. The teaching of academics must relate meaningfully to the delinquents' other treatment, work and living experiences. Well planned and coordinated involvement of teaching staff with parents, psychologists, psychiatrists, and social workers, administrators, work supervisors, resource specialists, community, and other related agencies must be achieved nationwide before success of broad scope can be expected. Assessment criteria must be developed in terms of the objective of rehabilitating delinquents as self-respecting, law abiding, useful citizens through the process of developing socially acceptable self-motivation. The influencing of attitudes and values is of basic importance here.

The amendment to Title I of the Elementary and Secondary Education Act provided the opportunity for working toward these educational goals for juvenile delinquents on a national scale. The grant funds authorized by the amendment amount to about one-half the State per pupil expenditure

for public education for each child living in the institution. Full funding was achieved in FY 1968 for State Agencies. Local Agencies will receive about 85 percent of their funding potential. This level of funding creates the possibility of implementing many of the successful approaches in experimentation and programming gleaned from the 1967-68 programs.

Title III of the Elementary and Secondary Education Act (P.L. 89-10) provides nonmatching grants to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs to serve as models for regular school programs. This program gives special consideration to projects that are truly innovative as well as being of high quality and responsive to local needs. In fiscal year 1966, one project was funded for $55,594.

Under LSCA Title IVA funds are authorized for State institutional library services. This may include penal institutions, reformatories, and residential training schools which are operated or substantially supported by the State. Under approved State plans State may provide books and other library materials and library services to inmates of such institutions. Funds were available in fiscal year 1967 for planning purposes only. Projects affecting juvenile delinquents under Title IVA in fiscal 1968 cannot be identified at this time as the annual State programs have not been submitted.

Manpower Development and Training has, since its inception, provided

opportunity for the training of youths under 21 and, in its redirection, 65 percent of its trainees are to be hard-core unemployed. More youth with records, of a minor or major nature, have been included as trainees.

Multi-occupational training programs have offered a wide variety of training, counseling, and supportive programs at one location for these youth. Implementation of the 1966 amendment to the Act which provides for the development and institution of pilot programs of training and education for persons in correctional institutions provides for the inclusion of projects which deal with youth in a variety of correctional institutions.

In fiscal year 1966, there were 27 programs begun in 21 states under the provisions of Title I of the Higher Education Act of 1965 (PL 89-329) which focused on the problems of youth, both pre and post delinquency. These programs include the counseling and training of youths in correctional institutions to rehabilitate them and help them re-enter society; training teachers, and school guidance personnel to work with youths to help prevent drop-outs which can lead to delinquency; strengthening the role of probation officers, retraining law enforcement personnel, and clarifying juvenile court procedures to cope with the problem of juvenile crime; identifying, counseling, and training culturally disadvantaged out-of-school youths to help them discover their abilities and find useful employment; and helping parents and society to better understand youths and their behavior patterns. In fiscal year 1967, 44 such programs were conducted in 28 states.

The Vocational Education Act of 1963 has stimulated activity on the

part of vocational educators in the area of correctional institutions. Under the authority of Sec. 4. (a) (4) some 16 States are using this money for equipment, instructional materials, and teachers salaries for programs in reformatories for both girls and boys. Many States are giving technical assistance to correctional officials as they set up vocational programs under their own auspices and use vocational educators as advisors.

During Fiscal Year 1967, Vocational Education programs have supported projects which deal with the problems of the disadvantaged, dropouts, the role and behavior of adolescents, and the effect of training on potential dropouts. Other studies which were supported were a comparison of education versus vocational training for young dropouts, motivation and achievement factors, and the relationship these factors have toward the prevention of Juvenile Delinquency by early detection of predisposition toward delinquency.

Current and planned projects are a study in which Pennsylvania State University will investigate the effectiveness of formal education versus vocational training with respect to rehabilitating high school dropouts. Two control groups and two experimental groups will be used for the study and an evaluation will be done based on the results. One group of 50 youths, who have completed at least the ninth grade, will be selected to take courses leading to a high school diploma. A second group of 50 will be given a 52 week training program for entry into specific occupations. Two control groups of 50 each will receive guidance and counseling over the period of one year, without any

education or training.

A 36-month curriculum demonstration program training school at Quincy Public Schools in Illinois will be available for approximately 45 drop-out prone students..The objectives of the program are (1) to provide a prevocational work laboratory for students, (2) to provide paid work experience, (3) to use the school to encourage local employers to hire successful trainees, and (4) to provide motivation for the students to stay in school. Based on these evaluations, students will be promoted and certificates of achievement awarded to those successfully completing the training. Job placement will follow.

The University of Chicago will examine relationships between aggression toward peers and aggression toward adult authority in terms of social, culture, and psychological variables. The data will be analyzed to determine the extent to which aggressive behavior and compliance toward peers and adult authority is determinable and predictable from variables built into the design of the study.

At Evansville College, Indiana, 16 academically deficient children, ages 9-11, will be studied for intellectual rehabilitation. Two groups, only one receiving training, will be used. A comparison between the two groups will be made based on performance tests, school grades and teacher rating.

OBLIGATIONS FOR PROGRAMS ON JUVENILE DELINQUENCY

AGENCY	1965	1966	1967	1968 Estimate	1969 Estimate
Office of Education	$ 370,279	$ 2,208,557	$5,495,562	$12,768,319	$14,785,000
Public Health Service: National Institute of Mental Health	$9,474,000	$10,709,000	8,900,000	9,165,000	9,660,000
Social and Rehabilitation Service: Rehabilitation Services Admin.	159,207	182,000	276,000	345,000	375,000
Children's Bureau	327,251	305,899	324,476	361,000	362,000
Office of Juvenile Delinquency and Youth Development	$11,474,984	6,552,185	8,171,868	640,000*	
TOTALS	$21,805,721	$19,957,641	$23,167,906	$23,279,319	$25,182,000

Authority to award grants expired 6-30-67

BLINDNESS

There are an estimated 420 thousand people in the United States who are legally blind. The estimated annual cost for care of these people is $400 million. An additional 3.5 million people are partially sighted, one million of whom are severely visually impaired. Of these, 32% (300,000) are so handicapped that they cannot work, keep house, or go to school. An estimated 12 million children in the United States require eye care.

The number of blind persons in the United States is increasing. The advances of modern medicine are largely responsible for this. New techniques and medicines are allowing more and more infants and children to survive complicated pregnancies, deliveries, and once fatal childhood diseases. Often, however, the child suffers some visual impairment. At the other end of the age spectrum, the older population is increasing. As people live longer, visual impairments such as cataracts and glaucoma become more common.

Obligations for programs in blindness

	1965	1966	1967	1968 Estimate	1969 Estimate
Office of Education:					
Elementary and secondary education activities.....	$--	$27,553	$50,000	$100,000	$150,000
Libraries and community services.....	--	--	110,000	100,000	90,000
Educational improvement for the handicapped.....	916,688	1,417,927	1,600,250	2,539,933	2,924,000
Research and training.....	65,221	38,415	55,393	80,768	80,000
Subtotal, Office of Education....	981,909	1,483,895	1,815,643	2,820,701	3,244,000

Obligations for programs in blindness
(Continued)

	1965	1966	1967	1968 Estimate	1969 Estimate
Social and Rehabilitation Service: Rehabilitation services and facilities training, and research and demonstration program:					
Vocational rehabilitation grants to States.....	9,300,000	13,600,000	7,704,000	9,200,000	10,800,000
Innovation grants.....	215,000	180,000	146,000	150,000	150,000
Expansion grants.....	--	122,500	639,000	650,000	650,000
Training and traineeships...	--	--	487,000	539,000	452,000
Project development.....	--	13,000	10,000	10,000	10,000
Construction...	--	--	822,000	592,000	592,000
Workshop improvement.....	--	59,000	99,000	86,000	99,000
Training services.....	--	--	--	200,000	200,000
Research and demonstrations.	1,317,000	1,481,000	1,428,000	1,716,000	1,274,000
Research and training(special foreign currency program).....	532,000	174,000	293,000	350,000	500,000
Grants to States for public assistance.	51,705,000	57,142,000	64,196,000	71,300,000	76,400,000
Subtotal, Social and Rehabilitation Service.	63,069,000	72,771,500	75,824,000	84,793,000	91,127,000

Obligations for programs in blindness
(Continued)

	1965	1966	1967	1968 Estimate	1969 Estimate
Public Health Service: National Institute of Neurological Diseases and Blindness.....	14,342,000	16,449,000	20,086,000	22,698,000	23,604,000
Chronic diseases.....	357,000	378,000	610,000	786,000	795,000
Subtotal, Public Health Service.....	14,699,000	16,827,000	20,696,000	23,484,000	24,399,000
Social Security Administration: Estimated benefit payment from trust funds: To blind persons.....	26,400,000	31,800,000	33,600,000	37,000,000	42,500,000
To families of blind persons..	4,500,000	5,800,000	6,200,000	6,900,000	7,800,000
Adjudication of claims and maintenance of beneficiary rolls.....	2,100,000	2,500,000	2,800,000	3,250,000	3,500,000
Subtotal, Social Security Administration.....	33,000,000	40,100,000	42,600,000	47,150,000	53,800,000
American Printing House for the Blind.....	865,000	1,000,000	1,028,000	1,225,000	1,340,000
Total.....	112,614,909	132,182,395	141,963,643	159,472,701	173,910,000

OFFICE OF EDUCATION

The number of school age visually handicapped children has increased considerably in recent years. Between 1957 and 1967 there was a 73 percent increase in the number of these children registered by State and local schools with the American Printing House for the Blind. It is estimated that there are about 57,000 visually handicapped children of school age in the United States and this number is expected to rise at about the same rate as that of the general school population. Partly because of a shortage of qualified teachers many of these children are not receiving the special instruction necessitated by their handicap. More than 300 newly trained teachers are needed each year just to keep pace with the annual attrition in this area of the handicapped.

During the first three years of the program of professional preparation authorized by Public Law 88-164, awards have been made for 336 graduate fellowships, 138 senior year traineeships, 461 summer traineeships, (includes summer '67), 417 institute traineeships and seven program development grants in the area of the visually handicapped. A total of 692 persons will receive training during school year 1967-68. It is expected that over 870 persons engaged or preparing to engage in the education of visually handicapped children will receive awards under this program during fiscal year 1968.

The leading obstacle in expanding educational opportunities for handicapped children is the lack of qualified personnel. Second is the dearth of scientifically tested knowledge relating to the education of these children.

The Research and Demonstration program for handicapped children within the U.S. Office of Education was begun during 1964 with a modest budget. By 1965 only about $100,000 had been invested in projects relating to blindness. This amount more than doubled in 1966 with an investment of $136,147. A decrease in research activities the following year reduced the figure to only $92,000. Only two new projects were initiated during that year.

The very small investment in the area of blindness from the beginning of the research program through 1967, i.e., $332,680 out of a total of $17.1 million, resulted in an intense effort on the part of our staff members to stimulate new activities. The expected investment in this area of the handicapped for 1968 will exceed $1,000,000.

Research and Demonstration projects supported under Section 302 of Public Law 88-164 include the following:

A study conducted at George Peabody in Nashville, Tennessee has demonstrated dramatically that children categorized as blind and taught

to read Braille can actually be taught to make significantly better use of their remaining vision. In some instances, such children have been able to switch from Braille to ink print. Additional research is needed to develop curricular materials relating to the teaching of those with extremely limited sight.

One of the most troublesome problems involved in educating blind children is the availability of Braille books. Such books are costly (from 10 to 20 times the cost of print books), bulky to handle, difficult to obtain when needed, in short supply, and in general, create many difficulties for the children. A development project initiated during 1968 seeks to eliminate most of the management problems relating to Braille books. This will be accomplished by putting Braille producing signals on magnetic tape and running the tape through a Braille producing machine. The signals from the magnetic tape will cause the Braille cells to be reproduced on a plastic belt which can be adjusted for speed of movement. The blind youngster will then read the Braille from the plastic belt much the same as he would read from a book. The new system will permit rapid and inexpensive reproduction of the Braille tapes, will permit easy mailing, and could even permit Braille materials to be transmitted by radio signals to children in isolated areas.

A demonstration project, supported in 1966, following up a significant research project from the years before, has attempted to develop teaching techniques which will keep the attention of blind children. The key elements of the technique are brevity of verbal presentation with many questions and requirements for pupil interaction.

A research professor at the University of Louisville is attempting to expand the present Braille code while another investigator in Washington, D. C. is experimenting with a totally different code for the blind. While these investigators are experimenting with the Braille code, other investigators are developing condensed speech recordings to enable a blind person to obtain more information in a shorter period of time through listening. Investigators at M.I.T. are developing systems of translating from print to Braille by computer, thereby eliminating the hours of work required by volunteers for this task, while an investigator at Stanford University is exploring techniques for using optical scanners which will enable a blind person to feel print in raised form.

Title III of the Elementary and Secondary Education Act provides for nonmatching grants directly--and, beginning in 1969, through State Education Agencies--to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs to serve as models for regular school programs. This program gives special consideration to

projects that are truly innovative as well as being of high quality and responsive to local needs. In 1966, one project was funded for $27,553; in 1967, one project was funded for $50,000.

Under Title I of the Library Services and Construction Act there are many projects which include service for the visually handicapped and a few projects which specifically aid the visually handicapped. New York State funded a project to test and evaluate the need and use of large-print books in 18-point type by readers who have severe sign limitations. Ohio provides support to two public libraries, Cleveland and Cincinnati, to provide library service to blind persons throughout the State. Minnesota grants Federal funds to its regional library for the blind to expand the availability of materials to the legally blind.

Under Title IV-A, State Institutional Library Services, residential schools for the visually handicapped which are operated or substantially supported by the State are eligible for funds for library services, and Title IV-B, Library Services for the Physically Handicapped, provides for library services through public or other non-profit libraries or agencies to the physically handicapped, including the blind and visually handicapped.

SOCIAL AND REHABILITATION SERVICE

The Social and Rehabilitation Service administers programs which provide financial and medical assistance (public assistance grants) for the blind and rehabilitation services and facilities and training to enhance the blind individual's opportunity for a useful life. In addition, funds are directed toward expansion of job opportunities for the blind through research and demonstration projects.

Rehabilitation services and facilities, training and research and demonstration program

Experience has shown that with good rehabilitation techniques and with the job opportunities currently available to blind persons, it is possible to rehabilitate at least 25 percent of the annual increment of 42,000 persons (approximately 10,500). If the backlog waiting to be served is to be considered as well as the increase in the total population, more than 12,000 blind persons each year should be rehabilitated into employment.

At present, there are 36 separate State agencies for the blind. In the remaining 18 States and territories, vocational rehabilitation services for blind persons are provided by a specially designated unit within the organizational structure of the State general agencies for vocational rehabilitation. Under these circumstances, the disability of blindness presents a unique opportunity to demonstrate how the total job of rehabilitation can be accomplished and how services can be provided to blind persons who can profit from them.

Although blindness is not the total disaster that the vast majority of the public believes it to be, it is nevertheless a severe obstacle which can only be overcome through professional help and courage on the part of the blind individual. Rehabilitation is not merely finding a job that a blind person can do. It involves finding a job that suits the individual's aptitudes, interest, and inclinations and training him so that he is thoroughly competent and is sought after not because of his disability, but because he can turn his skill into valuable cash for his potential employer.

Much has been learned about rehabilitation of blind persons in the last few decades. To attain complete rehabilitation, a blind

person must not only be given the tools to do an adequate job, but the job must be commensurate with his abilities. He must also be taught the skills which will make him socially as well as vocationally competent and acceptable to his sighted peers. True rehabilitation means finding as many substitutes for sight as possible and training the blind person to utilize the substitutes to his maximum advantage. It also means the psychological evaluation of the total human being and the re-focusing of the individual's talents in the achievement of a new and full life.

At first glance it might not seem that progress has been phenomenal in the last 25 years. After the passage of the Barden-LaFollette Act in 1943, the law which gave impetus to rehabilitation of the severely disabled, including the blind, only a few hundred were rehabilitated in the first year. However, over 6,000 blind persons were rehabilitated during the past fiscal year. What is of even greater significance is the variety of vocational opportunities now open to blind persons as compared with the circumscribed opportunities less than a decade ago.

The expansion of job opportunities is due in large measure to the amount of research, demonstration, and training which was permitted under the amendments of Public Law 565, passed in 1954. Since that time more than $9 million has been spent in research and training efforts demonstrating the feasibility of blind workers in computer programming, teaching in the public schools, and in many new categories of jobs in the service, semiskilled, and skilled occupations.

Through long-term training grants, support has been given to the development of highly trained professional personnel; e.g., mobility instructors who are most vital to the rehabilitation of blind persons. It has been estimated that 90 percent of all blind citizens of the United States are unable to travel without the aid of a human guide. It is toward overcoming this grave deficiency that efforts in mobility instruction are now concentrated. This problem must be overcome if there is to be true rehabilitation services. Currently there are 24 rehabilitation facilities for the blind throughout the country. To do an adequate job, the number of facilities must be doubled and the level of sophistication and potential of some of those already in operation increased. Research money is being expended in the development of many electronic devices which, hopefully, will aid a blind person to travel much more efficiently than is now possible by the use of a cane. Electronic know-how is also being applied in the development of new techniques for producing Braille and for other more efficient methods of reading.

New advances in the field of optics have been made. As a result, optical aid clinics for those with very limited sight have been opened in strategic locations throughout the country. These clinics are designed to fit persons who have some residual vision with microscopic and telescopic lenses which will enable them to expand their vocational opportunities and in certain instances will make it possible to read the regular printed page. A great deal of perseverance in training is necessary to obtain maximum benefit from such lenses. However, the clinics do represent a great stride forward. There are approximately

26 clinics across the country, and it is hoped that at least an equal number will be opened when funds are available.

The following are illustrative of the many new occupational fields which have been opened for the blind within the last decade:

1. Data processing, and in particular computer programming, is a field which has developed within the past 10 to 15 years. Many professional rehabilitation workers for the blind felt at one time that automation would pose very serious problems for blind workers, and would, in fact, reduce job opportunities drastically. However if computer programming is an example of what will happen as our economy becomes more and more automated, there is reason for great optimism. Findings from some diligent research programs which have been conducted during the past few years indicate that blind persons with the proper background and interest have an aptitude for computer programming and can be trained for very high level positions in this field. About 200 persons are successful computer programmers in industry and Government, and the potential within the next 10 years, according to experts, is unlimited.

2. It is estimated that in the next 10 years 6½ million entirely new jobs will be created in the service field. A substantial number of these will be in the many thousands of hospitals, hotels, and motels throughout the Nation. Research and training have demonstrated that many of the jobs, ranging from kitchen helper and laundry worker to telephone operator, clerk, and medical transcriber, are feasible for blind persons and that well-trained visually impaired workers make desirable employees.

3. In the first decade after World War II, the majority of competitive employment opportunities for the blind were found in industry, particularly in repetitive machine operations. These opportunities were slowly eroded by the installation of highly automated machinery. It is now essential to provide special technical training for the blind worker to prepare him to compete with his sighted colleagues and obtain his share of employment in the industrial labor market. We are now developing a long-range plan to support special units within trade schools designed to train blind persons to meet the numerous new challenges in this very important area of skilled employment.

4. Another area deriving a benefit through automation is the Randolph-Sheppard vending stand program. Potential progress in the number of employed operators and stand locations, amount of earnings to operators, and gross volume of business is outlined in the following table:

RANDLOPH-SHEPPARD VENDING STAND PROGRAM

Fiscal year	Number of stands	Number of operators	Gross sales	Annual average earnings
1967	2,808	3,117	$71,480,000	$5,244
1968	3,000	3,400	80,000,000	5,450
1969	3,200	3,625	90,000,000	5,750

According to a study conducted a few years ago, the potential in this field has barely been tapped. It is the opinion of the researchers that, with the proper accommodation to automated equipment the number of stand operators now employed can be trebled and the gross volume of business within the next 5 to 10 years can be doubled. However, this goal cannot be achieved unless vending stand installations are contunually upgraded, and blind operators and supervisors are kept abreast of new techniques. Equally important, of course, is the complete cooperation and acceptance by public and private building management.

The success of our rehabilitation program will be measured not in terms of what we do for the blind but of what is attained by them. Vocational success and full social participation for all blind individuals, who in other societies and in former times were passed over without a second thought, must be assured. Given essential funding, this goal can be attained.

Grants to States for Public Assistance

Grants to States are provided under titles X (or XVI) and XIX of the Social Security Act to assist needy blind individuals by providing financial assistance for their daily maintenance needs, to make payments for needed medical care on their behalf, and to provide social services to help them deal constructively with their economic, health and social needs. All 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have the program of Aid to the Blind (AB).

Total Federal, State, and local expenditures for maintenance payments under aid to the blind programs in fiscal year 1967 were $86,800,000, of which $48,291,000 represented the Federal share. In addition, total funds of $19,800,000 ($10,305,000 Federal) were expended for payments to medical vendors on behalf of the blind in 1967 (including recipients of maintenance payments and blind persons who only needed help with medical bills). Comparable figures estimated for fiscal year 1968 are: total maintenance payments, $87,300,000 ($48,900,000 Federal share); $30,600,000 for vendor medical payments, of which the Federal share is $15,500,000. Excluding a small amount of administrative expenses involved in processing vendor medical bills, costs of State and local administration, services, and training was $10,000,000 in 1967, of which the Federal share was $5,600,000; the 1968 estimate is $12,400,000 for these costs, of which the Federal share would be $6,900,000.

In fiscal year 1967, the average monthly number of AB recipients receiving money (maintenance) payments was 83,700, or 1,700 less than the average monthly number receiving payments in fiscal year 1966; the average monthly caseload in 1968 is expected to be 82,500 or 1,200 fewer than for 1967. This decline is a continuation of trends in this program in recent years. Average monthly payments to recipients, however, have continued to increase: in fiscal year 1967, the amount was $86.45 compared with $81.20 in 1966. The estimated monthly

average payment for 1963 is $88.20

To be eligible for Aid to the Blind, Federal policy defines visual eligibility as including "persons having insufficient vision to perform tasks for which sight is essential, as well as persons without vision." In other words, visual limitation determined by ophthalmic measurement must be severe enough to result in "economic blindness." It is not necessary to be totally blind.

The blind applicant must be a needy person but there are no age limitations in the Federal Act, although a number of States have laws excluding children. Unlike the other categories, Aid to the Blind may include the whole lifespan from infancy to old age.

In addition to providing needy blind with cash assistance for basic maintenance, public welfare assistance agencies may also provide for treatment to preserve remaining vision, for restoration of sight through surgical and medical attention whenever possible, for medically recommended optical aids to maximize use of residual vision, and for medical and dental care for other health needs.

The Federal Government will share the cost of special items related to the unique needs of the blind: a telephone, guide fees, transportation expenses, extra laundry and dry cleaning allowances, higher food expenses when the handicapped person does the cooking or must take meals in a restaurant. The food allowance for a seeing eye dog is another illustration of the flexibility that is possible.

Safe and sanitary housing is extremely important for the blind as well as safe household equipment to prevent burns and accidents. Hence, moving expenses and higher rent expenditures may be required to assure this protection for the needy blind.

The 1962 amendments encourage more comprehensive social services for the blind by providing 75 percent Federal financial participation in their costs. Over two thirds of the States are now receiving 75 percent Federal matching for these services. To obtain this additional money, a State's services must encompass the blind who are in need of protection because of physical or mental handicaps or adverse social circumstances. There must also be provision for those who require special help to remain in their own homes or elsewhere in the community of their choice, thus avoiding unnecessary institutionalization. Similar services must be given to enable clients to return to their communities following a period of institutional care. Blind recipients with potential capacity for becoming either partially or completely self-supporting will be assisted with plans to secure training opportunities. All of these service areas include not only the blind client but may be extended to relatives as well when their circumstances influence case planning.

Public welfare agencies collaborate with many other agencies toward the joint goal of restoration of blind people to the maximum level of

health, employability, and personal satisfaction their capacities permit. By proper referral and provision of needed supportive services, the public assistance agency implements this goal so the handicaps of severe visual limitations may be mitigated or overcome. Illustrative of the foregoing: utilization of vocational rehabilitation services for young adults and those of middle age; special educational provisions for blind young people; casework services for parents of young blind children; encouragement of attendance at adjustment and mobility training centers; use of home teachers; sheltered work opportunities and community recreational resources and acquisition of talking book machines with the wide choice of records available from the Library of Congress. Annually, in conjunction with the annual sessions of the American Academy of Ophthalmology and Otolaryngology, staff of the Department meet with State supervising ophthalmologists associated with State AB programs. This has proved to be a valuable opportunity to share information and hear about operation of the State AB agencies.

PUBLIC HEALTH SERVICE

National Institute of Neurological Diseases and Blindness

The Institute's eye research and training program represents one of the most rapidly growing programs of the Institute, showing a 600-percent growth over the past decade. The need for increased vision research has long been recognized, but the expansion of this research was dependent upon the training of a sufficient number of well-equipped visual scientists. Many more need to be trained, but some 1,500 have now received postgraduate training in the visual sciences through 53 NINDB-supported training grants. These well-trained research men now make it possible for eye research to be one of the most prominently targeted research areas of the Institute.

At the present time the Institute is supporting 12 clinical eye research centers, 9 outpatient clinical research units, some 350 individual vision research grants, a vision research program at the Institute's Bethesda laboratories, and a variety of collaborative and field projects.

Major Institute programs relating to the study of vision and diseases resulting in impaired vision and blindness are included in the categories of cataract; glaucoma; retinopathy; infections and inflammatory and parasitic diseases; tumors and vascular disorders; metabolic and degenerative diseases; myopia and other refractive anomalies; and strabismus and neuromuscular disorders.

Program Planning

To assist the Institute in reviewing and planning vision research, a permanent Subcommittee on Vision and Its Disorders has been formed by the NINDB Advisory Council, with a member of the Advisory Council serving as chairman. It provides information upon which the Institute can base long-term planning of its research and training program in the fields of visual science, visual disorders, and blindness. It engages in a continuing assessment of the status of knowledge in eye research, training, and identification of problem areas and special needs.

Plans are under way to establish a series of task forces to develop programs to attack each of the major causes of blindness. These task forces will review current research, supervise programs for the dissemination of scientific information, and organize programs of directed research and development. Since instrumentation has played an important role in the treatment of eye diseases, contracts with industry for the development of new instruments will be an important responsibility within this program. Among the major task forces established is one on drugs and toxic agents and another on glaucoma.

Others will include uveitis and infections of the eye, macular degeneration and retinopathy, diplopia and amblyopia, myopia, and other disorders of refraction.

Last year the Subcommittee consulted over 250 of the Nation's leading scientists regarding those areas of investigation now most important for intensive study. A report of the Subcommittee and recommendations, developed over a 2-year period, are in process of publication and will serve as the basis for the Institute's program development.

Information Network

To expedite the flow of scientific information from laboratories to eye doctors, and to aid in program analysis, the Institute has established a National Information Center on Vision Research at the Harvard University Library. Objectives of the Center are to define, identify, store, retrieve, and disseminate the literature of vision, so that the information may be communicated more quickly and completely. This university-based unit combines the resources of a research center and one of the largest medical libraries. Integration of the activities of the Center with the national network of specialized information centers, now being developed with the support of NINDB, is under way.

As a part of its program to promote exchange of information and generate new research approaches, a Workshop Conference on Rehabilitation and Visual Impairment was sponsored by the Ad Hoc Subcommittee on Rehabilitation of the Institute's Advisory Council last year. A report is forthcoming.

Eye Research Centers

At the Institute's 12 clinical eye research centers, strong multidisciplinary teams have been mobilized to carry out a broadscale attack on disorders of vision. Each center's research is focused on some particular area of the vision problem. Now in full operation are eye research centers at The Retinal Foundation of Boston; the Neurosensory Center at the State University of Iowa; the University of Chicago Program-Project for studies on Glaucoma and Disorders of the Retina; the Research Center for Corneal Disorders at Columbia University, New York City; the Massachusetts Eye and Ear Infirmary, Boston; the Institute of Visual Sciences, San Francisco; San Francisco Medical Center, San Francisco; the University of California, Los Angeles; Washington University, St. Louis; Mt. Sinai Hospital, New York City; Harvard University Medical School, Boston; and Johns Hopkins, Baltimore.

Outpatient Clinical Research Units

Established during the past 2 years are nine outpatient vision research units located at Duke University, Durham, North Carolina;

New York University Medical Center, New York City; University of Miami, Coral Gables, Florida; Wills Eye Hospital, Philadelphia; Boston University, Boston; Mt. Sinai Hospital, New York City; Jefferson Medical College, Philadelphia; and University of Wisconsin, Madison.

At these centers, persons whose eye disorders do not require hospitalization are being studied in a more organized fashion by physician-scientists seeking clues to many eye problems. These new units offer opportunities for studying ocular diseases which affect only humans and cannot be duplicated in animals, and for continuing research which has reached its limits in the laboratory or in animal trials. Specific research areas include human macular disease; herpetic keratitis; retinal disturbances; and diabetic retinopathy, among other visual disorders.

Blindness Statistics

Adequate statistics on blindness, well defined and carefully assembled, are essential to any program of prevention and control. The Institute now maintains a Model Reporting Area for Blindness Statistics (MRA) in 16 States to provide urgently needed information to upgrade the quality of statistics on blindness and visual impairment. These areas use a common method of classification and record keeping intended to produce comparable records from each of the cooperating States. With the addition of two States this year, the project represents approximately one-third of the States and also one-third of the population of the United States.

Research Progress

Cataracts

Institute research is seeking a better understanding of the mechanisms causing cataract formation, methods of prevention, and an effective medical substitute for cataract surgery. Research in chemistry, nutrition, and other scientific fields is revealing facts about how the lens grows, is nourished, and by what processes it loses its normal transparency.

Advancements in suture techniques, improved instrumentation, operation under microscopic control, and many other technical improvements, including cryosurgery, have made cataract surgery safer and easier. Improved preoperative medication, particularly glycerol and Diamox, for cataract surgery has reduced the incidence of complications during cataract operations. Investigators have learned that children born with cataracts will have the best chance to see normally if surgery is performed between the ages of 6 and 18 months. Increased evidence has been found of a relationship between cataract and the way the body uses sugar, especially glucose.

Glaucoma

Institute glaucoma research is aimed at a better understanding of the processes for maintaining proper pressure within the eye, including the early use of medication which saves vision by correcting pressure, and selection of techniques for detection and testing which yield the most consistent and accurate results. Particular attention has been given to biochemical processes related to secretion of aqueous humour in the eye, the effects of drugs and other types of therapy on the fluid balance in the eye, and the epidemiological determination of the characteristics of individuals especially prone to develop glaucoma because of heredity. The work of one research center, the Washington University School of Medicine, is wholly devoted to glaucoma research. Glaucoma can now be diagnosed and treated more effectively than ever before. Of all of the diseases affecting the eye and causing blindness, scientists seem closer to an understanding of its mechanism than of any other eye condition.

Through significant studies such as the Collaborative Glaucoma Study, it is now possible to predict glaucoma victims through their hereditary patterns and thus begin treatment before vision is lost. Also, the need for early correction of congenital glaucoma has been established.

Advances have been made in understanding the basic dynamics of intraocular pressure, in applicable diagnostic techniques, in pressure variations and aqueous humour drainage, and in understanding the activity of those parts of the brain believed to serve a pressure-regulating function. Useful data on the effectiveness and possibly harmful side effects of a number of drugs used for control of intraocular pressure have resulted in improved treatment for the disorder. The role of diabetes in development of glaucoma in juveniles has been recognized with consequent increase in vigilance over vision of young diabetics.

Corneal Disorders

Institute studies have concentrated on effective drugs which can be used to fight inflammation without harmful side effects; improving techniques for tissue transplants; microsurgery; use of synthetic substances which may be used to restore sight to persons blinded by severe cases of clouded or damaged corneas; and better understanding of the mechanisms of graft rejection.

Following the NINDB-supported discovery of several years ago that herpes simplex could be cured by idoxuridine (IDU), the first drug found effective against a virus, new approaches to the broader study of antiviral drugs have taken place. Increased understanding of the mechanisms by which antiviral drugs accomplish their task may lead to much improved treatment of systemic virus diseases as well as eye disorders. Phagicin, an antiviral substance, appears to be effective and non-toxic; it is a totally new type of antiviral agent which holds great promise.

New methods of freezing and dehydrating corneas for long-range storage have resulted in improved corneal transplants. Stains have been developed which identify changes in transplant material that might make it unsuitable for corneal transplant surgery, thus preventing many unsuccessful operations. After homograft immunity was established as one cause of graft failures, three immuno-suppressive chemicals were found which successfully delay and even suppress graft rejections in animals and may soon be used in man. Animal tests indicate that it probably will soon be possible to replace scarred corneas with artificial plastic corneas and restore sight.

A plastic mesh implant can now help restore the fractured base of the eye socket in cases of orbital injury. Because of hazards recently revealed, scientists now recommend that Imurin, a drug often used in avascular corneal wounds, be restricted to individuals with the most serious prognosis for successful corneal transplantation.

Retinal Disorders

NINDB investigators are seeking to understand the basic anatomy and function of the retina, necessary before treatment is possible; to find implant materials for use in retinal surgery; and to find suitable drugs to treat uveitis. They are seeking more knowledge about the mechanisms of diabetic retinopathy and attempting to develop a natural history which will make possible a more precise evaluation of present treatment methods. Through recent topographical studies they have learned much more about the general size and shape of the retina, the dimensions of the optic disk, and the relationship between the disk and the foveola.

Retrolental fibroplasia (RLF) was virtually eliminated with the discovery in the early 1950's through Institute-supported research of oxygen overuse as its cause. Recently high oxygen therapy has been found necessary to save the lives of premature infants who develop respiratory distress. Some 40,000 infants need such treatment every year. An Institute grantee has demonstrated the need for constant ophthalmic monitoring of the infants receiving such therapy to prevent blindness.

The chances for more successful repair of retinal detachment have been increased by advances in techniques of preoperative examination, preoperative management, surgery, and postoperative care. The laser has been used successfully to "spot weld" the retina in certain types of retinal detachment. The promising new technique of cryosurgery for retinal detachment has successfully undergone further trials this year and is being used in some hospitals; the technique has removed two complications of treatment--infection and scleral neurosis. While much still is unknown about the mechanism of the retinal tear, scientists are now agreed that vitreous traction at the

site of a vitreoretinal-choroidal adhesion is probably a primary factor. Surgery within the vitreous has been successful in some cases of retinal detachment where previous multiple retinal detachment operations failed.

Some advances have been achieved in the treatment of diabetic retinopathy; removal of the pituitary gland has been successful with some patients, resulting in improved visual activity with no known harmful effects from surgery. UC cyclotron has been utilized successfully in surgery to destroy the pituitary. Refined photographic techniques, using fluorescent dyes, have advanced understanding of the behavior of microaneurysms in the development of diabetic retinopathy.

In a concerted attack on uveitis, the use of antibiotics, antitumor drugs, chemotherapy, electron microscope studies, the laser beam, and other measures have been studied, and some progress has been achieved. The role of hypersensitivity to disease-producing microorganisms or to altered tissues in uveitis has received intensive study. To demonstrate more precisely how this infection is transmitted, extensive epidemiological investigations are now under way.

Diseases of the Conjunctiva

Research advances have been made this year regarding diseases of the conjunctiva. There is evidence that a Bedsoniae infection may be associated with Reiter's disease.

The development of an immunofluorescent technique represents a major advance in the diagnosis of trachoma. The monkey eye infection has proven a good laboratory model for evaluating further improvements in trachoma vaccine. The standard treatment of trachoma used throughout the world may be changed due to the discovery this year of a venereal disease in San Francisco's "hippies" which almost exactly mimics trachoma. Researchers have reason to believe that the disease, inclusive conjunctivitis, and trachoma are caused by the same organism. If so, the current treatment of trachoma, which is applied to the eye only, may arrest but cannot be expected to cure the condition since the organism attacks other parts of the body.

Exophthalmos

A surgical technique developed by NINDB grantees has achieved improvement of visual acuity in cases of dysthyroid exophthalmos. Studies reveal complications in the use of steroids in treating this disease, indicating the need for careful monitoring of such treatment.

Tumors

Research has concentrated on a search for the origin of eye tumors and early clinical detection of malignant tumors.

NINDB research has revealed some promising new methods for treating eye tumors, using fluorescent dyes and radioactive tracers. The laser is being used to burn off some tumors. Supervoltage irradiation in treatment of retinoblastoma (tumor of the retina) proved to be highly successful. Intense radiation has been found effective in treating eye cancer in children, enabling them to retain their vision. Two recent discoveries will result in the saving of many eyes which formerly might have been removed: first, that there is often a congenital predisposition for forming harmless tumors in the eye; and second, many tumors are non-malignant.

Ocular Motor System

Clinical experiments and studies of primates recently conducted indicate that multiple motor systems probably exist in the extraocular muscle of man. This concept should greatly accelerate physiological research and improve diagnostic techniques.

Color and Light

Recent discoveries in color vision won the Nobel Prize in Medicine in 1967 for a former NINDB grantee, whose discoveries have increased our understanding of color blindness, and a Swedish scientist, who was honored for his work in color reception research. A current NINDB grantee also received a Nobel Prize for his work in recording the electrical impulses from nerve cells and fibers when light reaches the retina, and for his studies of the impulse patterns representing the message to the brain by single visual cells. The combined discoveries of these three men raise new possibilities for the diagnosis of the mechanism of defective color vision.

Refractive Anomalies

NINDB efforts have been directed toward better understanding of the etiology of refractive anomalies. Important advances continue in the analysis and correction of errors of refraction and in the design of instrumentation needed to exploit these new developments, including lasers, X-rays, and ultrasound. Much of the work of Institute grantees has been directed toward mapping the visual impulse through the retina and the various nerve pathways in the brain. Knowledge gained from these studies has contributed greatly to understanding of the nervous system as well as the visual function.

Research indicates that the present greatest hope for those afflicted with amblyopia ex anopsia lies in early detection of the condition. Studies suggest that if ocular muscle defects are not balanced at an early age irreversible breakdowns in the visual pathways will probably occur. Therefore, surgery for infants under 12 months has been seriously considered as the best procedure. Other studies

indicate that treatment of strabismus should begin no later than 18 months of age if the condition is to be successfully corrected. Early treatment of all congenital defects is recommended.

Macular Degeneration

Understanding of the degenerative changes which take place in the eye as a consequence of aging has been considerably increased as the result of recent NINDB-supported investigations of the human macula. As scientists continue to study the anatomy of the eye, blood vessels, and genetic causes of macular degeneration, it becomes evident that pigmentary degeneration of the retina shows marked individual variation in its natural history.

Ocular Pharmacology

The search for better drugs to treat ocular disorders and the testing of currently used drugs for harmful side effects continues. Studies conducted during the past year indicate that the use of properly administered prophylactic antibiotics in all areas of surgery requires re-evaluation. The toxic effects of numbers of entities now being used have been studied; results provide excellent guidelines for treatment that may save many eyes from blindness. A task force of ocular pharmacological specialists, working under the NINDB Committee on Vision, currently is probing various facets of this field.

Model of the Eye

The development of a more accurate mathematical model of the eye, using high speed computation, opens the door to a better understanding of its optical performance. This has a great potential for the improvement not only of diagnostic and therapeutic instruments but also of optical aids to the visually handicapped.

Techniques

The application of space-age technology to the study and treatment of the human eye represents one of the outstanding advances in recent research. At Johns Hopkins University, for instance, a 5-million-dollar program, financed by a grant from NIH, uses sensitive new measuring devices, computers, and electronic equipment in finding new ways to diagnose eye maladies. Doctors are using new freezing, burning, and surgical techniques for saving diseased eyes and are transplanting human tissues and implanting artificial parts to save failing vision. A low-voltage laser device can now disclose in advance of surgery whether cataract removal can restore a patient's sight.

Now under development is a microsurgical machine that will scale down a surgeon's finger movements 40 to 100 times, enabling him to perform incredibly delicate operations on the eye.

The clinical usefulness of electroretinography (ERG) and evoked occipitagram (EVOG) in objective evaluation of blindness in infants has been demonstrated. Four kinds of ocular lesions have been investigated, using intravenous fluorescein, and treated, using photocoagulation. These four types are persistent central serous retinopathy, early senile macular degeneration, macular edema following lens extraction, and central chorioretinitis.

A hand-held direct view laser photocoagulator is in process of development. The uses of the laser have multiplied rapidly as scientific investigations of its usefulness continue. Ultrasound is proving an invaluable tool in diagnosing eye disorders. Cryotherapy has been improved and is increasingly used in therapy.

Devices

A great spurt of interest in devices to help the blind to "see" was apparent during the past year. Many of these projects, of course, have been under way for years, but are only now appearing to bear fruition of a sort, though far removed from the goal of actual restoration of sight for the blind. NINDB has participated in this type of research as have other Federal agencies. Scientists look forward to the day when an artificial eye may be developed, perhaps with the characteristics of a TV camera, which can replace a faulty human eye. NINDB research has already begun in anticipation of development of an instrument which will enable the blind to more fully utilize their remaining visual apparatus. A number of contracts have been made with industrial firms.

National Center for Chronic Disease Control

The Neurological and Sensory Disease Control Program provides for the development of new instrumentation, methods and techniques, for prevention, early detection and diagnosis, and improved treatment of neurosensory disorders.

The methods used by the Program to control blindness and disorders of vision are the support of studies and applied research; the provision of specialized consultation to officials of State, local, academic, voluntary and related agencies and institutions; the development of public information programs; dissemination of promising research results to professionals; and technical assistance to training and service programs.

Glaucoma

Glaucoma is a disease of particular concern to the Program. Two percent of people over forty years of age are affected by this desease. Early detection, diagnosis and treatment of glaucoma usually prevents further visual disability.

In 1968, the Program's Collaborative Glaucoma Study will continue yielding important information previously unavailable from any other source. Of primary concern is the accumulation of knowledge regarding the natural history of glaucoma and the relationships between various parameters. The information emanating from this study will have a more profound effect on the diagnosis and treatment of glaucoma than any other research accomplished in recent times.

A project to computerize tonography will get underway. The new instrumentation developed will make this diagnostic tool available to ophthalmologists who heretofore were excluded from using it because of lack of equipment, time and ability to interpret the tonographic reading.

Through Program encouragement, the American Academy of Ophthalmology and Otolaryngology has passed a resolution whch promotes the inclusion of tonometry as a routine part of a physical evaluation by non-ophthalmic physicians. Other professional groups are being encouraged to adopt similar resolutions.

Preliminary steps have been taken to impress upon medical school faculties the importance of teaching tonometry to medical students. This is being done through encouraging modification of curricula as well as the requirement that sophmore medical students purchase a tonometer.

Pre-School Visual Disorders

Many pre-school visual disorders readily respond to treatment if diagnosed and treated early. This often prevents not only monocular blindness, but also the possibility of total blindness should something happen to the one good eye.

The Program is concerned with reducing the disability resulting from pre-school visual disorders. The Program will continue to be on the alert to improve the techniques and methodologies involved in screening for pre-school vision disorders. Public information material to impress upon the public the importance of having children's eyes checked before they enter school is under development. A protocol for an epidemiological study of pre-school visual disorders is also under development.

Total Eye Care

In addition, the Program recognizes the importance of improving total eye care, as to both availability and quality.

Specific efforts include the evaluation of the use of the ocular fundus photograph for screening and diagnosing eye pathology and planning for an International Symposium on the Treatment of Proliferative Diabetic Retinopathy.

Program expertise continues to be available to official and voluntary health agencies, professional organizations, institutions of higher learning, and other groups to aid their efforts to establish or improve eye care service programs.

SOCIAL SECURITY ADMINISTRATION

The purpose of the old-age, survivors, and disability insurance program is to pay benefits to insured workers and their families when they have suffered a loss of earnings due to retirement in old age, the death of the insured worker, or a severe disability. As of June 1967, 35,000 individuals for whom blindness was a significant factor in their disability were receiving monthly an estimated $2,600,000 in disability benefits. In addition, their families were receiving an estimated $50,000 monthly. It is not known how many blind persons are receiving monthly benefits as retired workers, dependents of retired workers, or survivors.

Beginning with the enactment in 1954 of the disability freeze provision of the Social Security Act, the special problems of the blind in earning a living have been given particular recognition. The disability freeze protects a worker's future benefit rights, and the benefit rights of his family, under the social security program while he is unable to work because of disability. The 1967 amendments to the Social Security Act liberalized the definition of blindness for disability freeze purposes. Under the new definition a worker can qualify for the disability freeze based on "industrial blindness" as well as "statutory blindness This protection is offered to those who become blind even if they are still able to work. For example, a person who experiences a severe reduction in his level of earnings because of blindness can be protected from a comparable reduction in the level of monthly benefits he will receive in the future.

The new definition of blindness also applies for benefit purposes in the case of the blind worker who is aged 55 or over. If a worker over 55 becomes "industrially blind" and, although not totally disabled, cannot do work requiring abilities comparable to those of his regular occupation, he will be eligible for monthly benefits.

Currently, the Social Security Administration employs 14 totally blind persons. On an individual basis, their work performance equals or exceeds that of sighted employees.

AMERICAN PRINTING HOUSE FOR THE BLIND

This nonprofit institution in Louisville, Kentucky, supports the manufacture of special books and teaching materials which are distributed to all public educational institutions for the blind, as well as to regular public schools in which blind children are enrolled.

Number of blind children served by the program were 19,291 in 1967; 19,576 and 20,100 are estimated for 1968 and 1969.

92 - 594 O - 68 - pt 2 - 32

ALCOHOLISM

During the past two decades significant advances have been made in both public and professional acceptance of the concept that alcoholism is an illness rather than a form of moral transgression. The health professions have begun to assume leadership in developing an approach to the study and treatment of alcoholism that incorporates scientific and humanistic objectives. Most recently the courts have been viewing the alcoholic as a sick individual; hopefully, the process of litigation and criminal confinement for alcoholic patients will soon disappear.

There is no universally accepted definition of alcoholism. In general, the most widely used is that of the World Health Organization, which regards alcoholism as a chronic disease, or disorder of behavior, characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use or ordinary compliance with the drinking customs of the community, and that interferes with the drinker's health, interpersonal relations, or his job.

On the basis of several estimates, the number of alcoholics in the United States lies between 4 million and 6 1/2 million, and an estimated 200,000 new cases develop each year. It is estimated that each alcoholic directly affects four family members. If there are 5 million alcoholics, then as many as 20 million other persons are directly affected by alcoholism.

The United States leads the world in the rate of alcoholism. Unofficial estimates place the life expectancy for alcoholics at approximately 10-12 years less than average. Deaths officially attributed to alcoholism total about 11,000. This is probably a substantial underestimate because many physicians are reluctant to place such information on a death certificate when it would embarrass the survivors of the deceased.

Alcohol appears to be involved, although not necessarily the sole cause, in at least 50 percent and perhaps as many as 87 percent of fatal traffic accidents. Losses to industry from absenteeism and other occupational problems asscoiated with alcoholism are about $2 billion annually. An additional $1 1/4 billion per year are spent to provide care, financial support, and treatment for alcoholics and their families.

On any basis, the problem of alcoholism is a large and complex one. Perhaps no disease offers so unique a challenge as alcohol addiction, which can be investigated and treated through the cooperative and combined efforts of the behavioral, biological, and social science disciplines.

Most physicians concur that alcoholism results from a complex interaction of social, psychological, and biological factors. Even the most enthusiastic proponents of any specific theory regarding the causation of alcoholism agree upon the significance of an eclectic approach to the multifaceted problems of this illness. At the present time, no estimate can be made of the relative potential contributions of various disciplines to an understanding of the natural history of alcoholism. An adequate disease conceptualization of alcohol addiction must encompass a variety of biological, psychological, and sociological factors - and clarification of the relevant significance of these factors requires that research carried out within a single discipline must have a meaningful relationship to research conducted within other disciplines.

Obligations for programs on alcoholism

	1965	1966	1967	1968 estimate	1969 estimate
Social and Rehabilitation Service:					
Grants to States	$791,792	$1,504,206	$3,466,800	$4,400,000	$6,000,000
Research and demonstrations	504,000	498,000	254,000	200,000	200,000
Training and traineeships	17,000	8,000	27,720	35,000	45,000
Innovation grants	---	5,000	188,000	200,000	200,000
Expansion grants	---	450,000	756,000	775,000	800,000
Subtotal, Social and Rehabilitation service	1,312,792	2,465,206	4,692,520	5,610,000	7,245,000

Obligations for programs on alcoholism (continued)

	1965	1966	1967	1968 estimate	1969 estimate
Public Health Service:					
Health manpower education and utilization.	$33,908	$44,867	$67,105	$96,640	$75,000
Urban and industrial health.....	69,000	79,000	75,000	80,000	80,000
National Institute for Mental Health.....	3,350,000	3,267,000	3,349,000	5,763,000	6,107,000
Subtotal, Public Health Service...	3,452,908	3,390,867	3,491,105	5,939,640	6,262,000
Total.....	4,765,700	5,856,073	8,183,625	11,549,640	13,507,000

SOCIAL AND REHABILITATION SERVICE

Current Program

State vocational rehabilitation agencies are giving considerable attention to the rehabilitation of the alcoholic client, and activity in this area has expanded considerably since the enactment of the 1965 Vocational Rehabilitation Amendments. As a result of these efforts, the number of alcoholics rehabilitated by the State vocational rehabilitation agencies has shown a steady and consistent growth.

Estimated and Actual Number
of
Rehabilitants with Alcoholism

Fiscal Year Ending June 30	Persons Rehabilitated 1/	
	Total	Alcoholics
1965	134,859	1,136
1966	154,279	1,562

Estimated and Actual Number
of
Rehabilitants with Alcoholism
(continued)

Fiscal Year Ending June 30	Persons Rehabilitated 1/	
	Total	Alcoholics
1967	173,594	2,700
1968	200,000	3,200
1969	230,000	4,100

1/ Data are actual for 1965-67. Estimates are used for 1968-69.

Programs and services to rehabilitate persons disabled by alcoholism are organized in a number of ways. In some States, counselors have been assigned to work exclusively with alcoholic clients in order to provide specialized service. In Texas, for example, it is expected that twenty-two counselors and counselor aides will soon be serving alcoholics.

State vocational rehabilitation agencies throughout the country are working cooperatively with State agencies and organizations serving the alcoholic and are collaborating in programs in hospitals, clinics, treatment centers, rehabilitation centers, and halfway houses for the alcoholic.

A number of State agencies are developing special programs under Section 3 (Innovation) and 4 (A) 2 (A)-(Expansion). To give some example of State activity in this area: The Texas Division of Vocational Rehabilitation is supporting the Houston Alcoholism Rehabilitation Project, a new and comprehensive arrangement for rehabilitating alcoholic patients. The project will be conducted cooperatively with the Texas State Psychiatric Institute which in the past has had a minimal program for alcoholics. Services will be purchased by the Division of Vocational Rehabilitation from the Institute.

In Iowa the Division of Vocational Rehabilitation is participating in a Statewide program in cooperation with the Governor's office, the Office of Economic Opportunity, and a network of community resources. The State vocational rehabilitation agency will establish three transitional residential settings for alcoholics under a 3 year expansion grant. In addition, the State agency has set aside $75,000 of its basic support funds for direct rehabilitation services to alcoholics.

In Sacramento, California, the State rehabilitation agency and the Division of Alcoholism of California's health department operate a Center for alcoholics. This is a one-stop center, offering every needed service

from diagnosis and detoxification through comprehensive treatment and any rehabilitation services required to get the alcoholic back to a job and a satisfactory kind of life. A regional conference on the rehabilitation of the alcoholic will be held in Los Angeles in March 1968.

In King County, Washington, there is a three pronged program, with the State Division of Vocational Rehabilitation, the State Health Department, and the Sheriff's office operating a rehabilitation program at Cedar Hills Center.

A grant has been made to the D. C. Health Department to operate a halfway house for those returning from the treatment center at Occoquan. The D. C. Department of Rehabilitation cooperates closely with this program and provides staff.

Under the Research and Demonstration Grants program authorized under Public Law 565 the Social and Rehabilitation Service has granted funds for 17 projects on alcoholism. Thirteen of these have been completed.

Need for Future Research

The screening of alcoholics for rehabilitation poses a very real problem. Alcoholic individuals vary a great deal in personality characteristics. Their greatest similarity is simply the fact that they drink uncontrollably and exhibit certain symptoms caused by this condition: disturbed relationships, sense of personal inadequacy, social isolation, and instability of employment. There do appear, however, to be identifiable characteristics leading to a relatively good prognosis for rehabilitation. These relate to motivation for treatment and resources for improved social relations. So far such emerging factors have been "dryness" at time of clinic contact, sobriety during clinic interviews, age (older), voluntary visit to clinic, fairly good employment history, positive family relationships, keeping of at least six clinic appointments. No doubt other characteristics predisposing to attainment of continued sobriety can be identified and developed into a structured interview to be administered during early contact.

Procedures for incorporating vocational rehabilitation into the therapy of alcoholic patients need further exploration. The first problem in this connection is the place of vocational difficulties in the adjustment of the alcoholic patient. Cause must be distinguished from effect. The spotty work history of these individuals is a symptom, not a part of the basic pathological process. Thus counseling and placement presuppose therapeutic intervention into the fundamental adjustment processes. For this reason ways must be found of integrating vocational guidance with therapy of a group or individual nature.

Training Courses for the Rehabilitation of the Alcoholics

Alcoholism is given some attention in the two-year training grant program in the various universities receiving grants for counselor training. Some of the hospital field work programs afford an opportunity for some extensive study of the problem.

Each year a number of counselors from the State vocational rehabilitation agencies attend the Rutgers School on Alcoholism and also those held locally such as in Colorado, Utah, Louisiana, and the Southeastern Summer School in Georgia.

There is a need for an increase in intensive training activities in this area for rehabilitation personnel in all States. This staff will need greater knowledge of the pathology of alcoholism, modification of rigid and moralistic attitudes through recognizing the alcoholic's self depreciating image, his fundamental insecurity and dependence (especially important for the welfare client). The counselor must have some understanding too of the needs of families of the alcoholic. Spouses and children of alcoholics have been found to benefit from group therapy, which in turn benefits the entire family.

The six months internship courses for vocational rehabilitation counselors working with psychiatric cases located at Harvard School of Medicine, Harvard University, Nebraska College of Medicine, University of Nebraska and the University of Oregon School of Medicine include lectures on alcoholism and assignment of cases presenting the problem of alcoholism.

PUBLIC HEALTH SERVICE

National Institute of Mental Health

In recognition of the magnitude and social impact of alcoholism as a major public health problem, the National Center for Prevention and Control of Alcoholism was established in 1966 by NIMH to coordinate and serve as a focal point for departmental activities in the field of

alcoholism, to formulate new programs and to conduct research studies in its own laboratories. Its first year has been devoted to expansion of existing programs and initiating new program development activities in research, training, and service. The Center provides leadership in planning and developing national programs in collaboration with other Federal agencies, national organizations, State and local government and voluntary citizen groups, and is guided in its program development activities by the following goals: stimulation of research on the control and prevention of alcoholism; acceleration of communication and application of research findings to service programs; development of training programs for professional and para-professional personnel; and modification of public attitudes toward alcoholism by publicizing scientific knowledge through an expanded program of education.

At the time of establishment of the National Center for Prevention and Control of Alcoholism, only one university-based multidisciplinary research center for the study of alcoholism existed in the United States. It is located at Rutgers University. During the past year high priority was given to the development of additional university-based multidisciplinary research centers for the study of alcoholism and alcohol-related problems. By the end of 1967, funds had been awarded for five additional research centers: Boston City Hospital and Harvard Medical School; Barnes Hospital and Washington University School of Medicine; Baltimore City Hospital and the Johns Hopkins School of Medicine; University of Oklahoma Medical Center; and Houston State Psychiatric Institute.

The centers are distributed across the Nation and all are located in areas that show a high endemic incidence of alcoholism. Although the focus of research will differ among research centers, each will be involved in multidisciplinary research, integrating basic and clinical science disciplines, and will conduct a program of research training at the postdoctoral level in medicine and various basic science disciplines.

For example, at the Baltimore City Hospital-Johns Hopkins complex, one project is designed to determine the relationship between metabolic and behavioral changes in alcoholics. Objective criteria for evaluating behavioral changes and drinking patterns will be developed, and investigators will study environmental factors affecting drinking patterns and behavior.

Under the aegis of the National Center, a broad research program is being mounted to shed new light on the causes, natural history, and treatment of alcoholism. Major areas of investigation include the effect of alcohol on various physiological functions, the relationship between high levels of alcohol intake and physical health, experimental studies on alcohol addiction in animals, and evaluation of the use of different drugs in the treatment of alcoholism.

Studies are under way that seek to further understanding of the etiology of alcoholism and such alcohol-related phenomena as intoxication and withdrawal. From its survey of the scientific literature and of reports from such sources as the Rutgers Center of Alcohol Studies, the NIMH estimates that the alcoholism risk rate among drinkers is about 5.6 percent, or 1 in 18. Two major studies of drinking practices will be contributing data and methods on early case-finding and information that will be valuable for preventive programs. In the process of describing normal drinking practices in the United States, the investigators will identify individuals whose drinking ranges from abstention to heavy indulgence. Follow-up studies of selected individuals will make it possible to identify and evaluate the factors influencing heavy drinkers as they move into and out of difficulties concerning their drinking. Findings will be tested for general applicability through the use of a national probability-based sample of the American adult population.

Cirrhosis of the liver, gastritis, and gout are among the diseases associated with alcoholism. In a biochemical study of the pathologic effects produced by ethanol in man, researchers will reproduce investigations formerly done on

laboratory animals. Their objective is to uncover findings that may be useful in the prevention and treatment of these diseases in man.

A number of treatment methods are being explored and evaluated. Pharmacotherapeutic approaches are among the treatment procedures in which NIMH is supporting extensive research. At present, however, the evidence from controlled studies of a variety of compounds does not indicate that the drugs now available are of value in the treatment of alcoholism as an entity. Further evaluation of metronidazole (Flagyl), which last year offered promise as a means of decreasing the alcoholic's desire for alcohol has not borne out the original enthusiasm about its value.

It should be pointed out that the assessment of the efficacy of a drug - or any other therapeutic intervention for alcoholics - is a difficult task. There are limitations inherent in objective measurement of outcome in treatment programs with alcoholics as there are with all categories of mental illness. Moreover, it is hazardous to generalize findings gathered in studies of socio-economically deprived alcoholics. Such data may not be relevant to individuals with alcohol-related problems who show little social and economic disjunction. The Institute continues to support research to improve the instruments and methodology for assessing drug efficacy on adequate case sampling and population groups. The methodology developed by one investigator offers great promise for the evaluation of drug therapies. It is being tested with alcoholics in a municipal hospital and with middle class patients attending a community outpatient clinic.

Despite the widespread occurrence of alcoholism and the frequent contact that most caretakers have with problem drinkers, there has been only very limited provision of adequate assistance to these men and women. The alcoholic seems to engender mixed feelings in those with whom he is associated and in those who have some opportunity and responsibility to help him. In virtually all American communities, alcoholics are likely to receive less adequate care than individuals with other kinds of difficulties.

Often the actual medical care for alcoholics is minimal - substantial barriers still persist in the admission of alcoholic patients to general hospitals. In most mental hospitals, as well as in other psychiatric agencies, the level of interest in alcoholism is still very low. Public welfare agencies, with few exceptions, have not provided the type of financial assistance for indigent alcoholics that generally is offered to other indigent people. Among almost all helping agencies there has been a tendency to "pass the buck" in relation to alcoholic patients.

The unfounded belief that alcoholics cannot be helped has accompanied and supported the limited interest in providing assistance for them. The belief persists despite ample evidence that many alcoholics have been helped to control their drinking and to function again in the community. Large numbers have been helped by Alcoholics Anonymous, by psychiatrists and other physicians, and by various health and welfare agencies. Numerous follow-up studies of the treatment of alcoholics show recovery rates, based on both abstinence and improved social functioning, ranging from one-third to two-thirds of the patients treated. These figures compare quite favorably with results reported in the treatment of general psychiatric conditions and other behavioral problems.

The National Center supports applied research and demonstration projects designed to improve diagnostic, treatment, and rehabilitation services for the alcoholic. Major advances have been made at the Massachusetts General Hospital in a project designed to provide an around-the-clock diagnostic and treatment service for alcoholics within a comprehensive emergency ward facility. The service provides continuity of care through an alcoholism clinic within the outpatient department of the hospital. The findings obtained there strongly suggest that the general hospital can successfully provide assistance to alcoholics on an emergency basis and follow through with continuity of care in appropriate outpatient settings. The adequacy of comprehensive care for alcoholics that can be provided by a general hospital challenges the notion that specialized detoxification centers and treatment units are needed for these patients.

Treatment programs tailored specifically to serve different kinds of alcoholics are also being developed. These include integrated agency services to skid-row alcoholics and experimentation by a family service agency in developing effective casework services for middle class alcoholics and their families. In the past, few such agencies have been willing or prepared to undertake this kind of specialized treatment program. Having completed an earlier study, an agency in Cincinnati is now working with the teen-age children of alcoholic fathers. The staff is concerned with preventive measures and with learning how these youngsters cope or fail to cope with their family situation during critical periods in their own development. Treatment services will derive from this research, and it can be expected that other resources will need strengthening in order to meet the needs of these youngsters.

Family service and other social service agencies often encounter the problems of alcoholics. A project in New York City seeks to enhance the professional skills of social workers in agencies providing services to alcoholics and their families.

Although drug therapy will continue to be tested and used in most treatment settings for some alcoholics, major emphasis remains on psychological and social therapeutic approaches that try to help the alcoholic cope with his anxiety and tension without relying on alcohol and to improve his social functioning as a member of his family and his community.

The complicated feelings that most Americans have about their own and other persons' use of alcohol probably have been an important factor delaying the development of more adequate community services for alcoholics. In many communities, alcoholics are committed to the only available treatment facility, the State mental hospital.

The proportion of first admissions to State and county mental hospitals diagnosed with alcoholism rose from 14.4 percent in 1960 to 16.9 percent in 1965, an increase of 17 percent over the five-year period. In

1960 mental disorders due to alcoholism ranked third among first admissions, schizophrenia and diseases of the senium being the leading diagnoses. In 1965, however, alcoholism replaced diseases of the senium as the second-ranking diagnosis among first admissions. The increase in first admissions with alcoholism is rather significant in view of the fact that the proportion of first admissions and the first admission rates for the other two leading diagnoses (schizophrenia and diseases of senium) have been decreasing in recent years.

The number of States in which alcoholism leads all other diagnoses among first admissions to their public mental hospitals increased from nine in 1960 to eighteen in 1965. In eleven other States, alcoholism is the second-ranking diagnosis. Moreover, data from the Maryland Psychiatric Case Register show that admission rates for alcoholism to the State mental hospitals exceed by several fold the admission rates for this disorder to private, general and VA hospitals and outpatient psychiatric clinics.

Through the Institute's Hospital Improvement Project Grant Program, grants have enabled seven State hospitals to furnish services to a much larger number of alcoholics and to improve the quality of the treatment program. Three established special alcoholism treatment units and three provided for an expansion and diversification of sorely needed treatment and staff resources. The projects provide such services as individual and group psychotherapy, counseling for families of alcoholics, vocational guidance and placement, new approaches to hospital and post-hospital recreation. The seventh, in addition to extending its program, is providing aftercare to patients released from the hospital.

In the organization of services for alcoholics, there must be an awareness that other problems frequently coexist with the drinking problem. These "other problems" often determine where in the community the person with a drinking problem is seen and what types of immediate and long-term care and treatment he requires. Alcoholics may be hungry or obese, may suffer from diabetes

or cancer, may be unemployed or wealthy, have a fractured leg, be pregnant or psychotic. Sometimes these non-alcohol problems will need immediate and continuing attention before the drinking problem can be dealt with; in other instances these problems and the alcoholic problem will have to be tackled simultaneously. In still other cases no substantial progress can be made until the drinking problem has been dealt with.

The magnitude of the problem of alcoholism - and the fact that virtually all alcoholics also have other medical, social, and psychological problems in addition to their difficulty with alcohol - argues against the establishment of a special network of treatment services for these patients. Such specialized services could not be adequately staffed because of the great manpower shortages in all health and related fields - nor could they provide the broad range of services needed by most problem drinkers.

However, until such time as care and treatment for alcoholics are provided on a basis equal to that given other persons in need of help, some special assistance and measures will be required to insure that alcoholic patients do not get lost in the maze of agencies.

The Community Mental Health Centers Program and the Partnership for Health Legislation (P.L. 89-749) are of particular importance in relation to these objectives. The services being developed throughout the country in community mental health centers will finally provide to alcoholics the emergency, inpatient, outpatient and partial hospitalization care that for too long has been unavailable to these patients. Within the comprehensive health planning activities supported under P.L. 89-749 it will be possible to involve an even broader range of health and health-related agencies in the provision of treatment to persons with drinking problems. One of the major current activities of the staff of the National Center for Prevention and Control of Alcoholism is to work collaboratively with Federal, State and local groups to ensure that maximum advantage is taken of these two

unique opportunities to improve the quantity and the quality of help provided to alcoholics and their families.

Both community mental health and comprehensive health legislation emphasize the importance of preventive approaches. This emphasis applies with equal force to the problem of alcoholism. Early case-finding of potential alcoholics, followed by the provision of needed treatment, is a major element in the prevention of alcoholism. Equally essential is the development of broad programs of alcohol education within American schools and communities. Finally, a substantial improvement of general mental health probably will be accompanied by a reduction in rates of alcoholism. This is because psychological factors undoubtedly are a major element in the development of alcoholism. There is no sound evidence to date to point to biochemical or physiologic defects as causes of alcoholism.

A special brochure, The Community Mental Health and Alcoholism Programs, has been prepared and included among the literature distributed in reply to general and specific alcoholic-related requests for information. Although many centers have indicated their interest and willingness to develop specialized programs for alcoholics, budgetary and manpower restrictions have been constraining factors. Nevertheless, a number of centers are pioneering and developing programs for alcoholics. These include the Mid-Missouri Mental Health Center in Columbia, Missouri, the Central State Mental Health Center in Norman, Oklahoma, and the Pennsylvania Hospital Community Mental Health Center in Philadelphia.

Under the project grant program of the Partnership for Health, several alcoholism projects have already been funded. In Columbus, Ohio, an alcoholism unit in a general hospital is to be implemented, and Pennsylvania is developing a program to deal with problem drinking among State employees.

Overcoming the reluctance of many general hospitals to provide medical care to alcoholics on an equal basis

with other patients is a high priority concern of the National Center. Such consultation has included work with the Federal Department of Justice, lower level courts, and police agencies.

There also is an urgent need to overcome the continuing reluctance of many general hospitals to provide medical care to alcoholics on an equal basis with other patients. Overcoming these barriers has been a high priority concern of the National Center for Prevention and Control of Alcoholism. Activities have been initiated to develop pilot projects in a number of major teaching hospitals. These demonstration programs can serve as models for the treatment of alcoholics by general hospitals throughout the country. Staff have addressed meetings of local hospital associations, have provided consultation to major committees of the American Hospital Association and the American Psychiatric Association and are working with members of the Secretary's National Advisory Committee on Alcoholism to bring about rapid improvement in hospital care for alcoholics. Addresses have been made at special meetings called by Governors of several States, which have been attended by heads of key State agencies - health, mental health, public welfare, vocational rehabilitation, motor vehicle, education, etc. - whose work relates to the area of alcohol problems. Emphasis in these sessions has been on the appropriate role and contribution of each agency and on the importance of overall coordinated activities by the various agencies.

Voluntary health insurance coverage, commercial insurance carriers, prepayment plans, and the prepaid group practice plans generally restrict or exclude completely aspects of inpatient and outpatient care of alcoholism. Although the alcoholic may be eligible to receive medical care in a general hospital for medical problems associated with his alcoholism, both inpatient and outpatient psychiatric treatment for the alcoholism tend to be exclusions under insurance contracts. Staff of the National Center in cooperation with the NIMH Insurance Task Force are gathering data on existing

coverage as basis for suggesting guidelines for improved insurance coverage. Concomitant with this, an educational program will be mounted to acquaint and interpret to insurance carriers both currently available treatment knowledge and the potential for alcoholism service programs if adequate financing could become available under the voluntary insurance mechanism.

Prevention and Education

Although treatment for alcoholics is essential - and in need of improvement - it is not in itself prevention. Furthermore, treatment efforts probably cannot even cope with new cases as they arise. Thus it is unlikely that the rate of alcoholism can ever be substantially reduced by treatment approaches alone. It is for this reason that the Center is placing heavy emphasis on prevention and public education.

NIMH is supporting a number of research studies from whose findings are expected significant contributions to preventive and educational programs. Researchers on the two major studies of drinking practices are seeking to identify those individuals who constitute a "high-risk group" for later alcoholism. Teen-agers are the focus for two service demonstrations programs. In one, the investigators are working with youngsters of drinking fathers. In the second, consultation services from a specialized general hospital alcoholism program are being provided to community helping agencies. These agencies evolve and become involved in a coordinated treatment program for 14- to 16-year-olds who appear before the court for a first offense with alcohol use as a contributory or associated factor. The preventive process starts with identification of these youngsters so that there can be appropriate intervention to reduce the potential for subsequent alcoholism and related pathology. Preliminary findings indicate that such disruptive family factors as divorce, illness, rejection, or overindulgence appear frequently in the background of these youthful offenders.

92 - 594 O - 68 - pt 2 - 33

Among the wide range of helping professions who are in a position to identify and provide assistance to high-risk individuals with whom they come into contact, public health workers are frequently in a unique position to intervene at an early stage in the development of the medical-social problems of alcoholism. A publication, A Guide to the Public Health Control of Alcoholism, prepared under an NIMH grant to the American Public Health Association, will shortly become available and is expected to be an important vehicle for stimulating greater involvement and action by public health personnel.

Public education - in relation to alcoholism and to the use and abuse of beverage alcohol - is one approach to prevention that urgently requires additional soundly conducted research and evaluation. Existing channels are being used and new ones being developed in comprehensive educational programs on alcohol and alcoholism for junior and senior high school students and adults in two Mississippi communities. The investigators are evaluating responses elicited by different informational techniques and materials. Approximately 1,000 high school students will be interviewed as part of the evaluation of the education program.

A concern of particular importance that is likely to grow in future years is to find alternatives to the legal-criminal management of the problem of public drunkenness. Recent court decisions suggest a nationwide trend away from the criminal prosecution of alcoholics for the offense of public intoxication. This will necessitate the development of medical-social alternatives to the "revolving door" system of managing these unfortunate persons. A comprehensive program to deal with homeless alcoholics will have to include the participation of a wide range of health, social, public welfare and other agencies. In contacts with various professional groups, Federal, State and local agencies and key individuals, the staff of the National Center have been exploring various ways in which communities could be assisted to develop adequate programs for homeless alcoholics. NIMH-supported researchers in New York City are studying ways by which homeless alcoholics from Skid Row can be rehabilitated and returned

to productive life. Intensive casework services and halfway house residences are among the approaches and services being evaluated in this demonstration. It is generally agreed that one of the most important and potentially rewarding areas of preventive activity is in relation to alcohol-education activities directed at youngsters. The forthcoming publication, Thinking About Drinking, which was developed jointly with the Children's Bureau, is directed specifically at teen-agers. The widespread availability of such a publication for the first time will enable various youth-group leaders to utilize these materials to help teen-agers behave more responsibly in relation to the whole question of the drinking of alcoholic beverages. The publication will be distributed to schools and other organizations interested in working with youth throughout the country. It will be accompanied by a guide to assist youth-group leaders in making the best possible use of the publication.

During the past year the staff of the National Center for Prevention and Control of Alcoholism also provided consultation to the National Alcoholic Beverage Control Association on the production of a film on teen-age drinking problems. There also has been substantial consultation to a number of national church groups that are interested in developing and strengthening the church's role in the area of alcohol education.

Classroom teachers are a key group needing the background and skills to enable them to fulfill their role in educational programs for their pupils. For this reason, the staff of the National Center have been working with a major national educational organization to develop a study of the current training activities in teacher-training institutions that are relevant to the area of alcohol education. It is anticipated that such a study would provide a national survey of teacher-training activities in this area, would bring to the forefront a number of model programs, and would enunciate guidelines for the future development and strengthening of teacher-training programs.

The reception accorded two publications that appeared in the last few months suggests that each in its own way

will play a significant role in modifying public attitudes toward alcoholism and alcohol-related problems. The NIMH publication, Alcohol and Alcoholism, is a monograph summarizing basic facts and information in the overall field. Over 50,000 copies have been distributed; the publication has received considerable publicity and favorable response in the mass media as well as in scientific and professional circles.

In 1961, NIMH grant funds established the Cooperative Commission on the Study of Alcoholism. The Commission members, an independent group of experts in various professional and scientific fields, supervised a comprehensive nationwide six-year study of alcoholism and other alcohol problems. Late in 1966, the research studies carried out at Stanford University were completed and grant support terminated. In October 1967, Oxford University Press published the initial report of the Cooperative Commission, Alcohol Problems: A Report to the Nation. The report stressed the cost in terms of human suffering and dollars that result from alcoholism and other alcohol problems and recommended improved treatment and prevention programs as well as broad public discussions about alcoholism and drinking. Additional publications are anticipated in which the Commission will present material derived from its staff's independent assessment of this complex field.

Training and Manpower

It is clear that progress in research, services, prevention and public education is contingent upon the availability of knowledgeable and skilled, trained manpower to implement goals and objectives. Until very recently, major professional training institutions and programs devoted only very limited attention to alcoholism and other alcohol problems. One of the priority activities of the National Alcoholism Center is to secure appropriate attention to alcoholism and other alcohol problems in the basic curricula of the relevant professions - medicine, psychiatry, psychology, social work and nursing. In addition, personnel from a variety of other fields such

as the law, education, corrections and vocational rehabilitation need greatly to expand and strengthen their knowledge and activities in relation to alcohol problems. Moreover, because of the continuing manpower shortages in virtually all of the professions, experimentation is needed in training nonprofessional and subprofessional personnel to perform various roles in relation to alcohol problems.

A wide range of different activities were mounted during the past year in relation to training. The five new university-based multidisciplinary research centers as well as the Center at Rutgers University include training programs for researchers. NIMH grant funds are also supporting specialized training programs for social and behavioral scientists, social workers, psychiatrists, and chaplains. In addition, Baltimore is the site for two experimental training programs for nonprofessional personnel, one for alcoholism counselors, and one for various community caretakers serving the inner city. They, in turn, will become trainers of subsequent manpower ranging from mental health professionals to nonprofessional indigenous volunteers.

In the spring of 1968, the American Public Health Association will convene a conference of faculty from schools of public health to generate attention to this area in the training programs of schools of public health. The content and nature of the curricula materials will also be explored at this four-day work conference.

Professional organizations such as the American Association of Medical Colleges, the Council on Social Work Education, the American Psychiatric Association and the American Psychological Association have received consultation from NIMH staff on the inclusion of alcoholism in curricula and on general manpower needs and potentials. Staff have also participated in a number of summer schools of alcohol studies held during the past year. These summer schools have been a major source of specialized training in the field of alcoholism during the past years.

Scientific and Professional Communication

Accelerating the communication and application of research findings to service activities is an urgent need in the field of alcoholism. It is also essential that adequate interchange of information be maintained between various professional workers and scientific investigators. NIMH financial assistance to the 28th International Congress on Alcohol and Alcoholism, to be held in Washington, D. C. in September 1968, will foster exchange and collaboration on the international level.

On the national level, the staff of the National Center have been instrumental in organizing regular meetings of the major national groups principally concerned about alcoholism. Representatives of Alcoholics Anonymous, the Christopher B. Smithers Foundation, the North American Association of Alcoholism Programs, the National Council on Alcoholism, and the Alcoholism Sub-Committee of the American Public Health Association have met together regularly for the exchange of information and joint program planning. This is the first time that these various groups, primarily concerned with alcoholism, have ever worked together in this fashion.

The mandate to the National Center stresses its function of coordinating alcoholism activities throughout the Department and in the Federal Government generally. The staff of the National Center have worked closely with the National Advisory Committee on Alcoholism, which met four times during the past year. This Advisory Committee has already made a number of significant recommendations to the Secretary and the staff of the National Center are actively involved in their implementation. Staff have also participated in the meetings of the Intra-Departmental Committee on Alcoholism.

Presentation of papers as well as consultation on meeting plans were Center staff's contributions to several significant alcoholism conferences held last year. These included the Secretary's Conference on Social Welfare and Alcoholism and a U.S. Civil Service Commission Conference

for representatives of all major Federal agencies on drinking problems among Federal employees. Subsequent to this meeting, NIMH staff provided consultation to Civil Service Commission staff on guidelines for mental health services for alcoholism and alcohol-related problems under the Federal Employees Health Benefits Program.

To ensure appropriate liaison and exchange of information with other units of the Department, regular meetings have been held with representatives of the Office of Education and the Social and Rehabilitation Service. A second pamphlet to be published cooperatively by NIMH and the Children's Bureau will be for parents of teen-agers and will discuss social attitudes toward drinking, why some people drink and others abstain, and the potential hazards of drinking.

Consultation on alcoholism and other alcohol-related problems has been provided to such diverse Federal agencies as the Bureau of Indian Affairs of the Department of Interior, the Justice Department, and the Labor Department. In relation to the tragic problem of drinking and driving, there has been substantial collaboration both with the Center for Urban and Industrial Health of the Public Health Service and with the National Highway Safety Administration in the Department of Transportation. In addition, there have been consultations both with scientific investigators and with medical experts from the Veterans Administration and the Armed Forces.

As part of their own program goals, the Social and Rehabilitation Service and the Office of Economic Opportunity are concerned with the alcoholism problems of the economically indigent as well as with the extension of rehabilitation services to problem drinkers. Consultation is being extended to these agencies on a continuous basis to enable them to incorporate the latest research findings into the service programs they finance.

Both the national AFL-CIO organization and individual unions have sought consultation for the development of alcoholism programs under labor and labor-management

auspices. The expression of interest and concern from these groups are indicators of the broadened activities that the National Center will be carrying out in the coming years to overcome the serious neglect that has been the fate of the national health problem of alcoholism.

Bureau of Health Manpower

The Bureau of Health Manpower, through its short-term public health training program, enables professional health personnel to update their knowledge and skills relating to public health problems, one of which is alcoholism.

National Center for Urban and Industrial Health

The injury Control Program is supporting research to determine the relationship between use of alcohol and accidental injury and death, alcohol measurement, an epidemiological study relating to traffic accidents, and a study of patients admitted to hospitals to determine whether alcoholism or excessive alcohol ingestion may be a factor.

DRUG ADDICTION

The problem

Drug abuse is a composite problem composed of several rather distinct issues. First, there are the drugs themselves. The narcotic agents, morphine and heroin, are highly addictive and their abuse potential is great. Stimulants such as amphetamines, on the other hand, are not considered addictive but they are abused by a great many people, who may use them frequently to push their bodies and minds into unnaturally prolonged activity. Barbiturates, sedatives, and the so-called minor tranquilizers often referred to as "nice" drugs because they are prescribed by physicians to millions of people; yet these compounds, too, are misused and abused. Hallucinogenic compounds like LSD and mescaline do not cause physical dependence, but they can precipitate acute psychotic reactions in users. Marihuana typically produces a mild euphoria, although it may produce more severe reactions. The use of marihuana is a criminal offense, yet millions of citizens have used the drug on one or more occasions. From this brief list, it can be seen that the agents involved in the drug abuse problem are pharmacologically distinct entities, requiring separate and specific approaches to control.

Obligations for programs in drug addiction

	1965	1966	1967	1968 estimate	1969 estimate
Social and Rehabilitation Service	NA	$166,000	$454,000	$509,000	$575,000
Public Health Service: National Institute of Mental Health.	$8,945,000	9,214,000	12,003,000	26,000,000	30,500,000
Total.....	8,945,000	9,380,000	12,457,000	26,509,000	31,075,000

SOCIAL AND REHABILITATION SERVICE

Although the State vocational rehabilitation agencies have shown interest in providing vocational rehabilitation services to those narcotics addicts who have completed the necessary treatment period, few of these cases have been referred for service. Of those who have received services, the number of successful rehabilitations has been minimal.

Estimated and Actual Number of Rehabilitants with Drug Addiction

	Persons Rehabilitated 1/	
	Total	Drug Addicts
1967	173,594	110
1968	200,000	120
1969	230,000	140

1/ Data are actual for total rehabilitants in 1967; estimates are used for 1967 rehabilitants with drug addiction and for both categories in 1968 and 1969.

The 1965 Vocational Rehabilitation Amendments, however, have prompted some encouraging activity in this area. Under the innovation grant program, for example, the California Department of Rehabilitation is cooperating with the Department of Corrections in a project to provide vocational rehabilitation services to addicts who are inmates of California Rehabilitation Centers and who are residents of East Los Angeles or South Central Los Angeles poverty areas. When possible, they are housed in a separate unit at the institution so that the staff can provide coordinated procedures for their rehabilitation. In a related program, the California Department of Rehabilitation is developing the use of Synanon techniques to rehabilitate narcotic addicts who are residents of halfway houses. In New Jersey, the New Jersey Rehabilitation Commission is supporting a project in three counties to develop methods and techniques to improve the vocational rehabilitation of persons who have been addicted to narcotics.

In New York, under the authority whereby private funds may be matched for the establishment of rehabilitation facilities under Section 2 of the Vocational Rehabilitation Act, the New York Division of Vocational Rehabilitation has established a rehabilitation facility

at Exodus House, a center for the resocialization of narcotic addicts in East Harlem. The project includes building alterations, equipment, and initial staffing.

A grant was made to the Vocational Guidance Service of Houston, Texas, for the partial support of a halfway house providing intensive aftercare services for narcotic addicts released from the Public Health Service Hospital at Fort Worth. This project will demonstrate a combined hospital and post-hospital treatment program.

The Social and Rehabilitation Service has made a grant to Notre Dame University for a study of drug use, of the sociological and psychological factors which determine an individual's tendency toward narcotic addiction, and the resources which may be of special significance in helping him achieve rehabilitation. Part of the study is being carried out in a single block area of New York City which has a high proportion of addicts in its population.

Studies including a pilot project sponsored by the National Institute of Mental Health point to the need for closer coordination of community services, the fact that addicts are frequently members of families that may require as much help as the patient himself, and the need to recognize that addiction is a chronic problem and that any progress or even periodic assistance is a boost to the patient, his family and the community. Institutionalization is not enough; ultimate rehabilitation must be accomplished in the community.

Various new approaches were suggested in the report of the President's Advisory Commission on Narcotic and Drug Abuse. There are at present several halfway houses in operation where attempts are made to rehabilitate the addict and prevent relapse. The outpatient clinic is being considered, at least from the standpoint of research studies.

Pilot efforts would have to precede any substantial efforts to build continuing projects or activities for rehabilitation of narcotic addicts into on-going State vocational rehabilitation programs. They should concentrate in the cities with greatest incidence. They should also be planned to run for at least 5 years, and then hopefully to be absorbed into on-going programs. We do not believe States can afford as yet to go extensively into as uncertain and relatively costly a venture without Federal leadership in pilot, exploratory efforts.

Early in the planning, these pilot efforts should lead into the development of special training courses for rehabilitation counselors who will handle the vocational rehabilitation of narcotic cases, and others such as social workers, public health nurses, probation and parole officers who will work in this rehabilitation effort.

In cooperation with the Division of Hospitals, Public Health Service, a national working conference on narcotic addiction was held in February 1966. The main objectives of this conference were to: (1) provide factual information on the nature and extent of the problem and identify gaps in knowledge, (2) improve communications between treatment institutions and community agencies, and (3) develop plans for better coordination of rehabilitation efforts between community agencies.

In another Rehabilitation Service Administration training activity in 1967, funds were provided for Bibliography on Drug Dependence, a companion piece to the book Rehabilitation of the Narcotic Addict, which was distributed in the summer of 1967.

A $5,000 project development grant was awarded in 1967 to the Federation of the Handicapped, New York City, to plan the development of a narcotics addiction rehabilitation center. This well-established sheltered workshop is hoping to integrate this specialized program into the regular work of the agency.

National Institute of Mental Health

The National Institute of Mental Health actively supports and encourages a wide range of activities designed to counter the multidimensional drug abuse problem. The Institute's diversified efforts -- in basic and clinical research, demonstration projects, training, community service, and public information programs -- are coordinated and integrated through the Center for Studies of Narcotic and Drug Abuse. This report highlights current work of the Institute in the field of drug abuse.

The Demography of Drug Abuse

At any moment in time, the people who abuse drugs are to be found in every socioeconomic sector of our society, in every geographical region, in every type of community setting. Yet the demographic details of the national problem of drug abuse are in constant flux. In order to keep informed, the National Institute of Mental Health supports surveys and the development of increasingly refined reporting and survey techniques.

No more than a rough estimate can be made right now of the number of people physically dependent on or habituated to nonnarcotic drugs. The figure is placed between 200,000 and 400,000 persons. It is known, however, that tranquilizers -- a group that includes several compounds with established addiction potential -- constitute the largest single category of drugs prescribed today. In order to begin to clarify the extent of nonnarcotic drug abuse, the Center is supporting a national survey of drug use and attitudes towards drugs. The survey should provide the first reliable information about the use, on a national scale, of both prescription and illicit drugs.

Use and abuse of the hallucinogenic drugs LSD and marihuana are of special concern because young people seem particularly prone to involvement with these agents. In the absence of reliable data the incidence of hallucinogenic drug use frequently has been a matter of scare headlines and dire editorial pronouncements. The situation is changing rapidly now that the first of a series of Institute-supported surveys is reporting findings. This first survey was conducted on college campuses on the East and West coasts in the Spring of 1967; it yields a cross-sectional picture of LSD and marihuana use among college students. Here are the main findings.

Eighteen percent of the students surveyed reported using marihuana at least once, with a range for individual colleges of 10-33 percent. (It seems likely that experimentation with marihuana has increased since the time of the survey and that these estimates are now conservative.) Generally, more men students reported involvement with both marihuana and LSD. Approximately one-quarter of the male students reported using marihuana while one-fifth of the females questioned admitted such use. Of those who reported having ever used marihuana, 65 percent had used it less than ten times, with "once or twice" the most common response. The data suggested that most collegians learn about using the drug at college; about 10 percent first used marihuana in high school. Fifty percent of those who tried it experienced nothing from the preparation. There seemed to be a steady increase in the percentage of students reporting marihuana usage as freshmen, sophomores, and juniors, with some decline in the percentage of seniors. Graduate student usage showed a further decline.

Five percent of the college students polled said they used LSD. The range among individual colleges was 2-9 percent. Colleges reporting higher marihuana usage also reported higher LSD usage and men more frequently experimented with LSD than women (as with marihuana). Here again, LSD users tended to be "experimenters" with only 30 percent of the sample "serious" LSD users. Confirming the greater potency and simplicity of administration of LSD, over 80 percent of the sample polled had some reaction to LSD.

The academic standing of the occasional user was average-to-good, while the involved drug users had slightly lower average scholastic grades. The troubled group of heavy drug users is estimated to represent about 3-4 percent of the student users. Clinical data from other studies indicate that for these youths a problem of drug abuse has developed with adverse psychiatric complications. Reports from a number of observers of the college scene indicate that the extent of LSD use has decreased since spring 1967. There has been a concomitant decrease in the number of psychotic admissions, secondary to LSD usage, to student health services.

Other cross-sectional studies and longitudinal surveys of hallucinogenic drug use among high school and college students are now in progress. These can be expected to provide a realistic basis for future studies and for effective information programs to stem any further increases in incidence.

The relatively more fortunate young people who make up the collegiate group represent only part of the youthful population especially vulnerable to drug abuse. In urban areas, economically impoverished adolescents and young men and women constitute another highly visible group of drug abusers. All the known agents of abuse potential - amphetamines, barbiturates, hallucinogens, opiates - are heavily trafficked in our big-city slums. Of the 60,000 narcotics addicts known to the Federal Bureau of Investigation, the overwhelming majority live in our most populous cities.

The motivation and the maintenance of drug involvement here is quite different from that which prevails among collegians. One of the Center-supported investigations of this aspect of the problem is under way in Philadelphia. The researchers are seeking to uncover the psychosocial networks in which adolescent drug users live. They will also explore ways to use this network of family, peers, and social institutions for therapeutic purposes.

In New York City, a central registry of narcotic abusers continues to receive Institute support. The

registry has helped to increase efficiency of many city agencies concerned with illicit narcotics use, such as the hospitals, health and police departments, and has enhanced the effectiveness of voluntary agencies and private physicians in dealing with addicts. Under-reporting in specific areas has been detected and is being studied; for example, during one month-long period, only four private physicians were responsible for reporting 67 percent of all cases.

A State-wide registry of drug abusers has been established in Maryland. This group is also developing, from various community agencies, sources of reliable information about the extent and correlates of drug abuse. The researchers are gradually piecing together a picture of drug abuse in local communities.

In work such as this, the Institute hopes to encourage the skills and experience that will lead, ultimately, to accurate and comprehensive data about the demography of drug abuse on a national scale.

Biological and Behavioral Research

Investigators continue to explore the pharmacology of drugs liable to abuse, the characteristics of people who abuse them, and the complex interactions between agents and hosts. Many of the institute-supported studies in experimental psychopharmacology of drug abuse are variants of a model addiction system. This system previously yielded a good deal of theoretical information about the problem of relapse in post-addict patients. Current work ranges from experimental neurophysiologic studies, such as the ablation of sections of animal brain to determine the effect on the addiction process, to studies of the biochemical changes wrought by addiction to various drugs. Interest in questions of protein metabolism and enzyme synthesis in the various types of addiction has increased recently. Results from several studies of catecholamine metabolism in the various types of drug dependence are compatible with the hypothesis of denervation hypersensitivity. This hypothesis was advanced to explain the phenomena of physical dependence and tolerance.

The Institute's Clinical Research Centers in Fort Worth, Texas and Lexington, Kentucky have been moving ahead with studies of the biochemical and behavioral aspects of drug abuse. The factors underlying drug addiction are believed to be symptomatic of a personality disorder influenced by social, cultural, and economic as well as pharmacological factors. Drug abuse is viewed as the unsuccessful efforts of individuals with poor impulse control to cope with the stresses of daily life. Thus, for example, current treatment modes seek to support the "weak" individual and to modify his environment in ways that will enable him to develop better coping mechanisms as alternatives to drug abuse.

More generally, the relation between personality disorders and all forms of socially deviant behavior presents a major research challenge. Little is known about the dynamics of faulty personality development or the mechanisms underlying specific symptomatic manifestations of personality disorders. The insights gained from the study of manifestations of personality disorders will lead to a better understanding of the mechanisms that produce such socially deviant behavior as drug abuse. Future research by grant-supported investigators and at the Clinical Research Centers will increasingly focus on the potential addict and the discharged patient rather than concentrating on the physical and psychological symptoms of addiction *per se*.

Next to alcohol, marihuana is the most widely used intoxicating drug in the world. Yet research on the pharmacological and behavioral effects of marihuana has proceeded slowly because adequate amounts of a chemically pure active principle were not available. Chemists have now succeeded in synthesizing the isomer of tetrahydrocannabinol that is chemically identical to the tetrahydrocannabinol isolated from natural marihuana. Center staff is currently negotiating with the Hoffman-LaRoche Pharmaceutical Company and other potential sources of tetrohydrocannabinol to arrange for sufficient supplies of synthetic marihuana components. The staff has proposed a set of priorities for marihuana research and is preparing to undertake a massive interdisciplinary program to clarify the problem in scientific and public health terms. This program will extend substantially the pioneer work being carried out at the Lexington Clinical Center.

The research considered essential includes basic pharmacologic and biochemical studies with animals and man. Systematic data about the effects of chronic marihuana use, for example, have not been possible heretofore and such studies are given high priority. The possible psychotherapeutic use of tetrahydrocannabinol in depression has been proposed by a number of European investigators. For this purpose, human dose-response studies will be undertaken and the drug studied in various diagnostic groups. If it appears useful, controlled clinical trials should be pursued to determine its value in the therapeutic armamentarium.

Social and psychological investigations of marihuana users are also considered to be fundamentally important. Among the several studies outlined, the staff strongly recommended a thorough epidemiologic study of cannabis use in the Middle East or in India. The cultural side effects of endemic drug usage and the hazards to the individual can best be documented in settings such as these. A visiting epidemiologic team (modeled after Public Health Service teams at the Communicable Disease Center) could accomplish this mission effectively. Data obtained here could be compared with user data in the United States and with control populations of non-users of marihuana in the foreign populations studied.

A number of clinical and research observations have raised concern about possible outbreaks of new forms of acute or chronic organic psychosis related to hallucinogenic drug use. Further, preliminary reports from various laboratories suggest the possibility that LSD may be implicated in serious chromosomal aberrations. Concerned with these reports of psychological and biological damage, the Center for Studies of Narcotic and Drug Abuse convened a meeting of the leading research investigators in this field in September 1967.

The participants generally agreed that current information about the biological hazards of LSD and other hallucinogenic drugs must be considered incomplete. Moreover, the

92 - 594 O - 68 - pt 2 - 34

evidence for persisting psychological damage from LSD usage was found to be minimal. The participants felt, nevertheless, that in the absence of conclusive data, LSD in particular should be regarded as a hazardous drug, especially for women of child-bearing ages. The Center received the enthusiastic approval of these investigators for its efforts to support and integrate research into the mechanism of actions and biologic and psychologic effects of LSD and other hallucinogenic compounds. The proceedings of the meeting are currently being edited and will soon be ready for publication.

Researchers who are exploring the potential therapeutic value of LSD continue to report results suggesting that LSD combined with appropriate psychotherapy may be useful in both alcoholism and sociopathic states. In this context, the NIMH is looking ahead to problems that may arise regarding the legal significance of hallucinogenic drug research. A pilot study has been undertaken by an attorney to review existing knowledge about the hallucinogens and to survey the legal controls now in effect, vis-a-vis these drugs. The investigator will then explore alternative types of legal control systems that might be used. He hopes to be able to recommend actions that might increase the assimilation of the products of scientific research into legal decision-making.

Treatment and Rehabilitation Programs

The traditional treatment of narcotic abusers has consisted of humane withdrawal from drugs; rehabilitation has been limited essentially to psychotherapy in Federal and State institutions. In recent years, however, new drugs and techniques have been making it feasible to bring treatment and rehabilitation facilities closer to the abuser's home environment. Moreover, the Narcotic Addict Rehabilitation Act (NARA) of 1966 signified a new departure in the national policy regarding narcotic addiction. The NARA provides for civil commitment of narcotic addicts, including those charged with or convicted of violating Federal criminal laws. With the passage of the NARA, Congress authorized a comprehensive medically oriented approach to the treatment and rehabilitation of narcotic addicts.

Institutional treatment is to expand into its natural outlet - the supervised return of the patient to the community. For the first time, provision is made for professionally supervised aftercare for addicts in their own communities after discharge from inpatient treatment. In keeping with community mental health concepts, and to insure that close supervision of the addict will be maintained, contracts for hospital and aftercare treatment and rehabilitation services will be negotiated with appropriate facilities near the home of the addicts.

As of June 1967, ten community mental health centers were operating a drug-abuse program or had plans to develop one. Seventeen other centers indicated their intention to develop drug-treatment programs. A number of inquiries were directed during the past year to the Center for Studies of Narcotic and Drug Abuse and to its Regional Offices; inquiries regarding NARA were made from Congressmen representing 16 different States. Communities that have some program but need to develop further efforts include New York City, Washington, D. C., Newark, Bergen County, N. J., Eastern Texas, and San Antonio. Cities with significant populations of addicts, but with no treatment services are Albuquerque, Cleveland, Detroit, New Orleans, Philadelphia, Seattle and St. Louis.

The Institute expects to proceed with its NARA program in the coming months. Part of the program will be devoted to training activities and part to evaluation; a portion will be used for 100 percent support of newer treatment modalities and a significant portion will go into the development of 5 to 7 new programs within community mental health facilities.

In addition to the programs to be initiated under the NARA, the Institute has continued its support of a wide variety of treatment and rehabilitation projects. To suggest the direction of these activities, a few examples are provided in the brief descriptions of current work that follow.

A modification of the well-known Synanon approach is being evaluated at Daytop Village in Staten Island, New York. The addict must meet rigid criteria to participate in the program, which consists mainly in intense group interactions. He gains increasing responsibility and independence as he shows improvements in behavior and attitudes. Daytop Village has recently come under the auspices of the Staten Island Community Mental Health Center. This development has been encouraged by the NIMH because it links a new treatment modality based on a therapeutic community with newly emerging mechanisms of service through the community mental health program.

A day-night nonresidential center for addicted persons is operating in New York City. The project provides a quasi-natural setting for rehabilitation and for the evaluation of such rehabilitation. The investigators are seeking to increase the recognition of narcotic addiction as a community health problem through dialogues with neighborhood agency personnel, hospital staff, and lay leaders. The population studied is largely composed of heroin addicts, though other drug users are admitted for comparative studies. Patients receive a range of services including counseling, group therapy, and referral to other community agencies.

The staff at the Ft. Worth Clinical Research Center has developed a prerelease program for addicts hospitalized a long time. A month before discharge, selected patients undergo a "decompression" process. They are taken into the community, and members of the community are brought to the hospital to talk over with them some of the problems they are likely to encounter. Another experimental project of the Ft. Worth hospital provides a continuum of care for addicts of the San Antonio area. Part of the hospital's social work staff, based in San Antonio, contacts community agencies, maintains liaison with the hospital during the patient's treatment, and facilitates the patient's return to the community.

Drug maintenance is being evaluated in treatment programs for opiate addicts at the University of Chicago and at New York Medical College. In the New York study, methadone maintenance is being compared with cyclazocine maintenance. The investigators report that patients are quite amenable to treatment with cyclazocine, which does not possess the euphoric and addictive qualities of methadone. These workers have also treated several patients with naloxone, a new narcotic antagonist.

A study of naloxone carried out at the Lexington Clinical Research Center established that the compound can rapidly induce withdrawal symptoms in morphine-dependent patients, can produce blockade during prolonged administration, can be withdrawn without adverse reactions, and does not produce undesirable psychological effects. Naloxone has a major advantage over cyclazocine in that it produces no adverse side effects; a patient can be placed on the stabilizing and blocking dose the first day of admission, whereas cyclazocine requires a slow dose buildup. At present, the drug is short-acting and must be administered in such large, frequent doses that it is more useful for research purposes than for treating addicts. Center staff are currently exploring the possibility of developing a long-acting antagonist drug that could be employed in a clinical situation.

In sum, there are a number of promising treatment and rehabilitation programs for narcotic abusers that call for careful, controlled evaluation. To meet the challenge, the Center initiated collaboration with the Office of Economic Opportunity and the Division of Field Investigations, NIMH. A series of meetings were attended by responsible representatives from the principal narcotic addict treatment programs in the country. The discussions resulted in the development of a set of intake and status evaluation forms. These are now being tested under an NIMH grant by an investigator at Texas Christian University. Thus, comparable data are now

becoming available from a variety of treatment locations. Such data should facilitate program evaluation and the planning of further epidemiologic studies. OEO and NIMH plan to convene with these principal program directors again in order to expand the data collection system beyond the pilot stage. The Texas investigator is also involved in a typological study of all treatment programs in the country; he hopes to develop a typology and nomenclature for the different types of treatment and rehabilitation now available to narcotic addicts.

Training Programs

Institute support of programs to train mental health professionals is especially critical in the field of drug abuse. Drug abuse problems do not hold great interest for most scientists and physicians. The NIMH is especially concerned, therefore, with the training of workers who will be able to apply their skills to the special problems of drug abuse. The few examples cited here are typical of the Institute's efforts to train a large cadre of professionals skilled in the scientific and clinical issues related to drug abuse.

Under an Institute grant, a school of social work is using a hospital-based treatment program for narcotic abusers as a field placement for its students. Two psychiatric training grants emphasize drug abuse problems. One supports advanced training of psychiatric residents in community mental health principles. A second grant to the same institution supports basic residency training that includes a period of working with narcotic abusers in inpatient and outpatient settings. A social science training grant provides intensive training in the sociology of deviant behavior and gives instruction on drug abusers.

Another grant helps to train law enforcement officers to cope effectively and humanely with mentally ill and

socially deviant persons. Training in the psychopharmacology of drug abuse and other deviant behaviors is being given to the mental health professionals who work with children in a metropolitan area.

The NARA provides support for the training of various professional and nonprofessional workers. The Institute hopes to develop training programs for ex-addicts that will utilize their unique personal experiences in programs of prevention and treatment. There has been considerable interest in this idea, particularly in the New York area. The director of Daytop Village, a former addict, is an active consultant to the Ft. Worth staff in the development of a therapeutic community there.

Prevention and Public Information Services

In cooperation with the Food and Drug Administration, the NIMH participated in meetings with the National Association of Student Personnel Administrators. The goal was to inform college deans about the problems of drug abuse. Out of these meetings has come a valuable pamphlet, which will be distributed to interested professionals. Staff members of the Center for Studies of Narcotic and Drug Abuse are currently working with FDA personnel in a review and critique of existing preventive materials. The project is sponsored by the American Pharmaceutical Association. The Institute is also encouraging several private groups to develop a clearinghouse of preventive materials that can be utilized by schools, churches, and other interested groups.

During the past year, the Center provided interagency liaison to the Department of Defense concerning the problem of marihuana use among U.S. soldiers in Viet Nam, to the OEO in its development of opiate addiction treatment programs under the Community Action Agency, to the FDA, the Department of State, and to various groups within the Public Health Service. The Regional Offices in Boston and Colorado

sponsored regional meetings dealing with narcotics and drug abuse in an attempt to stimulate interest in these problems.

In the critical area of legal-medical relations, the Center for Studies of Narcotic and Drug Abuse is supporting a study of marihuana law enforcement practices, which is being carried out by the University of California at Los Angeles. Negotiations are now in progress with the Boston University Law-Medicine Institute to develop multiple models of drug-abuse legislation that can be distributed to interested State and professional organizations.

The Challenge Ahead

Drug abuse remains a major public health problem. The NIMH will continue to expand and integrate the efforts to counter it. We are particularly in need of more reliable information about the prevalence of nonnarcotic drug abuse and more effective methods of treating these individuals. Longitudinal studies of drug abusers would enhance our ability to identify potential addicts and to improve our aftercare programs. A major research challenge lies in understanding personality disorders and their relations with socially deviant behavior of all sorts - the chronic alcoholic, the sex offender, the violently anti-social youth, the drug abuser. The deleterious impact on society of such deviant behaviors requires the Institute to initiate bold clinical research efforts in this area.

CYSTIC FIBROSIS

The problem

Cystic fibrosis (CF) is an inherited generalized metabolic disorder characterized by an abnormality in the products of the body's glands which secrete fluid to body surfaces, particularly the skin and the gastrointestinal and respiratory mucosal linings. These glands secrete two major types of fluid, a watery substance produced primarily by the glands of the skin and a mucous fluid intended to lubricate the gastrointestinal tract and the bronchioles in the lung. The abnormalities which occur in both types of secretions are responsible for the major symptoms and signs in cystic fibrosis.

The basic metabolic disorder of exocrine secretion results in three principal clinical problems. The first of these is the production of sweat with a high salt content. Due to this defect many patients are unable to conserve salt, especially in hot weather, and are in constant danger of developing profound dehydration, which may lead to death. With the widespread use of the sweat test, the unique composition of the sweat in cystic fibrosis has become the primary basis for the diagnosis of this disorder.

A second, and considerably more serious facet of the disease, stems from the abnormal functioning of the mucus-secreting glands of the body. In cystic fibrosis, the mucus-producing glands fail to secrete normal, clear, free-flowing fluid. Instead, they produce an abnormally thick, sticky mucus which tends to obstruct the ducts or openings of the glands. When the thick mucus accumulates in the ducts of the pancreas, it interferes with the ability of this gland to supply digestive enzymes to the intestinal tract. Depending on the severity of this complication the patient may suffer from malnutrition and its sequelae. The resultant malnutrition in children with cystic fibrosis is one of the major factors resulting in general underdevelopment, poor musculature, and retarded bone growth.

The third and most serious complication involves the lung. Nearly all cystic fibrosis patients develop progressive chronic lung disease. Thick mucus obstructs the smaller air passages in the lung, causing labored breathing and a chronic productive cough. In time, bacteria multiply in the accumulated secretions, and the child may fall victim to chronic bronchitis or even pneumonia. The latter infection is the leading cause of death in these patients. Chronic lung changes may also increase resistance to pulmonary blood flow and may lead to an increased blood pressure in the lung; this can result in chronic right heart strain and, eventually, in heart failure.

Cystic fibrosis is the most common hereditary disease of children, and is often fatal. Its increasing frequency throughout the world has made it a public health problem of no mean proportions; estimates of its incidence in the population range as high as 1 in 1,000 to 2,000 live births.

Obligations for programs in cystic fibrosis

	1965	1966	1967	1968 estimate	1969 estimate
Public Health Service: National Intutute of Arritis and Metabolic Diseases.....	$999,000	$1,152,000	$1,385,000	$2,019,000	$2,025,000
Social and Rehabilitation Service: Children's Bureau.....	63,725	...1/	...1/	...1/	...1/
Total.....	1,062,725	1,152,000	1,385,000	2,019,000	2,025,000

1/ not identifiable

Public Health Service

National Institute of Arthritis and Metabolic Diseases

The basic defect underlying cystic fibrosis, although subject to intensive investigation during the last decade, is as yet unknown, and much of the research carried on by scientists of the National Institute of Arthritis and Metabolic Diseases (NIAMD) in Bethesda and by the Institute grant-supported investigators is devoted to discovering its nature. Institute scientists in Bethesda are currently conducting laboratory and clinical studies in an attempt to delineate further the chemical and clinical manifestations of cystic fibrosis and to uncover the fundamental defect causing abnormal secretion, as well as to develop new therapeutic and diagnostic techniques.

Sweat Test for Screening Newborn Infants

Half the children with cystic fibrosis who receive conventional, supportive therapy are dead by age three; two-thirds of these die in the first year. When prophylactic lung therapy is applied promptly, however, mortality is reduced to about two percent per year.

Thus, early diagnosis and treatment of cystic fibrosis are of utmost importance in order to forestall development of irreparable lung damage and to prevent early death. Although the disease is diagnosed principally by the detection of excessive amounts of salt in the sweat, test facilities are not always readily available, and their results are not always conclusive.

Calcium and Duct Obstruction

At present, no one hypothesis can link all the diverse and often conflicting observations which have been made concerning the widespread malfunction of exocrine glands in cystic fibrosis. In particular, it is not yet possible to give a unified and reasonable explanation of the abnormal behavior of mucus and sweat glands in this disorder. Recent observations, however, have helped to narrow the field for speculation and have helped to clarify some of the disease's mechanisms.

Institute scientists, in collaboration with scientists from the National Institute of Dental Research, have obtained evidence that excess calcium in the salivary glands of cystic fibrosis patients combines with a certain group of proteins to form an insoluble compound. It is possible that this precipitate may give rise to the widespread obstruction of various organ ducts and may eventually lead to many of the pathological and clinical findings in cystic fibrosis.

Saliva, normally a clear fluid high in glycoprotein content, has been found to be turbid in CF patients. This secretory product offers a unique opportunity for investigation because it is readily accessible for collection

in relatively large quantities. Production of visibly turbid submaxillary saliva was noted in 12 cystic fibrosis patients while that of ten normal subjects of the same age group was clear. Chemical analysis demonstrated an abnormally high calcium content in the saliva from patients with CF, in contrast to saliva from normal control subjects. By decreasing the elevated calcium levels in cystic saliva, the clear gross appearance of normal saliva was reproduced. Conversely, by increasing the calcium levels in normal submaxillary saliva, its appearance and chemical characteristics became identical to that of cystic fibrosis saliva. Subsequent analysis of the calcium precipitate revealed that it was composed entirely of a particular group of glycoproteins. These glycoproteins apparently combine with the calcium, when the latter is present in high concentrations, to form the precipitate.

For many years cystic fibrosis was considered an inborn error of glycoprotein metabolism; the observation that abnormal ionic calcium concentration in cystic fibrosis may have an effect on the solubility of glycoproteins has important implications in the pathogenesis of this disorder. The precipitation of a relatively insoluble calcium glycoprotein complex in various organs throughout the body might indeed explain many of the pathological and clinical findings in cystic fibrosis.

Induction of "Cystic Fibrosis" in Animals

A recent study by Institute grantees at the University of Wisconsin has shown that sweat and saliva from patients with cystic fibrosis can cause rats to excrete saliva with an abnormally high salt content (thus, resembling the characteristic saliva in cystic fibrosis). In these experiments the main excretory duct of parotid glands in anesthetized rats was cannulated and perfused in a retrograde fashion with saliva or sweat from normal children or children with cystic fibrosis. The glands were then stimulated (by intravenously administered pilocarpine) and saliva was collected.

It was shown that normal excretion of salivary sodium was not affected by retrograde perfusion of the gland with a control saline solution or with saliva or sweat from normal children. On the other hand, perfusion with sweat and saliva from patients with cystic fibrosis caused a large increase in sodium output of the glands. This effect could have resulted only from partial inhibition of sodium reabsorption by the striated ducts of the gland, which normally reduce the sodium concentration of the primary fluid secreted by the acini of the salivary gland by sodium reabsorption at a known rate.

The temporary abnormal behavior of the striated ducts is probably induced by an as-yet unidentified substance in the sweat and saliva of CF patients. The implication of this finding is significant: if there is some factor in

the sweat and saliva of children with CF which causes rats to excrete very salty saliva, then that same factor may be responsible for the high salt content of the children's own sweat and saliva. This factor, once isolated, may point the way toward elucidation of the inherited molecular defect which causes the disease.

Micropuncture Studies of Sweat Glands

Further evidence of the pathogenetic role of inhibition of normal sodium reabsorption in exocrine gland ducts of cystic fibrosis patients has been provided by applying micropuncture and microanalytical technics to the study of the function of normal and pathologic human sweat glands.

Institute scientists have employed these technics in cystic fibrosis patients to help clarify the genesis of salt depletion, a prominent clinical manifestation which has been thought due to either a disorder in formation of a hypothetical precursor solution in the coil of the sweat gland, or to impaired salt reabsorption from sweat gland tubules. Fluid from the sweat glands of cystic fibrosis patients was taken from the site of production (coil of sweat gland) and from the skin surface. Evaluation revealed elevated sodium and chloride concentrations only on the skin surface. These findings resolve an important area of controversy by showing for the first time that the abnormality in sweat in cystic fibrosis is not in the formation of the precursor solution but most likely in the reabsorptive capacity of the sweat duct (between the coil at the base of the gland, and the skin surface). These results are very consistent with the previously noted animal studies.

Scientific Communication and Information

The Institute has consistently made efforts to communicate, effectively and promptly, diagnostic and therapeutic developments to practicing physicians and research workers throughout the country. One particularly effective means of communication has been a comprehensive scientific exhibit on cystic fibrosis, which is currently being updated by the Institute to present new information on the disease. In the recent past this exhibit, along with detailed practical literature, has been brought to the attention of thousands of practitioners and scientists at medical meetings and conferences throughout the United States.

A new medical film, "Diagnosis and Management of Cystic Fibrosis", has been jointly produced by the Institute and the voluntary organization in the field, the National Cystic Fibrosis Research Foundation. The film is being shown to physicians, research workers, medical students, nurses, and physical therapists. In explaining the nature of cystic fibrosis, the film covers its transmission as a Mendelian recessive genetic trait, as well as diagnostic

procedures, and methods of treatment for afflicted children and adults. It also discusses diet, exercise, the role of parents in home care, surgical complications of cystic fibrosis, and child-bearing by young women with the disease. Diagrams, charts, and slides are interspersed with live action sequences filmed in the NIH Clinical Center in Bethesda and in the Children's Hospital Medical Center, Boston. The 26 minute color film also reviews current research efforts to establish the etiology of cystic fibrosis and to pinpoint the underlying biochemical defect.

A newly-revised brochure on cystic fibrosis has been produced by the Institute in response to inquiries from the lay public. The illustrated publication explains in simple, non-technical language what is known about the disease, what can be done for patients with the disease, and what efforts are being made by the Institute in researching its cause and management.

Outlook

Cystic fibrosis is a complex disease. Its multifaceted nature has prompted and encouraged many scientists in diverse disciplines to study its metabolic, genetic, and clinical aspects. In recent years, scientists in Bethesda and investigators supported by the Institute have contributed largely to dispelling misconceptions concerning the disease. Two major misconceptions had been that cystic fibrosis is rare and that it is invariably fatal. Neither has been shown to be true. Promising findings in basic research, as well as new methods of diagnosis and treatment, have brought about a more optimistic outlook for patients with cystic fibrosis and it is hoped that ways and means to manage the disorder optimally will eventually be found.

Social and Rehabilitation Service

Children's Bureau

The number of State crippled children's agencies which accept children with cystic fibrosis has been increasing each year. In calendar year 1964 35 of the 53 States and jurisdictions included cystic fibrosis under their crippled children's programs; by fiscal year 1966 the number had increased to 39; for fiscal year 1967, the number is estimated to be at least 43. The number of children receiving services for cystic fibrosis continues to increase, from 1,849 in calendar year 1964 to 2,762 in fiscal year 1966 to 3,102 in fiscal year 1967.

During the year one of the States (New Hampshire) developed a manual on cystic fibrosis as a guide for nurses, physical therapists, parents or others responsible for the home care of children with cystic fibrosis. It describes in detail treatments needed by patients and the care of the equipment used. Since cysitc fibrosis is a life-long hereditary illness and since much home care is essential, this guide meets a special need for patients scattered in a rural State.

Some States, for example, Pennsylvania, are regionalizing and decentralizing their services for better follow-up of cystic fibrosis patients. Most State programs work closely with the local branches of the National Cystic Fibrosis Research Foundation, which supports cystic fibrosis centers and may provide and repair equipment needed by patients in the home.

CEREBRAL PALSY

The problem

Cerebral palsy (CP), one of the most tragic and crippling disorders of children, afflicts an estimated half-million persons in the United States. The term "cerebral palsy" describes a number of chronic, nonprogressive conditions that may be rooted in any one of a number of circumstances, occurring at or before birth, in which brain damage impairs motor function. Symptoms may range from mild muscle incoordination to more severe physical handicaps. Not infrequently the condition is coupled with intellectual impairment, convulsive seizures, and defects of speech, hearing, and vision.

Obligations for programs in cerebral palsy

	1965	1966	1967	1968 estimate	1969 estimate
Social and Rehabilitation Service:					
Grants to States.....	$657,968	$936,999	$1,669,200	$1,900,000	$2,300,000
Innovation grants.....	13,000	73,000	54,000	50,000	50,000
Research and demonstration.....	70,000	24,000	...	20,000	20,000
Training and traineeships.	...	25,000	...	...	...
Research and training (special foreign currency program).....	18,000	9,000	...	...	...
Subtotal, Social and Rehabilitation Service.....	758,968	1,067,999	1,723,200	1,970,000	2,370,000

Obligations for programs in cerebral palsy (continued)

	1965	1966	1967	1968 estimate	1969 estimate
Public Health Service: National Institute of Neurological Diseases and Blindness.....	$14,014,000	$13,819,000	$9,973,000	$12,353,000	$12,970,000
Total.....	14,772,968	14,886,999	11,696,200	14,323,000	15,340,000

SOCIAL AND REHABILITATION SERVICE

Because of the variety of handicapping conditions present in cerebral palsy, an interdisciplinary approach is particulary essential to vocational rehabilitation of those afflicted with this disorder. The following table indicates recent and projected trends in rehabilitating cerebral palsied clients under the State-Federal progrm of vocational rehabilitation.

Estimated and Actual Number of Rehabilitants with Cerebral Palsy

Fiscal Year	Persons Rehabilitated 1/	
	Total	Cerebral palsy
1965	134,859	944
1966	154,279	973
1967	173,594	1,300
1968	200,000	1,400
1969	230,000	1,600

1/ Data actual for 1965-67; estimated for 1968-69.

92 - 584 O - 68 - pt 2 - 35

Under its basic support program, the Rehabilitation Services Administration has been steadily improving its efforts with the cerebral palsied. Since the determination of vocational potential of these individuals is often difficult to establish, vocational rehabilitation services may be provided under the public rehabilitation program for a period of up to eighteen months specifically for the purpose of evaluating the individual's rehabilitation capacities. Cooperative special education-vocational rehabilitation programs within the public schools have been responsible for work-study activities which have assisted large numbers of cerebral palsied young people. Throughout the country financial assistance has been provided to establish workshops sponsored by affiliates of the United Cerebral Palsy Association.

Substantial Federal financial assistance has been given to public and private nonprofit voluntary agencies for the development and expansion of programs serving the cerebral palsied. Many of the programs which serve the multi-disabled also serve the cerebral palsied.

By means of the new workshop improvement grant program, support has been given for staff expansion and other activities to improve the United Cerebral Palsy Association of Northwest Oregon workshop in Portland, Oregon.

In recent years short-term courses have been supported such as: (1) vocational rehabilitation methods for professional staff of local affiliates of the United Cerebral Palsy Association; (2) rehabilitation counseling techniques with the cerebral palsied client for the State rehabilitation agency counselors; and (3) executive development for administrators of cerebral palsy programs. In addition, instructional content on cerebral palsy is incorporated into the various long-term professional training courses sponsored at universities for rehabilitation counselors, nurses, psychiatrists, psychologists, physical therapists, occupational therapists, social workers, speech therapists, and recreation specialists.

Social and Rehabilitation Service research and demonstration activities related to cerebral palsy have been varied. A project at the Institute for the Crippled and Disabled in New York was designed to develop methods of evaluating the potential abilities of severely disabled cerebral palsied adults by means of a wide variety of sample jobs. Under the sponsorship of the United Cerebral Palsy Association of Los Angeles County, Los Angeles, California, an intensive service workshop program for severely handicapped cerebral palsied adults was developed, aimed toward eventual job placement within industry. The social, psychological, and physical problems of cerebral palsied young people in college were studied under a project at the College of Education, State University of Iowa, Iowa City, Iowa. United Cerebral Palsy of New York City, Inc., has received support to develop demonstration programs to meet the vocational rehabilitation needs of multiple handicapped

cerebral palsied young adults and to evaluate the effectiveness of methods of training cerebral palsied adults in activities preparing them for employment or more independent living. Goodwill Industries of America, Inc., conducted a conference to explore how two nonprofit agencies may plan the cooperative use of their respective resources, in a single facility, to provide vocational rehabilitation to the cerebral palsied. A follow-up study is being conducted by the University of Iowa to ascertain employment satisfaction and general life adjustment to determine the efficacy of a college education for cerebral palsied persons. Work classification and evaluation centers for the cerebral palsied have been supported in centers in Milwaukee, Wisconsin; Portland, Oregon; St. Louis, Missouri; Philadelphia, Pennsylvania; Miami, Florida; Memphis, Tennessee; and Des Moines, Iowa.

Public Health Service

National Institute of Neurological Diseases and Blindness

Program Developments

Before the National Institute of Neurological Diseases and Blindness was established in 1950, research had pointed to the period surrounding birth as the time when brain damage occurred which caused cerebral palsy. However, little was known about the causes. Therefore, early in the life of the Institute the need for a large-scale prospective study of the perinatal period was recognized.

After years of planning and pretesting, the Collaborative Project on Cerebral Palsy, Mental Retardation, and other Neurological and Sensory Disorders of Infancy and Childhood was launched in 1959. Its objective was to study all relevant health data on more than 50,000 women and their babies from early pregnancy, through labor and delivery, and until the children were of school age. Fourteen of the Nation's leading medical centers have cooperated with the Institute in this great effort.

Only the most preliminary analyses of data are yet available since the obstetrical phase of the study was only completed in 1966 and the youngest of these children have had their 12-month examinations. Complete data are now available on several thousand children born in the early years of the Project. Already many unexpected and challenging findings have emerged.

In addition to the Collaborative Perinatal Project, the Institute funds many individual grants relating to this condition and conducts a research program on CP at its laboratories in Bethesda. Cerebral palsy is also the major emphasis of the Laboratory of Perinatal Physiology in Puerto Rico, established in 1956 by the Institute.

To a large extent, the development in Puerto Rico was an outgrowth of the Collaborative Perinatal Project. As the Project developed, it seemed important that this massive program for the

study of humans be accompanied by experimental animal research. Whereas the human project was concerned with observation, the animal study could undertake experimentation and manipulation. The rhesus monkey was chosen as an ideal subject for the study because of its similarity to man in respect to its gestational physiology. There are now over 1,000 rhesus monkeys in caged and free-ranging colonies. Studies of pregnancies in these primates and their offspring have provided a unique opportunity to pursue and extend leads obtained in studies of humans, especially in the Collaborative Perinatal Project.

Research Advances

Many of the factors producing cerebral palsy and other forms of brain damage in infancy became more evident through the massive data acquired by the Collaborative Perinatal Project. These include such harmful factors as chronic or acute anoxia caused by oxygen deprivation or deficiency, and the viral infection rubella (German measles) in the mother within the first 3 months of pregnancy which may cause serious injury to the developing nervous system.

Other infectious diseases in the mother, often mild enough to go undetected, can cause serious brain damage. Maternal illnesses, such as toxemia of pregnancy and diabetes in the expectant mother, can be triggering factors in producing CP. Jaundice of the newborn that produces an illness (kernicterus) due to blood-type conflict between the fetus and the mother also can produce varying forms of central nervous system injury. During early childhood or infancy, postnatal infection such as encephalitis or meningitis may produce symptoms of CP.

The premature infant, particularly of low birth weight, is highly susceptible to respiratory distress that can cause not only oxygen lack but also excess carbon dioxide and other harmful changes in the newborn's blood and metabolic processes. Certain obstetrical complications also can be contributing factors. In short, the developing child in early life may be highly vulnerable to harmful influences on the areas of brain controlling motor function.

Analysis this year of Collaborative Project data has produced or confirmed a number of new findings. One of the most significant seems to be that a number of maternal disorders--particularly diabetes and gall bladder disease--may alter the nutrient supply to the fetus to cause mental and motor disorders. Intellectual and neurological function was affected in children of diabetic mothers who had episodes of acetonuria (an excess of acetone bodies in the urine). No such effect was observed in those whose mothers were free of acetonuria.

Among the more disastrous consequences of birth injury is hemiplegic cerebral palsy. This disorder results from trauma to the brain areas controlling movement, and is characterized by paralysis of one side of the body. An Institute scientist has confirmed from Project data that the side on which hemiplegia occurs is associated with the position of the infant's head during birth. He has found further evidence that abnormalities of the brain's electrical pattern (electroencephalogram) correlate with head position at birth. This information provides more understanding of the consequences of abnormal birth position, and should lead obstetricians to devise preventive measures during delivery.

Another Project study this year has confirmed previous work which indicated that spastic diplegia is a specific type of cerebral palsy found among premature infants. As the result of a survey of all prematures in the Project surviving to the age of 1 year and weighing less than 2,000 grams (about 4½ pounds), investigators confirmed the fact that almost all cerebral palsy cases classified as spastic diplegia occur in this weight group. They also found that prematures developing the disease suffered a postnatal weight loss of more than 10 percent.

At the Institute's Laboratory of Perinatal Physiology in Puerto Rico, intensive investigations continue on such major problems as the role of asphyxia in brain damage, placental blood flow, placental insufficiency, and placental abruption--among known complications in humans linked with infant death and high prematurity rate.

A recent finding in Puerto Rico of importance to investigators is that the brain may not be as vulnerable to loss of oxygen for short periods as now commonly believed. In experiments in which the major vessels in the chest were ligated, the effects of sudden circulatory arrest on the nervous system were studied. It was found that the sudden production of total circulatory arrest is tolerated by the animal for up to 16 minutes without brain damage. Apparently less extreme but continued impairment of blood supply and oxygen is the more common cause of the usual forms of CP.

The study of the causes and preventives of mental and motor deficits producing infantile brain damage is also being conducted in other Institute laboratories and clinics. Studies in brain pathology, for instance, are offering an opportunity to study the natural history of the disease.

Treatment

While research is the road to eliminating cerebral palsy as a future threat to the Nation's children, treatment remains an unending responsibility to the thousands who are already afflicted. One

hopeful avenue for children with severely incapacitating movement disorders is in neurosurgery. Clinical advances in recent years by Institute grantees, after long-term experimental efforts to understand the motor centers which regulate movement, have brought marked relief from pain and muscle spasms to a small number of selected children in whom all other alleviating therapies had failed. These neurosurgeons are alleviating symptoms by stereotactically creating lesions in certain areas of the brain.

Newer diagnostic skills are increasing our ability to diagnose cerebral palsy at an early age. Prognosis, however, is still uncertain since many children appearing to have significant impairment in early age may show great recovery. Long-term studies are required to determine the factors which influence the development of the neurologically handicapped and to test procedures of remediation.

Thus, the Institute's program is aimed at each aspect of cerebral palsy from prevention to remediation. We can anticipate continuing progress in each aspect of this important problem.

MUSCULAR DYSTROPHY AND RELATED DISORDERS

The problem

Progressive muscular dystrophy involves a gradual degeneration of the muscles, often marked by a displacement of muscle tissue with fatty and connective tissue. Etiology of the disease is unknown and there is no specific therapy. The disease may result in slow deterioration of the muscles, often with temporary periods of remission. Seldom a static disease, it usually results in death five to ten years after onset. An estimated 250,000 persons in the United States are disabled by this condition and approximately 25 percent are unable to perform activities of daily living.

Obligations for programs in muscular dystrophy and related disorders

	1965	1966	1967	1968 estimate	1969 estimate
Social and Rehabilitation Service	NA	NA	$410,880	$526,000	$643,000
Public Health Service: National Institute of Neurological Diseases and Blindness.....	$4,095,000	$3,704,000	3,931,000	4,394,000	4,557,000
Total.....	4,095,000	3,704,000	4,341,880	4,920,000	5,200,000

SOCIAL AND REHABILITATION SERVICE

Relatively few individuals handicapped by progressive muscular dystrophy have been rehabilitated under the State-Federal vocational rehabilitation program. It is hoped, however, that despite the limited vocational potential characterizing this disability group, more effective rehabilitation methods will be developed which will enable greater numbers to be served by State vocational rehabilitation agencies. The innovation grant program, which is emphasizing programs for individuals with particularly severe disabilities, may be a means of extending services to this disability group.

The Social and Rehabilitation Service supports the training of professional personnel in the fields of nursing, social work, physical therapy, occupational therapy, and physical medicine, incorporating those skills and techniques essential to the best management of persons disabled by progressive muscular dystrophy.

A study is also being conducted of Transamidase Activity in Myotonic Dystrophy at John Hopkins University. Implications of this research are that it will lead to a better understanding of: Creatine metabolism in patients with myotonic dystrophy; the pathogenesis of this disorder; and the enzyme system which may be abnormal in this condition.

It may be anticipated that biochemical investigations of muscle metabolism will lead to chemical therapies which will lead to increased life expectancy and concomitant expanded opportunities for persons disabled by this disease to engage in gainful employment. When this information becomes available, it will be used to translate this knowledge into community programs of public education, case findings, physical restoration or vocational training and placement for muscular dystrophy cases.

Estimated and Actual Number of Rehabilitants

with Muscular Dystrophy

Fiscal Year Ending June 30	Persons Rehabilitated 1/	
	Total	Muscular Dystrophy
1967	173,594	320
1968	200,000	380
1969	230,000	440

1/ Data are actual for total rehabilitants in 1967; estimates are used for 1967 rehabilitants with muscular dystrophy and for both categories in 1968 and 1969.

PUBLIC HEALTH SERVICE

National Institute of Neurological Diseases and Blindness

For more than a decade, the disorders of the neuromuscular system have been a major targeted program of the Institute's laboratories in Bethesda. More recently, the clinical research center mechanism has been used to further target this area of research, and centers have been established at the University of Pennsylvania, at Columbia University, and at Harvard University. A study with counterpart funds is being conducted at the Academy of Medicine, Warsaw, Poland, in cooperation with the Institute's Bethesda laboratories. Also under way is a screening program for inherited metabolic diseases.

Research Accomplishments

At the Institute's Medical Neurology Branch in Bethesda, scientists have discovered two new types of neuromuscular disease: a familial disorder consisting of loss of muscle fiber striations with progressive weakness; and complete atrophy of type I muscle fibers, associated with congenital weakness fatal at 18 months. These studies, along with extensive chemical study of muscle, have resulted in clarification of some of the causes of muscle weakness. Further correlation of muscle pathology with specific histochemical reactions is designed to give a more complete picture of the differences between muscle diseases.

To achieve the goal of arriving at a complete description of each neuromuscular disease, the Institute has developed biochemical assay methods for application to different kinds of abnormal muscle. These include tests for phosphorylase, debranching enzyme, acid and neutral maltase, phosphoglucomutase, and total glycolysis from glycogen to lactate.

In the hope that a central registry may eventually be established, the Institute has developed a new classification scheme for biochemical abnormalities in the hereditary neuromuscular disorders. The system is flexible, permitting revision and expansion of categories as new data appear. The system emphasizes disease specificity and the importance of biochemical defects to treatment of the disorder.

At the Institute-supported research centers of the University of Pennsylvania, Columbia University, and Harvard University, a strong emphasis is being given to drug evaluation programs. Recent

studies have clarified the mode of action of calcium on the muscle membrane. Calcium was found to reduce sharply the sensitivity of the muscle postjunctional membrane, blocking neuromuscular transmission.

Other scientists at an Institute-supported clinical research center have developed a method for the large-scale purification of acetylcholinesterase, an enzyme of great importance in the conduction of nerve and muscle electrical impulses. For the first time, studies of the protein properties of this enzyme are possible.

The value of two therapeutic approaches to myasthenia gravis (MG) has been demonstrated by Institute grantees. Germine diacetate was found to be useful in treating cases of MG in which tolerance is low for other drugs. Likewise, massive doses of corticotropin therapy in patients with severe, generalized MG proved effective in another Institute-supported study.

At the Academy of Medicine, Warsaw, Poland, in a study using counterpart funds and being developed in cooperation with the Institute's Bethesda laboratories, a Polish neurologist discovered a genetic protein defect which is specific for patients with progressive muscular dystrophy (PMD). The abnormal $beta_1$-globulin fraction in the patient's blood serum was found in a large majority of both PMD patients and their carrier mothers, but not in patients with other forms of muscular dystrophy (MD) or other neuromuscular diseases. This finding suggests that there is an inherited protein abnormality specific for progressive muscular dystrophy. Hope for the eventual development of preventive measures for this crippling disease is advanced by this discovery.

An Institute study of 65 families (more than 400 persons) has revealed that dystonia musculorum deformans (DMD) may be inherited in either an autosomal dominant or recessive form. This disorder of movement begins in childhood with unexplained turning of the foot or irregular jerking of the hand. The finding is of immediate importance to physicians engaged in genetic counseling of DMD patients and their families.

The investigators expect to obtain information on DMD from more than 200 additional patients and their families. They plan to assess the relationship between DMD and other inherited movement disorders. Eventually, knowledge of the basic neurochemical abnormality in DMD should permit development of a specific therapeutic attack.

With the support of the Institute, the National Foundation for Neuromuscular Diseases is conducting a pilot screening program for treatable genetic metabolic diseases. The program involves cooperation of four medical centers which obtain blood and urine samples from all children in a designated area. Tests are run at the central laboratory at Albert Einstein College of Medicine.

Institute scientists have contributed chapters to seven books on neuromuscular diseases, and have a book on muscle histochemistry in preparation which will present the detailed results of histochemical and cytochemical evaluation of muscle biopsies from approximately 1,500 patients. This year an Institute grantee prepared a comprehensive bibliography as a supplement to the journal Experimental Neurology. The exhaustive listing includes 1,470 articles appearing through 1966 on the morphology, pathology, and physiology of sensory receptors of muscles.

In cooperation with the Muscular Dystrophy Associations of America, the Institute held an important conference to review advances in the differentiation of the many varieties of neuromuscular diseases.

A "Workshop on Hereditary Neuromuscular Diseases in Children" will be supported by the Institute in 1968.

MULTIPLE SCLEROSIS

The problem

Multiple sclerosis is a neurological disease of the 20-40 age group for which no effective treatment is available. It is estimated that multiple sclerosis (MS) and closely related disorders affect more than a quarter of a million Americans during their most productive years, causing an economic loss of $250 million. Many additional millions are spent annually on patient care.

Obligations for programs in multiple sclerosis

	1965	1966	1967	1968 estimate	1969 estimate
Social and Rehabilitation Service	$173,553	$259,047	$500,760	$554,000	$670,000
Public Health Service: National Institute of Neurological Diseases and Blindness.....	2,953,000	3,019,000	3,301,000	3,486,000	3,652,000
Total.....	3,126,553	3,278,047	3,801,760	4,040,000	4,322,000

SOCIAL AND REHABILITATION SERVICE

Accomplishments

Federal-State Program

Estimated and actual number of rehabilitants with multiple sclerosis 1/

Fiscal Year Ending June 30	Persons Rehabilitated	
	Total	Multiple Sclerosis
1965	134,859	249
1966	154,279	269
1967	173,594	390
1968	200,000	400
1969	230,000	460

1/ The total number of rehabilitants is actual for 1965, 1966, and 1967; for 1968 and 1969 they are estimated on the basis of State budget estimates and Federal fund requests. The number of rehabilitants disabled by multiple sclerosis is actual for 1965, and 1966; for 1967, 1968, and 1969 they are estimated on the basis of the proportion in the group for the preceding 5-year period.

Because multiple sclerosis is a progressive disease, forecasting employability for these individuals is difficult and unpredictable. For this reason, State rehabilitation programs often have not undertaken services for larger numbers of this disability group. In 1968 and 1969 an estimated total of 860 persons handicapped by multiple sclerosis will be rehabilitated.

Training

There have been no specific training programs sponsored by the Social and Rehabilitation Service for multiple sclerosis. However, instruction about a number of neurological diseases is incorporated into the basic training program for a number of professional personnel such as rehabilitation counselors, nurses, psychiatrists, physical therapists, and occupational therapists.

Research

A research project has been supported at Georgetown University Medical School, Washington, D. C.. The project was designed to establish a model program in the rehabilitation of multiple sclerosis patients and establish predictive factors for the disease.

Research and Training Needs

Rehabilitation research needs

1. The study of various physical modalities used in physical medicine in the treatment of multiple sclerosis.
2. The use of orthotic devices.
3. The causes and treatment of spasticity.

4. The causes and treatment of contractures and other complications.
5. The therapeutic uses of various forms of heat to reduce symptoms.
6. The use of activities of daily living techniques.
7. Homemaking programs.
8. Psychological and psychiatric evaluation and treatment of this condition.
9. The use of various aids in increasing the vocational potential of these patients.

Training needs

The basic need is that of trained personnel to treat, study, and to train patients with multiple sclerosis. These would fall in the category of physiatrists, physical therapists, occupational therapists, psychiatrists, psychologists, counselors, homemakers, nurses, speech therapists, and other related personnel.

Prospects for the Future

With further advances in drug therapy, neurosurgical procedures, and rehabilitation techniques, the rehabilitation potential of those suffering with multiple sclerosis should be much greater than at present. It is our plan to encourage further research and training programs as well as the educational aspects of this disease. Since the larger proportion of persons with multiple sclerosis are women in the 20 to 40 age group, the objective should be to accept increasing numbers for services with the vocational goal of homemaker.

PUBLIC HEALTH SERVICE

National Institute of Neurological Diseases and Blindness

The Institute has given special emphasis to MS research for a number of years. Exploiting a variety of new research approaches within its own laboratories, the Institute at the same time provides financial grants in support of research relating to the cause, prevention, diagnosis, and treatment of MS. This support has increased from about $70,000 in 1951, the Institute's first year, to over $3 million for the present fiscal year.

Program Development

At the present time the Institute has two targeted MS programs and is supporting many other MS research projects. The first of the targeted programs is the development of a laboratory and an animal-holding facility for the long-term inoculation of animals with a number of "slow viruses." The second project is a therapeutic trial of a drug which, though long used by physicians, has been considered of doubtful value in the treatment of MS.

A major effort is now being made by the Institute to investigate any possible relationship of viruses to MS. Of special interest are those viruses which lie dormant in the nervous system for long periods of time in such diseases as herpes simplex and the disease of sheep called scrapie. It is thought that such viruses could cause MS by damaging the nervous system and by liberating a fraction of the very complex protein and lipid material that make up the nervous tissue.

A series of recent events have given greater credibility to this thesis. In 1966, a mysterious human degenerative disease was transmitted from man to chimpanzee. In 1967, the disease was passed by brain inoculation from chimpanzee to chimpanzee, with a shortening of the incubation period to a year or less. Although efforts to filter the infective agent have failed thus far, investigators believe they are dealing with a virus.

This research was conducted at a special virus laboratory established by the Institute at Patuxent, Maryland, in cooperation with the Fish and Wildlife Service, Department of the Interior. Here material from patients suffering not only from kuru but from MS, amyotrophic lateral sclerosis, and related diseases is being injected into primates and other animals in the search for a transmissible agent.

In a closely related study, funds have been provided by the National Multiple Sclerosis Society to purchase viral antigens to detect virus antibodies. Institute scientists are using these antigens to search for such antibodies in patients with MS. This search has already revealed that antibodies against measles and mumps are more prevalent in MS patients than in the general public. The significance of this finding is not yet known.

During the past year, there has been additional support for the belief that infective agents may contribute to MS. In an Institute-sponsored conference, scientists from around the world met to compare research methods and findings on a rare disease of young people, subacute sclerosing panencephalitis (SSPE). A relation between measles virus and SSPE has been suggested by the discovery of very high measles antibody in the blood of patients with this disease. This discovery has further stimulated interest in the possible contributions of viruses in the production of MS.

Studies on the epidemiology of the disease also now indicate that viruses may have some connection with MS. In a study of 1,000 veterans being conducted by the Institute with the Veterans Administration and the National Research Council, it has been found that urban Americans with higher education and earning power are most susceptible to MS. This suggests that people living under lower socioeconomic circumstances with possibly less sanitary conditions tend to develop antibodies to MS early in life and do not later become victims of this disorder. However, much intensive investigation is needed to prove the effect of such environmental influences.

In another study, also on the epidemiological aspects of the disease, a higher prevalence of MS was confirmed in immigrants from temperate latitudes. However, this study indicated that the onset of the disorder may be as long as 10 or 15 years after leaving the temperate climate for the subtropical area. Data on immigrants migrating to Israel from a temperate climate also suggest that MS is acquired before age 15 years. This evidence is compatible with the hypothesis that MS is an infectious disease acquired in childhood but having a prolonged latency.

Although no cure for MS is known, some have believed that the symptoms might be ameliorated by the use of drugs to reduce brain inflammation and to suppress the body's presumed autoimmune reaction.

92 - 594 O - 68 - pt 2 - 36

ACTH is a drug which has been used by many physicians in the hope that it would have some beneficial effect. However, there is no clear proof that the drug is effective in the long-term treatment of MS. The Institute therefore has organized a cooperative therapeutic trial with 11 medical centers to determine whether this drug is effective in treating MS patients. A preliminary report on this study, now nearing completion, is expected early next year.

Research Approaches

In addition to the possible relation of MS to viruses, two other theories on the cause of the disease are receiving major attention: a biochemical deficit or an autoimmune response.

A major research effort is being directed toward understanding the biochemistry of the disease. It is believed by some scientists that the degeneration of myelin characteristic of MS is due to a biochemical deficit. Some nutritional deficit, some toxin, or an inborn metabolic error might be responsible. To investigate this possibility the Institute has an important program on the biochemistry of myelin.

Two Northwestern University medical researchers in a recent report raised the question of a metabolic defect in patients with MS. A 5-year study of biochemical processes in the brains of chicken embryos, combined with autopsy results and a survey of world statistics, has led the researchers to suspect a deficiency of linolenic acid as a cause of MS. Linolenic acid, apparently necessary for building a structurally normal brain, is found primarily in seed oils and fresh fish. In tropical as well as certain Asiatic countries where diets are rich in seafoods, soybeans, millet, and vegetable oils, MS is rare.

Another possibility, now being investigated by Institute programs, is that MS is due to an autoimmune disease--a process wherein the body's antibodies are being directed against its own brain tissues. Normally, the body's protective immunity is directed only toward the destruction of foreign substances or germs introduced into it from outside. Under certain abnormal circumstances, the body may direct its immune defenses against its own tissues. Thus, if specially prepared brain extracts are injected into an animal, the animal's immune defenses are mobilized and attack the animal's own brain tissues. The belief that such a mechanism may be operative in MS has been strengthened by the observation that, when serum from patients with MS is applied to nerve cells in tissue culture, liquefaction of the myelin sheath occurs.

Although anti-myelin antibodies have thus been demonstrated in the blood serum, there is evidence to suggest that the circulating blood cells (lymphocytes) may play an essential role in antibody

production and in the autoimmune process, because lymphocytes produce most antibodies. In one study evidence has been presented that the alteration of immune function which occurs in MS may be mediated by lymphocytes that are sensitized against nervous tissue. In the same study, animals deprived of lymphocytes by neonatal thymectomy did not develop demyelinating disease.

The Institute is supporting a number of studies to determine the nature of the chemical which initiates the autoimmune response, the body mechanisms involved, the evidence that such a process might be operative in patients with MS, and the means to prevent such destructive processes.

SPEECH AND HEARING

Obligations Fiscal Year 1965 to Fiscal Year 1969

Agency and Program	1965	1966	1967	1968	1969
REHABILITATION SERVICES ADMINISTRATION:					
Grants to States	$ 6,774,840	$10,246,320	$15,665,000	$19,100,000	$22,500,000
Research and demonstrations	398,000	365,000	1,754,000	1,473,000	1,558,000
Research and training centers	---	100,000	150,000	250,000	300,000
Training and traineeships	3,495,000	3,772,000	4,299,000	4,041,000	3,818,000
Innovation grants	112,000	112,000	58,000	100,000	100,000
Expansion grants	---	235,000	246,000	250,000	300,000
Foreign currency program	153,000	233,000	256,000	350,000	400,000
Project development	---	9,000	---	9,000	9,000
Construction	---	---	113,000	82,000	82,000
Subtotal, Rehabilitation Services	10,932,840	15,073,320	22,541,000	25,655,000	29,067,000
OFFICE OF EDUCATION:					
Educational improvement for the handicapped	3,279,999	6,554,175	7,930,465	9,011,728a/	10,189,000
Elementary and Secondary Education-Title III	---	1,086,341	1,480,000	3,500,000	3,700,000
Research and training	534,635	471,562	401,172	355,869	335,035
Libraries and Community Services	---	---	11,000	20,000	20,000
Subtotal, Office of Education	3,814,634	8,112,078	9,822,637	12,887,597	14,244,035
PUBLIC HEALTH SERVICE:					
Chronic diseases and health of the aged	1,341,000	1,344,060	1,644,000	676,000	676,000
National Institute of Neuroligical Diseases and Blindness	5,645,000	6,533,000	7,929,000	9,601,000	10,130,000
Subtotal, Public Health Service	6,986,000	7,877,060	9,573,000	10,277,000	10,806,000

a/ Not including funds authorized under Title VI of P.L. 89-10, as amended by P.L. 89-750.

SPEECH AND HEARING

Obligations Fiscal Year 1965 to Fiscal Year 1969
(Continued)

Agency and Program	1965	1966	1967	1968	1969
WELFARE ADMINISTRATION:					
Children's Bureau:					
Salaries and Expenses	$ 20,763	$ 28,123	$ 32,583	$ 33,000	$ 34,000
Special project grants	542,500	714,966	1,396,312	2,146,890	2,500,000
Subtotal, Welfare Administration	563,263	743,089	1,428,895	2,179,890	2,534,000
ST. ELIZABETH'S HOSPITAL	30,500	25,500	31,000	50,500	56,500
OFFICE OF THE SECRETARY:					
National Technical Institute for the Deaf	---	420,000	491,000	2,035,000	1,908,000
National Advisory Committee on Education of the deaf	---	---	100,000	100,000	100,000
Model Secondary School for the deaf	---	---	---	425,000	1,120,000
Subtotal, Office of the Secretary	---	420,000	591,000	2,560,000	3,128,000
TOTAL, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE	22,327,237	32,250,047	43,987,332	53,609,987	59,835,539

PROGRAMS IN HEARING, SPEECH, AND LANGUAGE

PREFACE

The prevalence of communication disorders can be more readily understood in the facts and figures supplied by the United States National Health Survey of 1959-1961 which disclosed that 8,000,000 Americans have hearing, speech and language handicaps. Hearing disorders alone account for approximately one-fourth of all impairments involving over 6,000,000 persons. Profound or near-profound deafness prevents 250,000 persons from acquiring language, speech, and knowledge by ordinary means. Persons with handicapping speech problems number over 1,500,000. Their disability relates to cleft palate, aphasia, stuttering, laryngectomy, mental retardation, or cerebral palsy.

Strides in medicine, education, and rehabilitation are showing that much can be done to assist the communicatively handicapped individual to take his place as a productive member of society. Specific techniques vary with the nature and severity of the disability but almost all individuals can be helped to overcome, at least partly, their handicaps. Medical and surgical treatment, artificial aids, language and speech therapy, and other newly developed techniques are restoring the speech and hearing of many persons and sharply reducing the handicaps of others.

Increased financial support over the past several years has stimulated the Vocational Rehabilitation Administration, the Public Health Service, the Office of Education, and the Welfare Administration to mount more effective programs to meet the needs of persons with communication disorders. Among the especially noteworthy items of progress are the following:

The Vocational Rehabilitation Administration continues to expand its programs of training and research in speech pathology, audiology, and rehabilitation of deaf persons. Improvement of vocational training for deaf persons is receiving special emphasis. Recent legislation has authorized the establishment of a National Technical Institute for the Deaf and use of existing community facilities for the vocational training of deaf persons. Post-master's and post-doctoral graduate study and short-term training courses related to rehabilitation of the adult aphasic and the laryngectomee are in progress. A study has revealed that 900 of approximately 1,000 former trainees in the fields of speech pathology and audiology are employed in rehabilitation settings which provide services to adults with communicative disorders.

The Office of Education has further expanded its activities related to improving and enlarging educational opportunities for hearing, speech, and language handicapped children. Training grants awarded to colleges and universities are steadily increasing the number of professionals trained to work with communication disabled children and research and demonstration projects are determining the effectiveness of special education methods.

Captioned Films for the Deaf are expanding services to deaf persons through multiple distribution facilities and the improvement of techniques for captioning films. Also during Fiscal Year 1966, through P.L. 85-905, there has been expansion of visual aid services for deaf persons.

The Children's Bureau continues to encourage, through its grants program, demonstration research projects and training programs, the development and improvement of programs in State health departments and crippled children's agencies for children with communication disorders. A major conference was held to assess the scope and direction of future training needs in speech pathology and audiology.

The Public Health Service neurological and sensory disease service program continues its activities in expanding community service programs for persons with communication disorders. It also provides support to graduate training programs in speech pathology and audiology for persons who plan to provide services in medical environments.

The National Institute of Neurological Diseases and Blindness has developed a comprehensive program to promote understanding of the fundamental nature of human communication and its disorders. The Advisory Council Sub-Committee on Human Communication and its Disorders provides guidance for these activities and organizes special conferences.

St. Elizabeth's Hospital has been operating a speech and hearing clinic for four years. The clinic is equipped to offer a wide variety of evaluative and rehabilitative procedures and affords excellent opportunity for development of research and clinical training activities.

The Office of the Secretary has administered programs which have included the following activities: the appointment of a National Advisory Committee on Education of the Deaf; the appointment of a National Advisory Board for the National Technical Institute for the Deaf; and plans to conduct a national conference on education of the deaf.

REHABILITATION SERVICES ADMINISTRATION

SUMMARY OF PROGRAMS FOR THE DEAF, FOR THE HARD OF HEARING, AND FOR THE SPEECH IMPAIRED

The limited achievement in vocational rehabilitation of persons with communication disorders makes the promise and challenge of Vocational Rehabilitation Act Amendments of 1965 (Public Law 89-333) especially significant. The complexity and diffusion of the problems that surround hearing deficiences and speech impairments require bold new concepts of service for their effective solution. Focus on the adjustment needs of deaf persons previously classified as not feasible for vocational rehabilitation can be expected to lead to development of appropriate services and training opportunities. Likewise, improved programs and services for the hard of hearing and the speech impaired will bring greater occupational fulfillment and a more satisfactory living pattern.

Americans who are vocationally handicapped by varying degrees and kinds of communication disorders exceed 3,000,000 in number. Some have disorders of the ears, the normal channels for receiving verbal messages. Some have defects in the vocal mechanisms, the main means for sending verbal messages. Some have disorders of the central nervous system which interfere with receiving and sending even though the ears and vocal apparatus are whole. Some have peripheral involvements that curb free verbalization. Some have combinations of causes.

The complexity and variety of the causes frequently obscure the fact that speech and hearing are variables that fluctuate with physical, mental and emotional conditions. Normal ears, normal mentality, normal vocal mechanisms and so on should result in normal hearing and normal speech. One abnormality or more results in abnormal communication. The person permanently affected faces formidable barriers. Fortunately, the condition for many is transitory due to the wonders of medicine and related disciplines. These are not among the above named 3,000,000 whose disabilities are constant, who continuously search for ways to reduce the handicap of communication limitation.

Vocational rehabilitation workers share with teachers, audiologists, speech pathologists, medical workers, and others the responsiblity to create, extend and improve knowledge and resources by which the communicatively handicapped can attain adjustments commensurate with their mental and residual physical capacities.

THE DEAF

Deafness is, in fact, a multiple handicap. Total lack of hearing prevents th individual from using a major way of communicating with others. It also denies him the personal enjoyment that others receive through listening. More importantly, however, he cannot utilize his hearing as an ever-alert warning system of approaching danger which cannot be detected through the eyes. For those who are born deaf, their handicap imposes a most serious deficit upon their ability to learn language, which is fundamental for future intellectual and educational development. Finally, and perhaps most

penalizing of all, deafness is a hidden disability. The deaf person moves and lives in a hearing world, unidentified and isolated.

RSA has long given special priority to research and demonstration projects which attempted to define and resolve the many problems of the deaf. The task, however, is overwhelming in its magnitude. Many questions remain to be answered, and for every answer found, new questions emerge. For instance, how best can the deaf be helped to secure and keep jobs in spite of the fact that their traditional entry jobs in industry are rapidly being eliminated by automation. The deaf, themselves, ask whether they can ever realistically hope for job advancement and promotion or whether they must confine their goals to low level jobs and menial tasks, as at present. On the social front, research is showing many unmet needs for the deaf. At present, the deaf do not have access to the kinds of medical guidance and advice that are so readily available to all other segments of our society; few physicians know how to communicate through finger spelling and the language of signs and written messages are a poor foundation for an adequate diagnosis. This language barrier is particularly evident in the area of mental health counseling for the deaf. Many deaf individuals who need and could benefit from such guidance may develop serious and incapacitating problems if it remains unavailable. The question of how psychotherapy can be carried on between a psychiatrist and a deaf patient through manual communication is just now beginning to be answered through pioneering research sponsored by RSA. Basic to all these problems are the unanswered questions about the language development and functioning of the deaf and the yet undiscovered ways that creative and flexible language skills can be taught to them effectively and efficiently.

Research and demonstration activities have already resulted in a better understanding of the problems which exist. They also have shown the way for a better solution for many of the problems. The major task of finding answers and implementing them remains to be done.

The 250,000 deaf people have very complex problems. Many of them are without useful speech despite years of training. Many have limited language skills. They receive messages principally through their eyes. They send messages by combinations of signs, gestures, speech, and writing. Most of them have normal strength, mobility and intelligence. They strive for achievement within the limitation society imposes in the face of their inadequate verbal communication. This is the handicapping base of their disability. It is primarily psycho-social. It manifests itself in many ways: underinvolvement in the main stream of community life; limited sharing with fellowmen; lack of acceptance among neighbors, employers, and fellow employees; severe underemployment. It seldom yields at all to medical intervention such as drugs surgery or prosthesis. It does yield in approximate ratio to their availability in quality and depth, to training and adjustment services that stem from comprehensive, expert diagnosis that may involve the disciplines of psychology, audiology, medicine, and education and to public relations activities that stress the deaf person's strengths.

Two deep-seated problem areas for vocational rehabilitation exist with respect to deaf people. First, the most basic and achievable need of the deaf person, specifically skill in reading and writing, is insufficiently emphasized in childhood training. Formal training has generally so heavily emphasized the development of speech skills in the deaf child that speech has erroneously assumed the position of being the equivalent of rather than a vechicle for language. To put it another way, teachers of the deaf have focused disproportionate time and energy upon an outlet (speech) for language rather than power in language itself. Language and speech are referred to interchangeably, confusing professional and lay workers alike. Hence, the handicapping aspects of deafness are often intensified by a needless wall of language deficiency.

Second, an incorrect image of the deaf person's potential in verbal communication skills stems from this heavy emphasis on speech and frequently unrealistic publicity that generates from it. These together create everywher an expectancy in oral communication performance which very few deaf people can fulfill. Employers and others are, thus, not conditioned to look beyond the poor speech for the hidden, often rich, human resources.

The Rehabilitation Services Administration is attacking the roots of under-employment: (1) By encouraging and assisting in the establishment of rehabilitation centers to diagnose and train deaf people; (2) by extending its training operations (a) to reduce the communication barrier facing deaf people by developing standards and new procedures for speech conservation and instruction in sign language, (b) to qualify more professional workers in psychology, social work, vocational rehabilitation, speech therapy and audiology to work with the deaf, (c) to develop better understanding of the potentials of deaf people among vocational rehabilitation workers and others, including employers and community leaders, (d) to improve the understanding among professional and voluntary workers of how they can assist the State vocational rehabilitation agencies in serving the deaf, and (e) to help deaf people and their co-workers develop more productive concepts of community inter-relationships; (3) by encouraging researchers to study and resolve the many economic, social, and psychological problems associated with deafness.

THE HARD OF HEARING

The several million hard of hearing pose quite different problems from the deaf. The two groups cannot be treated as one. Whereas the deaf receive verbal communication almost solely through their eyes, the hard of hearing rely principally upon their ears, even though these are defective. The hard of hearing generally have near-normal speech and language. Their disability often had a late onset as opposed to the early affliction of the deaf. Partial hearing impairment is less a psycho-social than a medical problem and often yields significantly and quickly to medical intervention and prosthesis with speedy return to an old job or a new one.

It is known that the number of individuals with debilitating hearing loss is far greater than those who have lost their hearing completely. How much greater is unknown. More accurate estimates are needed before the full magnitude and vocational significance of this problem can be assessed. Deteriorating job performance, eventual loss of job, and gradual withdrawal from family and society are three of the more obvious results of gradual and progressive hearing loss. Too few of these people request help from the State divisions of vocational rehabilitation.

The problems of the hard of hearing are many; this the State vocational rehabilitation counselor knows. How best to solve them, no one yet knows. Much remains to be accomplished in helping the hard of hearing person retain the skills he had before the onset of his handicap. Better diagnostic methods need to be developed to permit earlier prediction or identification of hearing loss. Such methods would also enable a more successful prescription of hearing aids. Abilities which permit a person to speech read (lipread) successfully are, at present, unidentified. And yet, accurate prediction of such ability would have profound effects on the rehabilitation management of hard of hearing and deaf children as well as adults.

Further attention should also be given to ways of helping the person with progressive hearing loss retain his speech intelligibility while he is losing his major sensory pathway for judging the accuracy of his speech production.

THE SPEECH IMPAIRED

The speech impaired, including the language impaired, necessarily include many of the deaf and the hard of hearing because normal speech production depends to a great extent upon self-monitoring which in turn depends largely upon the speaker's hearing. We hear ourselves and correct as we go along. It is not the same for the hearing disabled. However, the speech impaired also number millions whose abnormal or absent output stems from organic disorders other than hearing.

The special needs of stroke victims, particularly those with debilitating language problems due to aphasia, have recently received nation-wide attention. Surprisingly little, however, is known about the actual incidence of the disability, particularly in its more subtle and partial forms. Also, diagnostic techniques to determine the most appropriate treatment problem and the outlook for recovery remain crude and inexact. Unavailability of crucial specialized services within the aphasic's home community, particularly language therapy, poses insurmountable problems for most aphasics living outside large metropolitan areas. New methods of extending services to those people and/or training other family members to assume the task must receive highest priority. The use of programmed teaching machines represents one partial solution to this problem, but self-teaching programs must be developed and evaluated. The spotlight of attention given to this affliction merely highlights the problems which are as yet unsolved.

Equal attention has recently been given to cancer victims. In great need of rehabilitation are those who have lost their larynx because of cancer, thus, their ability to produce voice. Such a sudden handicap usually results in loss of job and loss of family responsibility. Training procedures now exist to help the laryngectomees learn to use esophageal speech, but too often, those methods fail. Many individuals, therefore, go for the rest of their lives without the ability to speak. Reasons for this failure must be found. Better techniques for identifying those people who will be able to learn esophageal spech--and those who will not--are needed. Programmed learning methods also need to be considered as possible retraining procedures. Presurgery personality factors deserve investigation as probable reasons for post-surgery response to rehabilitation efforts.

Stuttering is another wide-spread speech handicap which deserves greater research attention. Over 1,000,000 people in the United States suffer from this affliction. The problems of the adult stutterer are particularly damaging and cause the individual to lead a restricted and sterile life. This is true primarily because the speech defect is variable; the stutterer rarely knows when he begins to speak whether he will talk normally or will produce a spasm of muscular tension and an explosion of distorted words. Most stutterers, therefore, remain constantly "on guard" and resort to bizarre tricks and body motions (which themselves attract attention) to avoid stuttering. Some stutterers even pose as deaf to avoid having to speak. Consequently, many stutterers of superior ability accept jobs which require little or no talking and remain at a level of employment far below their aspirations and capacities. Underemployment, self-imposed, may sometimes be the stutterer's greatest handicap.

Usually, these problems are most resistant to change, even though research has shown that most of the stutterer's speech problem has been learned and can be unlearned. The reasons for the tenacity of stuttering are unknown. What is particularly puzzling is the fact that for a few persons, long-time stuttering can be eliminated with relative ease. Clinical observation has indicated that there are different types of stutterers and much more research is needed to find ways of identifying each kind and the critical factors which determine their response to rehabilitation. Also, better ways of helping stutterers achieve and retain more normal speech must be found. To do this, better methods of judging the effectiveness of speech therapy are needed. The goal is doubly worthwhile since if the stutterer's speech can be improved, most of the associated psychosocial and vocational problems which his stuttering creates will also be eliminated.

The State vocational rehabilitation agencies find that a major problem is the lack of guidelines that enable staff to relate speech impairment to occupational handicap. Moreover, standards of casework performance and progress in therapy are not so closely defined nor apparent in speech rehabilitation as in other areas. The resources that serve the hard of hearing can be effective for the speech handicapped if qualified staff are available. The Rehabilitation Services Administration's drive for more hearing and speech centers relates to speech rehabilitation, too. Additionally, special emphasis is being given (1) to the development of authoritative

literature on the handicapping aspects of speech disorders and their treatment and (2) to the fostering of voluntary work for the speech impaired throughout the national community on a level equal to that for the hearing impaired. Research in speech performance, production, and diagnosis continues. Also in the making is the development of casework standards as guidelines for vocational rehabilitation counselors serving hard-of-hearing clients.

NUMBERS SERVED BY STATE VOCATIONAL REHABILITATION AGENCIES

The aim of the public vocational rehabilitation program is the preparation of the occupationally handicapped disabled person for suitable employment. The State vocational rehabilitation agencies actually determine eligibility and provide services using grant-in-aid funds administered by the Rehabilitation Services Administration.

All of the resources of the public vocational rehabilitation services are directed toward the occupational adjustment of the person whose disability is a vocational handicap. The media for attaining this end with each client are the case services that are patterned to individual needs. The research, training, and facility development activities of the Rehabilitation Services Administration and the State agencies are carried on for the purpose of strengthening case service techniques, developing new ones, improving the capacities of the case worker and the personnel upon whom he draws, and developing resources for better diagnostic, evaluation, training and restoration services. The dual aim of sharp increases in the quality and quantity of services and persons served permeates the whole program.

The extent to which the State agencies rehabilitated the deaf, the hard of hearing, and the speech impaired in the fiscal year 1965 through 1963 and the numbers estimated to be rehabilitated in fiscal 1969 are shown in the following table:

NUMBER OF REHABILITANTS OF THE STATE VOCATIONAL REHABILITATION AGENCIES WITH SPEECH AND HEARING IMPAIRMENTS, FISCAL YEARS ENDING JUNE 30, 1965-69

	Estimated and actual Number of rehabilitants in fiscal year[1]				
	1965	1966	1967	1968	1969
All rehabilitants	134,359	154,279	190,000	213,000	———
Number of rehabilitants with major disability of speech or hearing.....	9,720	10,640	12,200	13,600	14,900
Deaf.....	2,560	2,731	4,900	5,200	6,200
Hard of Hearing.....	5,570	6,234	5,300	6,200	6,400
Speech.....	1,590	1,625	2,000	2,200	2,300

1/ Data are actual for fiscal years 1956-66, estimates are used for fiscal years 1967-1969.

The effectiveness of casework rests in appreciable measure upon the joint planning of the counselor and the client. Clients who are hard of hearing or who have serious speech problems of other than hearing origin tax even the most skilled caseworker. Even so, counselor and client do have a line of verbal communication which encourages rapport. They can develop a good rehabilitation plan together. The profoundly deaf client, however, especially that large majority who have serious language deficiencies, are not able to communicate by normal means. This is the crux. There must be communication between counselor and client for effective casework.

The State agencies have recognized this basic factor and are moving to rectify it as qualified workers become available or through special training of current counselors. Thirty-eight States[1/] now have or are actively recruiting staff who may be classified as expert vocational rehabilitation workers for the deaf since they are trained as professional counselors and are also able to communicate by sign language with deaf clients. Several of the States are searching for additional qualified counselors because their caseloads of deaf clients have rapidly grown beyond the capacities of the special staff as their deaf citizens have become aware that the vocational rehabilitation agency is now able to work more effectively with them. The Rehabilitation Services Administration urges that each State should have at least one highly skilled vocational rehabilitation counselor for the deaf and preferably that there be one in each metropolitan area.

A continuing problem in the area of the hard of hearing through the years has been developing and maintaining adequate channels of referral of hard of hearing persons needing vocational rehabilitation services. Major efforts have focused on encouraging the professional, the medical, and the voluntary worker to refer persons with hearing impairment to State vocational rehabilitation agencies for evaluation and consideration of possible services. The results have been disappointing as witnessed by the relatively small number of hard of hearing clients rehabilitated each year as compared to the many thousands needing or able to benefit from our services. The persistence of this problem has encouraged us to look to other channels by which more persons may become knowledgeable of their entitlements under the vocational rehabilitation service. Accordingly, we are now developing formal working relationships with the National Hearing Aid Society, a principal feature of which encourages referrals by hearing aid dealers of persons coming to their attention who may be eligible for the services of our State agencies. If this move is as effective as we expect, the number of hard of hearing rehabilitants each year should increase rapidly into the tens of thousands.

1/ Alabama, Arizona, Arkansas, California, Connecticut, District of Columbia, Florida, Georgia, Guam, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

SERVICE CENTERS

Most of the many hearing and speech centers that have been established in the past twenty years have come into being in universities as training and research facilities, in large hospitals as service units, and in metropolitan areas. They fill vital rehabilitation needs in diagnosis, in evaluation, in training in lipreading, speech, and listening, and in selection of hearing aids. We may have as many as 400 of widely varying levels of effectiveness and uneven distribution. Many thousands of people with communication problems are just too far away from even the least of these service centers and even further from the more technical assistance that they may need. For example, a hard of hearing person who is 50 miles away from lipreading instruction, auditory training, hearing aid evaluation, is not likely to be able to travel this distance several times per week for instruction and service. The Rehabilitation Services Administration is attacking this problem directly through a carefully designed project to bring the basic hearing and speech services that the majority of these disabled people need into the local community at a cost that it can afford to maintain, leaving for the more comprehensive center the intricate services needed by more difficult hearing or speech cases. Successful initial experiences with two projects now underway[2] are in the process of developing a prototype for a nationwide program that could bring basic hearing and speech rehabilitation services within reach of all.

The State vocational rehabilitation agencies are making important contributions to the availability of hearing and speech evaluation services through grants to extend and improve vocational rehabilitation services for the communicatively impaired.

The practical needs of deaf people are little related to speech and hearing centers. Almost all of them have had several years of intensive, expert training in speech and use of residual sound perception in their special schools. The deaf need the same vocational rehabilitation services as other clients, specifically diagnosis, evaluation, training, counseling, and placement, but in language that they understand. There are very few persons in rehabilitation centers or vocational schools who can communicate with deaf people to the point where a good learning situation may be said to exist. Consequently, the Rehabilitation Services Administration has had to concentrate on developing centers where there are expert professional workers for the deaf. Usually, these have proven to be the residential schools for the deaf. Diagnostic, evaluation, prevocational, and adjustment centers have been established or are planned at the State schools for the deaf in sixteen[3] States.

Encouraging by-products of this activity is the interest in other States and the growing efforts by established rehabilitation centers to qualify themselves to serve the deaf.[4] Community service centers for deaf people

---

2/ Macon, Georgia and Mansfield, Ohio.

3/ Alabama, Arizona, Arkansas, Colorado, Florida, Georgia, Indiana, Louisiana, Mississippi, Nebraska, New Mexico, Oklahoma, South Carolina, Tennessee, Vermont, and Wisconsin.

4/ Seattle, Washington; Kansas City, Missouri and Pittsburgh, Pennsylvania.

that are relieving residential schools for the deaf of counseling responsibility of deaf adults are located in three metropolitan areas.

Justification - The most pervasive, persistent yet reducible problem of deaf people is their underemployment. It has always been so. The normal strength, mobility, and intelligence of deaf people do not help them find satisfactory employment, that is jobs that are appropriately challenging. Much manpower is wasted. Underemployment is increasing as job demands become more complex and preparation therefore less available.

The experience of the Rehabilitation Services Administration emphasizes that a principal cause of underemployment is inadequate training. Appropriate resources for deaf people of employable age simply do not exist. By appropriate resources we mean training situations which fully compensate for the handicapping aspects of the disability, that is by providing for the special communication needs of deaf people so that transfer of ideas, exchange of thinking really takes place at more than a superficial, fragmentary level.

It is widely recognized that formal training for most deaf people terminates at the elementary level or slightly above. The average age of departure of the mass of deaf students from this level of training is about 15 years. Moreover, recent reports suggest the average age of departure is dropping. This is disastrous, except for the small percentage who qualify for and go on to secondary and higher educational opportunities, because there is no permanent school or other fixed training situation which the young deaf person may consider and toward which he may aspire. There is an utter vacuum of opportunity aside from an occasional local situation, such as on-the-job training or a receptive vocational school for normally hearing people, which may rise and fall in accordance with attending circumstances. Moreover, apprenticeships are seldom available to deaf people for age or other reasons. None of these latter provides the rich depth in training experience by which a permanent institution with its highly skilled staff reaches and motivates the deaf person to be somebody.

The tragedy of these failures of our society to meet its responsibilities is that a large portion of deaf people can benefit very much from more training. However, when their formal schooling is terminated, there is no place for them to go for more at the time or when they are motivated to want more training.

Of continuing concern to the Rehabilitation Services Administration is the decline in the vocational training of deaf clients. The accelerating inroads of automation seem to have sharply reduced the number of entry level jobs by which the deaf have gained their footholds in industry. Consequently, more vocational training has been necessary for deaf people who frequently are being pushed aside by overcrowded vocational schools. This intensifies the training void for deaf people that exists between the special school system which generally terminates at 9th grade or less and Gallaudet College, a void which has nurtured and partially perpetuated their serious underemployment.

Accomplishments - The establishment of the National Technical Institute for the Deaf authorized by Public Law 89-36 is a very important step toward reducing the underemployment of deaf people. It will contribute vital new concepts in the training of deaf people and through its special job development and placement program open employment that has not had many or even any deaf practitioners. The State vocational rehabilitation agencies will naturally be directly involved with every student.

The most promising accomplishments for that large fraction of deaf people who are the most severely handicapped because of limited or no formal education, emotional problems, mental deficiency, or other difficult-to-manage circumstances, have been the successful transfer to State operations of three pioneering Rehabilitation Services Administration conceived and sponsored research projects. These are glowing examples of research results being incorporated in regular operations.

The Michigan Rehabilitation Institute in Pine Lake is operating the personal adjustment and prevocational center for unemployed deaf men that the RSA supported in Lansing for over three years. It successfully demonstrated, through techniques that its staff developed, that uneducated, seriously maladjusted deaf men who have not been eligible for vocational rehabilitation because suitable services were not available could in fact be prepared for and placed in competitive employment. This center is a regional model from which equivalent service centers in other States will be established as soon as possible.

The RSA project at Lapeer (Michigan) State Home and Training School to demonstrate rehabilitation of the hospitalized deaf-retarded has been made a part of regular State operations. It is essentially a training operation to make retarded deaf individuals more effective, varying from greater individual contribution to in-institutional life to discharge to independent living of those who have been patients because of improper diagnosis. It is being developed as an innovation project for adoption in other States. It has unusual economic significance in view of the larger ratio of deaf persons in institutions for the mentally retarded.

The State of New York has absorbed, after nine years of RSA supported demonstration, the mental health project for the deaf in the New York State Psychiatric Institute. It is expected that other large population States will emulate this pilot experience as mental health workers who are able to communicate with the deaf (the crux of the project) become available.

TRAINING

Communication is the most complex aspect of human behavior. Impairments in the processes of communication--speech, language, and hearing--leave a multitude of problems in their wake. The child with a communication disorder may encounter overwhelming obstacles to learning and may find it difficult to establish the relationships with other children which are essential to growing up to healthy, stable adulthood. The adult who acquires a speech or hearing disorder may experience a variety of social

problems. His livelihood may be endangered; he may withdraw from his friends and cease to be a participating member of his community. It is not surprising, then, that persons with speech and hearing disorders form one of the largest disability groups in the country. What is surprising--and intolerable--is the fact that adults with communication problems form one of the smallest groups of successful rehabilitants.

The purpose of training grants in speech pathology and audiology is to increase the number of speech and hearing specialists qualified to diagnose and treat adults with communicative disorders. Teaching grants are made to assist university training centers to expand their programs and modify their curricula to provide more extensive training for work with adults. Prior to the initiation of the RSA training grants program, the majority of the programs traditionally prepared students to work with children in the public school system. A significant number of graduate training programs have modified their curricula to include extensive training in the area of adult rehabilitation. Traineeship grants are made to training centers so that students may gain experience with adults and so that experienced clinicians may secure advanced training to prepare for university teaching positions.

Accomplishments - Significant progress is being made in the effort to alleviate the shortages of qualified personnel to diagnose and treat individuals with communicative disorders but shortages continue to exist. Since RSA began to support graduate training in this field in 1955, the number of universities with teaching grants has grown from seven to 66 in fiscal year 1967, and the number of traineeships from 22 to 713 in fiscal year 1967. Approximately 1,200 RSA trainees have completed their graduate study in this field and of this number over 1,000 (90 percent) are employed in rehabilitation settings which provide services to adults with communicative disorders.

The number of speech pathologists and audiologists who have met the requirements for the certificate of clinical competence, as established by the profession, has increased in the past few years. They now total over 6,000 as compred with less than 1,000 in 1953. Improvements in the graduate curricula account in large measure for this increase. At the present time it is estimated that less than 500 trained persons are providing services in postlaryngectomy or esophageal speech to the laryngectomee. More persons are being trained in this area through short-term training programs.

A very conservative estimate of the number of trained persons providing language and speech training to the aphasic on a full-time basis would be 250. In addition there are a number of speech clinicians, some with limited training, providing minimal services. Some of these clinicians may provide services to one or two aphasic patients each year. It is important that every speech clinician receive specialized training in working both with the laryngectomee and the aphasic. These competencies are most important to every clinician, working in a large rehabilitation center, in small community hospitals, private practices, or in any of the work environments.

Needs - Precise figures on the number of speech pathologists and audiologists now employed are lacking. The membership of the American Speech and Hearing Association is now over 12,000, and there are perhaps an additional 5,000 persons working in the field who are not members. It is estimated that about 20,000 clinicians are required to provide the necessary services to the approximately 3,000,000 persons in the United States who have defective speech or hearing serious enough to handicap them in their social relationship and vocational adjustment. Approximately 300 students are completing their studies at the master's or doctoral level each year. This number represents about half of those needed to reach the goal of 20,000 trained clinicians in practice and 1,500 graduates a year.

Of the approximately 6,000 clinicians who have received the certificate of clinical competence, only 900 have certification in audiology and about 150 have dual certification. The need for bringing new workers into the field is clear and the increase in college enrollments will result in larger graduate student bodies. At the same time, many of the clinicians now working lack competencies in dealing with specialized problems, such as work with the laryngectomized patient, the adult aphasic, or those with profound hearing loss. There is a need for the continued training of these individuals who are presently providing only limited or inferior services.

Every rehabilitation environment should have at least one speech clinician who possesses the special competencies in working with the aphasic. This would mean that some 400 to 500 speech clinicians with special competencies in working with the aphasic should complete their training each year. In addition, training should be provided to the clinicians presently in practice.

Estimate manpower figures in speech pathology-audiology are:

	1963	1968	1973
Number enrolled in graduate education programs			
Master's Degree	1,500	1,750	2,000
Doctoral	160	130	200
Number receiving RSA Traineeships	673	673	1,500
Number of graduates			
Master's Degree	1,100	1,400	1,300
Doctorate	155	170	130
Number needed for replacement and to fill new positions	2,750	3,250	4,500

New Activity--A major effort in the recruitment of students to work in this profession is underway at the present time. It is anticipated that by 1969, effects of this activity will begin to have an impact on the graduate enrollment, and by 1972 some of the manpower needs will be met. This can be accomplished only through the continued increase in support of the program.

1969 Proposed Program - In 1969 funds amounting to $3,267,000 are requested for support of 61 teaching grants and 673 traineeships, the same level as 1967. Components of this request are: $1,006,000 to continue support of 61 continuing teaching grants; and $2,261,000 for 673 traineeships.

REHABILITATION OF THE DEAF

Trained personnel to meet the needs of people who are deaf are in short supply. Special skills are required to work with this group of handicapped persons. It is important for the trained worker to have some understanding of the psychological, social, and communicative problems of these individuals. The skill of manual communication is most important to the worker serving a deaf person whose verbal communication ability is limited or completely lacking. Teaching grants are made to prepare speech pathologists, audiologists, social workers, rehabilitation counselors, psychologists, physicians, and others to work with this specialized group. Research in this area continues to expand, but the quick incorporation into the curricula in the respective professional fields of new knowledge gained through this research continues to be difficult. Traineeship support is important to help prepare a number of individuals to work with the deaf.

Accomplishments - Until recent years, academic programs to prepare personnel for rehabilitation of deaf persons did not exist in the United States except those of preparation of teachers of deaf children. In fiscal year 1961, VRA began support of a specialized training program at the master's degree level which was designed to prepare a small number of persons now working with the deaf for leadership positions in rehabilitation of the deaf. The curriculum drew upon a number of disciplines and is composed of both classroom instruction and actual field experience in varied settings serving deaf persons. In 1963, three programs were developed to provide orientation of professional personnel to work with the deaf, through training courses of four to six weeks' duration. These courses were primarily geared to meet the needs of rehabilitation counselors, social workers, psychologists and other rehabilitation personnel. In 1964, an inter-disciplinary program was developed to provide greater breadth and depth in the understanding of the problems of deaf persons. The students in this program are individuals from the fields of speech pathology, audiology, social work, or rehabilitation counseling. All of these programs are comparatively new and their full effectiveness will not be realized until the students have returned to their work environments to try the new skills and knowledge gained. So little has been done in the past in the rehabilitation of deaf adults that it is premature to attempt an objective assessment of accomplishments.

Needs - Relatively few professional workers are now equipped with enough knowledge about problems of deaf persons or with skill in communicating with totally deaf persons. State vocational rehabilitation agencies need more counselors with adequate preparation for serving deaf persons. Only thirty-eight of the agencies have even one counselor with special competence in serving deaf persons. Only eleven[1] State agencies have more than one such specialized counselor.

Although some university training programs in rehabilitation counseling offer limited field work experience in rehabilitation of the deaf, most of them are faced with inability to locate satisfactory facilities for student clinical practice. Counselors with knowledge of the problems of the deaf are needed in residential schools for the deaf, in public employment services, in rehabilitation facilities, in vocational schools, and in mental hospitals and schools. Skilled audiologists are needed in the schools for the deaf to assist in determining the level of residual hearing and its possible contribution to independent living and employment.

Manpower figures are:

Manpower Estimates	Fiscal Year 1968	1969	1973
Number of students enrolled in specialized training programs related to the deaf	100	115	150
Number receiving VRA traineeships	72	72	135
Number of graduates	60	60	120
Number needed for replacements or expansion	200	230	300

In 1967 we saw the successful development of guidelines for case service standards for vocational rehabilitation counselors serving deaf people; increased activation of the registry of interpreters for the deaf; assistance in the establishment of a professional organization of rehabilitation workers for the adult deaf; and a pilot effort to develop an intensive training program for interpreters of the deaf.

New Activities - In 1968 program plans include the development of guidelines for the integration of special education and vocational rehabilitation; an intensive effort to interest psychiatrists in serving deaf people; development of guidelines for professional non-medical and lay workers in extending mental health services to the deaf; design of better techniques of communication for severely handicapped deaf people; orientation of religious workers for the deaf to vocational rehabilitation; and the preparation of guidelines and standards for teaching the language of signs.

1/ Alabama, California, Georgia, Illinois, Minnesota, North Carolina, New Jersey, Ohio, Texas, West Virginia, Wisconsin.

1969 Proposed Program - In 1969, $551,000 is requested for 8 teaching grants and 72 traineeships, same level as 1968. Components of the request are $243,000 for continuation of eight teaching grants; and $308,000 for 72 traineeships.

REHABILITATION FACILITIES AND WORKSHOPS

Project development grants are available for the planning of new and expanded speech and hearing facilities under Section 12 of the Act. During 1966, two awards amounting to $9,000 were made for this purpose.

Funds for the construction of new facilities are also available under Section 12 of the Act and during FY 1967, one award amounting to $113,000 was made for a comprehensive rehabilitation facility serving this group.

RESEARCH

Rehabilitation of Deaf Persons

Accomplishments - Investigations are being continued and broadened on a national level to determine the actual occupational status of young deaf adults. Two intensive surveys have already been completed in the New England States and the Southwestern States, and the findings were combined with those from earlier VRA-sponsored studies of the vocational achievements of the deaf in representative urban and rural communities. The most significant finding to emerge from these investigations was documentation of the fact that the deaf, as a group, were not receiving vocational training of a type which would prepare them to compete for or retain jobs in the present day labor market. Much of their present training was for jobs which are rapidly being eliminated by automation. An immediate outgrowth of these survey findings was the preparation and passage of Public Law 89-36, "To Provide for the Establishment and Operation of a National Technical Institute for the Deaf." It is intended that the newly-created Technical Institute for the Deaf will begin to provide the kind of modern training, counseling, and ancillary services which the deaf must have if they are to achieve suitable employment in the coming years.

Another of the many discoveries to emerge from these research surveys was the fact that most deaf adults who are working are grossly underemployed in view of their inherent intellectual and personal capacities. As a consequence of this finding, VRA-sponsored projects are now under way in St. Louis, Boston, Chicago, and Little Rock to demonstrate the long-term value to society of providing continuing vocational counseling and training to the underemployed deaf adult as well as to the unemployed deaf persons. These projects are also investigating the economic and educational feasibility of providing such services for the deaf in existing rehabilitation facilities, under the guidance of specially-trained personnel, rather than in more expensive and virtually non-existent vocational training centers established exclusively for the deaf. If these demonstrations prove productive, they will have widespread influences on future State vocational rehabilitation programs for the deaf.

Many projects are under way to demonstrate ways in which the hearing community can assist the deaf to become active and well-informed members. Two sociologists from Catholic University are completing their second study of the personal and social interaction of deaf and hearing people within a community in an attempt to discover unmet needs and unrecognized deterrents to effective relationships.

The close involvement of the vocational rehabilitation program with deaf people and the foregoing and other sociological studies have brought into focus the urgent need for a coordinating, referral, interpreting and supportive counseling service for deaf people in metropolitan areas. We have found that most deaf people seldom know about community services to which they are entitled and which they need. Moreover, the relatively few who do become clients of these services may remain very much underserved because of the severe communication problem inherent in their disability.

Consequently, their vocational rehabilitation potential may be seriously affected. We are now carrying out demonstrations of the kind of a supportive service communities can most economically provide while not duplicating other services. Speech and hearing societies in Pittsburgh, Kansas City, and Seattle are sponsoring community service centers for deaf people. A statewide program is now operating in Utah under the State vocational rehabilitation agency. We expect to be able to support similar work in other hearing societies, in an independent voluntary agency, and a university.

The new authorization in Public Law 89-333 that permits Federal funds to be used for interpreting language in describing and providing services for deaf vocational rehabilitation clients without regard to economic need underscores the urgency of finding successful patterns for this needed community service.

DePaul University in Chicago is instituting a metropolitan mental health facility for the deaf patterned after the successful demonstration project recently completed at the New York State Psychiatric Institute which established new ways of providing professional psychiatric services through the use of the language of signs. In San Francisco, a pilot program will soon begin to demonstrate the mental health service needs of deaf people.

The need to explore untried employment areas for the vocational rehabilitation advancement of deaf people and better utilization of their talent and capabilities has focused interest on the theater. The O'Neill Foundation of New York City is presently conducting a pilot program in repertory theater for the deaf that holds considerable promise of opening an area of new employment opportunities for deaf people.

The newly established Research and Training Center at New York University holds great promise for the conduction of studies in breadth and depth that will yield answers to the persisting problems that continue to surround deafness.

The National Health Council and a distinguished committee of prominent citizens have joined with VRA in sponsoring the formulation of an American Council of Organizations of and for the Deaf. This Council will include representative members from approximately 20 national organizations concerned with the deaf and should provide an effective mechanism for consolidation of the many independent and largely ineffectual efforts made in behalf of the deaf at the present time.

We anticipate that this Council will take leadership in developing urgently needed services for the deaf community such as management of a nationwide program of communication improvement centers, the publication of a regular paper to keep deaf people aware of their opportunities and roles in the larger society, the development and management of an appropriate program whereby deaf people can share the cultural resources of society, a job development service, and so on.

Research scientists from other professional fields are also beginning to turn their interests and talents to the problem of the deaf. Medical geneticists and audiologists at Johns Hopkins University are conducting an exhaustive search for new classifications of hereditary deafness. Engineers at Northeastern University, Wayne State University and Gallaudet College are perfecting new teaching machines which should greatly improve methods of teaching intelligible speech to the deaf. Joint research is being conducted by Ohio State University and the University of Zagreb, Yugoslavia, on a dramatically new technique for teaching the totally deaf to utilize sounds for possible understanding of speech. Further efforts along these lines relate to a project which is investigating the possible usefulness of technological developments coming from the space program as new sensory aids for the deaf. On another front, research projects at Vanderbilt University, Catholic University and the Institute for the Deaf in the Netherlands are investigating ways in which the characteristic lack of creative language in the deaf can be overcome.

1968 Proposed Program - In 1968, a total of $966,000 is requested for 18 projects. Emphasis will be given to the establishment of demonstration centers to develop and test better methods of vocational evaluation and assessment of the deaf, techniques for their placement, specific counseling methods, and ways of establishing a closer association with business and industry during on-the-job trials. Efforts to expand the number of professional fields in which the superior deaf adult may find employment will also be made. Supporting these activities, research will continue into ways of improving the language and the psychosocial relationships of the deaf so they may function more effectively and competitively on the job. Continued search for new sensory aids for the deaf will be conducted.

Rehabilitation of Speech Impaired

Accomplishments - Finding ways in which the stroke patient with aphasia can obtain more intensive language retraining is the purpose of a research project being conducted jointly by Ohio State University and the Catholic University of the Sacred Heart in Milan, Italy. Devices and materials are

University of the Sacred Heart in Milan, Italy. Devices and materials are being developed and evaluated which provide the aphasic with opportunities for intensive drill and self-instruction in language during periods in which he is not receiving formal speech and language training from a qualified therapist. A new type of teaching machine, designed specifically with the aphasic's problems in mind, has been developed and is being tested in several clinical settings. This device, utilizing a typewriter keyboard, promises to increase ten-fold the amount of self-training opportunities presently available to the aphasic. An obvious extension of this research is determining the feasibility of the stroke patient using the programmed learning sequences and machines in his own home and with the assistance of his family. Should the investigators find that such home instruction is productive, one solution will have been found for the perplexing problem of providing specialized services to home-bound and rural stroke patients.

An initial research project has just been completed, with RSA support, at Washington University in St. Louis which may, eventually, pave the way for physical restoration of the laryngectomized patient who has lost his larynx because of cancer. Medical specialists have studied and identified some of the basic neurophysiological requirements necessary for the reestablishment of normal swallowing and voice production through reconstructive surgery.

Future research projects are being developed which will utilize this information with laryngectomized animals and, eventually, laryngectomized humans.

Several research programs are presently underway to determine better ways of helping adult stutterers obtain normal speech. Speech pathologists at Northeastern University are conducting careful studies of the therapeutic progress of stutterers, and concomitant psychological and physiological changes, in an attempt to determine factors associated with an improvement in speech and to predict the likelihood of a patient's successful rehabilitation. At Western Reserve University, work is underway to develop methods whereby reliable and precise judgments can be made of a stutterer's speech improvement. Ways of helping speech therapists ascertain the success of their own therapy with stutterers by establishing personalized but objective criteria of judgment are being tested at the University of Kansas Medical Center with the use of closed-circuit television and video tape. Also, scientists at the State University of Iowa are testing new methods for conducting therapeutic counseling for stutterers. Combinded, the outcome of these 4 studies should represent a major advancement in the development of more precise rehabilitation techniques for this speech handicapped group.

At present, most of RSA-sponsored projects involving the hard of hearing concern the development of more precise audiologic measures to be used in diagnosis. Two projects, one at the Houston Speech and Hearing Center and the other at the University of California Medical School, are independently investigating audiological findings which are proving to be predictive of the outcome of surgery for patients with particular types of hearing loss. These findings are of inestimable value to the surgeon in selecting potentially successful candidates for surgery and subsequent restoration of hearing. The University of Oklahoma Medical Center, the Johns Hopkins University and Vanderbilt University are undertaking the development of new

audiologic tests which promise to provide some of the kinds of specific information State rehabilitation counselors and others need to be of greatest help to their hard of hearing clients.

In quite a different view, RSA recently awarded a contract for the writing and production of a stage play which would help inform the general public of the importance and seriousness of partial hearing loss. Reaction to the play's first public performance before the American Hearing Society was enthusiastically positive. The play script has now been made available to community groups across the nation.

1968 Proposed Program - For 1968 $314,000 is requested for 13 projects. Primary emphasis will be given to the development and establishment of better rehabilitation methods for the aphasic patient and the laryngectomized person. Community demonstration projects, involving a multi-disciplinary approach, will be encouraged. The feasibility of establishing an organized and standardized reporting system to be used with large numbers of aphasic patients across the country will be studied for the purpose of collecting sufficiently large amounts of data to permit predictive studies. Research concerning better diagnostic and treatment methods for laryngectomized patients will receive high priority. In the area of stuttering, particular attention will be given to new ways of treatment. The possible usefulness of operant conditioning therapy and pharmaceutical treatment, among others, will be considered. Determination of the true vocational significance of partial hearing loss seems to be a most critical need at this time and efforts will be made to find such answers.

OFFICE OF EDUCATION

OBLIGATIONS FOR PROGRAMS ON SPEECH AND HEARING

	1965	1966	1967	1968 Estimate	1969 Estimate
Office of Education					
Elementary and secondary activities	---	$1,086,341	$1,430,000	$ 3,500,000	$ 3,700,000
Libraries and community services	---	---	11,000	20,000	20,000
Educational improvement for the handicapped	3,279,999	6,554,175	7,930,465	9,011,728	10,189,000
Research and training	534,635	471,562	401,172	355,869	335,039
	3,814,634	8,112,078	9,822,637	12,887,597	14,244,039

OFFICE OF EDUCATION

PROGRAMS IN HEARING, SPEECH, AND LANGUAGE

Grants for Training of Professional Personnel

According to the most recent estimates of the American Speech and Hearing Association, speech and hearing disorders account for more than 8 million handicapped individuals. Of this number approximately 3 million possess hearing difficulties severe enough to interfere with communication and the development of normal speech and language. 125,000 of these are considered totally deaf, and thereby incapable of receiving any speech through the auditory mechanism. The remaining 5 million represent children and adults with significant speech and language difficulties generally unrelated or only in part related to hearing disorders. Among the types of speech and language problems found are those related to stuttering, aphasia, laryngectomy, cleft palate, cerebral palsy, or mental retardation.

The Office of Education activities related to improving and enlarging educational opportunities for handicapped children has expanded significantly during the past year. A number of training grants have been awarded to colleges and universitites to help increase the number of professionals trained to work with children with communication disorders. Grants have also been awarded to training institutions for the purpose of developing graduate programs in the area of speech pathology and audiology. Research and demonstration projects are being carried out in several areas, such as determining the effectiveness of instruction in the classroom and other learning situations for communicatively handicapped children and youth.

To encourage State departments of education to expand their services to the communicatively handicapped in the schools, a National major conference was held by OE in the fall of 1966 for State supervisors in speech and hearing. Problems in the development of school programs with and without Federal assistance were identified and discussed by participants. A study of the recipients of OE training grants in Speech and Hearing under P.L.85-926, as amended, revealed that almost all trainees and fellows have indicated the vocational goal of providing speech and hearing services in the schools.

Sixteen program directors representing 16 colleges and universities attended the first conference for Program Development Grant Awardees in the spring of 1966. During the spring of 1967 twenty directors attended. The purpose of these meetings was to discuss the implications of funding for the development of training programs as well as the details of the policies and procedures concerning program development grants.

For academic year 1968-69, it is estimated that a total of $3,152,160 will be obligated for awards for speech and hearing in the following categories:

	Number	Amount
Post Masters fellowship.....	27	$ 186,300
Masters fellowships.....	481	2,549,300
Senior year traineeships.....	44	123,200
Summer traineeships.....	56	65,850
Program Development Grants....	13	227,510

An additional $613,225 will hopefully be obligated for awards to States.

Although the school-age population of deaf children has remained relatively constant in the past few years, the downward extension of educational services to very young preschoolers has increased the total number. It is estimated that there are over 40,000 deaf pupils in the United States. Due to a shortage of teachers and other obstacles, an additional 14 percent (8400 children) are not receiving the specialized help necessary from schools and classes appropriately equippped to serve these children. A recent survey has identified an annual need for 500 new teachers of the deaf plus 500 more to overcome existing shortage and annual attrition.

Public Law 87-276, approved September 22, 1961, authorized a grant program of $1.5 million for each of 2 years to accredited public and non-profit institutions of higher learning for the training of teachers of the deaf. This program was extended for an additional year in fiscal year 1964. In the three-year tenure of the act, 1,376 scholarships have been awarded to train teachers of the deaf.

The program was expanded in academic year 1965-66 to include, in addition to the training of teachers, the preparation of college instructors, supervisors, administrators, and research personnel as authorized by section 301 of Public Law 88-164. A total of $2,068,350 was utilized in support of the program in the area of education of the deaf.

The program incorporated by Public Law 85-926, as amended, was extended by Public Law 89-105 in 1965. Further support of the program activities in academic year 1966-67 and 1967-68 was $2,552,180 and $2,832,839, respectively.

For academic year 1968-69, it is estimated that total funds of $2,559,157 will be awarded for the following categories:

	Number	Amount
Senior year traineeships...	141	$ 394,800
Masters fellowships.....	312	1,653,600
Post Masters fellowships...	11	75,900
Summer Traineeships.....	176	189,300
Special Study Institutes...	96	55,168
Program Development Grants.	7	138,045
Special Projects.....	---	52,344

An additional $196,000 was obligated for awards to States.

It is anticipated that in 1969-70, a total of $4,002,000 will be available for the preparation of prefessionals to work in the area of the deaf.

RESEARCH

The research and demonstration program for handicapped children established under Public Law 88-164 has become the principal source of funds within the Office of Education relating to speech and hearing problems. During recent years, research has been supported which focused upon a wide variety of problems in this critical area. The largest and most complicated project currently in progress is a national survey of speech and hearing problems in school children. This study will test more than 25,000 school children in order to establish the prevalence of a variety of speech and hearing problems.

Other studies in this area include the development of curricula for the deaf, the development of auto-instructional aids for lipreading, the development of other teaching aids for both deaf and speech impaired children, the development of new signs to enrich the sign language of the deaf, and the development of instructional methods to reduce stuttering.

One study of particular merit is attempting to make the telephone available to the deaf. This project will develop an easily portable device which will permit the deaf to communicate over the telephone by use of specially constructed portable typewriters which act very much like teletype machines.

A number of investigators are studying testing procedures, both for identification purposes and for suggestions regarding treatment. An investigator at Gallaudet College is experimenting with a variety of electronic aids which can be useful for helping the deaf to speak. He held a conference during 1967 which brought to Gallaudet College researchers and technicians from around the world to demonstrate the various new devices now available. As a result of this work many new devices should soon become available to help teachers with the speech problems of deaf youngsters.

MEDIA SERVICES AND CAPTIONED FILMS

Expanded to provide media services to all types of handicapped children by enactment of P.L. 90-247, the former Captioned Films for the Deaf program was redesignated as Media Services and Captioned Films in fiscal year 1968. Since no funds were appropriated, however, to serve any of the handicapped other than the deaf, actual program activities are essentially the same as in the previous year.

Groups served will reach a total of more than 1,700 and film attendance will number about one and three-quarter million. Addition of forty feature titles spur showings to a new high of 2,500 per month on the average.

Educationally, the principal gain is the completion of a three year project to supply basic projection equipment to all classes for the deaf. Addition of 1,100 overhead projectors, 2,300 filmstrip projectors, 4,300 projection tables and 4,000 screens equip every listed class of deaf children with these aids. In addition, 300 motion picture projectors for 8mm single concept films were put out on loan. Production activities accounted for 150,000 special transparencies and 9,000 motion picture loops in casettes or cartridges as well as some 16,000 filmstrips.

Training activities continue through the services of four regional centers at the universitites of New Mexico, Nebraska, Massachusetts and Tennessee. Two basic media institutes were provided for sixty teachers of the deaf and one advanced institute for supervisors of media programs. Each of the centers continues to provide inservice training through demonstrations and on-site workshops from Maine to Hawaii.

Release through the National Educational TV network of some 30 television programs selected from a series of 100 produced last year provided the first national television service for the deaf. Identification of other possible media services to the adult deaf was the purpose of a national meeting jointly sponsored by Vocational Rehabilitation and Captioned Films at the University of Tennessee.

Demonstrations of the effects of saturation use of educational media were carried on in California, Utah, Idaho, and Washington, D.C. Research in programming language for deaf children provided enough materials to supply more than thirty hours of self-instructional lessons. Development of teacher training materials for speech instruction saw the completion of six, ten-minute films together with audio training tapes and manuals.

Title III of the Elementary and Secondary Education Act (P.L. 89-10) provides nonmatching grants to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs to serve as models for regular school programs. This program gives special consideration to projects that are truly innovative as well as being of high quality and responsive to local needs. In fiscal year 1966, 15 projects were funded at a total of $1,086,341; in fiscal year 1967, 22 projects were funded for $1,480,000.

Funds under LSCA Title IVA are for the purpose of establishing and improving State institutional library services. Residential schools for the handicapped, including hard of hearing, deaf, and speech impaired, may be included in a State plan if these schools are operated or substantially supported by the State. Funds may be used to provide books and other library materials as well as other library services to students in such residential schools under an approved State plan. Fiscal 1967 funds were limited to planning purposes. Fiscal 1968 Title IVA projects affecting the mentally retarded cannot be identified at this time as the annual State programs have not been submitted.

Under Title I of the Higher Education Act of 1965 (PL 89-329), there was one program in the University of Vermont focused on hearing and speech activities. This program was for the purpose of training teachers, nurses, and supportive aides in the needed skills and techniques to work with persons with speech, hearing, language, and learning deficiencies.

In fiscal year 1967, the Office of Education supported research projects in such areas as school achievement as related to developmental speech inaccuracy; learning of aurally received verbal material; the effects of training and proficiency in public speaking on the dimensionality of speech evaluation, as well as, studies of speech dialects in various areas of the country.

The factors which may influence the permanency of protrusional lisps will be investigated to develop standardized criteria for kindergarten children. On a continuing basis, several tests are to be administered, but no child will enroll in speech therapy while participating in the study. After four years, the subjects will be divided into two groups-- those who no longer lisp and those who still have a lisp problem. A profile of significant factors will then be developed for determining those children who may require the help of therapy to achieve normal speech.

Gallaudet College in Washington, D.C. is preparing an analytic curriculum in English for 200 deaf students at the secondary level. During the first 2 years, instructional tools for improving English proficiency are to be developed centering around the belief that a set of teaching materials can by synthesized from an analysis of difficulties encountered by deaf students and students learning English as a second language. During the third year, formal comparisons will be made.

At New Mexico State University, University Park programmed instruction based upon stimulus control will be studied for application to the speech and language disorders of adults and children. The application will be made through an automated speech correction system (ASCS) and supervised by school personnel other than speech therapists. Instruction provided by the ASCS should be effective in producing marked changes to functional misarticulation of mental retardates and in the articulation and/or verbal linguistic function of both children and adult aphasics.

PUBLIC HEALTH SERVICE

SPEECH AND HEARING

Disorders of hearing and speech, and neurological disorders which hamper or prevent language development are major national problems. This is true not only because of the large number afflicted and the health problems involved but because of their associated educational and economic implications. Because these disorders are so interrelated, they are usually referred to as the communicative disorders. This general concept also includes problems of voice and reading disability.

OBLIGATIONS

	1965	1966	1967	1968	1969
Chronic diseases	$1,341,000	$1,344,060	$1,644,000	$676,000	$676,000
National Institute of Neurological Diseases and Blindness	5,645,000	6,533,000	7,929,000	9,601,000	10,130,000
Totals	6,986,000	7,877,060	9,573,000	10,277,000	10,806,000

National Institute of Neurological Diseases and Blindness

Disorders of hearing, speech, and language became an early targeted area for the National Institute of Neurological Diseases and Blindness. These disorders include:

- Deafness resulting from malformations or malfunctions of the ear, the auditory nerve, and sound-receiving centers of the brain;
- Delay or failure to talk;
- Defects of articulation, including cleft palate, facial malformations, and other speech-affecting organic disorders; and
- Inability to receive, interpret, retain, and express language, including aphasia and central disorders of perception.

Because of the urgent need for trained personnel, training received a major emphasis. At the present time 377 postdoctoral students are receiving training in 69 programs in otolaryngology, audiology, speech pathology, and sensory physiology.

Research in the communication field is one of the most rapidly expanding areas of the Institute, and almost 200 separate Institute-supported research projects are under way at medical centers across the Nation. Five multidisciplinary clinical research centers are now being supported at Princeton University, Central Institute for the Deaf in St Louis, the University of Chicago, the Kresge Hearing Research Institute of Ann Arbor, Michigan, and the University of Florida. The Institute's cerebrovascular center at Boston University is also emphasizing research on aphasia. In addition to these centers, the Institute is supporting a temporal bone bank program for the long-term study of structural and pathological changes relating to functional disorders of hearing, and an Information Center for Hearing, Speech, and Disorders of Human Communication at Johns Hopkins Medical Institutions. This communications center is providing an efficient interchange of important scientific information between researchers.

To tie all facets of the program together and plan for the future, a subcommittee on the Institute's National Advisory Council has been reviewing and assessing the field during the past 2 years. They have outlined unresolved problems, pointed to unmet needs, and are suggesting new approaches to many areas of need. A detailed report from the subcommittee is expected later this year.

Research Accomplishments

A research tool, evoked response audiometry, is presently being developed and refined at several medical institutions to permit physicians to test hearing independent of the individual's conscious participation. One of the greatest problems facing hearing and speech professionals is the very early identification and management of children with impaired hearing. In most children, speech develops naturally between 18 months and 3 years of age and for maximum effectiveness , therapy should begin at that time. Current audiometry techniques often cannot detect hearing loss in a child before he is 5. In evoked response audiometry, a specialized computer analyzes brain wave tracings and provides a true picture of the brain's responses to sound--making accurate diagnosis possible for tiny babies as well as for mentally retarded, brain damaged, and other uncooperative patients.

The current interest in all types of organ transplants is reflected in research programs concerned with developing and implanting an artificial larynx. This device would be of immediate benefit to laryngectomy patients as well as to accident patients and the growing number of soldiers in Viet Nam receiving wounds or injury to the throat. Scientists already have successfully removed and reimplanted the larynx of an experimental animal in a study of the basic mechanisms of laryngeal implantation.

One study of the vestibular system, which controls balance, has provided researchers with information about the biochemistry of fluids in this organ, (the labyrinth) and about the pathology of ossification in the labyrinth and cochlea. Advances also have been recorded in understanding the central connections of the vestibular system and of the processes producing dizziness. These and other important basic studies of the anatomy, physiology, biochemistry, and development of the inner ear have provided information and understanding of the basic structure of the ear and of processes of disease production.

An improved technique for staining temporal bones, willed for research by patients with hearing problems, has been developed. This technique promises to greatly shorten the time needed to prepare temporal bones for study, increasing the number that can be used for research and reducing the possibility of chemical and structural change in the bone during the preparation process.

In a landmark study this year, an Institute-supported investigator reported that in kernicterus, a disorder that may develop in a newborn with jaundice, the damage may be central rather than peripheral. Knowledge of the actual site of damage is necessary for the most effective management of a child with hearing loss. The finding that it may be the nerve pathway from the ear to the brain that is damaged, rather than the inner ear as was believed, has important implications for handling patients with kernicterus-induced deafness. This finding, with its important clinical implications, also is providing investigators with further knowledge of central hearing damage.

The Institute is supporting studies on the characteristics of hearing aids and their suitability in specific types of deafness. For hearing aids to be used effectively, the Institute strongly emphasizes the importance of a thorough otologic examination before any remedial steps are taken. Because of the complexity of the auditory system and the great variety of underlying disorders that may contribute to hearing disability, too many people are still being fitted with hearing aids who cannot be helped by this means at all; too many are being sold the wrong type of hearing aid; and too many with remediable ear disease are going undiagnosed while they try one hearing aid after another, until they pass the point where the disease is remediable.

Speech and language disorders and learning disabilities in children are receiving increasing attention by the Institute because of the possibility that many of these disorders have a neurological basis rather than a behavioral one. Institute-supported studies of minimal brain dysfunction are continuing, as well as studies of actual brain damage. In minimal brain dysfunction, the Institute is supporting Task Force studies of medical facilities needed by children with this disability, and studies of research gaps and opportunities in this area. Elucidation of the factors responsible for the development of neuropsychiatric damage in children is a major Institute activity through its Collaborative Perinatal Research program.

National Center for Chronic Disease Control

The Neurological and Sensory Disease Control Program provides for the development of new instrumentation, techniques, and methodologies for prevention, early detection and diagnosis and improved treatment of communicative disorders.

The ability to communicate is vital if a person is to develop himself as a contributing member of society. Yet, communicative disorders are one of the most prevalent handicapping conditions in this country. Today, they encompass approximately eight million people. Hearing impairment is the greatest single disabling condition, estimated at 6,000,000 cases. There are several reasons why this is so. Speech and hearing impairments, which originate in childhood and persist to maturity, such as stuttering, faulty articulation, and language deficits due to sensory and cultural deprivation, have always been prevalent. Congenital problems, such as cleft palate, otosclerosis, and cerebral palsy also frequently affect the ability to receive and/or transmit speech. In addition to these causes of communicative disorders, however, the technological advances of our modern civilization have increased the number of communicatively impaired persons. Trauma from noise and cerebral damage resulting from automobile accidents cause hearing loss. More important, modern medicine, through its strides in saving the child who might otherwise not survive long after birth, and in prolonging life, has been responsible for increasing the number of people living who are communicatively impaired. Children are saved, but they often have damaged nervous systems or congenital defects affecting their potential for learning speech and language. People are living longer, but hearing degenerates with age.

The most common cause of hearing loss is chronic otitis media. About 5% of the children in the United States have repeated episodes of serious middle ear infections sometime during the early years of life, and approximately 10% suffer at least one major episode. The magnitude of this problem can further be seen in the estimate that 50% of all adult hearing problems have their origin in these childhood infections.

Program interest in noise induced hearing loss has expanded to include other aspects of noise. This year, the Program will support a National Conference on Noise as a Public Health Hazard. Resulting from this Conference will be a definition of the noise hazard problem and specific recommendations for the control and minimization of this hazard. These will pertain to the effects of noise on man; industrial noise and the worker; noise in the community; special problems of recent technological development, e.g., sonic boom, and community control.

In keeping with its view that loss of hearing is primarily a health problem and that the medical and allied medical specialists most concerned with the ear and hearing should be involved in the diagnosis and treatment of the disorder, the Program is investigating ways to increase the effective use of hearing aids.

Of broader significance, but also applicable to the effective use of hearing aids are improved diagnostic techniques which the Program is developing. Evidence is available that current audiometers have a tendency to drift out of adequate calibration without the fact being known to the user of the equipment. The development of an audiometer which has self-calibrating features as well as methods for determining the instrument's level of calibration will be supported.

Investigation will continue into the clinical usefulness of evoked response audiometry, a technique which permits the audiologist, by observing brain waves, to determine hearing loss in people too young or too physically or mentally impaired to offer verbal response.

Another study being continued will determine selected speech and neurological characteristics of dysarthria (imperfect articulation in speech due to neurological lesions). Data resulting from this study will be used to determine the feasibility of applying speech physiology and analysis techniques to the problems of early diagnosis of neurological dysfunctions.

A project will be supported to continue the evaluation of pitch perturbation as a diagnostic and screening tool for laryngeal pathology, both benigh and malignant. An electronic device will be developed and assembled which will have the capability of analyzing speech data through the use of a specialized computer in order to determine the presence or absence of abnormalities.

There is a critical shortage of professionally trained personnel (otolaryngologists, speech pathologists, audiologists) who provide services to people with communicative disorders. Not only are large sections of the country without the services of such people, but also the number of people available in urban areas is inadequate. The Program will continue to make available its expertise to stimulate and aid in the implementation of training programs for persons who provide services to those with communicative disorders. These programs are both long-term training and continuing education.

Consultation is also available to official and voluntary health agencies, professional organizations, institutions of higher learning, and other groups to aid their efforts to establish or improve service programs for persons with communicative disorders.

CHILDREN'S BUREAU

PROGRAMS IN SPEECH AND HEARING

	Actual Obligations 1/			Estimated	
	1965	1966	1967	1968	1969
Special project grants ..	$542,500	$714,966	$1,396,312	$2,146,890	$2,500,000
Salaries and Expenses ...	20,763	28,123	32,583	33,000	34,000

Casefinding and Screening

Research studies continue to verify that stimulation of a child's hearing must occur in infancy and early childhood for the normal development of speech and language. For the child with a normal hearing mechanism this stimulation occurs naturally, but for many children medical and audiologic treatment are required. To find such children, the Children's Bureau in partnership with the States has developed and improved programs to discover children with partial or total loss of hearing.

While there are still questions about the feasibility of testing the newborn's response to acoustic stimuli, hospitals have been encouraged to add hearing testing to their procedures for the total evaluation of the newborn. Continuing study of the effectiveness of different ways of testing hearing at different ages is carried on as part of projects supported by the Children's Bureau at the medical schools of Johns Hopkins University, Vanderbilt University, University of Texas (Houston), New York University, and University of Kansas. Similar studies are supported by funds administered by the Children's Bureau under the special foreign currency program, P.L. 480, at the Institute for Mother and Child, Warsaw, Poland, and at the Rambana Hospital, Haifa, Israel.

State health department programs for maternal and child health in Georgia, Michigan, Massachusetts, Oregon, and Maryland for several years have conducted programs for testing at the early preschool years. This kind of a testing program is more difficult to develop than is a hearing testing program in school settings. Nevertheless, the State directors of hearing and speech services in a number of State health departments and in State crippled children's agencies are actively seeking to extend the State screening program for hearing impairment to early preschool ages. Utah, Minnesota, Ohio and Colorado are among these States.

1/ Excludes formula grant funds expended by States for speech and hearing activities, for which no estimate is available.

The child's failure to respond to acoustic stimuli is oftentimes an indicator that he is delayed in neurological development even though his hearing mechanism is functioning. This fact makes hearing testing a significant tool in overall casefinding programs for children with impairments.

Because of the rubella epidemic of 1963-65, there has been an increase in the number of children with hearing impairment. These children, soon to enter school, will pose not only a numerically greater problem for the schools, but also a more complicated problem for they are likely to have multiple impairments, including reduced vision. In order to provide an increased number of specialists to cope with the problems in the early testing of multiply handicapped children, the Children's Bureau supports the professional training of audiologists and speech pathologists. Support for specialized, post-academic training for audiologists has been continued at two institutions with a special focus on the infant with multiple handicaps, including those who suffer from the results of the rubella virus.

The data reported for hearing testing in the schools has not varied greatly over a period of years. In 1966, the latest year for which nationwide data is available, 46 State health departments reported testing the hearing of 5,425,000 children and referred 151,000 to physicians for further evaluation and treatment. These data do not reflect all of the testing carried on in the schools, for some school programs are not reported. The data show that about 2 percent of the children fail to pass the screening tests and are referred for more thorough diagnostic evaluation. Evidence from individual State reports indicate that there is a range of approximately 3-5 percent of the school children who fail the initial screening test and that about 1 percent have a condition requiring medical treatment.

States have kept the cost of school testing programs low by the use of volunteer workers and by the use of salaried but nonprofessional personnel. In order to explore the limits of activities which might be carried on by the nonprofessional worker, the Children's Bureau is supporting a research study in cooperation with the Ohio State Department of Health. Inservice training for such workers is encouraged as a part of the regular formula grants made available to the States. States have been encouraged too, to use the screening testing program as a means of recruiting additional health service workers. Evaluation of this activity as a recruiting device is planned.

Casefinding for hearing impairment and speech and language impairment has been established as one of the requirements in the special projects supported by the Children's Bureau for comprehensive health services for children and youth in selected poverty areas. With the support of project funds, the facilities for hearing and speech services in hospitals and universities have been strengthened and expanded. The development of satellite centers related to the comprehensive care facility around which screening activities can be programmed promises to be a means by which better casefinding for communications disorders can be accomplished.

Treatment and Remedial Services

All but nine States have employed in their State health department or crippled children's agencies, speech pathologists and audiologists who have the responsibility for developing services for children with hearing, language, and speech disorders. The State crippled children's services reported giving services in 1966 to 32,344 children with hearing impairments and to 8,530 with cleft lip or palate, most of whom received speech therapy. Technical assistance and professional consultation was provided to these State programs by specialists on the Children's Bureau staff. As a means of promoting the exchange of information between States, and to promote the improvement of State programs, the Children's Bureau conducted regional meetings of the speech and hearing specialists in State programs. Two meetings, combining regions, encompassed Regions I, II, III, and V-VI.

In addition to the services provided by the States, the Children's Bureau supported special projects in the amount of about $200,000 to demonstrate the contributions of speech and hearing specialists in providing services for multiply handicapped children. These grants to the John Tracy Clinic, Los Angeles, the Iowa Crippled Children's Division, the Department of Health in Colorado, Tennessee, Alaska, Hawaii and Utah combine a concern both with casefinding and provision of the required services.

Hearing aids are provided by most of the States. A special study was conducted which showed that approximately 4,500 hearing aids are provided yearly. The report of a three-year research study supported by the Children's Bureau was published and distributed in January 1967. This study is an attempt to develop guidelines for the evaluation of hearing aids which will assure the children of the most effective aid at the least cost to the agency or family.

Services for children with hearing, language and speech disorders have been considered as a basic requirement in the projects for comprehensive care for children and youth. Approximately $225,000 was made available in fiscal year 1964 and about $800,000 is planned for this purpose in fiscal year 1968 in these projects for services specifically related to communicative disorders. The Children's Bureau has held two regional meetings of the speech and hearing specialists in these projects to plan and to promote the development of more effective services in the selected poverty areas.

The provision of speech and hearing services as a part of mental retardation evaluation centers supported by the Children's Bureau has increased for two reasons: (1) the profession of speech pathology and audiology has increasingly focussed its attention on this problem in recent years and (2) the establishment of university-affiliated training centers for mental retardation and related disorders has motivated the training centers to develop specialized curricula. The Children's Bureau conducted a seminar on speech and mental retardation for leaders in Region IX and also a national conference of those academic leaders responsible for developing the training programs in mental retardation.

One of the difficulties in examining the very young child is to determine whether his response to acoustic stimuli results from a hearing loss, or a central nervous system developmental retardation, or some other problem. Prior studies supported by the Children's Bureau indicated that electro-encephalography in connection with a computer could be helpful in diagnosis. As part of a continuing study of the cost effectiveness of such testing, a national conference was held at the University of California in connection with an ongoing research project of the outstanding experts in EEG Audiometry. The conferees cast doubt that the technique is ready for use generally as has been suggested by some experts. Further studies to refine the procedure and the means for interpretation of the results are planned.

Training

The professional training program for audiologists and speech pathologists has been continued at six medical schools: Johns Hopkins University, Vanderbilt University, University of Iowa, University of Kansas, Stanford University and the University of Oklahoma. Nonacademic training was continued at the Iowa Crippled Children's Division, and New York University. Approximately $504,258 was expended on this training program in fiscal year 1967.

The training program in speech and hearing associated with the university-affiliated centers for mental retardation and related neurological disorders has expanded rapidly. Staff and student support s have been added to 12 projects at a cost of $289,600 and plans call for additional expansion of the training program in speech and hearing to 18 universities at an approximate cost of $350,000.

Publications

A series of lessons for a home training program were developed in cooperation with the John Tracy Clinic and the University of Southern California. This material is designed for use by mothers of children with delayed development of language for reason of hearing impairment or other causes.

A report on "Hearing Aid Evaluation Procedure" was developed in cooperation with the American Speech and Hearing Association.

"Services for Children With Communicative Disorders" a guide for public health personnel was prepared by Children's Bureau staff and published in cooperation with the American Public Health Association and the Public Health Service's National Center for Chronic Disease Control.

SAINT ELIZABETHS HOSPITAL

PROGRAMS IN HEARING, SPEECH AND LANGUAGE

Saint Elizabeths Hospital has been operating a speech and hearing clinic for five years. The clinic is equipped to offer a wide variety of treatment, evaluative and rehabilitative procedures, including (1) pure tone and speech audiometry, (2) involuntary response audiometry, (3) hearing aid evaluations, (4) speech reading, (5) auditory training, designed to make maximum use of residual hearing acuity, (6) speech conservation and correction to prevent and treat the deterioration of speech which often accompanies hearing impairment, and (7) speech rehabilitation for patients with speech defects unrelated to their hearing acuity. The last procedure deals, on both a group and individual basis, with patients suffering from such problems as aphasia, stuttering, and language/voice disorders. Rehabilitative training is also provided for patients who have had laryngectomies. Approximately 250 different patients are expected to be referred for services at the Hospital's speech and hearing clinic in fiscal year 1968, with some 300 patients estimated for 1969. Although treatment, evaluation and rehabilitation are the primary objectives of this facility, excellent opportunities are afforded for training and research.

The amounts shown reflect obligations for supplies, equipment, and a pro rata share of staff time allocated to speech and hearing activities:

Fiscal Year	Amount
1965	$30,500
1966	25,500
1967	31,000
1968 estimate	50,500
1969 estimate	56,000

OFFICE OF THE SECRETARY

SPEECH AND HEARING

NATIONAL TECHNICAL INSTITUTE FOR THE DEAF

The National Technical Institute for the Deaf (NTID) Act of 1965 (Public Law 89-36) authorized the Secretary, after consultation with an Advisory Board, to enter into an agreement with one institution of higher education for the establishment and operation of a residential facility for postsecondary technical training and education for persons who are deaf. On December 20, 1966, the Secretary entered into such an agreement with the Rochester Institute of Technology.

The establishment of the NTID represents a pioneering effort in the U.S. to provide broad post-secondary technical education and training which will lead to diversity in employment opportunities for productive deaf citizens. To date major activities have included development of educational and program requirments, recruitment of professional staff, production and collection of instructional materials, and planning for facilities construction. During FY 1969, a pilot program will be initiated to enroll 100 deaf students in regular RIT courses. The special training needed for these students will be developed so that when facilities become available, the substantive program involving an integrated RIT-NTID curricula will be available.

MODEL SECONDARY SCHOOL FOR THE DEAF

Public Law 89-694 provides for the establishment of a Model Secondary School for the Deaf and authorizes the Secretary of Health, Education, and Welfare to enter into an agreement with Gallaudet College to operate such an institution to serve primarily residents of the District of Columbia and nearby States. The facility will provide day and residential facilities for secondary education for persons who are deaf in order to prepare them for college and other advanced study, and to provide an exemplary secondary school program to stimulate the development of similarly excellent programs throughout the country. The initial year of activity was devoted principally to curriculum planning and development of instructional material, development of professional staff, and studies related to site preparation. Plans for FY 1969 include the initiation of an interim program -- pending completion of facility construction -- to enroll approximately 100 students.

NATIONAL ADVISORY COMMITTEE ON EDUCATION OF THE DEAF

Establishment of a National Advisory Committee on Education of the Deaf (NACED) was provided for by Section 5 of Public Law 89-258. The Committee advises the Secretary of Health, Education, and Welfare with respect to the administration of present programs and need for new or modified programs. The Committee and its staff have been involved in the development of plans for both the National Technical Institute for the Deaf and the Model Secondary School for the Deaf. In addition the Committee in FY 1967 sponsored a National Conference on Education of the Deaf to consider the problem of total state planning for the education and training of deaf children and youth.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REPORT ON FAMILY PLANNING ACTIVITIES

A REPORT TO THE
HOUSE COMMITTEE ON APPROPRIATIONS

Prepared by:

The Office of the Deputy
Assistant Secretary for
Population and Family
Planning

REPORT ON FAMILY PLANNING ACTIVITIES OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Table

I. Preface

II. Office of the Secretary

Summary of Programs Related to Family Planning

III. Social and Rehabilitation Service

Summary of Programs Related to Family Planning
Current and Projected Family Planning Activities

IV. Public Health Service

Summary of Programs Related to Family Planning
Current and Projected Family Planning Activities

V. Office of Education

Summary of Programs Related to Family Planning
Current Family Planning Activities

VI. Food and Drug Administration

Summary of Programs Related to Family Planning
Current Family Planning Activities

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
FAMILY PLANNING ACTIVITIES

Obligations, FY 1965 -- FY 1969

Agency and Program	Fiscal Year 1965	1966	1967	1968	1969
	(in dollars)				
Total, Department of Health, Education, and Welfare	8,652,000	13,380,000	19,719,000	28,172,000	56,297,000
SOCIAL AND REHABILITATION SERVICE					
Maternal and child health and welfare:					
Maternal and child health services formula grants to States.....	1,500,000	1,800,000	2,500,000	2,500,000	2,500,000
Special project grants for maternity and infant care.	350,000	1,200,000	2,500,000	2,500,000	21,000,000
Research and training.....	100,000	600,000	500,000	500,000	500,000
Child health research and demonstration..	---	---	---	---	250,000
Public Assistance:					
Social services.....	1,000,000	2,000,000	3,000,000	6,300,000	8,300,000
Medical assistance..	500,000	1,000,000	1,500,000	3,000,000	4,500,000
Cooperative research to prevent and reduce dependency....	---	---	---	200,000	200,000
Subtotal, Social and Rehabilitation Service	3,450,000	6,600,000	10,000,000	15,000,000	37,250,000
PUBLIC HEALTH SERVICE:					
Bureau of Health Manpower training grants.	72,000	81,000	199,000	361,000	362,000
National Center for Health Statistics.....	---	---	---	---	450,000
Partnership for Health.	---	---	125,000	171,000	391,000
National Institute for Child Health and Human Development.....	4,289,000	5,257,000	7,219,000	8,113,000	12,086,000
Bureau of Health Services:					
Community Health Services	---	---	---	56,000	200,000
Patient care and special health services.....	---	---	---	160,000	220,000

FAMILY PLANNING ACTIVITIES

Obligations, FY 1965 -- FY 1969

Agency and Program	Fiscal Year 1965	1966	1967	1968	1969
		(in dollars)			
PUBLIC HEALTH SERVICE: (Continued)					
Indian health.....	110,000	152,000	181,000	273,000	320,000
National Institute of Mental Health.....	167,000	416,000	481,000	554,000	635,000
Bureau of Disease Prevention training grants..	---	---	20,000	20,000	57,000
Subtotal, Public Health Service	4,638,000	5,906,000	8,225,000	9,708,000	14,721,000
OFFICE OF EDUCATION:					
Elementary and Secondary Education:					
Supplementary educational centers and services.....	---	63,000	502,000	1,485,000	2,062,000
Grants to States for guidance, counseling, and testing.....	233,000	233,000	233,000	233,000	233,000
Dropout prevention programs.....	---	---	---	---	50,000
Higher Ecucation:					
Grants to States for community service and continuing education.	---	175,000	225,000	315,000	440,000
Prospective elementary and secondary teacher fellowships.....	---	72,000	121,000	121,000	162,000
Adult basic education programs.....	317,000[1/]	317,000[1/]	317,000	644,000	800,000
Grants to States for vocational education.	14,000	14,000	14,000	14,000	14,000
Subtotal, Office of Education	564,000	874,000	1,412,000	2,812,000	3,761,000
FOOD AND DRUG ADMINISTRATION					
Research contracts...	---	---	82,000	652,000	565,000
Subtotal, Food and Drug Administration	---	---	82,000	652,000	565,000

1/ Funds transferred from OED

REPORT ON FAMILY PLANNING ACTIVITIES OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

I

Preface

In January 1966, the Department of Health, Education, and Welfare broke the "barrier of silence" on the subject of family planning. A memorandum from the Office of the Secretary was circulated throughout the Department which laid down departmental policy on the subject. Family planning policies were then developed by each of the four relevant agencies: Social and Rehabilitation Service, Public Health Service, Office of Education, and Food and Drug Administration.

This created the necessary climate for the development of family planning services in HEW-supported programs, particularly the maternal and infant care programs.

Family planning activities in the Department of Health, Education, and Welfare include the promotion and support of services -- making family planning information and services available and accessible to all in the population who desire and need them; training -- meeting the professional and lay manpower needs in health, social services, and education; research -- promoting and supporting research and research training in the biomedical and broad behavioral aspects of fertility and sterility; and public education -- increasing opportunities for sex education and public understanding of human sexuality.

Family planning services are an integral part of adequate medical care and have been available easily and routinely to the great majority of the population. But there is an estimated almost 5 million women who, because of poverty, have access to such services only through public or voluntary agencies. These women should have the same freedom to choose what more affluent women enjoy. Under recent legislation, particularly the "Child Health Act of 1967" (P.L. 90-248), such services will be available to them through a variety of sources, and at all levels of government.

The position of Deputy Assistant Secretary for Science and Population was established in 1966, but it soon became apparent that the tasks in family planning alone were sufficiently demanding to require a separate post. In 1967, the position of Deputy Assistant Secretary for Population and Family Planning was created, and on January 31, 1968 the first Deputy Assistant was sworn into office.

To acquaint State and local organizations with the opportunities opened up by the Department's new policy, nine regional conferences were held in 1966 and early 1967.

The results of the new policy have been substantial. Other Federal departments and agencies followed suit (e.g. Defense, OEO). The States developed a new interest in the field. In 1964, only 13 State health departments were providing family planning services; by September 1966, the number had increased to 40. By September 1967, only three State health departments had no immediate plans for family planning services. By the end of this fiscal year, FY 1968, it is expected that all the States will be involved in such programs.

Sixteen States reversed legal barriers to the provision of family planning; seven eliminated laws restricting the purpose for which contraceptives can be disseminated; and 12 enacted positive legislation setting forth the duties and responsibilities of State and local agencies with regard to family planning services.

Our best estimate is that some 800,000 women are now receiving services through public or voluntary agencies, almost 500,000 through programs aided by the Department.

It is generally believed that the increasing use of contraceptive measures is contributing to the decline in the United States birth rate and infant mortality rate. In 1964 the provisional birth rate was 21 per 1,000 population; in 1966 it was 18.5 per 1,000 population. As of 1967, it fell to a new low of 17.9 per 1,000 population.

The infant mortality rate for the calendar year 1966 of 23.4 per 1,000 live births was 5 per cent less than the previous year and represented the sharpest decrease since 1950. This significant decline continued in 1967, when the infant mortality rate dropped to 22.3 per 1,000 live births.

The Department has actively supported research and research training through the National Institute of Child Health and Human Development, the National Institute of Mental Health, the National Center for Health Statistics, the Children's Bureau, and the Food and Drug Administration. It expects to greatly expand its research on human reproduction, fertility, sterility, population problems, and safe methods to effectively control them according to individual choice and without coercion.

The Social Security Amendments of 1967 (P.L. 90-248), contain several important new provisions affecting family planning. Under Title IV, States are now required to make family planning services available to needy mothers who choose to use them. Under Title V (The Child Health Act of 1967), not less than 6 per cent of the moneys appropriated for Maternal and Child Health Services, beginning in F.Y. 1969, are to be for family planning services. Also under Title V, provision of family planning services under State health plans must be extended so that by July 1, 1975, all health services are available to needy mothers throughout the State.

Although the Office of Education does not prescribe school curricula, which is a State and local function, it has encouraged national interest in family life education and sex education, through grants and funded projects. Such program support is made possible under various Acts of Congress, e.g. the Elementary and Secondary Education Act, and its Amendments of 1967; the Vocational Education Act of 1965; the Higher Education Act of 1965 and its Amendments; the National Defense Education Act, and the Economic Opportunity Act of 1964 and its Amendments.

Under Title III of the Elementary and Secondary Education Act, demonstration projects in effective and innovative approaches to school programs in sex education have been funded. Under Title I, projects have been funded which include improved concepts of family life for educationally deprived children in low income areas. Under Title VIII (Dropout Prevention Projects), it is anticipated that increased attention to family life and sex education as part of comprehensive education programs will decrease the incidence of dropouts by teenagers because of pregnancy.

92 - 594 O - 68 - pt 2 - 39

The Department has set as a goal, the development of a system of uniform reporting of family planning data, to serve as a basis for the evaluation of progress in the provision and effectiveness of family planning services, and for the determination of future policies and programs. To that end, the Deputy Assistant Secretary for Population and Family Planning has brought together a working committee with representatives from the Office of the Secretary of HEW, the four HEW operating agencies in family planning (SRS, PHS, OE, and FDA); various interested government agencies OEO, DOD, State, and Budget); and voluntary groups working in the field (Planned Parenthood and World Population).

It is hoped that family planning data will be reported uniformly by all public and private agencies, so that accurate information will become available for planning and programming, and for evaluation of progress.

II

OFFICE OF THE SECRETARY

Summary of Programs Related to Family Planning

The Office of the Secretary, in particular the Assistant Secretary for Health and Scientific Affairs, his Deputy Assistant Secretary for Population and Family Planning, and the four operating agencies with direct responsibility for family planning -- Social and Rehabilitation Service, Public Health Service, Office of Education, and Food and Drug Administration -- are in the process of developing new guidelines, handbooks, manuals, and procedures to implement newly enacted legislation.

Departmental policy and objectives in family planning are set forth in the Secretary's memorandum of January 31, 1968, which expands and extends existing family planning programs based on enacted legislation and increased appropriations which are expected to total over $28 million in F.Y. 1968 and over $56 million in F.Y. 1969.

Family planning has been established as an HEW priority program, free from coercion or pressure, with the following five objectives:

(1) To extend family planning services to all those desiring such services who would not otherwise have access to them. Plans for comprehensive health services including maternal and child care must include consideration of the need for family planning services.

(2) To meet the manpower needs in the family planning field.

(3) To expand research and research training in the biomedical and behavior aspects of fertility research.

(4) To continue to assure the safety and effectiveness of contraceptives.

(5) To increase public and individual understanding of family life and sex education.

Responsibilities of Deputy Assistant Secretary for Population and Family Planning

The Deputy Assistant Secretary for Population and Family Planning is the focus for policy and program coordination, and has the specific charge "to identify gaps in research, training, public information and provision of services, and to assist in determining the means of filling such gaps."

The office is participating in the development of a uniform reporting system; it is serving as a communication channel between other Federal agencies, non-Federal agencies and institutions, and the four HEW operating agencies; it is responsible for the evaluation of agency family planning programs to ensure that projects are comprehensive and that services from other agencies are encompassed when necessary.

In additon to direct coordination of programs and projects within HEW, the Office of the Secretary is working in close cooperation and giving leadership to family planning activities of other agencies in the government. For example, the Department of Agriculture has a large staff in Agriculture Extension which is appropriate to enlist in spreading information about the availability of family planning services and to change outmoded attitudes among rural families whose births per woman is 48 percent higher than for the nation as a whole and for non-white women 156 percent higher. The Department of Defense has inaugurated family planning services to be made available to the families of all members of the Armed Forces.

Close coordination is essential not only with the Department of Housing and Urban Development but with the family planning programs of the Office of Economic Opportunity. A comprehensive look at DHEW and OEO service programs so that they are located with respect to need, geographical distribution and factors relating to excess maternal or infant deaths is promoted by the

close liaison the Deputy Assistant Secretary maintains. Cooperation with the Department of State and particularly AID is helping in advancing domestic programs in light of the contribution to international programs by opening opportunities for training and observation.

Interrelationships between governmental and voluntary agencies are at the core of strengthening activities in service programs, in programs for sex education and for reducing the present problems of illegitimacy. Therefore high priority is given to effective liaison through the Office of the Deputy Assistant Secretary.

Close communication is maintained with the major universities which have population centers, geared to training future personnel to the actual needs as they are revealed in the on-going programs of HEW.

Professional organizations such as the Council on Social Work Education are being assisted in developing curriculum not only for the basic professional graduate student but for in-service training and short-term institutes. Similarly, it is important to give leadership in the development of auxilliary personnel whose training has been mandated under the 1967 Amendments to the Social Security Act. These workers serve as health aides, community aides, or Teacher Corps aides. This prospective personnel requires appropriate training in the sensitive area of family planning.

Special projects include consultation with groups of experts from medical or behavioral sciences and other fields to work on the problems of resistence by special sub-groups in the population. The aim is to establish guidelines for personnel to work more effectively on practical problems of making services available and acceptable.

Problems of teenage pregnancy require key decisions so that parents, health and welfare agencies, schools and others who serve them can be guided in dealing with this dilemma.

In order to stimulate concerned professional or citizen groups, the Office of the Deputy Assistant Secretary gives leadership at regional meetings, conferences or other activities which will help develop family planning resources.

Departmental publications and reports are being prepared to add visibility to the multiple approaches to meet the problems in this new field of government endeavor which supplement each other and do not duplicate the effort to provide equal access to family planning services for all women who need and want them.

Responsibilities of Operating Agencies

The broad areas of family planning activity in HEW are in (a) services; (b) training; (c) research; and (d) education.

Each of the four operating agencies that have direct responsibility for family planning programs -- the Social and Rehabilitation Service, the Public Health Service, the Office of Education, and the Food and Drug Administration -- function in one or more of the areas. There is cooperation and coordination, through the Office of the Secretary, within agencies and between agencies in the various family planning activities in order to achieve coverage, and to maintain the freedom of choice and the freedom from coercion which has been rigorously written into law.

The basic responsibility for family planning in each of the four HEW operating agencies is given below:

Social and Rehabilitation Service has the basic responsibility for family planning services as a regular part of health services for the underprivileged, in particular AFDC recipients and other low-income families; for those eligible for medical assistance (both men and women); and for mothers and children in low-income and depressed areas in order to promote their health, reduce maternal and infant mortality and morbidity, help reduce out-of-wedlock pregnancies; and enable State welfare departments to carry out their responsibilities in work-training and employment programs for AFDC recipients. It has carefully targeted program research and demonstration projects in family planning.

Public Health Service has the basic responsibility under P.L. 410 for the preservation and improvement of the public health (which includes establishing and maintaining adequate family planning services), through grants and as otherwise provided,

to the States, counties, local health departments, etc.; assisting in and promoting research, experiments, demonstrations and studies relating to the basic reproductive process, to sterility and fertility, to the prevention of impairment to the health of the community, etc.; providing for the public health training of graduate and allied health personnel, etc. It also has the responsibility for direct services to a number of specific Federal beneficiaries, e.g. Indians and Alaskan natives.

Office of Education has the basic responsibility in family planning to assist and support communities and educational institutions, through State and local education agencies, in setting up and developing school curricula in sex education and family life education; establishing, through grant programs to the States, basic adult education programs, dropout prevention programs, including comprehensive education, health, and welfare services for teenage pregnant school girls, and innovative research and demonstration projects in all aspects of the teaching of family life and sex education.

Food and Drug Administration has the basic responsibility in family planning to insure the safety and efficacy of contraceptive drugs and the safety of devices; for approval before the drugs and devices are marketed, and for maintaining surveillance afterwards. It supports some epidemiological and research studies on human experience with oral contraceptives.

Table 1 summarizes HEW family planning programs for delivery of services by function, local delivery agency, and HEW operating agency with funding and program responsibility.

Table 2 summarizes other HEW family planning programs (research training, education, and evaluation) by function and HEW operating agency with funding and program responsibility.

These tables follow:

Table 1

DHEW Programs for Delivery of Family Planning Services by Function, Local Delivery Agency, and DHEW Operating Agency

Function	Local Delivery Agency	DHEW Operating Agency with Funding and Program Responsibility
Contraceptive Services -- Medical (either as separately organized services or integrated into larger systems of maternal or comprehensive care), Information, Counseling, and Referral	Hospitals and Clinic Services	SRS -- Children's Bureau -- Medical Services Administration PHS -- Bureau of Health Services Div. of Indian Health Div. of Direct Health Services Div. of Medical Care Administration (Migrant Health)
	Health Departments	SRS -- Children's Bureau -- Medical Services Administration PHS -- Office of Comprehensive Health Planning -- Bureau of Health Services Div. of Medical Care Administration (Migrant Health)
	Voluntary Health Agencies	SRS -- Children's Bureau -- Medical Services Administration PHS -- Office of Comprehensive Health Planning -- Bureau of Health Services Div. of Medical Care Administration (Migrant Health)

Table 1 (Cont'd)

DHEW Programs for Delivery of Family Planning Services by Function, Local Delivery Agency, and DHEW Operating Agency

Function	Local Delivery Agency	DHEW Operating Agency with Funding and Program Responsibility
Contraceptive Services -- Medical etc. (Cont'd)	Private Physicians	SRS -- Medical Services Administration
Contraceptive Services -- Information, Counseling, and Referral only	Public Assistance Agencies	SRS -- Children's Bureau -- Medical Services Administration -- Assistance Payments Administration
	Voluntary Social Agencies	SRS -- Children's Bureau -- Medical Services Administration -- Assistance Payments Administration
	Employee Health Services	PHS -- Bureau of Health Services Div. of Federal Employee Health

Table 2

Other DHEW Family Planning Activities
by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
Training Programs for Family Planning Workers	
1. Short-term Pre-Service and In-Service Training of:	
(a) Physicians, nurses, other professional health personnel	SRS -- Children's Bureau PHS -- Bureau of Health Manpower
(b) Social workers and other public assistance personnel	SRS -- Children's Bureau -- Assistance Payments Administration
(c) Teachers	OE
2. Subprofessional Workers	SRS -- Work and Training (coordinated with Dept. of Labor) PHS -- Bureau of Health Manpower OE -- Adult and Vocational Education
3. Curriculum Development for Above Programs	SRS -- Children's Bureau PHS -- Bureau of Health Manpower OE
Education Programs	
1. Sex and Family Life Education at Elementary and Secondary School and College Levels	OE

Table 2 (Cont'd)

Other DHEW Family Planning Activities
by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
Education Programs (Cont'd)	
2. Professional Schools --	
(a) Physicians, nurses, and other health professionals	SRS -- Children's Bureau PHS -- Bureau of Health Manpower
(b) Social workers	SRS -- Children's Bureau
(c) Teachers	OE
3. Curriculum Development for Above Programs	SRS -- Children's Bureau PHS -- Bureau of Health Manpower OE
Research	
1. Reproductive Physiology and Contraceptive Development	PHS -- National Institutes of Health National Institute of Child Health and Human Development FDA
2. Social Research	PHS -- National Institutes of Health National Institute of Child Health and Human Development National Institute of Mental Health -- National Center for Health Statistics

Table 2 (Cont'd)

Other DHEW Family Planning Activities
by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
Research (Cont'd)	
3. Administrative Research	
(a) Utilization studies (b) Demonstrations in innovative service delivery mechanisms (c) Evaluation methods	PHS -- Office of Comprehensive Health Planning -- National Center for Health Services Research -- Bureau of Health Services SRS -- Children's Bureau -- Medical Services Administration -- Assistance Payments Administration
Evaluation	
1. Overall Evaluation and Coordination	Office of the Secretary -- Assistant Secretary for Health and Scientific Affairs Deputy Assistant Secretary for Population and Family Planning
2. Medical Services Evaluation	SRS -- Children's Bureau PHS -- National Center for Health Services Research -- Bureau of Health Services

Table 2 (Cont'd)

Other DHEW Family Planning Activities
by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
Evaluation (Cont'd)	
3. Social Services Evaluation	SRS -- Children's Bureau -- Medical Services Administration -- Assistance Payments Administration

SOCIAL AND REHABILITATION SERVICE

Summary of Programs Related to Family Planning

The recent Social Security Amendments of 1967, (P.L. 90-248), to be administered by the Social and Rehabilitation Service, are especially pertinent to family planning programs. The legislation provides added authority to make family planning services in our society available, accessible, and free from coercion to large groups of individuals with little or no income. Implementation of the following provisions makes possible progress towards fulfilling several of the Departmental objectives in its family planning programs:

(1) Under Title V of the Act, a substantial increase in Federal funds is authorized for the Maternal and Child Health Programs, and the Maternal and Infant Care, and Children and Youth projects of the Children's Bureau. Not less than 6 percent of the amount appropriated for the fiscal year ending June 20, 1969 and each fiscal year thereafter is earmarked for family planning services.

As a condition of State plan approval, the plan for maternal and child health services must provide for the development of demonstration projects with special attention to family planning services for mothers in needy areas and among groups in special need, and that acceptance of family planning services be voluntary and not a prerequisite of eligibility for or the receipt of services under the plan.

The amendments further require a State to make a satisfactory showing that it is extending the provision of services under its plan, including family planning services, with a view to making such services available in all parts of a State by July 1, 1975. Specific authorization for projects for the provision of family planning services has been added. The authorization for research projects has been broadened and family planning related research projects can be carried out under this authorization.

(2) Under Title IV, Part A, of the Act, effective July 1, 1968, States will be required to offer family planning services to appropriate Aid to Families with Dependent Children recipients. They may also use Federal matching to offer these services to other former or potential AFDC recipients. From the date of enactment (January 2, 1968) until July 1, 1969, Federal funds will be available at the matching rate of 85 percent and, subsequently, at the rate of 75 percent. The acceptance of family planning services must be voluntary and must not be a prerequisite to eligibility for receipt of any other agency service or aid.

States will be required to develop a program for each child, relative and other "essential" persons in the home, which in appropriate cases is to include the objective of preventing or reducing the incidence of births out-of-wedlock. The same effective dates and rates of Federal matching apply.

States are required to report the results of implementing the cited provisions to the Secretary, and the Secretary is required to make similar annual reports to Congress. The first report is due no later than July 1, 1970.

(3) Title XI of the Social Security Act authorizes cooperative research or demonstration projects relating to the prevention and reduction of dependency, aid in effecting coordination of planning between private and public welfare agencies, or which will help improve the administration and effectiveness of programs carried on or assisted under the Social Security Act and programs related thereto. These projects may be supported by grants to States and public and other non-profit organizations and agencies, and contracts or jointly financed cooperative arrangements with public or private organizations and agencies. Five million dollars is authorized for the support of these projects in each fiscal year. In addition, up to $4 million of the aggregate amount appropriated for payments to States under Titles I, IV, Part A, X, XIV, XVI or XIX is available in any fiscal year, to cover the cost of such projects as is not covered by payments under such Titles and is not included as part of the cost of projects mentioned above for experimental, pilot, or demonstration projects which, in the judgment of the Secretary, are likely to assist in promoting the objectives of these Titles.

(4) Title XIX of the Social Security Act provides for Federal sharing from 50 to 83 percent of costs of health services for the indigent and the medically indigent. To participate in the program, each State must develop a State plan and the plan may include the provision of hospital in-patient and out-patient physician services and out of hospital physician services. All of these physician services could include family planning services. Moreover, Federal policies specifically authorize the inclusion of family planning services, drugs, supplies, and devices, when such services are under the supervision of a physician. To date, 40 States have programs in operation under Federally approved plans.

The 1967 amendments to the Vocational Rehabilitation Act, (P.L. 90-99), provide project grants for services to handicapped agricultural migrant workers and non-handicapped members of their families. Family planning services should be included in the comprehensive services offered these individuals. Federal sharing up to 90 percent of the cost of projects is authorized.

Public Law 90-170, (Mental Retardation Amendments of 1967), provides for the staffing of new services and facilities for the mentally retarded. Family planning education and services should be included in the comprehensive services offered the mentally retarded. The law authorizes $7 million this fiscal year, $10 million next year, and $14 million the succeeding year for initial grants, and additional sums for subsequent grants.

Current and Projected Family Planning Activities in the Social and Rehabilitation Service

Considerable progress has been made in the development of projects and activities in SRS related to family planning, especially when the complexity of the task is considered.

A primary source of this complexity is the tremendous variation among the States and the localities in reference to their administrative, financial, informational, and attitudinal readiness for comprehensive family planning services.

Secondary sources of complexity derive from shortages of trained medical and social service personnel in family planning fields, at all levels of government. A third problem derives from the fact that reporting systems specifically related to family planning are difficult to devise for the wide range of general social and medical programs carried out at local and State levels, with Federal financial participation provided through the former Welfare Administration programs. For example, specific maternal and child health projects, such as those operated through the Children's Bureau, can be readily listed and counted; however, general medical care for the needy, as administered through the Medical Services Administration (the former Bureau of Family Services), and the Assistance Payments Administration includes a wide range of medical services for a wide range of medical problems. Plans are currently under way to obtain more specific family planning figures for these and the related social services programs.

Equal stress has been placed on the development of social services, as well as medical ones. Social services related to family planning include information-giving, referrals for medical care, personal counseling regarding the many social and psychological aspects of family planning, follow-up of medical referrals, provision for transportation and child-care arrangements so that parents may obtain medical care, and the development of medical resources when none exist. Related social service activities include helping families obtain basic education (including family life and sex education, as well as literacy training), job-training, and job-placement. Family planning programs are likely to be most effective when they are linked to other relevant services that, together, they upgrade the economic, occupational, physical, and educational level of the entire family.

An annual analysis is planned of the AFDC caseload to determine special groups for concentrated services. Groups would be identified as mothers with one child born out-of-wedlock, mothers with two children born out-of-wedlock, persons living in nonlegal unions who have children. This analysis will be done to determine the groups needing special services or requiring services to be provided on an intensive basis. Research and demonstration projects will be encouraged based on these findings and compared to the findings of the previous year or years.

92 - 594 O - 68 - pt 2 - 40

All the research evidence confirms that family planning programs are not likely to be accepted or continuously used by low-income families unless their total life-situation improves, as suggested above. Therefore, efforts have been made to coordinate family planning programs and research along with other related areas, such as those in overall medical care, basic education, job-training and placement, and income maintenance.

Children's Bureau

The two major sources of support for family planning services in the Children's Bureau are the Maternal and Child Health formula grants and the special project grants for Maternity and Infant Care.

The Maternal and Child Health grants assist the States to extend and improve their services for the promotion of the health of mothers and children, especially in rural areas. The States have broad discretion in the use of these funds but the programs are generally characterized as being primarily preventive health services in nature.

Typical services are the provisions of Maternal and Child Health services in well-baby clinics, maternity services in postpartum clinics, providing payment for hospital delivery care for babies or mothers at high-risk in respect to complications in child-bearing, school health services, immunizations, nutrition services, public health nursing and related services. In F.Y. 1967, 400,000 women received maternity services in this program.

Following the announcement of the Secretary's policy on family planning in January of 1966, an item on family planning was added to the statistical reporting requirements of the Maternal and Child Health program.

For the first time there is reported the number of women who received family planning services in the Maternal and Child Health program. Over 300,000 women received family planning services in this program in F.Y. 1967, including the 87,000 in the 54 Maternal and Infant Care projects located in the slum areas of large cities and health depressed rural areas.

A very significant change within the last few months in family planning activities administered by the Children's Bureau is the result of the enactment of the Child Health Act of 1967 (P.L. 90-248, Jan. 2, 1968).

This authorizes for the first time project grants to meet up to 75 percent of the cost of family planning services. Such grants may be made to health departments, hospitals, and any public or non-profit voluntary organizations. No less than 6 percent of the amount appropriated under the Act (Title V of the Social Security Amendments of 1967), is to be used for family planning. A reporting system is in the process of development.

In the 1969 budget estimate, the Secretary is requesting 10 percent of the Title V budget, or $24 million, to be available for family planning in the next fiscal year. Of this sum, $18,500,000 is being requested for family planning project grants and the remainder is to be used for family planning expenditures in the maternal and child health programs and in the maternity and infant care projects and research.

The continuing favorable trends in infant mortality are undoubtedly associated with the Children's Bureau supported programs of maternity care and family planning services. In the fiscal year 1967, over 300,000 women received family planning services through these programs. The national infant mortality rate in 1966 was 23.4 per 1000 live births or 5 percent less than in 1965 and represented the sharpest decline since 1950. The provisional rate for the first 11 months of 1967 was even less than the 1966 rate, 22.3 per 1000 live births. Even larger reductions are taking place in major cities.

A. Ongoing Inter and Intra Agency Activities

1. State plan materials and guidelines are being developed in response to the amendment in Title IV of the Social Security Amendments of 1967 in which State welfare departments are required to offer family planning services under certain conditions.

2. The Children's Bureau has participated in a series of departmental meetings on a uniform reporting system that have been held with other agencies in the Department, with OEO staff, and with other interested non-government agencies. The principal focus of activity of these meetings is identification of those information items on family planning and related subjects which are of common interest to all agencies in Department of Health, Education, and Welfare, and to other departments. Presumably there can be the joint common core of "an evaluative system of uniform reporting" to agencies of the Department and to others administering family planning services. It is expected that a pre-test of uniform data processing will prepare the way for a system to go into effect July 1, 1969.

3. The Division of Research in parallel activity is initiating a pilot study in District of Columbia on feasibility of precoded-scanner read forms. Other tests are partially planned in North Carolina State Health Department and in the Maternal and Infant project Grady Hospital, Atlanta.

4. Plans are underway for a joint project with FDA's Bureau of Medicine, funded by FDA, to improve record systems in an Obstetric Department of a medical institution with a related Maternal and Infant project. The objective, assuming reliable observations, recording, storage, is to gradually develop a set of sites where (a) Children's Bureau could conduct occasional surveys, and (b) FDA could similarly use these sites for special studies on "adverse drug reactions."

B. Ongoing Extra-mural Activities: Research and Demonstration Grant Projects

1. The Division of Research, Children's Bureau, is currently funding a study at the Department of Maternal and Child Health, School of Public Health, University of North Carolina which continue for five years. Its purposes are to (1) design a set of six to nine model family planning programs, incorporating the most successful program elements known for the achievement of the goals of the program and to solicit applications for the establishment of these programs from agencies qualified to carry them out effectively; and (2) design and execute an evaluation of the model programs so established.

In connection with the model family planning study, definition of goals of the family planning program will be one of the first problems to be attacked. Ultimate goals to be sought are concerned with the reduction of (a) unwanted pregnancies, (b) illegitimacy rates, (c) welfare dependency rates, and (d) perinatal mortality rates. Some intermediate goals to be sought are to (a) increase fertility control behavior among those persons at greatest risk of experiencing unwanted pregnancy, welfare dependency, illegitimate birth, and perinatal losses, and (b) increase the efficiency of the methods of fertility control used by such persons. Immediate goals to be sought may be considered "service" goals, such as (a) increasing the proportion of medically indigent women who are receiving subsidized family planning services, (b) increasing knowledge in the eligible population in the community concerning available family planning services.

The preliminary findings for the first year of operation of some programs are expected to be available by January 1970.

2. Tulane University School of Medicine, is conducting a study entitled "Assessment of Family Planning for High Risk Patients." This project, in its second year of operation of an anticipated five years duration, is funded by the Division of Research, Children's Bureau. The specific aims of this project are as follows: (1) To determine criteria for selecting high risk obstetrical patients and to estimate the approximate percentage of high risk patients in the Charity Hospital obstetrical population in New Orleans. (2) To determine the best means of providing information to patients concerning reproductive physiology and means of conception control. (3) To determine the most affective means of sustained contraception in a high risk obstetrical population. (4) To provide training in a family planning clinic for medical students, resident physicians, practicing physicians, and premedical personnel.

3. Department of Maternal and Child Health and Population Studies, Tulane University School of Public Health and Tropical Medicine, is directing a project for this study funded by the Division of Research, Children's Bureau, entitled "Fertility, Family Structure, and Family Planning." This study is in its second year and is expected to continue with another two years of support. The principal objectives of this research are 1) estimation of parameters of knowledge about and attitudes toward reproduction and family planning, of differential

fertility, and of compositional changes in family structure, and 2) identification of factors relating to the effectiveness of family planning programs and examination of their interrelationships.

4. The Department of Maternal and Child Health, University of California School of Public Health is conducting a study entitled "Study of Recidivism of Unmarried Pregnant Girls." This project, funded by the Division of Research, Children's Bureau, is a one-year study that started January 1, 1968. The objective is a retrospective study of the occurrence of recidivism. After this project is completed, it is planned to conduct other studies in the Bay Area of California on out-of-wedlock pregnancy. These additional studies will be concerned with the needs of unmarried pregnant girls, and the degree to which these needs are being met; the effects of services on recidivism; and a long term follow-up study on the eventual outcome and history of a present group of unmarried pregnant girls for whom ongoing multidisciplinary assistance is provided and group for whom it is not available.

5. A national survey of Comprehensive Programs for School-Age Pregnant Girls has been completed and will be published in March (1968). This will be followed with a report of an evaluation of a Children's Bureau financed demonstration in the District of Columbia for pregnant school-age girls. This evaluation is based upon three years of experience with a school-centered program that served 478 girls.

6. In Boston, a study by the Harvard School of Public Health was completed and published, focusing on the service patterns for the Negro unmarried mother. This received wide newspaper and TV coverage and set in motion an action program to improve services for this group of women.

7. Currently, the Children's Bureau is discussing with the National Planned Parenthood Association the development of a cost analysis system related to outcomes for the voluntary family planning clinics. This study, if approved, will begin by April of this year. Also under discussion is the establishment of a national inventory of family planning services.

8. A Child Welfare Research and Demonstration grant has been approved in the amount of $107,000 for a program of comprehensive services for teen-age pregnant girls in Cleveland, Ohio.

9. Grants for two institutes in family planning have been approved to be carried out in cooperation with the Western Branch, American Public Health Association and the University of California School of Public Health -- one held in January 1968 in New Mexico and one to be held in April 1968 in Washington State -- amount for both, $11,126.

C. Proposed Family Planning Activities, F.Y. 1968-69

1. Services

State plan requirements for maternal and child health, child welfare and AFDC services are now being rewritten to conform to the 1967 amendments and some preliminary draft material is under review.

A statement of policies and procedures governing family planning grant applications under Title V, Sec. 508 is in a preliminary draft form and is being reviewed. This includes a new application form. It is to be completed by the first quarter.

The policies, guidelines and reporting system will be consistent with the objective of making family planning services increasingly available in order to promote the health of mothers and children, reduce maternal and infant mortality and morbidity including handicapping conditions and, help reduce out-of-wedlock pregnancies and to enable State welfare departments to carry out their responsibilities for work training and employment of recipients of AFDC.

In approving applications for family planning project grants, priority will be given to the 42 counties which, in the period 1961-1965 had 400 or more infant deaths in excess of the expected number had the tenth percentile county rate (17.8 per 1,000) or lower, prevailed. In these counties, consultation will be directed to assisting communities in the development of programs large enough in scope and size to have a significant effect upon the infant mortality rate.

All but a few State health departments and maternity and infant care projects are prepared to respond rapidly to the opportunity to expand their family planning services. Technical and financial assistance will be provided to enable them to do

so. Voluntary planned parenthood agencies and hospitals will be given particular attention in view of the fact that this will often represent a new relationship for them and the Children's Bureau.

Regional conferences are being planned around the Child Health Act of 1967 and the amendments to Title IV of the Social Security Act.

Regional staff will encourage State welfare departments to assist in the development of community studies focused on two subject areas; (1) identification geographically and numerically of the persons desirous of utilizing family planning services, and (2) a survey of available medical resources and a determination of where medical resources will need to be developed.

Consultation will be provided regarding measures to assure that beneficiaries of assistance programs and clients in the Child Welfare Services programs are informed about family planning programs but that eligibility for financial aid or services is in no way dependent upon such persons' acceptance or refusal of contraceptive advice.

2. Training

A statement of guidelines for training in family planning is in draft form. It presents information regarding training opportunities provided under Title V, for the training of personnel for health care and related services for mothers and children. Such personnel may be professional and non-professional who may be based in health, welfare, or education departments or in community voluntary agencies. Short or long-term training and institutes for continuing education are included.

In the administration of Child Welfare Training Grants under Title IV, Sec. 426, special attention will be given to applications by institutions of higher learning for the training of social workers in family planning.

3. Research and Demonstration (See Grant Projects p. III-7)

4. Publications - 1968

Planning for Your Babies

This booklet will be addressed to mothers with limited reading ability. Parents will be told that spacing of babies safeguards the health of both mother and baby, and for some women may actually prolong life.

Grants for Family Planning Services.

Social Worker's Role in Family Planning. (Adelphi Institute)

Guidelines for Training in Family Planning.

Mothers at Risk: The Role of Social Work in the Prevention of Morbidity in Infants and Socially Disadvantaged Mothers. (Reprint).

National Survey of Comprehensive Programs for School-Age Pregnant Girls.

IV

PUBLIC HEALTH SERVICE

Summary of Programs Related to Family Planning

The second session of the 89th Congress enacted P.L. 89-749, "Comprehensive Health Planning and Public Health Services Amendments of 1966," and the first session of the 90th Congress enacted P.L. 90-174, the "Partnership for Health Amendments of 1967." Under these laws, the Public Health Service has an opportunity to make an important contribution in the development of family planning services as part of comprehensive health programs.

Through Comprehensive Health Planning, each State Planning Agency and area planning group has been encouraged by the Surgeon General to assign priority to family planning services. In the review of each plan the Department of Health, Education, and Welfare Regional Office will give special attention to family planning programs. In the training of personnel for planning agencies adequate attention must be given to population and family planning considerations. The Regional Offices will provide consultation and technical assistance in the development of family planning comprehensive health service project proposals. Priority is given to these proposals when they are reviewed for funding.

The Public Health Service is responsible for direct health services to certain Federal beneficiaries. These direct health services include family planning services. The basic Public Health Service Act, (P.L. 410, 78th Congress, 58 Stat. 683, 1944), and as amended, particularly Sections 321-346 and the Dependents Medical Care Act and its amendments (P.L. 84-569) provide for comprehensive in-patient and out-patient medical services through the Division of Direct Health Services in the Bureau of Health Services. This Division also administers the medical assistance program for Cuban refugees under the Migration and Refugee Assistance Act (P.L. 87-510). Family planning services may be provided through this program.

Comprehensive health services, including family planning, are provided to American Indians and Alaska natives by the Division of Indian Health under the Indian Health Services Act (P.L. 83-568).

Information and counseling on family planning for Federal employees may be provided through the Federal Employee Health Program. Authorization for this program is through P.L. 79-658 and administration is by the Division of Federal Employee Health.

Public Laws 87-692 and 89-109 (untitled; both Amendments to the Public Health Service Act), provide for project grants for health services for domestic agricultural migrant workers and their families, and family planning services may be included in these projects. The Bureau of Health Services is responsible for the administration of this program. Under provisions of the Public Health Service Act for the improvement of the organization and delivery of health services, the Bureau supports research and demonstrations related to family planning services through grants and contracts.

The Bureau of Health Manpower is responsible for the administration of certain training grants under the Public Health Service Act. Section 309 of this Act authorizes grants for graduate or specialized training in public health which may include training in family planning, and which cover faculty salaries, travel, consultant and guest lecture fees, equipment, and other expenses necessary to the successful development of such training programs. Section 306 of the Act authorizes support of traineeships in public health. This authority is exercised by five types of training grants: (1) general purpose, awarded in blocks to accredited schools of public health for distribution to their students; (2) special purpose, awarded in blocks to special training programs selected on a competitive basis for distribution to students who would be enrolled in these programs; (3) short-term, awarded in blocks to institutions or agencies offering special training programs selected on a competitive basis, and designed to cover the expenses of offering such programs and stipends for students; (4) residencies in public health and preventive medicine, awarded to residents through applicant institutions or agencies whose residencies must be approved by the American Board of

Preventive Medicine and Public Health; and (5) apprenticeships, awarded in blocks to institutions and agencies for the support of field experience in public health and preventive medicine for medical students.

The National Communicable Disease Center of the Bureau of Disease Prevention and Environmental Control under the Public Health Service Act has the authority to train Epidemic Intelligence Service (EIS) Officers. This program is being utilized to train individuals in an epidemiological approach to evaluating family planning and population problems.

Section 444 of the Public Health Service Act authorizes the National Institute of Child Health and Human Development to conduct and support research and training relating to maternal health, child health, and human development, including research and training in the special health problems and requirements of mothers and children and in the basic sciences relating to the processes of human growth and development, including prenatal development.

The National Institute of Mental Health is authorized to serve as the principal focus for research and training in the behavioral and basic sciences related to the causes, diagnosis, treatment and prevention of disorders in the biological and psychosocial factors that determine human behavior and development. Under this broad mandate many activities related to family planning are supported.

The authority for the activities of the National Center for Health Statistics in Population derives from the general data collecting and research provisions of the National Health Survey Act of 1956, (P.L. 84-652), and the transferring of certain functions of the Census Bureau relating to vital statistics to the Public Health Service. The National Center for Health Statistics is responsible for collecting and analyzing the wide range of health and demographic statistics needed for health planning and program evaluation.

Current and Projected Family Planning Activities in the Public Health Service

The Surgeon General included family planning in his Priority Statement on the Partnership for Health Program issued on November 7, 1967. It is anticipated that the States will give due consideration to this statement in the development of their comprehensive State health plans under Section 314(d) and that State and local agencies and institutions will take cognizance of this in the preparation of project proposals under Section 314(e). The way in which the States use the formula grant, 314(d), funds will be especially noted this next fiscal year, since it will then be apparent what changes have been made in State line-item budgets submitted to the State legislatures, many of which meet biennially. It will then be possible to tell whether or not the States have assigned family planning a priority in their programs. Under the project grant authority, 314(e), three projects have been funded this fiscal year. Two of these are for the establishment of demonstration genetic counselling clinics -- one at Johns Hopkins University in Baltimore and the other at Washington University in St. Louis. The third project is a family planning service demonstration at the University of Texas at Galveston. Additional projects are anticipated in response to the priority statement.

The National Center for Health Statistics has among its on-going programs the collection and publication of natality statistics, marriage and divorce statistics, and mortality statistics. It also engages in research on the dynamics of population change and examines some of the social and economic factors associated with change. The Center is conducting a vital records survey, and proposes to carry out a national survey of family growth. The latter survey will yield information which will be useful in planning for Federal programs to make family planning services more widely available. The Center and the Research Triangle Institute in North Carolina are collaborating in the development of a computer model intended to simulate the dynamics of population growth. In conjunction with the Research Triangle Institute and the University of North Carolina a method to estimate birth and death rates from household surveys is being studied. Under contract the University of North Carolina is carrying out a survey of recently married persons to obtain information not available through marriage certificates.

The Bureau of Health Services is responsible for the provision of direct health services to certain eligible beneficiaries and for the development of improved health care systems. Since the inception of the family planning program in the Division of Indian Health in F.Y. 1965 family planning services have been provided to 14,900 or over 20 percent of the Indian and Alaskan Native women of child bearing age. In F.Y. 1967 there were 31,300 visits to the Division's family planning clinics. There has been a steady expansion of the program since it was initiated. The Division of Direct Health Services through its system of hospitals and outpatient clinics provides comprehensive family planning services to its eligible beneficiaries. At the Public Health Service Hospitals which have obstetrical services (Staten Island and New Orleans) all postpartum patients are offered family planning information and services as part of the medical care rendered. It is estimated that approximately 7,000 patients have received family planning services at these two facilities during F.Y. 1967. A community oriented family planning clinic was established at the Boston Public Health Service Hospital through an agreement with the Massachusetts State Department of Health and the St. Elizabeth's Hospital.

The Division of Medical Care Administration has supported three contract demonstrations to evaluate the effectiveness of indigenous workers in extending family planning services. The contract recipients are the Muscogee County Health Department in Columbus, Georgia, the Planned Parenthood League of Alabama, and the Planned Parenthood Association of New York. The Georgia project evaluates the effectiveness and the cost of using community workers in urban and rural settings; the Alabama project compares the effectiveness of professional and non-professional workers in providing family planning information and services in eight rural counties characterized by marked poverty and high fertility; and the New York project is utilizing neighborhood workers to assist postpartum mothers in Negro and Puerto Rican areas to return for services. Under development are research and demonstration projects including: (1) exploration of the role of the pharmacist as a family planning counsellor; (2) study of methods of utilization of hospital outpatient facilities in the delivery of family planning services; and (3) study of the application of modern demographic techniques to determine the optimum placement of service facilities. Family planning efforts in the Division of Medical Care Administration also is involved in the extension of comprehensive health services to domestic agricultural migrants. Through

approximately 115 private and public health facilities, family planning services have been made available to this special population group.

The Division of Federal Employee Health plans to incorporate family planning education and counselling services into the present health unit operation through the following steps during F.Y. 1969: (1) in-service educational programs for health professionals on modern methods of contraception, concepts of child spacing, and counselling techniques; (2) family planning literature will be made available to employees upon request; (3) individual employees will have access to appropriate consultation resources with a physician and/or a nurse to discuss family life and family planning; and (4) employees upon request, will be referred to public and private health care facilities for family planning services.

Within the Bureau of Disease Prevention and Environmental Control the Epidemic Intelligence Service of the National Communicable Disease Center has been engaged in training and supporting health personnel in the evaluation of clinical family planning services. In F.Y. 1967 three officers were assigned to family planning evaluation projects in three cities. During F.Y. 1968 six additional officers have been assigned to projects. Expansion of this program is intended for F.Y. 1969.

The Bureau of Health Manpower supports trainees in Population and Family Planning under the public health traineeship program. During F.Y.'s 1967 and 1968 two Special Purpose Traineeship Grants have been awarded in this area. The first to the University of California at Berkeley supports 17 trainees in 1967 and ten trainees in 1968; the other to the University of Hawaii supports five trainees in 1967 and seven trainees in 1968. Short-Term Traineeships in family planning were awarded to three agencies in support of a total of 240 trainees in 1967 and have been awarded to three agencies in support of 700 trainees during F.Y. 1968.

It is the policy of the National Institute of Mental Health to support research in the mental health and behavioral aspects of fertility and family life, to recognize the special contributions that can be made in clinical family planning services by mental health-trained personnel, and to encourage increasing efforts to meet the family planning needs of psychiatric patients. The NIMH plans to encourage and support the inclusion

of family planning services in community mental health facilities whenever possible. Through the various manpower training activities of the NIMH support is planned for new programs of training for workers in the family planning field, and to train mental health specialists in this subject. It is also planned to support summer programs for teachers involved in sex education and health education, using the skills of mental health professionals. The NIMH plans to stimulate programs for the training of clergymen, public health nurses, social workers, probation officers and others whose work brings them in direct contact with people who may have need for information and services related to family planning. The focus of NIMH activity on family planning resides in the Center for Studies of Child and Family Mental Health. A few research grant projects supported by the NIMH deal directly with family planning, e.g., psychological effects of vasectomy, family planning attitudes in an Indian village, and sequellae of therapeutic abortion. A large group of research grant projects bear indirectly on the topic; communication and decision-making within families, motivation, sex education, and birth order studies. The NIMH Division of Intramural Research is carrying out projects on family formation, child spacing, and animal studies of population density.

The basic research programs of the Department of Health, Education and Welfare in the fields of population and human reproduction are centered in the National Institute of Child Health and Human Development. About half of the NICHD population budget of $7.7 million in F.Y. 1967 supported projects designed to obtain fundamental information on reproductive processes. Smaller portions were devoted to studies of contraceptive methods, to the social sciences, and to intramural research. The NICHD has concentrated its contract studies in the area of the medical effects of oral contraceptives. The problems under study extend beyond the immediate side effects and include: (1) the effects on blood coagulation and the cardiovascular system, (2) alterations in endocrinological relationships, (3) changes in glucose and lipid metabolism, (4) possible carcinogenic effects, and (5) effects on progeny.

The NICHD supported the 1965 study of American family planning practices carried out by Princeton University. Support is also being given to the reproductive physiologists in the Department of Agriculture who have been studying the effects

of intrauterine devices on the reproductive performance of several species of experimental animals. Studies are also being supported into the systemic effects of intrauterine devices in human females.

The bulk of support for research by the NICHD is through the research grant mechanism. A major problem in F.Y. 1968 is that only about half the approved research grant applications will be funded. This situation is regarded with great dismay throughout the research community. A considerable expansion of the intramural research activities of the Reproduction Research Branch will soon take place, and activities will concentrate in the area of the endocrinology of reproduction.

A marked increase in the collaborative research program is anticipated in F.Y. 1969. It is planned to use these additional funds in an organized program of contraceptive development. Some of the areas where a breakthrough in contraceptive technology may be anticipated are luteolytic agents, sperm capacitation, alterations in the composition of the seminal fluid, and bioengineering studies into methods of sterilization.

The plans are now being made for the new National Center for Studies of Population and Human Reproduction. The new Center will be housed within the NICHD and will encompass the activities here described, and will lead to an intensification and expansion of research endeavor in family planning and population.

92 - 594 O - 68 - pt 2 - 41

V

OFFICE OF EDUCATION

Summary of Programs Related to Family Planning

The Office of Education does not prescribe State and local school curricula. However, through its varied grant programs made possible under general legislation, it has encouraged educational institutions at all levels, community organizations, etc., to include family planning in their programs. It has given financial support to innovative demonstration projects in new approaches to sex education.

Legislation beginning with the National Defense Education Act of 1958, (P.L. 85-864), has made it possible for the Office of Education to support training and curriculum development in family life and sex education. The same legislative authorizations make possible the opportunities for activity in family planning education. The recently enacted P.L. 90-35, the Education Professions Development Act, modifies the professional training aspects of some of the authorizations discussed below, but only one program, the Teacher Corps, is substantially altered prior to F.Y. 1969. Legislative support for family planning through special training of professional education personnel is forthcoming through the following:

Title V-B of the National Defense Education Act of 1958 authorizes the Commission to arrange, through grant or contracts, with institutions of higher education for the operation by them of short-term or regular session institutes for advanced study, including study in the use of new materials, to improve the qualifications of individuals who are engaged, or are teachers preparing to engage, in counseling and guidance of students in elementary or in secondary schools or in institutions of higher education, including junior colleges and technical institutes.

Title XI of the same Act, NDEA of 1958, provides for institutes of advanced study by teachers, supervisors, trainers of teachers and educational media specialists, to raise the quality of instruction for elementary and secondary school children. Institutes are conducted by institutions of higher education selected by the Commissioner of Education after evaluation of

their proposals by a panel of consultants. Program content, staff and facilities, equitable geographic distribution, the need for balance among subjects, and the availability of funds are among the factors considered.

The Elementary and Secondary Education Act of 1965, (P.L. 89-10) and its amendments provide several titles under which family planning educational activities are eligible for support. The purposes of Title I are to assist in expanding and improving education programs which contribute particularly to meeting the special educational needs of educationally deprived children; namely, through payments to State educational agencies for:

1. Grants to local educational agencies having concentrations of children from low-income families.

2. Grants to State agencies operating or supporting schools for handicapped children.

3. Grants to State agencies operating or supporting institutions for delinquent or neglected children.

4. Grants to State educational agencies for establishing or improving programs for children of migratory agricultural workers.

5. Administering the program.

In addition, payments are made to the Secretary of the Interior for grants with respect to educationally deprived Indian children in Bureau of Indian Affairs schools and for payments by the Secretary of the Interior to local educational agencies with respect to the out-of-State Indian children in elementary or secondary schools of such agencies under special contracts with the Department of Interior.

Grantees may use the money for programs for dropouts, preschoolers, and teenage unwed mothers, or for any other imaginative approach to remedying educational deprivation.

Title II of the Elementary and Secondary Education Act of 1965, as amended, provides formula grants to States for supplementary educational materials to enable educational agencies to acquire

library resources, textbooks, and other printed and published instructional materials for the use of children and teachers in public and private elementary and secondary schools. These materials may include instructional material on family life and sex.

Title III of the same Act, ESEA as amended, known as the PACE Program (Projects to Advance Creativity in Education), enables schools to provide services presently unavailable to their children, to raise the quality of educational services already offered, and to stimulate the development and evaluation of experimental elementary and secondary educational programs to serve as models for regular school programs. Grants are made to local public education agencies by the Commissioner of Education. This program has been changed to a primarily State plan program for fiscal years 1969 and 1970.

Since 1954, the Cooperative Research Act has supported educational research projects by colleges, universities, and State educational agencies. Title IV of the Elementary and Secondary Education Act amends the Cooperative Research Act to strengthen and broaden the scope of educational research and development. It establishes a new training program for education researchers by providing grants to colleges and other participating agencies and makes other grants to students for research traineeships, internships, and fellowships. Title IV also provides for the establishment of a system of regional educational laboratories. The laboratories will provide classroom facilities where teaching experiments can be conducted and newly developed technics demonstrated and evaluated. Universities, colleges, and other public or non-profit private agencies, institutions, and organizations, and individuals may apply for grants for educational research, surveys, and demonstrations, and to establish and maintain research and traineeships, internships, personnel exchanges, and pre- and post-doctoral fellowships.

Title I of the Higher Education Act of 1965, (P.L. 89-329), provides financial assistance in the solution of community problems through college and university extension and continuing education programs. A National Advisory Council is required to review the administration and effectiveness of all Federally-supported extension and continuing education programs, including community service programs. A State desiring to receive its allotment of Federal funds under this title must

designate or create a State agency or institution to develop and administer the program in the State. States desiring to participate in the program are required to submit a State plan to the Commissioner for approval. The State plan must set forth the criteria for determining which institutions of higher education in the State are to participate and the policies and procedures to be followed by a State agency in selecting the community problems to be solved.

Title V of the Higher Education Act as amended by the Education Professions Development Act provides for the Teacher Corps. The purpose of this subpart is to strengthen the educational opportunities available to children in areas having concentrations of low-income families and to encourage colleges and universities to broaden their programs of teacher preparation by --

(1) attracting and training qualified teachers who will be made available to local educational agencies for teaching in such areas; and

(2) attracting and training inexperienced teacher-interns who will be made available for teaching and inservice training to local educational agencies in such areas in teams led by an experienced teacher.

A major program included in the Economic Opportunity Act of 1964, (P.L. 88-452), is the Adult Basic Education Program administered by the Office of Education. It is designed to encourage and expand basic educational programs for adults to enable them to overcome English language limitations, to improve their basic education in preparation for occupational training and more profitable employment, and to become more productive and responsible citizens. These programs include family planning education.

The Elementary and Secondary Education Amendments of 1967, (P.L. 90-247), contains a new section 807 in Title VIII "Dropout Prevention Projects" which should have far-reaching effect on the problem of teen-age pregnant girls and their continuing education, particularly in family life education and sex education.

Under this section, appropriations not to exceed $30 million for F.Y. 1969 and F.Y. 1970 are authorized for the establishment by the Commissioner of Education, under contract grant or otherwise with local educational agencies, of projects in low-income areas and in areas where there is a high percentage of children who do not complete elementary or secondary school education. Demonstration projects involving the use of any innovative methods, materials, systems or programs, that would reduce the number of dropouts, may be established.

Inasmuch as pregnancy or early marriage is the largest single cause of dropouts by teen-age girls -- about 30 to 40 percent, the need for family planning, and sex education can be seen in proper perspective, as part of public comprehensive school-centered services to teen-age parents.

Current Family Planning Activities

The immediate plans of the Office of Education call for a series of discussions on family life and sex education with representatives of various professions and disciplines, ethnic and cultural groups, as well as lay leaders. HEW Regional Offices have indicated a need for such meetings. The sessions will afford opportunities to explore in some depth the why, the what, and the how of the area under discussion. Guidelines may result that have implications for schools, teacher education institutions, State departments of education, and the Office of Education.

The role of the school for providing information regarding modern scientific advances in the field of contraception and its meaning in relation to child spacing and responsible parenthood has not been discussed widely or openly. However, HEW's emphasis at the present time on family planning appears to imply that the school should assume a greater responsibility than they have in the past for such education. This makes a suggested meeting especially significant.

The Office of Education believes that the education component should be positive and strong in the extension of family planning services to people seeking them. It would seem appropriate for the Office to call attention to school and

college personnel who might work with the providers of these services in deciding on the educational aspects of the program; e.g., counselors, teachers, health educators, school psychologists, social workers, and aides in education and school health. The second objective, to meet manpower needs in the family planning field, is one in which the Office would also be interested. The Education Professions Development Act offers a yet unexplored possibility for training leaders (nurses aides and others under various education programs). There always is the problem of training priorities and the Office would have to give serious consideration to setting a high priority on the area of preparation of family life and sex education personnel.

In addition to the proposed regional conferences, the Office will continue to encourage proposals under the various programs in which family life and sex education can be supported. While the Office will make every effort to increase the support, it is likely that funding will stabilize at the 1967 Fiscal Year level, due to restricted funds available under the various Titles.

VI

FOOD AND DRUG ADMINISTRATION

Summary of Programs Related to Family Planning

Under the authority of the Food, Drug and Cosmetic Act of 1938, as amended, the Food and Drug Administration is responsible for approving contraceptive drugs for safety and effectiveness before they are marketed and for maintaining surveillance over the drugs after their approval.

The first oral contraceptive agents were approved by the Bureau of Medicine of FDA in 1957, after some years of research, testing, and evaluation. By 1967, there were 16 such agents on the market.

Studies are being carried out under contract to evaluate the experience of human populations utilizing oral contraceptives.

Although the Food and Drug Administration does not have pre-marketing controls over contraceptive devices, it is responsible for maintaining surveillance over such devices to ensure their safety. At the present time there are no standards of manufacturing or pre-marketing investigation required by law. However, the FDA has taken steps to set such standards and to provide such consumer protection as is possible under the Food, Drug, and Cosmetic Act of 1938, as amended.

The FDA has established an expert Advisory Committee to assist it in its programming of activities related to family planning. The Advisory Committee on Obstetrics and Gynecology is made up of some 14 outstanding obstetricians, gynecologists, epidemiologists, and consultants in oncology.

As part of its ongoing program activity, FDA also consults frequently with scientific and administrative representatives of pharmaceutical firms in its programs to ensure safety and effectiveness of contraceptive drugs to the women who use them, to the doctors that prescribe them, and to the pharmacists who dispense them.

Current Family Planning Activities

The activities of the Food and Drug Administration do not include provision of either services or training programs which might be utilized by the recipients in family planning projects.

Of more direct concern to the FDA is the development of adequate information to assure the safety and effectiveness of those methods, both pharmacological and mechanical, which are being promoted by such programs. To this end, a number of research projects are either in active development or in actual progress.

The three general areas of FDA activity in research into the safety and effectiveness of contraceptive methods are in (1) epidemiological studies; (2) research studies; and (3) reports. The current status of a specific project under each of the three areas is given below.

(1) Epidemiological Studies

(a) Under the direction of Dr. Philip Sartwell, Department of Epidemiology, Johns Hopkins University School of Medicine, a case-control analysis of hospital records, relating to the occurrence of idiopathic thrombotic episodes, is being conducted.

The primary study objective concerns a possible relationship of such events to the oral contraceptives. Information concerning carcinoma is also being collected.

Completion of data collection is scheduled for January 1969.

(b) Active negotiations with suitable military and civilian populations have been under way for several months. Two feasibility pilot studies have been completed and have yielded useful planning information.

The primary objective of such a study will be to examine the occurrence of carcinoma in women treated with oral contraceptives.

The anticipated duration of the study is at least 10 years. Based on the current status of negotiations, it is probable that such a long-term study of the relation between carcinoma and oral contraceptives will be initiated before the close of F.Y. 1968.

The medical reports of the women under the long-term study will be analyzed closely by teams of scientists and biometricians who will watch particularly for adverse reactions. The results of such a study will be pooled with those of similar studies supported by the National Institutes of Health, and by independent organizations, to arrive at an even closer estimate of the full effect of oral contraceptives when used by women continuously for many years of reproductive life.

(2) Research Studies

(a) Since an appreciable number of women treated with oral contraceptives develop carbohydrate intolerance, a study to characterize the mechanism of this effect is under way under the direction of Dr. William Spellacy at the University of Miami School of Medicine.

In order to achieve adequate follow-up of study subjects, the study will extend over 2 to 3 years.

(b) Projects concerning the effects of oral contraceptives or plasma lipids, on blood coagulation mechanisms, and on patients with sickle

cell disease, are all either being developed or have been received and are under evaluation.

It is likely that several of these projects will be supported before the close of F.Y. 1968.

In addition, laboratory studies concerning certain mechanisms of blood coagulation as effected by estrogens are being conducted by the Bureau of Medicine staff members.

(3) Reports

(a) Intrauterine Devices (IUD's) — The Advisory Committee on Obstetrics and Gynecology has prepared a monograph on present information relating to mechanism of action, safety, and effectiveness of the IUD's. This will be published in the spring of 1968.

(b) Oral Contraceptives — An earlier report on oral contraceptive will be revised by the Advisory Committee during 1968-1969. A tentative completion date has been set for March 1969.

FDA maintains a continuing liaison with appropriate groups, through the PHS Population Committee and the Departmental Ad Hoc Committee on Family Planning, since certain of the Family Planning Clinics supported by other agencies in the Department may provide suitable patient populations and investigative staff to perform specific studies as required by FDA in the performance of its surveillance duties.

The FDA maintains an adverse reaction reporting system which receives information on adverse reactions to oral contraceptives and serves as a clearing house for such information.

The Bureau of Medicine in the FDA recently requested each of the manufacturers responsible for the production and marketing of oral contraceptives, to carry out long-range animal studies in primates of their oral contraceptive product.

LIST OF WITNESSES

	Page
Cardwell, J. B	1
Cohen, W. J	1
Huitt, R. K	1
Kelly, J. F	1

INDEX

	Page
Adult basic education	206
Budget:	
Operating agency	111
Comparison, fiscal year 1968 and 1969	203
Distribution by type of recipient institution	127
Estimates contingent upon enactment of extension legislation	201, 233
Funds placed in reserve (fiscal year 1968)	197
In brief	107
Lapses	198
Overview of	107
Reductions across the board, effects of	206
Request and authorizations compared	144
Child health	74
College enrollment, 1967–75	208
Committee on Government Operations, report of	158
Construction	143
Dental costs	211
Education, block grants for	199
Education, construction costs for	212
Elementary and secondary education	88
Financing	218
Expenditure limitation. (*See* H.J. Res. 888.)	
Expenditures, public and private	19
Expenditures, social welfare	20
Expenditures, total	17
Family planning services	76, 213
Food and Drug Administration	114
Future Farmers of America	221
Health:	
Economics	186
Manpower	79
Reorganization	128
Research	77
Higher education	85
Facilities	207
House Joint Resolution 888	97
Impacted areas, aid to	161
Impacted areas, proposed legislation affecting	206
International education program	159
Junior college enrollment	168
Language changes, proposed	160
Legislation, proposed	110, 162
Legislative authority due to expire before 1969	233
Legislative authority, programs for which extension will be requested	201
Maternal and child health and welfare	118
Medicaid and medicare	62, 69
Estimates	117
Payments	232
Medical services, cost of	44, 64, 133, 210–212
National Institutes of Health	157
Nursing home costs	211
Obligations, actions taken to reduce	98
Office of Economic Opportunity, possible program transfers	129
Office of Education	112
Positions, new	203

	Page
Positions, total increase in	140
Poverty programs	214
Program information and statistics	233
Programs for which legislative authority is due to expire before 1969	233
Public assistance	51
Number of eligibles	203
Public Health Service	114
Reorganization	130
Public Law 90–218. (*See* H.J. Res. 888.)	
Secretary, Acting, statement of the	1
Social and Rehabilitation Service	115
Social Security:	
Amendments, 1967	57, 61, 126
Budget changes	119
Recipients, number of	204
Trust fund	120
Special reports:	
Aging	341
Alcoholism	484
Blindness	460
Cerebral palsy	530
Cystic fibrosis	523
Drug addiction	507
Family planning	589
Juvenile delinquency	416
Mental health	258
Multiple sclerosis	543
Muscular dystrophy and related disorders	538
Speech and hearing	550
Stipends, fellowships and allowances, policy regarding uniformity of	159
Supplemental appropriation request (fiscal year 1968), timing of	45
Supplemental appropriations, fiscal year 1968	109
Unobligated and unexpended balances	174
Urban problems	92
Vocational education	192, 208

○