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

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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

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PART 7

Members of Congress, Interested Individuals and Organizations

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U.S. GOVERNMENT PRINTING OFFICE

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TUESDAY, APRIL 23, 1968.

EDUCATION, EMPLOYMENT, AND MANPOWER PROGRAMS

WITNESS

MRS. BRUCE B. BENSON, SECOND VICE PRESIDENT, LEAGUE OF WOMEN VOTERS OF THE UNITED STATES

Mr. SMITH. The committee will come to order. We are happy to have with us this morning, as the first of our public witnesses, Mrs. Bruce B. Benson representing the League of Women Voters. You may proceed, Mrs. Benson.

Mrs. BENSON. I am Mrs. Bruce Benson of Amhurst, Mass., second vice president of the League of Women Voters of the United States, and chairman of the league's national program on development of human resources. The league is a volunteer citizens' organization of nearly 150,000 members from more than 1,200 communities in the 50 States, the District of Columbia and Puerto Rico. The league is nonpartisan and is concerned with Government and governmental issues at all levels.

Our national position in human resources is support of policies and programs in the United States to provide for all persons equality of opportunity for education and employment. This position is an outgrowth of intensive study by local leagues of the actualities of poverty and discrimination in their own communities and in the country as a whole. From this experience league members all over the country developed a knowledgeable background on which to base their consensus for this national position in 1966.

I appreciate the opportunity to appear before your subcommittee today to present the position of the league in support of a number of appropriation requests:

$2.18 billion for the economic opportunity programs

1.2 billion for title I funds for fiscal year 1969 for the Elementary and Secondary Education Act (which is less than half of the authorization of $2.6 billion)

1.2 billion for ESEA title I funds for fiscal year 1970

31.1 million for the National Teachers Corps, administered under the Education Professions Development Act

2.1 billion for manpower programs for fiscal year 1969

The members of the league believe that the Federal Government must continue to assume a large share of responsibility for providing equal opportunities in education and employment. Further, in the aftermath of the disorder which has convulsed many of our cities in the past 3 weeks, the league believes it is even more obvious than it was before that there must be strong Federal leadership if our country is going to succeed in bringing disadvantaged people into the mainstream of American life. Americans must deal with the economic plight of this Nation's poor, but we must also deal with the exclusion of Negroes from American society, and the attitudes of the

white Americans which continually nourish this exclusion. Our president, Mrs. Robert J. Stuart, has sent to each of you a copy of the statement which she issued for the league upon the assassination of Dr. Martin Luther King, Jr., urging that "Now is the time for vigorous and constructive action by the Congress, the State legislatures, and by every community to see that Negro citizens take their rightful place in American life."

Gainful employment is one of the most effective ways to enable people to live with a sense of dignity and accomplishment. The League agrees with the National Advisory Commission on Civil Disorders in its urgent recommendation that there be immediate action to provide thousands of additional worthwhile jobs. It is now an accepted fact and if it is not it should be, that the problem of finding or creating jobs and training the hard-core unemployed and underemployed is a task of such massive proportions that resources of both the business sector and the Federal Government must be utilized if we are to mount programs on the scale required. Programs must be authorized and funds must be appropriated at unprecedented levels in order to deal with the unprecedented gap in our society between the people who have and the people who do not have.

The League of Women Voters of the United States strongly supports full budget appropriations for all the manpower programs including (1) the JOBS program which brings the private sector into partnership with the Federal Government to provide on-the-job training for the untrained, unemployed and underemployed, (2) the Manpower Development and Training Act of 1962, as amended, which will provide for the cooperation of the Labor Department in the JOBS program, (3) the concentrated employment program, which will be a supporting arm, under the OEO, to the JOBS program, (4) the Job Corps for poor youngsters who need to have a different environment from their homes and the Neighborhood Youth Corps out-of-school program for those who will require somewhat less intensive training (both programs funded under the OEO), and (5) work and training programs funded through the Office of Economic Opportunity as well as other agencies.

The League of Women Voters of the United States also supports full appropriations for other programs which are administered and/or funded through the Office of Economic Opportunity; one of these is the community action program. May I refer your committee to the hearings before the House Committee on Education and Labor on the Economic Opportunity Act Amendments of 1967, which contain letters from a number of local Leagues over the United States detailing the many successes which they have observed in their work with these programs. The community action agencies not only offer employment to approximately 50,000 disadvantaged people, but also enable members of the community to participate in the planning and administration of the program. The League of Women Voters of the United States believes that this kind of participation is extremely important in lessening the gulf which has existed for a long time between people who are poor and their Government. We believe this participation helps to build good community relationships and establishes a better line of communication in our widely divided society.

Although the League is well aware that not all the community action agency programs nor all other programs of the Office of Eco-

nomic Opportunity or of other agencies have been entirely successful, we do believe that progress is very definitely being made. We are also convinced that not only a great amount of time, but a greater commitment of ideas, energy, and funds, will be required before we begin to get the upper hand over the root causes which continue to generate poverty.

In the field of education, the League of Women Voters of the United States urges full budgetary appropriations for a number of programs which aim to promote equality of opportunity for all children from the preschool level through high school.

Our leagues have reported that school officials are becoming more aware of the nature of the special problems of poor people and of people who have been and who continue to be discriminated against because of their color. These officials are becoming more anxious to move ahead in remedial and enrichment programs. Since such programs extend beyond the financial ability of most local communities—especially those where the need is the greatest—the league believes that full Federal support should be guaranteed. Further we urge the full appropriations for both years be approved so that local school districts will be able to plan their programs well in advance of each school year and therefore better utilize their allotted funds. The league also strongly supports the Headstart and follow through programs which are administered and/or funded through the Office of Economic Opportunity and recommends full appropriations for these programs, as well as the National Teacher Corps.

I would like to add at this juncture a point which the members of the League of Women Voters of the United States believe are very important. That is: All these programs—(title I–ESEA, Headstart, follow through, National Teachers Corps)—are directed at improving the quality of education for children who have great need of help. The league believes, however, that if we are to achieve the goal of quality education and equal educational opportunity we must also have integrated education. There is overwhelming evidence to date that compensatory education programs as provided under title I–ESEA are not and cannot be a substitute for values of the racial integration of our schools. The League of Women Voters of the United States believes therefore that we must work for both quality and integrated education.

Even as the league urges full appropriations for these programs, we are ever mindful of the highly competitive demands on the Federal budget at a time austerity is required. We all know that the administration's appropriations requests for the programs to combat poverty and discrimination represent only a very small fraction of the total need. The League of Women Voters of the United States does realize that many people feel that higher appropriations are not advisable. We believe, however, that the national crisis which we are in the midst of makes passage of less than the full budgetary appropriations unjustifiable. That is, it is not justifiable if we really mean to give assurance to the 20 percent of our citizens who are outside the mainstream of American life that we want them to be a part of that mainstream, in reality.

Mr. SMITH. Mrs. Benson, you are recommending, then, the budget level on these various items in recognition of the tight budget situation we are in rather than a larger amount, but you are not recommending any reductions in any items, either, are you?

Mrs. BENSON. No; we are not recommending any reductions. In fact, we recognize that even the requested budgetary amounts are not adequate, but being politically realistic we think there is very little chance of getting more than the budgetary request.

Mr. SMITH. Has the league taken any position, then, on an increase in taxes or where to secure the money?

Mrs. BENSON. No; we have not. I think it is implied in our position that if it is necessary to increase taxes to support these programs, then we are in favor of increasing taxes, but we have not studied the precise question of shall we or shan't we. But it is obvious you can't increase Federal expenditures or Government expenditures without raising taxes.

Mr. SMITH. Even to come to the budget level would require more money.

Mrs. BENSON. Yes.

Mr. SMITH. Mrs. Benson, thank you very much for a fine statement.

Mrs. BENSON. Thank you. I wanted to give you this copy of a pamphlet that we published with Urban America, Inc. Here is something you might be interested in also from the Iowa League, a speech which the chairman of our work in Iowa, Mrs. D. R. Waterman, of Muscatine, who is the State chairman, wrote for the use and adaptation of local leagues throughout the State. It is a good speech.

Mr. SMITH. Thank you very much.

Mrs. BENSON. Thank you.

TUESDAY, APRIL 23, 1968.

PUBLIC BROADCASTING PROGRAM

WITNESSES

WILLIAM G. HARLEY, PRESIDENT, NATIONAL ASSOCIATION OF EDUCATIONAL BROADCASTERS

CHALMERS MARQUIS, EXECUTIVE DIRECTOR, EDUCATIONAL TELEVISION STATIONS DIVISION

Mr. SMITH. We now will hear from Mr. William G. Harley. How do you want to proceed?

Mr. HARLEY. I would like to introduce my colleague, Mr. Marquis, who is the executive director of our educational television stations division, and then I would like, in the interest of time, to digest this statement.

Mr. SMITH. That would be fine. You would like to insert your statement into the record?

Mr. HARLEY. Yes.

Mr. SMITH. We will do that, and you may go ahead and digest it.

(The prepared statement follows:)

STATEMENT BY WILLIAM G. HARLEY
BEFORE
THE SUBCOMMITTEE FOR THE DEPARTMENTS OF LABOR
AND
HEALTH, EDUCATION, AND WELFARE
OF THE
APPROPRIATIONS COMMITTEE OF THE HOUSE OF REPRESENTATIVES

April 23, 1968

I am William G. Harley, President of the National Association of Educational Broadcasters. With me is Mr. Chalmers Marquis, Executive Director of our Educational Television Stations Division.

The Association for which I speak is the professional organization of institutions and individuals engaged in educational radio and television. Its membership consists of universities, colleges, schools, and non-profit corporations which operate educational radio stations, educational television stations, and closed-circuit and 2500 mg. television systems. It also represents nearly 3000 individuals who are involved in educational applications of radio and television.

In appearances before committees of both Houses of the Congress, the NAEB has given detailed testimony in support of the Public Broadcasting Act of 1967. We re-state today our belief that the three titles of this Act represent a unified program for the extension of an effective, independent, financially sound, non-commercial broadcasting system through all parts of our country.

Specifically, first, we urge the appropriation in the 1969 budget of $12.5 million to implement Title I. This title, in effect, continues (and expands to include educational radio) the program of matching grants for educational broadcasting facilities which the Congress established under the ETV Facilities Act of 1962.

Funds which the Congress appropriated in past years to implement the ETV Facilities Act of 1962 have been exhausted. It has been eight months since any facilities project has been able to be funded. We were deeply disappointed that the $10.5 million authorized by the Congress to implement Title I in 1968 was not appropriated. The Department of Health, Education, and Welfare reports that it has already received applications for a total of more than $40 million which would require, in eligible support, up to nearly $20 million in Federal funds. [1.]

It can thus be seen that the needs of educational broadcasting stations are both real and urgent. There is another factor which adds to this urgency. Each of the applications delivered to HEW must, in order to fulfill the terms of the grant, attest to the fact that local matching funds are presently on hand.

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1. The Act provides that no State may receive funds totalling more than 8⅓ % of an annual appropriation. Of the total of projects now awaiting action by HEW, there are six states whose applications total more than 8⅓% of the $12.5 million authorized for 1969. Thus the actual total in existing projects eligible for consideration is reduced to $25,933,000, based on the 75% Federal share authorized under Title I; up to $19,500,000 in projects are eligible for Federal funding support.

These local matching funds add up to more than $6 million and the kinds of monies represented by this $6 million frequently have limited life: legislative funds can be granted only for a stated period, then lapse; private funds are often withdrawn when the projects for which they were pledged begin to appear uncertain of realization; project costs are frequently based on bids, and bids also hold firm only for a limited period. Thus, the facilities program under Title I must be funded soon if these local matching dollars are to be put to work.

Projects presently on file with the Department of Health, Education, and Welfare represent only a portion of the needs of educational broadcasting. Many stations are waiting to make application pending the publication of new guidelines by the Department. Moreover, since radio facilities were not included under the old ETV Facilities Act, no guidelines at all exist for radio applications; consequently, the educational radio stations throughout the country are yet to be heard from.

The NAEB therefore urges that the $12.5 million authorized under Title I for the facilities program be appropriated by the Congress at the earliest possible date so that a start can be made on this program of construction and expansion so vitally important to the continued growth of a non-commercial educational broadcasting system.

Second, we urge the appropriation of the $9 million authorized under Title II of the Public Broadcasting Act to support the first year operation of the Corporation for Public Broadcasting. The facilities which Title I will make possible provide only the technology; to be truly effective, these facilities must be used to broadcast programs of substance, quality, and depth. The Corporation for Public Broadcasting established by Title II is intended to provide material of diversity and significance in order to project educational radio and television into the full usefulness of which they are capable.

We believe this demonstration year will provide the opportunity to gain practical experience in the operation of this unique structure and, by providing a working model for study, gain accurate information on future costs, procedures and policies.

The directors of the Corporation have been selected and will hold their first formal meeting April 26. With the requested financial support, the Corporation is capable of beginning its work - now - to facilitate efficient and mutually productive efforts on behalf of the hundreds of educational radio and television stations, and their regional and national networks and services.

We recognize that, in these times when the Federal government is being called upon for extensive funding of many needed undertakings, new projects such as that represented by Title II must be of high priority. We believe that the Public Broadcasting Act deserves such priority, not merely because public broadcasting is new or

non-commercial, but because of what it enables us to do and to accomplish.

Many of the problems which the nation faces today are due in large measure to the inability of many of our people to share in the broad cultural and educational spectrum of American life. With improved and extended facilities and with the resources of the Corporation for Public Broadcasting, educational radio and television broadcasters can reach out to the problems of our people and furnish the means for effecting communication with them, among them, and by them in a way no one else can.

To take a contemporary illustration, radio and television are part of the regular daily life-experience of the poor; consequently, these electronic media can make contact with every person in the ghetto or rural slum and make him a participant in the process of social and individual reconstruction. They provide an effective way to establish a reciprocal communication access between minorities and the total community and an effective way to destroy the isolation of the disconnected poor.

Educational radio and television are not in competition with other important needs and demands. Rather, they are a means by which other social educational and cultural efforts can be carried forward. They provide a medium through which the resources of the community and the nation can be brought to bear upon these problems to produce a high yield of effective outcomes from the investment of effort and funds.

Educational broadcasters are eager to use their expertise and facilities to get on with this and other urgent tasks - but they need financial help in order to do it - outside funds to supplement their own in order to mount an adequate effort. The early appropriation of funds for Title I and Title II of the Public Broadcasting Act would go a long way to help them help.

Mr. HARLEY. In essence, we have three recommendations to make to you this morning about the Public Broadcasting Act, which we feel constitutes a unified program for the extension of an effective, independent, financially sound, noncommercial broadcasting system through all parts of the country.

First, we urge the appropriation in the 1969 budget of the $12.5 million authorized to implement title I of the act. This title in effect continues—and expands to include educational radio—the program of matching grants for educational broadcasting facilities which the Congress established under the ETV Facilities Act of 1962.

The funds which the Congress appropriated in past years to implement this program have been exhausted now and, in fact, it has been 8 months since any facilities project has been able to be funded. We were very much disappointed that the $10.5 million authorized by the Congress to implement title I in 1968 was not appropriated. HEW reports to us now that it has already received applications totaling about $40 million and that, in turn, would require in terms of eligible Federal support nearly $20 million. So the needs of educational broadcasting stations for facilities modernization and construction is real and urgent.

There is another factor which adds to this urgency. Each of the applications delivered to HEW must in order to fulfill the terms of the grant attest to the fact that local matching funds are presently on hand. These local matching funds add up to more than $6 million but the kinds of moneys involved frequently have limited life. Legislative funds can be granted only for a stated period, then lapse. Private funds are often withdrawn when the projects for which they were pledged appear to be uncertain of realization. Project costs are frequently based on bids, and bids also hold firm only for a limited period.

Thus, the facilities program under title I must be funded soon if these local matching dollars are to be put to work.

Mr. LAIRD. For facilities we have a request of $12.5 million before us at the present time. That is the only request which we have before us.

Mr. HARLEY. Right.

Mr. LAIRD. And $587,000 for salaries and expenses.

Mr. HARLEY. Right.

Mr. LAIRD. As far as the previous request that you refer to, the $10.5 million for fiscal 1968, that was never requested of this committee.

Mr. HARLEY. I know that.

Mr. LAIRD. The reason I brought it up, Mr. Chairman, was that page 2 of the statement says the $10.5 million authorized by the Congress to implement title I in 1968 was not appropriated. I would like to point out that was not appropriated for a good reason—the executive branch did not make a request of the Congress.

Mr. HARLEY. Right.

Mr. LAIRD. We don't normally appropriate until we see a program request.

Mr. HARLEY. I understand. I wasn't in any way condemning this committee. I was expressing our disappointment in the fact that we had lost all this time because the administration had not made this request. We are aware that this did not come before your committee.

May I add, with reference to this request, that many stations, although there are $40 million in requests in total in there, have not made

applications because no guidelines have been developed by HEW. In addition, since radio was not included in the ETV Facilities Act, we still have the educational radio stations to hear from in these grants. We therefore urge that the $12.5 million authorized under title I for the facilities program be appropriated by the Congress at the earliest possible date so that a start can be made on this program of needed construction and expansion.

Congressman Laird and Mr. Chairman, I come now to a technical circumstance, for which I ask your indulgence. The technical amendment to the Public Broadcasting Act which shifts the request for the authorized $9 million for the Public Broadcasting Corporation has not yet been passed upon by the House. We understand the Rules Committee is meeting on it at 11 o'clock today. The presumption is that it will come out on the floor tomorrow afternoon. Since this is a technical amendment and the act received substantial endorsement when it was originally passed, we trust that it will be passed tomorrow afternoon and therefore, if it is in order, I would like to address myself to the need for the funding of the Public Broadcasting Corporation.

Mr. SMITH. You can address yourself to it. We have legal technicalities which we may have to deal with.

Mr. HARLEY. Right. We understood this was a difficulty, but since we had no control over when we were invited to come, it has come out this way. Accordingly, we urge the appropriation of the $9 million authorized under title II of the Public Broadcasting Act to support the first year operation of the Corporation for Public Broadcasting. The facilities which title I will make possible provide only the technology; to be truly effective, these facilities must be used to broadcast programs of substance, quality, and depth. The Corporation for Public Broadcasting established by title II is intended to provide program materials of great diversity and significance as well as to make available operating dollars to help establish strong, energetic local stations which are the heart of the educational broadcasting system.

The directors of the corporation have been selected and will hold their first formal meeting April 26. With the requested financial support, the corporation is now capable of beginning its work to facilitate efficient and mutually productive efforts on behalf of the hundreds of educational radio and television stations, and their regional and national networks and services.

Actually, the corporation itself is in the best position to speak authoritatively about its plans and its procedures. We would assume that Mr. Frank Pace, the chairman of that commission, will be invited by your committee to appear before it—perhaps immediately after this meeting—so that he can report to you on their deliberations and make a presentation in behalf of the corporation.

Now, gentlemen, we recognize that in these times when the Federal Government is being called upon for extensive funding of many needed undertakings, new projects such as that represented by title II must be of high priority. We believe that the Public Broadcasting Act deserves such priority, not merely because public broadcasting is new or noncommercial, but because of what it enables us to do and to accomplish for our country.

Many of the problems which the Nation faces today are due in large measure to the inability of many of our people to share in the broad cultural and educational spectrum of American life. With improved and extended facilities and with the resources of the Corporation

for Public Broadcasting, educational radio and television broadcasters can reach out to the problems of our people and furnish the means for effecting communication with them, among them, and by them, in a way no one else can.

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Educational broadcasters are eager to use their expertise and facilities to get on with this and other urgent tasks—but they need financial help in order to do it—outside funds to supplement their own in order to mount an adequate effort. The early appropriation of funds for Title I and Title II of the Public Broadcasting Act would go a long way to help them help.

In our judgment, to paraphrase the Carnegie Commission's report, the American people have a great instrument within their grasp which they can turn to great purposes.

Mr. SMITH. Mr. Harley, so that those who read the record might more fully understand your interest and know how to interpret your remarks, would you tell us exactly how your association represents the applicants, as well as those operating educational stations? Do you contact them, or how can you say you represent all of them?

Mr. HARLEY. In the first place, they elect a board of directors which represent them. These directors operate regionally in the sense of representing the constituency that is in their State, or the immediate area. So they are in contact with them. Then the board meets every now and again to make broad policy. The executive committee meets more often and checks with the board. So that we have a normal system of representation.

Mr. SMITH. How many applicants are there now for educational television facilities?

Mr. HARLEY. Do you mean for licenses?

Mr. SMITH. No. I mean for the $12.5 million which is requested.

Mr. HARLEY. Do you know?

Mr. MARQUIS. It is our understanding that more than 60 applications have been received. Of these, more than 40 have been formally accepted for filing by the Department of Health, Education, and Welfare, and another 20 exist——

Mr. SMITH. Take the 60. How can you say you represent all 60? Do you have personal contact with them?

Mr. HARLEY. We have close contact with them by mail and phone, and, through their board of directors, they are in constant touch with our headquarters.

Mr. SMITH. Do they contact you before they make an application?

Mr. HARLEY. Not always. They sometimes do when they need help. Sometimes they are unsophisticated in making grant requests. We provide them with some sort of forms that suggest how they might go at it. We have developed these in conjunction with HEW. In addition, they often send us copies of their proposals, so that we are aware of the fact that they have made these requests.

Mr. MARQUIS. We have over 3,000 individual members who reach out into many communites, school systems, and universities—interested persons, who may for a small sum become an individual member of the association. They receive our news letters and bulletins and come to our conventions. These are the people with whom the impetus usually begins to form a new educational broadcasting station.

We have in our office been in touch with your staff about a station in Fort Dodge and have over a period of a couple of years tried to see what we could do to provide information and suggestions that would be useful in building community support in Iowa. Our association conducted a study for the State government of Iowa in order to best find what resources could be useful for educational broadcasting throughout the State. So that both through the State government and then through individual resources and local community support we believe a good plan for the whole State has been developed. I might say that without the Federal dollars, though, I don't think that this program will get off the ground at all.

Mr. SMITH. What have you done to try to reduce the amount of redtape that an educational television station has to go through to get a license? I just do not understand why they should be required to go through all of the procedures that profitmaking corporations would because there are very few possible conflicts with other applicants.

Mr. HARLEY. We are in hearty sympathy with your position on this. For years we were obliged to use exactly the same application forms and report forms that the commercial stations did. Much of it was nonrelevant. When I was at the University of Wisconsin station, I used to spend hours crossing out huge sections of these as not applying. After many years of work, we finally got the FCC to alter their forms somewhat, but they are still far too complicated.

Mr. SMITH. They still require great delays waiting to see if someone may oppose it, when they could easily get a waiver signed by everybody who might be an opponent.

Mr. HARLEY. Right; I quite agree. We wish we could do something about improving the situation. We try to give every assistance we can to the applicants.

Mr. SMITH. Anyway, you are testifying in favor of the $12.5 million for facilities?

Mr. HARLEY. Yes, indeed. And, also, when it is appropriate technically, in favor of the appropriation for title II.

Mr. SMITH. Mr. Laird?

Mr. LAIRD. Mr. Chairman, it would seem to me that there is a question as to whether these construction moneys would be released this next year even if they were appropriated. At the present time there is a freeze on projects similar to this in other agencies of the Federal Government. Have you had some discussions with the people in HEW as to whether the funds would be released?

Mr. HARLEY. No; we have not.

Mr. MARQUIS. It would be our assumption that they would.

Mr. LAIRD. They are even freezing construction funds that would provide needed hospital beds. I have reviewed the number of hospital construction projects we have and noted the real shortage of hospital beds. I have been trying to shake loose a few dollars for some hospital construction because I feel that these hospital beds are more important than seats in a supersonic transport. I have been having a little difficulty, however.

Mr. HARLEY. This is another inhibition that we were unaware of. We assumed if the money were authorized, which was perhaps naive of us, that it could be expended.

Mr. LAIRD. I don't have any further questions.

Mr. SMITH. Thank you very much.

EDUCATION

WITNESSES

JOHN M. LUMLEY, ASSISTANT EXECUTIVE SECRETARY FOR LEGISLATION AND FEDERAL RELATIONS, NATIONAL EDUCATION ASSOCIATION

WILLIAM H. McLIN, SENIOR LEGISLATIVE CONSULTANT

Mr. SMITH. Dr. Lumley, please. How do you want to proceed?

Dr. LUMLEY. I think, to save your time, why don't we enter the statement in the record and let me make two or three comments, and then answer any questions that you may have.

Mr. SMITH. We will do that.

(Dr. Lumley's prepared statement follows:)

Testimony on
FISCAL 1969 APPROPRIATIONS FOR THE U.S. OFFICE OF EDUCATION

in behalf of
THE NATIONAL EDUCATION ASSOCIATION OF THE UNITED STATES

presented by
John M. Lumley

before the
SUBCOMMITTEE ON LABOR, HEALTH, EDUCATION, AND WELFARE
of the
House Committee on Appropriations

Tuesday, April 23, 1968

I am John M. Lumley, Assistant Executive Secretary for Legislation and Federal Relations of the National Education Association. The membership of NEA totals 1,060,000 professional educators, most of whom are classroom teachers.

We appreciate the opportunity to present our views to this distinguished Committee. We recognize the problem the Committee faces in reconciling conflicting demands upon a tight federal budget. Demands on the nation's resources have increased enormously within the past three years as a result of our commitments abroad. Moreover, the dollar is under attack in the wake of the devaluation of the British pound. But as we wrestle with serious international problems, we cannot turn our backs on the mounting crisis at home.

The most visible evidence of our domestic crisis is violence in the streets of our cities. It is a manifestation that blinds many to the root causes: ignorance and poverty, human ills that go hand in hand. We see them in Washington and in the other cities of America, but they are present in rural areas. Indeed, in an effort to escape rural poverty, many families are flocking to the city, only to find their problems intensified.

The Administration has obviously weighed these problems, and the Fiscal 1969 budget reflects a thoughtful allocation of available resources. As taxpayers and citizens, as well as educators, we are faced with painful choices at all levels of government. We share your concern, and know that you share our belief that education is basic to the solution of this nation's social problems. Education alone cannot solve the problems--but the problems will not be solved unless the people are educated.

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We know that money alone won't improve education, but we cannot improve education without a substantial federal expenditure. The tax base of the states and local communities is not growing fast enough to keep pace with the rising costs of education. But the states and local communities, according to NEA research, are footing most of the bill; the average state/local contribution in 1967/68 is 92 per cent.

With respect to the Fiscal 1969 budget, we find certain increases which we would normally welcome. But these increases would draw funds away from programs which are already seriously underfinanced. I refer to Titles I and II of the Elementary and Secondary Education Act, the Vocational Education Act, and the various student assistance programs. These federal programs hit hard at the evils of ignorance and poverty. They deserve, in our opinion, top priority in the education budget. We recommend, therefore, that this Committee review the Fiscal 1969 budget requests primarily as they relate to the social ills that education can help cure, and that as much money as possible be reallocated to the programs that have shown concrete results in the lives of our children--especially the under-privileged, the potential dropouts, youngsters who in previous times were considered "born losers."

As to specific items in the USOE budget request, we have the following comments:

(a) We urge that the appropriation for Title I of the Elementary and Secondary Education Act to assist local educational agencies in providing programs for educationally deprived children be increased to the full amount authorized by the addition of the incentive grant program by P.L. 90-247, the ESEA Amendments of 1967, i.e., $1,151,977,990. The budget request figure of $1,101,977,990 will, in any event, result in reducing the amounts to each participating district because the number of eligible children has increased at a greater rate than the appropriation request indicates. We also strongly urge that the request of the Commissioner to include funds for Fiscal 1970 for this program in this year's appropriation be granted. This is vitally important to the school districts, which can plan more effectively and efficiently if they are aware well in advance of the school year of how much they will receive. This is in keeping with the provision of the ESEA Amendments of 1967.

(b) The reduction of over $58 million in the amount appropriated in Fiscal 1968 for Title II of ESEA (textbooks, library books and instructional materials) is drastic. We urge that the appropriation be at least equal to that provided for Fiscal 1968, which was $104,457,000. This program has been of equal value to pupils in both public and

non-public schools and we believe has been instrumental in developing good relationships at the local community level. We believe the proposed curtailment is unwise.

(c) In the request for equipment and minor remodeling the reduction is even more drastic. The most important feature of the original program, Title III of NDEA, was the provision of state supervisory staff in the curricular areas of science, mathematics, history, civics, geography, modern foreign language, English and reading. Apparently it is the intent of the USOE to eliminate this valuable part of the program. We urge that the Committee add $10 million as authorized in P.L. 85-864, Title III, Sec. 301, as a line item at this point earmarked for continuation of the state supervisory staff positions which are of inestimable value in improving the academic programs. We also urge serious consideration to restoring the $79.2 million appropriated last year for equipment and minor remodeling.

(d) We urge that the appropriation for the Bilingual Education Program as authorized in the ESEA Amendments of 1967 be raised to at least $10 million. This program holds great promise for a long neglected group of children who are severely educationally handicapped by lack of ability to speak English at the time they first enter school. The authorization for Fiscal 1969 is $30 million. The request for $10 million is not unreasonable in light of the clearly documented need.

(e) We strongly urge the full request of $31,100,00 for the Teacher Corps be approved. This program, especially after the enactment of the 1967 amendments which strengthened state control, is proving to be one of the most valuable of all federally supported education programs.

(f) The dropout prevention program authorized in the 1967 ESEA amendments is, in our opinion, a promising approach to a very difficult problem. We ask that this program be funded to the fullest extent possible.

(g) We are concerned that the budget request for the impacted aid program falls short of school district entitlements, and therefore recommend the requested appropriation of $442,074,000 for this extremely important program.

(h) Congress enacted a landmark program, the Education Professions Development Act, last year. In order to test the effectiveness of this legislation on a realistic basis, we urge that the Committee approve the request of $215,913,000.

(i) The nation is watching the development of higher education opportunities for its youth, and the legislation enacted since 1963 is crucial to this effort.

With federal funds, our colleges and universities have been able to improve and expand their curricular offerings, and provide adequate facilities for instruction. We urge fullest possible funding of the Higher Education Facilities Act of 1963 and the Higher Education Act of 1965, as amended.

(j) Libraries and Community Services legislation have similarly enriched the education and cultural life of our citizenry. NEA asks that this program be supported to the fullest extent possible, at least at the Fiscal 1968 level.

(k) Title IV of the Civil Rights Act of 1964 has been consistently underfunded. The purpose of this program, to provide grants and technical assistance to state and local school systems in the process of desegregation, will be advanced considerably if Congress approves the $14,796,000 requested by the Administration.

In conclusion, I would comment on two matters of grave concern to the National Education Association:

Despite strong opposition from the education community of the country, the Office of Education asks again for funds to establish a nationwide program of national assessment of educational achievement. We urge that the Committee delete the $2 million requested for this project. We would emphasize that the National Education Association does not object to evaluation. We do believe it to be most important, however, that this evaluation should be done by the states and not by the Office of Education.

Last year we urged the Committee to eliminate funds for the staffing of regional office for elementary and secondary education. We believe this weakens the state departments of education. The Committee acted as shown by House Report No. 271 of the 90th Congress. During this year the office did continue this expansion in certain fields claiming that regional offices must be uniform.

We again call this matter to the attention of the Committee and urge further action to stop any further expansion of this kind.

Again, I wish to thank this Committee for the opportunity to present the viewpoint of the NEA regarding this vital legislation.

Dr. LUMLEY. I am Dr. John M. Lumley, Assistant Executive Secretary for Legislation and Federal Relations of NEA; accompanied by Mr. William H. McLin, our senior legislative consultant.

Let me say when we start out that we are well aware of the fiscal problem that is faced by this committee, faced by the country. I was sitting here as you asked the question about the imposition of new taxes. Certainly, when it comes to the imposition of new taxes, I am sure that you will find that the National Education Association will join and do everything it can to support you in that program. We talk in here about increasing funds. You understand, we recognize you cannot increase funds even if you increase taxes, that there is a limit on the amount of money that can be spent. What we are saying in our testimony, members of the committee, is that we believe that there can be some priorities and we do not therefore necessarily agree with the priorities as established by the Office of Education.

Let me say to the committee, first, that one of the things that the National Education Association is most concerned about is Federal control of education. We believe that the control of education belongs to the States. We believe that there must be some fiscal support from the Federal Government with the least amount of control possible. I said to the education committee just recently that for 25 years I went up and down the country saying that you could have support for education without Federal control, but I am getting a little concerned the last couple of years whether that is possible. It seems every time we get some money we get more regulations and more directives and more centralization. Enough of that.

Mr. LAIRD. It seems to me that you are shifting a little bit from the categorical approach to general funding of education.

Dr. LUMLEY. Congressman, we have always advocated general aid; we made very little headway, however. So we got over to the categorical. Now we are not too sure that we didn't get into a morass.

Mr. SMITH. I am afraid you jumped the other way at the very time when you could have gotten the general aid. You supported general aid until we had the votes and then you jumped over to categorical aid.

Dr. LUMLEY. I know.

Mr. SMITH. Now we are locked into that.

Dr. LUMLEY. This is the problem. We have the programs now.

Mr. LAIRD. You have the programs now and you have to do the best you can with them.

Dr. LUMLEY. This is right. We have to make them work. We think the Congress made a great step forward when it put title I under the control of the States. Last year, if you will recall, the Congress shifted title III to the control of the States. We believe this was a real step forward.

Title II of ESEA is also a State program. What we are saying here is that we believe that title I, which is a basic program support for the cities and for the disadvantaged even in the rural areas, that title I should be more fully funded than the request that was made of the Congress, by the administration. If you talk about increased enrollment, we find that title I does not have any more per child than it had last year, yet the problems are just as great. So we would suggest an increase here.

We go to title II, the textbook program. Here we find a reduction of over $58 million on the reasoning that we were taking money away

from things to give it to people. But if you examine the Office of Education request very carefully, this doesn't hold true. There are increases that do not involve people. We say that title II, which involves not only the public but the nonpublic school children—the one program that involves all people—should be fully funded.

Title III of NDEA is the next one where we believe again that too drastic a reduction was made, cutting the amount of money from roughly $90 million to about $17 million, again on the basis that it was things. There is a part in title III of NDEA which we think is important, the part that provided for State supervision, which is a line item.

Mr. LAIRD. Also, there is matching required there.

Dr. LUMLEY. That is right. The States had to match it. We believe this is a very important feature.

You started a new program last year, the bilingual education program. Of course, the Office of Education didn't request any money for it because they hadn't supported the legislation to start with. The Congress passed it. This year they have asked for $5 million. We think it should have the full authorization of $10 million because $5 million is not going to get you very far.

The Teacher Corps, we believe, has justified itself now. We would suggest the appropriation that the Office asks for.

Impacted aid, of course, is another program that has proven itself over the years. Yet each time we are coming back with a request for a reduction. We are saying again that this should be funded, to the extent that is necessary, because this is for the local school districts to keep them operating. I have said to you "Increase this, increase that, increase something else," and I have not said to you, "Where are you going to cut?" So I point out to you that in your request for appropriations from the Office of Education you will find that the request for research is increased by roughly 95 percent and through newspaper publicity—we have nothing to go on except newspaper publicity—we learn this includes money to establish model schools in certain selected cities, one of them being the District of Columbia.

This concerns us because of the fact that we believe that the Office of Education again is getting into the business of operating local school systems. Take the District of Columbia, it has a model school system which has been operating to do these things. If there is some money, let's put a little more money into that, let's not start a whole new set-up. The proliferation, I think, is the thing that concerns us mostly.

Mr. LAIRD. That is a good point.

Dr. LUMLEY. Last year we pointed out to you that we adopt a lot of programs and then we put $5 million here, $2 million there, $5 million here, and, as I say, this is a proliferation. Let's get a program and let's make it work, make sure that it is right.

Last year there was a national assessment program established as a trial. The National Education Association objected to a national assessment program. In a conference with the Commissioner, it was agreed that this would be simply an experimental program. There was $1 million appropriated for it. They are coming back this year and asking for $2 million for a national assessment program, and we object and object strongly to a national assessment.

It is not that we do not believe that the Congress should have programs evaluated. Every program for which you spend money should

be evaluated. But what we do object to is that the Commissioner of Education has $2 million to run a national assessment program across the United States.

Mr. LAIRD. They want to evaluate their own programs. I think we should be evaluating some of them in the legislative branch.

Dr. LUMLEY. That is right; or else have each State department of education evaluate and submit an evaluation of what has happened in the various States. What has happened in Kentucky or Tennessee or Texas or Pennsylvania or any other State is what I mean. How have they spent their money? This evaluation should be done. How are the children learning? But we don't want the process centralized. We believe this is most important.

We urged you last year, and you included language in the report, both in your report and in the conference report, against these regional offices for elementary and secondary education. You see, we admit that there may be justification for higher education to have a regional office because you have many colleges and universities and not all States have a bureau of higher education. There may be an excuse for that.

Mr. SMITH. It just makes an extra office to deal with.

Dr. LUMLEY. That is right. But in the case of elementary and secondary education you actually have 50 State departments and there is no reason to superimpose another layer of administration over the State departments.

Mr. SMITH. How much do you think this research should be reduced? They have requested an increase of $53 million over last year, or a total of $142 million.

Dr. LUMLEY. We think it was pretty high last year, if you want an honest answer.

Mr. SMITH. How much do you think it ought to be cut?

Dr. LUMLEY. If we are at a place where we have to make choices, we say there is enough research that has been developed now, so let's take advantage of it and let's use it.

Mr. SMITH. What do you think that ought to be—zero?

Dr. LUMLEY. Increased?

Mr. SMITH. No; the total amount.

Mr. LAIRD. They thought it was too much last year, Mr. Chairman.

Dr. LUMLEY. What I am saying to you is that, very frankly, I don't see any reason for any increase in the request.

Mr. SMITH. Then, are you recommending the same level as last year or less?

Dr. LUMLEY. I am saying let's take what it was last year.

Mr. SMITH. That is $53 million you would take off. You have recommended increases of $200 million, approximately, have you not? Where do you recommend securing the rest?

Dr. LUMLEY. This is always a very difficult thing.

Mr. SMITH. We have this difficulty, too.

Dr. LUMLEY. You have to go through that, too. Perhaps we have to reduce research to a little less than they had last year. We go also to title III which is the supplementary centers. You go into the fact that there is a request for 373 new positions in the Office of Education. These, I think, are things that have to be evaluated. I don't know.

Mr. SMITH. All these things together wouldn't come to as much as you have recommended in increases.

Dr. LUMLEY. There are some new programs that are involved that are costing money that I wouldn't cut, I wouldn't say to reduce those.

Mr. SMITH. Then the net effect is you are recommending an increase in the amount spent for elementary and secondary education.

Dr. LUMLEY. This is always difficult, Congressman. I guess I have to back up and say to you, I noted this when I read it to you, that I probably had gone too far; that is, when I said that title I should be funded at its full authorization. I would say that there should be a percentage of increase in title I to keep it growing with last year's budget because of the increased enrollment.

Mr. SMITH. Would you, in the next day or so, get together the exact figures that you would recommend on each so that we can see whether or not you are recommending actually a total increase, or the same amount, or how you would arrange your priorities?

Dr. LUMLEY. We would be very happy.

Mr. SMITH. We can put that into the record.

(The information follows:)

NATIONAL EDUCATION ASSOCIATION,
Washington, D.C., April 25, 1968.

Hon. DANIEL J. FLOOD,
Cannon House Office Building,
Washington, D.C.

DEAR CONGRESSMAN FLOOD: On April 23, the National Education Association testified before the Subcommittee on Labor, Health, Education, and Welfare of the House Appropriations Committee on fiscal 1969 funds for the U.S. Office of Education. In our testimony we requested the following increases in the proposed budget:

Program	*Increases*
ESEA title I	$50,000,000
ESEA title II	46,000,000
NDEA title III (supervisory services)	8,000,000
NDEA title III (equipment and remodeling)	64,000,000
Bilingual education	5,000,000
Libraries and community services	7,400,000
Total increases	180,400,000

After careful reconsideration we recommended the postponement in fiscal year 1969 of our proposed $50 million increase for ESEA title I. In our opinion, the incentive grant program authorized by the 1967 ESEA amendments can be assigned a lower priority. Thus, the actual total of increases requested by NEA amounts to $130,400,000.

At the request of the committee, we have compiled a tabulation of specific reductions.

Program	*Reductions*
Elementary and secondary:	
Dissemination of information	$2,000,000
Program, planning, and evaluation	14,000,000
Education professions development: Institutes for educational media	7,500,000
Research and training: Hold to fiscal 1968 level	54,333,000
(The above figure reflects the elimination of the $1,000,000 in the fiscal year 1968 appropriations for the national achievement study.)	
Salaries and expenses	5,000,000
Total reductions	82,833,000

We believe that the dissemination of information and program planning and evaluation are the proper functions of the States rather than the U.S. Office of

Education. Further, we believe that the budget squeeze in Fiscal Year 1969 indicates curtailment of educational research. The proposed reduction in salaries and expenses reflects NEA's concern regarding the establishment and continuation of regional offices in the field of elementary and secondary education.

Further reduction and adjustment could be made by limiting the funds set aside for discretionary use by the Commissioner of Education. The sum of these set-aside funds is considerable.

With the exception of the program support funds for the Teacher Corps and education for the handicapped, we believe that the program support requests are excessive for this fiscal year and suggest a reduction of at least 50 percent for these items. This would reduce the budget by at least another $2 million.

The National Education Association believes that quality education is the primary domestic concern of government. We suggest that the increases we have proposed be offset by the reductions proposed above and reevaluation of other budget requests for the Department of Health, Education, and Welfare.

Enclosed is a marked copy of the data upon which our suggestions are based.

Sincerely,

JOHN M. LUMLEY,
Assistant Executive Secretary for Legislation and Federal Relations.

Dr. LUMLEY. As I say, the only other thing that I do want to emphasize to you is this regional office program because this we feel very seriously about. The Commissioner has told us that during this past year he has, because of the limitation you put into it the law, increased only the elementary and secondary education people in the offices that did not have them. In other words, he has six offices and people for four, so he could not let them do that. He agreed that he would call a halt until it can be reevaluated. We believe it is essential that Congress make that decision. There is no way for us to have legislation on this matter because this is under the general authority of the administration.

Mr. SMITH. Mr. Laird?

Mr. LAIRD. There are discussions going on in the executive branch about sending Congress a request to reallocate the title I money. That reallocation would be to take about $200 million and earmark it for the 50 largest cities in the United States without regard to the other provisions of title I. The figure that they are talking about now is about $200 million. What is the position of the National Education Association going to be on such a request?

Dr. LUMLEY. I can't answer to give you a policy decision. We have called our legislative commission to come to meet on the 4th.

Mr. LAIRD. Did they call and ask you for your views on this?

Dr. LUMLEY. No. We got word that we were going to face this, but we did not get a request.

Mr. LAIRD. You got the word via the grapevine and not directly from the Office of Education?

Dr. LUMLEY. That is correct.

Mr. LAIRD. This funding arrangement would require some language being written into the Appropriation Act. As I understand it, the administration is not going to request additional funds. The plan is to take off from the top before any allocation is made on the basis of the formula as passed by the Congress. The $200 million would go to the 50 largest cities in the United States on a direct per capital distribution.

Dr. LUMLEY. I can say to you what I think the reaction would be.

Mr. LAIRD. What do you think, personally?

Dr. LUMLEY. What I think the reaction of the legislative commission of the NEA would be is that there would be opposition to it because, you see, here once again we are up against the thing that I mentioned to start with, and that is title I funds now are under the control of the State departments and projects are approved by he State departments. Here we have the Office of Education coming in and saying "Let us take off and administer $200 million out of these funds."

Mr. LAIRD. This $200 million is going to be used almost entirely for summer programs——

Dr. LUMLEY. We understand.

Mr. LAIRD (continuing). Not for the regular educational offering in these communities.

Dr. LUMLEY. That is right.

Mr. LAIRD. I am concerned about this.

Dr. LUMLEY. We all recognize the importance of summer school programs and the need to get children and young people off the streets. It becomes a question of where do you get the $200 million. So if you take this money out of this program and administer it from the Office of Education through the big cities program it solves one problem, because it reduces the possibility of the schools doing something on their own. I have said in the beginning that this request for next year is not enough to do the job now.

Mr. LAIRD. Do you think that the school districts in this country would be prepared to match under title III of the National Defense Education Act in fiscal year 1969 at about the same level as they did in 1968 if the funds were available?

Dr. LUMLEY. I would feel confident they would; yes.

Mr. LAIRD. Will we get more direct results in education if we use the title III program of the National Defense Education Act? You see, in the budget that we have before us the Department says that they are going to spend $153 million on equipment under title I of the Elementary and Secondary Education Act. As you know, that doesn't require any matching whereas title III of NDEA does. They cut back about $70 million out of the program for equipment where you do have some matching. Benefits under both programs go to about the same schools. The only difference is that it is up to the school administrator to decide what his priorities are within his schools under title III. Under title I those priorities are established by a formula. But I think that any school administrator worth his salt knows where those priorities are in his school district.

I think the superintendent of schools in New York City knows where his priority areas are. They don't have to be told by the Office of Education where they are.

Dr. LUMLEY. That is correct.

Mr. LAIRD. But I am trying to find out which program would give the most impact for the dollar.

Dr. LUMLEY. Temporarily you could accomplish what you are saying by restricting the expenditure of title I funds for equipment and put the other equipment purchase in title III.

Mr. LAIRD. And you would get much more equipment purchased.

Dr. LUMLEY. Because you double your purchases there.

Mr. LAIRD. Don't you think you can trust the school administrator to put it in the right place?

Dr. LUMLEY. I hope so. If we can't, we are in bad shape.

Mr. LAIRD. I think you have to trust them a little bit.

Dr. LUMLEY. This is my great concern, that we are not giving the local school administrator the opportunity to use the ability—and the school boards—the ability and the sense that they have. I mean, we are putting up all kinds of regulations and directives saying "You have to do this, that, or the next thing to get your money." I think, by and large, the great percentage of school administrators, the great percentage of school directors in this country are competent people and they are doing competent jobs. I think you can trust their judgment.

Mr. LAIRD. I agree with you.

I have no further questions, Mr. Chairman.

Mr. SMITH. I just want to say this: It would help me, anyway, if in submitting this list of priorities you would show, for each dollar of increase you recommend, an offsetting reduction.

Dr. LUMLEY. I would be very happy to.

Mr. SMITH. So that we come out with the same as the budget request. It would be helpful to me, anyway.

Mr. Casey?

Mr. CASEY. Dr. Lumley, as you know, for the past several years we have been having difficulty here on this impacted aid program because the request for funds, in the last few years, has been less than the formula of entitlement. As a result, various districts plan for full entitlement and then they run short. You say this is an extremely important program. Is it a fair program? By that, say, Houston, Tex. might receive funds and yet we do not have anyone living on a military base, we do not have anyone living on a Federal installation while some other city gets nothing because they don't have a sufficient number of Federal employees or Federal personnel in their school districts.

Dr. LUMLEY. Who are living or working off of a Federal project or a defense project, you mean?

Mr. CASEY. Yes.

Dr. LUMLEY. We have felt that it was fair. The school districts were faced with the establishment of new defense programs originally, or Federal installations, which threw the burden on the schools, to start with. Of course, you had 815 money for building and 874 money for operating. But this was due to the fact that you had these Federal employees. We feel that it was a workable program and it did the very thing that I just said to Congressman Laird, that is, it provided the money to these school districts for them to spend as a part of their operation. It was in lieu of the taxes that they would have gotten if the property had been used some other way. Of course, now it has been expanded.

Mr. CASEY. I can readily understand where if the Federal Government should open up an installation, be it military or otherwise, and would push in on a short period of time a large mass of population, that would throw a terrific burden on the schools.

Dr. LUMLEY. On the other taxpayers.

Mr. CASEY. You need the alleviation there, so they think, to help them build the facilities and staff the schools. But these people then begin paying their taxes just like everybody else. I think at some point it should be cut out. Otherwise you would go right ahead to where the emergency has been met, but here is this school system still

drawing these funds while the people that the Federal Government put in there are now taxpayers, homeowners, they have generated new businesses and increased the tax income.

Dr. LUMLEY. I am sorry that we do not have the research to answer your question directly.

Mr. CASEY. That is the problem that is in the minds of the Congress. That is why you have trouble getting the full entitlement.

Dr. LUMLEY. I understand. I was going to say we generalize and say that in many instances in these communities these populations are transient. Now, that isn't altogether true, as you have just said. You have built up businesses, and so on. So there may come a time when the Federal Government has paid out for its impact. I am sorry, as I say, that we do not have the research to answer your question.

Mr. CASEY. That is one reason why there is difficulty in raising this to the full entitlement because of this doubt as to whether or not it is a fair distribution of tax funds.

Dr. LUMLEY. I think in the case of Federal installations, children living on Federal installations, I would think there would never be any end to it.

Mr. CASEY. No. I don't think there would be any question about that at all.

Dr. LUMLEY. The thing you are raising, and I understand it perfectly, concerns the people who are living off the reservation, so to speak.

Mr. CASEY. I live in Maryland, and I have quite a few children.

Dr. LUMLEY. They benefit by it.

Mr. CAS5fl. Yes; they benefit by it. I pay taxes, a pretty good chunk of taxes on this house that I have out there.

Mr. LAIRD. It is getting higher this year, too, isnt' it?

Mr. CASEY. It surely is.

Dr. LUMLEY. The only satisfaction to you is that it probably has prevented them from going higher.

Mr. CASEY. By the same token, there is some small district that is bearing its full share of the load because its has no Congressman with lots of kids living in their school district, and so forth. I think what we need is that the law ought to be amended so that the districts would then know exactly how to plan because, frankly, as long as we are in this tight situation that we are in and the Bureau of the Budget is going to submit less than the entitlement, and the Congress is going to wrangle around on it, maybe split the differences, they never know just how to plan.

Dr. LUMLEY. It is unfair; I agree it is unfair as it is now because you end up with an 89-percent entitlement payment. The conference report this year, on the supplemental appropriation would have made about an 89-percent payment for those that were living on base, but would have dropped down to a little less than that for those off base. Then this puts all the Members of Congress under a terrific pressure because the school districts say "We have planned on the full amount."

Mr. CASEY. We want to get out from under that heat every year. I wish you would give it some thought.

Mr. LAIRD. The conference report would have given them 98 percent instead of 81 for those living on Federal property, and it would be 81 percent of those that do not.

Dr. LUMLEY. Yes. I am sorry.

Mr. LAIRD. I think there should probably be another category included in that group that was to receive 98-percent entitlement because there is another priority group that was not covered. But I think the point that Congressman Casey makes is a very good one.

Dr. LUMLEY. This is a legitimate question, and when I was talking about research a little while ago, here is a question that should be researched.

Mr. LAIRD. If the gentleman will yield to me again.

Mr. CASEY. Surely.

Mr. LAIRD. We have a request in the budget for such a study being made. We had one made about 5 or 6 years ago which really didn't get to this point.

Dr. LUMLEY. It wasn't too good.

Mr. LAIRD. We have a request here now to go into this very area. I think it should be granted. I think the funds that we spend on that study will be worthwhile.

Dr. LUMLEY. There is no question because, you see, you have got a number of questions. One of them, as I have said, is what about the transient problem? How much is involved there? How much new business has come in?

Thank you very much, sir. We will send this material over to you in the next 2 days.

Mr. SMITH. Thank you.

TUESDAY, APRIL 23, 1968.

POPULATION CONTROL

WITNESS

W. LLOYD TUPLING, WASHINGTON REPRESENTATIVE OF THE SIERRA CLUB

Mr. SMITH. Mr. Tupling, you may proceed.

Mr. TUPLING. Mr. Chairman and members of the committee, my name is Lloyd Tupling. I am Washington Representative of the Sierra Club, whose 60,000 members in 21 chapters throughout the United States constitute the Nation's largest outing organization.

Principal purposes of the Sierra Club—as set forth 75 years ago by its founder, John Muir—are to explore, enjoy, and preserve the scenic resources of the United States and its forests, waters, wildlife and wilderness. Toward attainment of these objectives, the Sierra Club in recent years has moved on trails blazed outside the domain of forest and mountain—toward support of policies dealing with explosive population growth.

The direct relationship between preservation of scenic grandeur, elements of our environment and population growth was recognized by the Sierra Club board of directors in a resolution adopted March 13, 1965. The Sierra Club policy statement said: "The 'population explosion' has severely disturbed the ecological relationships between mankind and his environment. It has caused increasing scarcity of wilderness and wildlife and has impaired the beauty of whole regions, as well as reducing the standards and the quality of living. In recognition of

the growing magnitude of this conservation issue, the Sierra Club supports a greatly increased program of education on the need for population control."

On March 13, 1966, the Sierra Club board of directors considerably broadened the scope of the organization's interest and concern. A resolution was adopted stating that "The Sierra Club endorses the objectives of legislation to establish Federal machinery to deal with the problems of rapid human population growth." The action was taken with specific reference to legislation on the population crisis pending before the Senate Committee on Government Operations.

These actions by the Sierra Club are cited because we believe that an organization with a conservation policy but no population policy is fooling itself. We don't want to fool ourselves into thinking that the natural resource values we seek to preserve—the areas of scenic beauty, the forests, streams, and unspoiled natural areas—can be perpetuated unless action is taken to curb the "people impact" on them. It is apparent that the manmade forces now disturbing the ecology of the earth are likely to multiply in direct proportion to the number of people.

President Johnson gave recognition to this threat in his recent conservation message to Congress. He said: "From the great smoke stacks of industry and from the exhausts of motors and machines, 130 million tons of soot, carbon, and grime settle over the people and shroud the Nation's cities . . . Wastes pollute our rivers and streams, endangering the waters we drink and use. The debris of civilization litters the landscapes and spoils the beaches. Conservation's concern now is not only for man's enjoyment—but for man's survival. Our environment can sustain our growth and nourish our future. Or it can overwhelm us."

In conclusion, the President said: "The new conservation is work not for some Americans—but for all Americans. All will share in its blessings—and all will suffer if the work is neglected. That work begins with the family..."

We must enlarge our commitment of national resources so that the family is indeed the unit for securing conservation goals. More funds should be allocated to development and research in the technology of fertility control. Educational efforts must be expanded so that families are aware of both the techniques for curbing reproduction and the socially desirable fruits of such action. Moreover, our Nation should investigate means for motivating men and women to use the methods for controlling reproduction. Without incentives, neither pills nor loops nor other contraceptive devices will be able to cope with the population crisis.

The President's budget has made provision for some new starts in these areas. Whether the allocations in the budget are optimum sums, we are not in a position to judge. However, the Sierra Club supports appropriations for these purposes at the level which can be used most effectively by the agencies.

The $450,000 requested for the national survey of family growth under the National Center for Health Statistics will launch a long-overdue project. More information is needed on the demographic, sociological, and health-related aspects of fertility, and this amount will at least provide a start. Another new program of value would be funded with an allocation of $5 million to the National Institute of Child Health and Human Development for research in the develop-

ment of new contraceptive techniques. Although pharmaceutical companies may not be held back in research because of a vested interest in products already developed, additional research activity outside the industry undoubtedly would have a stimulative effect.

We endorse as a minimum the allocation of $24 million for family planning services under the Children's Bureau and of $13 million to the office of Economic Opportunity for similar activity by antipoverty agencies.

Of particular concern is the need to adequately fund the work of the newly established Center for Population and Human Reproduction within the National Institute of Child Health and Human Development. Nongovernmental sources have recommended an investment of $150 million a year by the Federal Government in this program. The budget allocation of $12.8 million would appear to fall far short of need, in view of the scope and significance of the population crisis. Population research by the social and behavioral sciences should parallel the work already underway in the biological sciences. The problem is not only in finding ways to control fertility but how individuals may be moved to put these techniques to work.

We face a stern task. Namely, how to keep the quantity of people from overwhelming the quality of environment. Even if technology could devise ways of extracting from limited resources the material needs of an ever-expanding population, would the effort be worth it? Man has basic esthetic and psychological needs which are nurtured by contact with unspoiled nature. Fulfillment of these needs is important. Control of overpopulation can enhance the prospects for a pleasing environment, as well as one which fills material wants.

Mr. SMITH. I wasn't aware you were so heavily concerned and in favor of birth control before. So what it really amounts to, you are for both an increase in natural resources and a reduction in human resources; is that the situation?

Mr. TUPLING. Well, I don't think I want to put it exactly in that context, Mr. Chairman.

What we are interested in is preserving and protecting some of those areas in our country which have not been affected by the impact of man or his technology.

Mr. SMITH. Do you want to keep people out of there; is that it?

Mr. TUPLING. In some areas I think people should be kept out. We should let the natural forces work.

Mr. SMITH. Are you going to do that by reducing the number of people that might go there?

Mr. TUPLING. No. I think we are going to try and educate people to the value of protecting these things in their natural state, make it a matter of personal choice with the individual.

Mr. SMITH. But in summary—and I do not want to be unfair—but in summary you are saying that we need to increase natural resources but not increase human resources at the same rate?

Mr. TUPLING. Yes; that is right.

Mr. SMITH. Mr. Laird?

Mr. LAIRD. Mr. Chairman, I notice this statement endorses the activities not only in OEO but also in the Department of Health, Education, and Welfare. I wondered if your group had given any study and discussion as to whether it might not be desirable to bring all these activities together in one place.

Mr. TUPLING. A committee was appointed the first of March by the president of the Sierra Club, Dr. Wayburne, to advise the club on how to implement this policy statement which I read into the record. This group is expected to report at our next board meeting which comes the first week in May, and I had hoped that they would have had something available for me to present at this time.

Mr. LAIRD. We have had some reports that in some of the communities where you have both agencies setting up the clinics and giving the services and making them available to people, that the agencies are not even talking to one another. It would seem to me that in these communities we should have a greater degree of coordination between the efforts of the HEW people and OEO.

Mr. TUPLING. Well, perhaps there would be something gained from a combination of these programs. Our purpose in endorsing the two programs was to expand the total scope rather than to make a decision as to who should administer them.

Mr. SMITH. Mr. Casey?

Mr. CASEY. No questions.

Mr. SMITH. Thank you.

Mr. TUPLING. I have a reprint of an article I would like to have included in the committee's files.

Mr. SMITH. Thank you.

TUESDAY, APRIL 23, 1968.

LEGAL SERVICES PROGRAM, OFFICE OF ECONOMIC OPPORTUNITY

WITNESSES

ORISON S. MARDEN, PAST PRESIDENT, AMERICAN BAR ASSOCIATION

JOHN D. ROBB, CHAIRMAN, STANDING COMMITTEE ON LEGAL AID AND INDIGENT DEFENDANTS, REPRESENTING THE AMERICAN BAR ASSOCIATION

PHILIP J. MURPHY, FIELD DIRECTOR, AMERICAN BAR ASSOCIATION, STANDING COMMITTEE ON LEGAL AID AND INDIGENT DEFENDANTS, NATIONAL LEGAL AID AND DEFENDER ASSOCIATION

JOHN P. TRACEY, ASSISTANT DIRECTOR, WASHINGTON OFFICE, AMERICAN BAR ASSOCIATION

Mr. SMITH. Mr. Marden, I believe you are next.

Mr. MARDEN. Mr. Chairman and members of the subcommittee, my name is Orison S. Marden. I reside in Scarsdale, N.Y., practice law in New York City and am the immediate past president of the American Bar Association. I am accompanied by John D. Robb who lives and practices law in Albuquerque, N. Mex., and currently serves as chairman of the American Bar Association's Standing Committee on Legal Aid and Indigent Defendants.

We appear here to urge appropriations for the legal service program in an amount not less than $60 million for the next fiscal year. We also urge the earmarking of that sum.

I would like to file with the committee for the record a joint statement of Mr. Robb and myself on behalf of the association and then, if it please the committee, I would like to make a few very general observations and then ask Mr. Robb, if he will, to discuss with the committee some of the specifics.

Mr. SMITH. Go ahead.
(The statement follows:)

STATEMENT OF ORISON S. MARDEN, ESQ., AND JOHN D. ROBB, ESQ., IN SUPPORT OF THE LEGAL SERVICES PROGRAM OF THE OFFICE OF ECONOMIC OPPORTUNITY

Mr. Chairman and members of the subcommittee, my name is Orison S. Marden, I resiue in Scarsuale, N.Y., practice law in New York City and am the immediate past president of the American Bar Association. I am accompanied by John D. Robb who lives and practices law in Albuquerque, N. Mex., and currently serves as chairman of the American Bar Association's Standing Committee on Legal Aid and Indigent Defendants.

The American Bar Association deeply appreciates the opportunity to appear before you on behalf of the national organized legal profession to express the great need for more adequate appropriations for the legal services program of the Office of Economic Opportunity. For a current statement of the deep interest of the association in the legal services program, we respectfully refer you to the President's page of the American Bar Association Journal of March 1968, appendix I.

On July 17, 1967, in conjunction with the National Legal Aid and Defender Association and the National Bar Association, we expressed our full support of the legal services program in a statement to the House Committee on Education and Labor. Our considered appraisal in that statement, copies of which have been made available to the subcommittee staff, and also at the present time is that the general objectives of the program are being achieved and that good quality legal services are being provided as an effective part of the antipoverty program. We have also testified to a like conclusion before the cognizant subcommittee of the Senate Committee on Labor and Public Welfare.

Since July 1967, we have substantially increased our first-hand knowledge of the program by having representatives of the ABA, NLADA, or NBA make visits and appraisals of local operating programs in the 56 communities listed in appendix II. We have also made periodic close reviews of its policies and procedures through continuous contact with OEO officials and with lawyers and laymen in many communities in addition to those listed.

In our testimony before the Committee on Education and Labor in July, we asked that Congress consider a $90 million appropriation for this vital program. Congress did not appropriate sufficient funds to enable the Director of the Office of Economic Opportunity to allocate that amount to the legal services program. Yet, it did appropriate $1.77 billion to meet the request of the Director to continue the overall OEO program at 1967 levels. Had the Director been able to follow out this understanding with Congress, $45 million would have been made available to the program which would have permitted a modest $3 million expansion to cover critical needs. An unexpected development occurred after Congress acted. The Bureau of the Budget reviewed and changed the planned allocation of funds within the agency. It excised large sums from all OEO programs and legal services actually suffered a demoralizing 8.5 percent budget cut rather than the anticipated $3 million increase. Incalculable damage is occurring to this meaningful young program from being thus cut back and stunted.

The legal services program is unique in several respects.

First, the investment by the private sector is probably greater in this program than any other component of the OEO. The legal profession itself and other private sources were contributing $5 million in cash annually to legal aid programs prior to OEO's involvement. Not only has this level been maintained as required by the Economic Opportunity Act, but in 3 short years it has increased to over $8 million. Added to these cash contributions, the legal profession has stepped up its volunteer effort by giving over $7 million in contributed time for direct assistance to legal services programs. There are additional thousands of hours devoted to service upon boards of these agencies and efforts spent in the promotion and development of new programs now applying for funds. This substantial increase in private response demonstrates the independent strength of legal services and evidences the widespread recognition, at local levels, of the need for increased rather than diminished legal services. It further indicates that Congress should consider steps to strengthen and expand this particular OEO program.

Secondly, legal services furnishes personal and direct service to the poor so that their grievances can be channeled into the legal structure and resolved in

the courts. The National Advisory Commission on Civil Disorders has pointed out the many areas of discontent which cause a sense of injustice among our poor. (See app. III.) This rankling underlies the outbreak of many of the recent civil disorders and incidents of lawlessness by the poverty communities. The legal services program is attacking each and every one of these critical areas of discontent.

It is helping the poor fight consumer exploitation. It is helping the poor obtain better housing and enforcement of building codes. It is helping the poor fight arbitrary administrative practices. It is aiding them in overcoming discrimination in employment. No other OEO program is working so directly and effectively with the underlying causes of discontent in the poverty communities.

It is critically essential that funds for this program be legislatively earmarked so that the growth and achievement of this proven service is protected and not further impaired. Earmarking is particularly indicated: (1) to prevent a recurrence of the aforementioned unfortunate administrative reallocation of funds; (2) to assure the continuance of the vital independence of the legal services program; and (3) to establish a congressional level of support for the program should it be shifted from OEO.

In 1966, Congress did earmark funds for programs within OEO—for Headstart and legal services. We strongly urge that this committee recommend that this same course again be followed. Certainly, there should be earmarking for legal services as defined under subsection 222(a)(3) of the Economic Opportunity Act.

While the needs for legal services remain at the $90 million level we recognize that present fiscal difficulties may make such a figure unattainable. Therefore, we urge that $60 million be appropriated for the program. This compares with the $38 million available during fiscal 1968. Such an amount would allow existing programs to return to their 1967 annularized levels (approximately $42 million) and permit extremely modest expansion. Both ghetto and rural poor are now becoming aware of and confident in their legal services made available to them by the profession and Congress. Because of this burgeoning response of the indigent, the ABA is fearful that stagnation at this point may doom many programs to the fate of several old line legal aid societies whose abilities to bring the judicial process to the poor were undermined by overwhelming caseloads.

We must at all costs avoid a return to the pre-OEO situation where such caseloads often resulted in second-class, ill-prepared legal representation. In many cities at present funding levels, programs have reached a saturation point in their ability to handle clients in the manner required by the ethics of the profession. These programs need funds for supportive research, training, law reform and proper recruiting which will extend the abilities of their present manpower to meet caseload demands.

Sixty million dollars would also allow for the most urgently needed expansion. Specifically, it would allow thoughtful consideration and selection among 117 proposals for new programs, 87 of which are actually completed applications. Over 50 percent of these are rural programs which, as a class, have developed at a much slower pace than the urban programs.

Yet, many are large cities in which the association has worked hard and long through its members to promote adequate legal services for the poor. Birmingham, Memphis, and Nashville are good examples of communities which have submitted applications for which there are no present funds in sight.

There has been careful investment of program funds thus far and this will continue. The performance of funded programs has been good, but has not reached a point of optimum efficiency yet. We call the attention of the committee to the earlier testimony before it of Earl Johnson, Jr., Director of the legal services program. He has set forth its effect and achievements within slightly more than 2 years of operation. It is currently providing high quality service to more than 500,000 clients and is producing remarkable results for the benefit of our society at a cost of less than $50 per case—a figure which the most financially stringent accountant would approve.

In the face of conflicting demands for funds, Congress must elect to allocate funds to Federal programs which have the broadest impact and significance to our citizens. These programs must also give the top-dollar return on their investment. Judged by these criteria we believe that legal services deserves a high priority. We ask the Congress to safeguard its sound investment in the legal services program by appropriating to it not less than $60 million and by clearly earmarking these funds to insure that this decision is carried out.

APPENDIX I

[From the American Bar Association Journal, March 1968]

THE PRESIDENT'S PAGE

(By Earl F. Morris)

Lawyers, through both organized legal aid and individual efforts, have historically provided legal representation for the poor in criminal and civil matters. However, despite the considerable contribution of time and energy and the extensive inflow of private funds to the legal aid movement, the complexity of present-day life, the mobility of a large portion of the population and the rising need for legal services have caused our profession to assess its role in assuring that legal services are available to all those who require them regardless of means.

When the Federal Government proposed the rendition of legal services under the Economic Opportunity Act, the legal profession responded in strong, affirmative fashion because we recognized that an enormous positive growth in legal services for the indigent could be made possible through the infusion of Federal funds. Although at the end of 1964 there were 246 organized legal aid offices handling civil matters and 140 public defender services in the criminal field, as well as 136 local bar association legal aid committees, a large number of the legal aid services did not meet American Bar Association minimum standards, and 22 cities, each with a population exceeding 75,000, had no organized legal aid operation.

The bar, in making its commitment, recognized the weaknesses, current and potential, of a federally financed program. It understood the fear of many lawyers that the Government would take paying clients away from lawyers; that the canons of professional ethics would be subverted; that private contributions of funds would be discouraged and reduced; and that the Government, not the bar, would become the provider of legal services. But we believed that, if the bar took an active role in the development and implementation of the program, those fears would prove baseless, and that the problems would be far outweighted and the disadvantages heavily overbalanced by the benefits of the program.

There have been problems, but the legal services program has deservedly gained the respect of those groups that have been most intimately affected by it: the bar, the Congress, and the poor people who have received the aid.

The participation of the bar has been effective, both quantitatively and qualitatively. According to OEO figures, 2,000 lawyers are working in 850 neighboring law offices in 260 communities. During 1967, about 500,000 indigents received advice and representation from OEO lawyers in consumer, housing, welfare, family and juvenile matters. OEO lawyers won 70 percent of 30,000 court trials, 66 percent of 228 appeals, 79 percent of 2,074 cases involving administrative agencies and averted or obtained stays in 86 percent of 1,900 evictions. In the qualitative sense, the program has perhaps had its brightest moments in the area of law reforms. Significant changes in the law, with direct economic and social impact, have been made by OEO lawyers throughout the country.

Although no component of the poverty program, with the possible exception of Project Headstart, has received as much commendation among the Members of Congress as the Legal Services Office, the law reform efforts provided a certain amount of ammunition for critics of the legal services program during the last session of Congress. An amendment to the OEO bill that would have prohibited legal services programs from bringing "any action against any public agency of the United States, any State, or any political subdivision thereof" failed of passage in the recent congressional session. Such an amendment would have been unfortunate because a substantial percentage of poor people's problems relate to governmental action or inaction. Some amendments were enacted that are of concern, but that providing for consultation with State and principal local bar associations on all projects proposed is in accord with the practice to date and is, of course, salutary.

An auspicious start must be followed by a constantly improving performance. This will, in large measure, be assured if the deep involvement of the organized bar in these early stages continues unremitting. In this context, the American Bar Association's Standing Committee on Legal Aid and Indigent Defendants has participated in evaluations of the effectiveness of several legal services programs, and more such activity is planned. Our association and State and local bar associations must keep the functioning of the program under constant

vigilance, ready to criticize if fault arises and equally ready to help when help is needed. If we do this and if we continue our efforts in the private sector of legal aid and defender services, the future of legal services for the poor will be one of which lawyers of this country will justly be proud.

Appendix II

Communities Visited by Representatives of American Bar Association and National Legal Aid and Defender Association, July 15, 1967 to April 15, 1968

Anchorage, Alaska
Florence, Ariz.
Sells, Ariz.
Tucson, Ariz.
Window Rock, Ariz.
Oakland, Calif.
Redwood City, Calif.
Richmond, Calif.
Riverside, Calif.
San Diego, Calif.
San Francisco, Calif.
Pueblo, Colo.
Commonwealth of Puerto Rico
Bridgeport, Conn.
New Britain, Conn.
New Haven, Conn.
Waterbury, Conn.
Washington, D.C.
Savannah, Ga.
Honolulu, Hawaii
Edwardsville, Ill.
Indianapolis, Ind.
Iowa City, Iowa
Waterloo, Iowa
Kansas City, Kans.
Grayson, Ky.
Louisville, Ky.
Alexandria, La.
Boston, Mass.
Cambridge, Mass.
Detroit, Mich.
Leach Lake, Minn.
Minneapolis, Minn.
St. Paul, Minn.
Philadelphia, Miss.
Kansas City, Mo.
St. Louis, Mo.
Omaha, Nebr.
Bridgeton, N.J.
Albuquerque, N. Mex.
Zuni, N. Mex.
Albany, N.Y.
Cleveland, Ohio
Chester, Pa.
Charleston, S.C.
Columbia, S.C.
Greenville, S.C.
Fort Thomas, S. Dak.
Chattanooga, Tenn.
Austin, Tex.
Dallas, Tex.
San Antonio, Tex.
Montpelier, Vt.
Charleston, W. Va.
Casper, Wyo.
Wind River, Wyo.

Appendix III

Excerpt From Report of the National Advisory Committee on Civil Disorders, March 1, 1968

Accessibility.—In large cities, ready access to grievants may require setting up neighborhood offices in ghetto areas. In others, local resident aides could be empowered to receive complaints. It should be possible to file a grievance orally or in writing. If forms are used, they should be easily understood and widely available.

Participation in grievance process.—Grievants should be given full opportunity to take part in all proceedings and to be represented by counsel. They should receive prompt advice of action taken; results of investigations should be made public.

EXPANDED LEGAL SERVICES

Among the most intense grievances underlying the riots of the summer of 1967 were those which derived from conflicts between ghetto residents and private parties, principally white landlords and merchants. Though the legal obstacles are considerable, resourceful and imaginative use of available legal processes could contribute significantly to the alleviation of resulting tensions. Through the adversary process which is at the heart of our judicial system, litigants are afforded a meaningful opportunity to influence events which affect them and their community. However, effective utilization of the courts requires legal assistance, a resource seldom available to the poor.

Litigation is not the only need which ghetto residents have for legal service. Participation in the grievance procedures suggested above may well require legal assistance. More importantly, ghetto residents have need of effective advocacy of

their interests and concerns in a variety of other contexts, from representation before welfare agencies and other institutions of government to advocacy before planning boards and commissions concerned with the formulation of development plans. Again, professional representation can provide substantial benefits in terms of overcoming the ghetto resident's alienation from the institutions of government by implicating him in its processes. Although lawyers function in precisely this fashion for the middle-class clients, they are too often not available to the improverished ghetto resident.

The legal services program administered by the Office of Economic Opportunity has made a good beginning in providing legal assistance to the poor. Its present level of effort should be substantially expanded through increased private and public funding. In addition, the participation of law schools should be increased through development of programs whereby advanced students can provide legal assistance as a regular part of their professional training. In all of these efforts, the local bar bears major responsibility for leadership and support.

ASSISTANCE FOR MAYORS AND CITY COUNCILS

In the chapters that follow, we direct attention to broad strategies and programs of national action. Yet the capacity of the Federal Government to affect local problems depends to a great extent on the capacity of city government to respond competently to Federal program initiatives.

In the face of the bewildering proliferation of both community demands and local, State, and Federal programs, mayors and city councils need to create new mechanisms to aid in decisionmaking, program planning, and coordination. At this time, however, no assistance is available to develop these new and critically necessary institutional capabilities or to support the required research, consultants, staff, or other vital components of administrative or legislative competence.

The Commission recommends, therefore, that both the State and Federal Governments provide financial assistance to cities for these purposes as a regular part of all urban program funding.

HEARINGS ON GHETTO PROBLEMS AND ENACTMENT OF APPROPRIATE LOCAL LEGISLATION

Many of the grievances identified in our study of the conditions underlying civil disorders can be redressed only through legislative action. Accordingly, we recommend that the legislative body of each city with a substantial minority population hold, as soon as possible, a series of hearings on ghetto problems. In large cities, these hearings could well be held in the ghetto itself to facilitate full citizen participation.

In addition to establishing a foundation for needed legislative measures, these hearings would constitute a visible demonstration of governmental concern for the problems of ghetto residents. They would also provide a most useful means of bridging the communications gap, contributing to an improved understanding in the white community about the conditions of ghetto life.

Mr. MARDEN. As the subcommittee I am sure is aware, the legal services program has from the beginning had the enthusiastic support of the organized bar. In the beginning the American Bar Association began working with Mr. Shriver and the directors of the program. We have assisted in preparing the guidelines, we have overseen the work of the program directors to assure that the canons of ethics of the profession are being observed and that the dollars which have been appropriated for these purposes are well spent.

Mr. LAIRD. What you are really asking for then is an increase over the present budget of $18 million?

Mr. MARDEN. That is right.

Mr. LAIRD. And an increase over last year's program level of $22 million?

Mr. MARDEN. Yes; I think that is right.

Mr. LAIRD. Last year the Congress made available $38 million. The President has requested this committee to consider increasing that rate to $42 million. Your statement evidently asks for an increase of $18 million over and above the recommendation of the President and Bureau of the Budget for fiscal 1969.

Mr. MARDEN. That is right. We feel this program as it has been implemented has proved so important, not only to the poverty program but also in assuring equal access to legal services in this country for those who need it that it deserves a high priority and the full support of the Federal Government. We have access to the evaluation reports of the various programs and the association itself, through Mr. Robb's committee, and the National Legal Aid and Defender Association, have themselves inspected about one-fifth of the existing programs. And our purpose is to develop our own evaluation independent of the OEO to make sure that from a professional standpoint the program is being properly administrated.

Mr. SMITH. Did your evaluation include a determination as to whether or not these lawyers were really practicing law as they were supposed to be doing or if they used some of their time on nonlegal activities?

Mr. MARDEN. We certainly attempt to, Mr. Chairman. We are very encouraged by the high quality of the lawyers who are going into these programs, not only the young men, and we are finding it difficult frankly in the bigger cities to get the best boys coming out of the law schools.

Mr. SMITH. Obviously this could happen in some cases, but is there any substance to the complaint I have heard that some of these lawyers are not really doing what they were expected to do, and that is furnish legal services, but instead are engaging in other types of activities? Do you think that is a justified criticism or not?

Mr. MARDEN. Mr. Chairman, I cannot answer that specifically. That certainly would be contrary to what we have urged on these programs. I do not think we have run into instances where that has occurred.

In addition to what the American Bar Association and the National Legal Aid and Defender Association are doing, we have the state bar associations and the local bar associations, which are in a number of cases overseeing the operations of these agencies and are participating in guiding their work.

Mr. SMITH. You have already indicated there is more work to be done than there is money to do.

Mr. MARDEN. That is right.

Mr. SMITH. And this would also mean then, I think it would naturally follow, that they should not be doing any work other than legal work.

Mr. MARDEN. I agree with you, sir. These are law offices and they should be run as law offices. That is what the guidelines provide, including the observance of the canons of ethics and I think, by and large, our belief is they are doing that.

Mr. ROBB. May I amplify that by saying I think some of the misunderstanding, if there is any, may result from the fact that lawyers in legal service programs, Mr. Chairman, are now doing things for poor people that they were never able to do before because of funding limitation.

For example, in old line legal aid agencies, there simply was not enough money to permit a full range of legal services to be rendered to poor people. Now that there are adequate funds available or there were until quite recently to try to develop programs to provide that the poor would get full representation in all of their legal matters, we have been able to do in legal services programs things we were unable

to do before. But they are legal services. The objective is to give to the poor the same kind of representation that the rich, both corporations and individuals', have been able to afford, and legal services programs by and large, based on our observance, are doing the same things for poor people that advocates and lawyers have done for years for the rich.

Mr. MARDEN. I might make one further observation.

We have a real manpower problem here which I think is peculiar to this program. If funds are cut back, we have lawyers, professional men, involved in these programs, men who have left their own practices in order to take on this public service, which it is essentially. It is not as easy for a lawyer to move back into full employment as it is for those, for example, engaged in a health program. Medical professionals can always go into a hospital and are in demand.

We have a genuine fear, Mr. Chairman, that the very good people we are getting into these programs, especially the young men, are going to be lost if this program is cut back. We are going to lose the high quality professionals we are now injecting into the program.

Mr. LAIRD. Mr. Chairman, the program is not being cut back under the terms of the President's budget. When the Office of Economic Opportunity testified here I asked that question specifically and they said they could maintain the same program level as last year.

Are you talking about the action of the Senate the other day in cutting the expenditure level $6 billion. If that is what you are talking about, that might have some effect. But the testimony before us was that if the committee recommended the $4 million increase, the program level could be maintained at last year's level.

Mr. MARDEN. We are concerned not only about maintaining the present level, but we have 117 applications now pending which were carefully worked over by the bar and OEO for which there are no dollars, no money available.

Mr. LAIRD. We are hearing from an awful lot of attorneys around the country right now. As a matter of fact, I looked at three attorney's letters early this morning in which they said the financial situation in this country is such that we want to have some expenditure reductions. We are willing to go along with the tax increase but we need expenditure reductions even if it affects our programs. A lot of your own people are saying this.

Mr. MARDEN. I do not suggest that I speak for 100 percent of the bar, but I do say that the organized bar believes this program to be first rate, that it has proved itself and it is entitled to very high priority and we insist the great investments put in the program will be lost if it is not continued and expanded.

Mr. LAIRD. I think it is a good program. I am for the program. My only problem is that you are asking for an increase of about 30 percent as we go into one of the most severe financial crises this Government has ever faced. Those of us on the appropriations committee that serve on this subcommittee, as well as the defense subcommittee, have got to be very careful about going above what the President has recommended. We have to be very careful about going above his recommendation and the recommendations of Sargent Shriver and the new acting director, Bert Harding.

Mr. MARDEN. Mr. Laird, I appreciate that problem. What we are trying to give you is our best judgment of what should be done. Then of course you must be the judge.

Mr. ROBB. May I say this, Mr. Laird, on your question: Speaking of cutbacks, the legal services program was cut back 8.5 percent last year as a result of the reshuffling of OEO funds.

There was an 8.5-percent cut from the level of the spending that had been set forth for legal services and for funds that had been committed. For example, the New York program.

Mr. LAIRD. This was a reduction from the budget figure, not an 8.5-percent cut from the program level of 1967.

Mr. ROBB. You can phrase it any way you want.

Mr. LAIRD. I want you to know we appropriated $25 million in 1967 for this program and we provided $38 million for the present fiscal year, 1968. So when you talk about an 8.5-percent cut, I think the members of the bar should understand there was a substantial increase in 1968 over 1967 funding levels. You are talking about a cut in something that was a program level, not an actual cut as far as expenditures were concerned.

Mr. ROBB. You may be right. Money, however, had actually been set aside, grants had actually been made at a level approaching $45 million. Because of the fact that we were stepping up our operation, we were phasing in lawyers; commitments had been made.

Mr. LAIRD. That is right.

Mr. ROBB. And this resulted in OEO having to break faith with those commitments and resulted in some lawyers having to be laid off, resulting in some offices that had actually been programed and agreed upon not being opened. In that sense it represents a cut from commitments made by OEO. That is the point we are trying to get across.

I would like to say, it may sound to you gentlemen unusual we would be here asking for a large increase over the administration. We are not critical of the administration. We know it has many problems of its own. We are saying it is not directing its attention to this problem because of its preoccupation with many other things, it has not directed itself really to the real problems of the legal services program. This is one of the reasons we asked for a hearing because we wanted to tell you what our candid assessment was of the program and the limitation in the administration figure.

Mr. LAIRD. I have heard your position expounded before.

Mr. ROBB. I would say, gentlemen, there are two or three reasons why we feel that you should expand legal services at this time. We know you have priority allocations that you have to make. We know you have problems of picking and choosing, but we say that legal services programs have some justification and some reasons for the expenditure of funds that are not necessarily shared in some of the other programs.

In the first place, as Mr. Marden just touched on, we are, I think, one of the very most effective parts of the war on poverty. Our legal service lawyers are helping poor people keep their jobs so they can remain off relief. We are protecting them against unscrupulous merchants and landlords who are helping to shove these people deeper and deeper into poverty by reason of their practices.

We are doing many things which address themselves directly to the issues of the war on poverty. I think one of the most effective

parts of the war on poverty is this program. It is much more than just a war on poverty. The very basis for rendering legal services relies on the fact we have a Government of laws where we guarantee equal rights to everyone. For too many years we have broken this promise to people who are poor. They have not received the representation necessary to vindicate and assure those rights. The basis for this program goes far beyond the war on poverty.

Finally, I would say to you gentlemen one of the most important results of the legal services program is something that strikes at the core of some of our key problems, and that is legal services are generating a respect for law and order which is long overdue in this country. Our rising crime rate, our riots, many of the serious problems we are faced with, while they are complex problems and I do not purport to be an expert on either one, I would say underlying these is the very common basis of disrespect for law and order. I say we cannot expect people to have respect for the rights of other people if their rights themselves are not respected, and the rights of the poor people have not been respected because they have not had legal representation.

I say if you are going to address yourself to our present problems, you have to get to the core, and one of the core problems is the lack of legal representation. If you respect their rights, give them lawyers, give them a chance for redress, of grievance, and I think you are going to find they will respect the property rights of others. I think you will see a decrease in the crime rate, you will not see quite so many people anxious to go out and loot and rob and burn the property of other people.

These we think are essential and important things that are very timely and that you are accomplishing by enhanced investment in these services.

Gentlemen, I know of no program where we are getting so much for our money. This is the best program I can imagine. You have 600,000 people being provided with professional, high-class, quality service at a very low cost, less than $50 a case. Not only that, but you have set a precedent as a result of actions that have been brought than redounded to the benefit of millions of people who never saw the inside of a law office, legal services office, or any other office, and you are getting a whale of a lot of service for a very small investment.

May I also address myself to the earmarking. Earmarking is utterly essential for this program. Last year we had an example where commitments were made, which we discussed with Mr. Laird, that had to be broken, because of the 8.5-percent problem that occurred after Congress adjourned, and after Mr. Shriver indicated to the Appropriations Committees he was going to advance the level of spending for legal services on the order of $45 million, and he wanted a minimum of that amount of money and was prepared to make that available in legal services. Then there was a readjustment of the budget by the Bureau of the Budget because it was necessary to create jobs. Under administrative order there was a cutback in legal services. We cannot have a recurrence of that.

If you gentlemen share our conviction of the importance of the program, you must earmark these funds to see we do not have a recurrence of that.

A second reason for earmarking, which is very important, gentlemen, is the fact that the legal services program must be permitted a certain amount of independence. What we are doing is representing clients against all comers. If poor people have been put upon, we are taking on Government agencies if necessary, we are taking on the establishment, you might say, we are taking on merchants and landlords. We do not show any favoritism. If poor people have a problem that has a legal remedy, we protect that. In order to preserve our right of independence so we can give these people the very best advice untrammeled by any outside influences, we need our own money earmarked. We have had some interior problems in OEO.

For example, the McKinsey Report problem where OEO tried at one time to submerge lawyers and put them under the domination of laymen, a professional program under the domination of laymen.

The House Education and Labor Committee in its report earlier this year contains a very strong statement that legal services must remain independent, professionally controlled and directed. We hope OEO is going to observe this, but we have no assurance. Also, local communities are starting to move on it. It is a good program. The local mayor says to sue everybody but not the city administration. He says, "Sure, we have poor people, sure, we have cut back on welfare, but leave us alone. Sue somebody else or tangle with somebody else."

We must preserve the professional independence of this program. This is a unique problem to legal services, gentlemen. This is why I think it must be earmarked.

Finally, because of the uncertainty surrounding the political situation, because we do not know what is going to happen to OEO, we hear a lot of talk of transferring OEO-sponsored programs to other agencies. We need a solid base of support to show that Congress is committed to the legal services program so that it does not get emasculated or cut up in the process of any transfer.

I would urge you very strongly to earmark legal services if you believe in the program as we do.

Mr. SMITH. There have been a number of court decisions, as you all know I am sure, requiring that poor people charged with crimes be fully represented, and in those jurisdictions where they have not previously been represented, some way must be found to get representation for them.

Do you think that this program should absorb that cost which has in many jurisdictions been provided by the local court system?

Mr. ROBB. No, sir; we do not believe that the legal services program should step in and supplant what is already being done or what is an obligation of the State. The amendment at the last session of Congress actually has curtailed the right of legal services to render representation except in the very most limited circumstances, and those circumstances are that prior to arraignment some kind of service can be rendered. Actually, the legal services programs are not representing a defendant charged with crime in the normal course of events. What we have done, however, is in a few special circumstances, for example Detroit, where the riot created an extraordinary demand on members of the bar, at the request of the American Bar Association and the Governor and the mayor, the legal services program there stopped its work and turned out its lawyers to help in an emergency situation.

Mr. SMITH. Do you think that amendment should be continued then?

Mr. ROBB. I have mixed feelings about it.

I, first of all, would say we should not duplicate obligations that are imposed on the State for general representation in felony matters.

Mr. SMITH. Before that amendment, were they being duplicated?

Mr. ROBB. No, sir. In general, felony representation was not provided, except in that one emergency situation.

What we were doing in many local legal services programs was representing people charged with misdemeanors. There is no constitutional requirement as yet by Supreme Court interpretation that persons charged with misdemeanors and other minor offenses are entitled to counsel, and we feel they should have counsel, and as a result some kind of representation has been provided by OEO in misdemeanor cases, and I think that was a wise decision. We can no longer do that under the amendment of the Congress.

Mr. SMITH. In some States an indictable misdemeanor is a very serious crime.

Mr. ROBB. That is right. And I know of no reason to draw a line between a felony and a disdemeanor on representation. The Supreme Court has not gone that far and the States have not gone that far. If we did not have a limitation by Congress, I would personally favor the legal services program providing defense services in misdemeanor cases.

Mr. SMITH. Mr. Laird?

Mr. LAIRD. I think you have made a very good presentation. I do not know what we can finally do for this program. I am sure the committee will examine your request very carefully. We realize it is a good program. I hope when you get back to Albuquerque you will give my regards to my Uncle Modrall, who practices there.

Mr. ROBB. I shall indeed. He is a very close friend.

Mr. SMITH. Mr. Casey?

Mr. CASEY. Of the few complaints I have ever had about the program, occasionally I have complaints from attorneys stating that there is representation of people who have property rights or something that may develop into a compensable case. In other words, do you have many complaints of that nature as a committee, or do they ever lodge them with you, or do they just write to their Congressmen?

Mr. ROBB. We get complaints of all kinds where there are complaints to be had. Occasionally we have had criticism of that kind. But it is a very minor amount. Obviously where you draw the line between representing and say that the people making so much money are going to be represented by legal services and those making a dollar more are going to be represented by the private bar, you are going to find some practitioners watching that line very closely.

On occasion, of course, legal service programs make mistakes just like anyone else. Occasionally they take a case they should not. But by and large they are administering the program very closely on the guidelines provided. I would say there is not any general abuse by programs in taking cases they should not.

Mr. MARDEN. The guidelines are very specific on that point. No service is supposed to be provided in any matter in which a private lawyer might conceivably be interested.

Mr. CASEY. I think the point you made about the people in the ghettos and so forth having representation where they see the law respects their rights is a good one, because I have heard one of the things that excites them is high charges, carrying charges on purchases, and the first thing they do is tear up the store that has their accounts and burn the books, hoping they do not have a duplicate set, to wipe out the account they finally realize was eating them up with high carrying charges and so forth.

I think that is a very good point you made that these people never had anyone to speak up for them particularly. To know that they do have recourse where they are being charged usury or what have you, unusually high carrying charges or interest rates, whatever you want to call it, to get redress, this will give them more respect for the law.

Mr. ROBB. The stores they pick or places they pick on to loot and burn is the best indication of the direction in which their frustration lies and the direction from which the oppression is coming.

Mr. CASEY. It was very obvious here the stores they hit were the ones they traded with. They did not touch the large department stores right in that area. They hit the small stores where they had been trading. It is a resentment I presume that has built up in that regard. I think you have an excellent point there for continuation of the program and the expansion of it, but I notice in one of the President's messages you had in your presentation here that you must observe the criticism and try to correct that as well as urge a continuation of the program.

I have heard the criticism that you employed some attorneys at a pretty high rate of pay who were not making a living when they went on your payroll. Of course, I think by the same token some of these in my part of the country were Negro attorneys, and they are probably very capable attorneys but just cannot get clients to come to their offices. Anyone would go to a larger office in a major city if they had the money. I do not think that is a real valid criticism. You find out whether the man has the capabilities to merit the pay he is getting after he is on the job. That is about the only way you can find out in some instances.

Mr. MARDEN. I was reminded by something you said a moment ago about the importance of this program in breeding respect for the law, of what that great lawyer and legal aid leader, Reginald Hebert Smith, once said:

> Nothing rankles in the human heart as the brooding sense of injustice. Illness we can put up with, but injustice makes us want to pull things down.

I think that is what is happening today in so much of this rioting and so much of the unrest, that brooding sense of injustice. I think we do contribute to the alleviation of that.

Mr. CASEY. I am sure you know there is no client any more angry or mad, so to speak, than one who has lost and thinks he did not get justice.

Mr. MARDEN. We have all had that experience.

Mr. ROBB. May I say one thing on earmarking I think might be of much interest to your committee?

There is solid precedent for earmarking legal services. The appropriation bill earlier, the year before last, earmarked $22 million at a time when the legal services program was much smaller than it is now,

and also earmarked Headstart. So I would say our proposal to earmark is not novel, it is something that has been done in the past, and we hope you will do it again.

Mr. LAIRD. We earmarked that back in 1967. Last year we earmarked Headstart and some other programs. We did not earmark legal aid because we had been assured of the funding level.

Mr. SMITH. I cannot help but think you might have gotten more money because it was not earmarked. You see, they are treating this program better than others, you know, and if it had been earmarked the Congress might have cut it back, or, if not, at least kept the same expenditure level. You may have gotten more money because it was not earmarked.

Mr. LAIRD. Earmarking would make legal aid stand out very clearly in the report of the committee. It was felt at that time this was not one of the areas that had widespread popularity. I hear about it from my friend, Mr. Westwood, and a few people that understand the program. But it is not one of those programs that gets a great amount of national attention. You have to be a little careful about calling attention to it by standing it out in the report. This would be something that you would have to take that gamble on.

Mr. ROBB. We think legal services will stand on its own feet. We are not suggesting a ceiling, we are suggesting a floor.

Mr. LAIRD. In appropriations you know the Congress cannot require expenditure simply by earmarking. We cannot require expenditure by the executive branch.

Mr. SMITH. Thank you, gentlemen.

Mr. MARDEN. Thank you, gentlemen.

TUESDAY, APRIL 23, 1968.

VETERANS EMPLOYMENT SERVICE

WITNESSES

AUSTIN E. KERBY, DIRECTOR, NATIONAL ECONOMIC COMMISSION, THE AMERICAN LEGION

JOHN S. MEARS, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. SMITH. Mr. Kerby, do you wish to read your statement?

Mr. KERBY. I would like to read it, Mr. Chairman.

Mr. SMITH. Proceed.

Mr. KERBY. Mr. Chairman and members of the subcommittee, I appreciate this opportunity to present the views of the American Legion on the fiscal year 1969 budget request of the Department of Labor.

The American Legion's current resolutions in support of adequate funds for certain programs and activities within the Department of Labor were adopted at our 1967 national convention. For the sake of brevity this statement addresses itself primarily to the veterans employment service. Attached to this statement is a brief résumé of other resolutions relating to programs in which we are interested. If there is no objection, Mr. Chairman, I respectfully request that it be included in the record of this hearing.

The American Legion has always been vitally concerned with the proper functioning of the veterans employment service and the State employment security agencies in affording veterans adequate job counseling and employment placement service. At our 1967 national convention, Resolution 59 was adopted urging the Congress to appropriate sufficient funds for these activities. It also requests that the necessary steps be taken to assure each veterans employment representative in the local employment offices sufficient time to properly perform his primary duties which is service to veterans. A copy of Resolution 59 is attached.

Over the years, the veterans employment service, the bureau of employment security and the State employment agencies have done an excellent job. The American Legion appreciates the employment service they have provided veterans and the assistance they have given our national economic commission in implementing our own nationwide employment program for veterans.

The veterans employment service budget request for fiscal year 1969 is $2,001,000 which represents a moderate increase over the appropriation for fiscal year 1968. We understand this increase will provide for three additional Federal positions (two professional and one clerical) in the veterans employment service and for new printed information for veterans with employment problems, particularly those now returning to civilian life after active duty in the armed forces.

The American Legion believes this appropriation request is fair and reasonable and is the minimum amount required for the operation of the veterans employment service. In fact, it is urgently needed and we respectfully request the subcommittee to act favorably thereon.

Mr. Chairman, the American Legion is gravely concerned over an apparent lack of proper staffing in the State employment services local employment offices. Statistics published by the Department of Labor indicate that 1,827,000 veterans applied for employment assistance in these local offices during the calendar year 1967. This represents a 22 percent increase over the previous year and 66 percent over 1965.

Several factors contribute to this increased workload. As the subcommittee knows, the Veterans Readjustment Assistance Act of 1966 provides, among other things, job counseling and placement service for post Korean war veterans. Over 5 million of these veterans, including those of the Vietnam era, are now in civilian life. An additional 800,000 to 900,000 Vietnam veterans are being separated each year.

The public employment offices are not waiting for these returning veterans to find their own way to their local office. On August 14, 1967, the President gave the State employment agencies the tremendous responsibility of seeking out all recently discharged veterans for the purpose of counseling them with respect to their employment problems and job training needs on an individual basis. We understand that the State employment services have accepted this rsponsibility and are attempting to carry it out even though additional staff personnel have not been provided to do the job. In many areas our Department (State) employment chairmen are reporting that the State employment offices simply do not have the resources to carry

out this program as requested by the President. In lieu of personal contacts which were contemplated, most of the 840,000 veterans who will return to civilian life this year will merely receive a form letter. Several States have requested additional personnel to properly carry out this responsibility but their requests have been denied.

Members of our organization concerned with employment problems report that this denial of service to veterans is occurring at the same time when a substantial number of employees have been assigned the specific responsibility of assisting certain economically disadvantaged individuals, a group which includes very few veterans.

The American Legion understands the need for and supports the effort of giving special assistance to the economically disadvantaged. However, we urge in the strongest possible terms that the Department of Labor be given sufficient funds so that they may allocate adequate staff in the State employment agency offices to provide as is stated in existing law, a maximum of job opportunities to war veterans.

At our 1967 national convention Resolution 582 was adopted which commended the President for his directive of August 14, 1967. We regret, however, that this program is not being carried out as anticipated. We believe that veterans should have real priority in the public employment service offices to which they are entitled by law and that appropriate commitments of staff, time and energy should be made for this purpose. We do not believe that the public employment system should concentrate its resources on certain groups to the extent that the veteran with employment needs becomes the "lost man."

The Department of Labor and its affiliated State employment service now have the greatest opportunity since the Korean war to help solve, the employment and job training problems of all veterans—especially the recently disabled, the GI making the crucial transition from military service to a civilian career, and the older war veteran facing the serious problems which today confront the unemployed who have passed the prime of their youth.

The American Legion will carefully observe the veterans employment program during the forthcoming year and we certainly hope that service to veterans will be emphasized as Congress intended when the original GI bill was passed. We urge you, Mr. Chairman, and members of the subcommittee, to make available sufficient funds to provide the manpower necessary to do this job.

In closing, Mr. Chairman, may I say that over the years the American Legion has been very well satisfied with the operation of the Bureau of Employment Security and its Veterans Employment Service. We are hopeful that any proposed realinement of responsibilities within the Manpower Administration of the Department of Labor will not adversely affect the work of these agencies.

Again, I thank you for the opportunity of appearing here to present our views on this subject.

Mr. SMITH. I think your statement pretty clearly sets forth your position and the supplement you have will be inserted in the record.

(The supplement follows:)

RÉSUMÉ OF AMERICAN LEGION RESOLUTIONS REQUESTING SUFFICIENT FUNDS FOR THE OPERATION OF CERTAIN PROGRAMS UNDER THE JURISDICTION OF THE DEPARTMENT OF LABOR

ADEQUATE LOCAL VETERAN EMPLOYMENT REPRESENTATIVE POSITIONS

1967 Convention Resolution No. 190—Urges Congress to make adequate appropriations to create sufficient local veteran employment representative positions in the various State agencies to better serve the employment needs of all veterans.

VETERANS' REEMPLOYMENT RIGHTS

1967 Convention Resolution No. 243—Endorses the reemployment rights program and requests Congress to provide the Office of Veterans' Reemployment Rights with adequate funds and personnel to enable them to give prompt and effective service to all persons having rights and obligations under the reemployment statutes.

EMPLOYMENT NEEDS OF OLDER AND DISABLED VETERANS

1967 Convention Resolution No. 262—Urges the Congress to make adequate appropriations to Federal and State agencies in order that they can fully comply with their responsibilities in meeting the specialized employment needs of older veterans and disabled veterans.

DESIGNATION OF FUNDS FOR LOCAL VETERAN EMPLOYMENT REPRESENTATIVES

1967 Convention Resolution No. 371—Urges that sufficient moneys be allocated to the States in order that one or more local veterans' employment representatives be located in each employment office, and that such funds be over and above all other program requirements, and be spent for no other purpose.

FORTY-NINTH ANNUAL NATIONAL CONVENTION OF THE AMERICAN LEGION, BOSTON, MASS., AUGUST 29, 30, 31, 1967

Resolution No.: 59.
Committee: Economic.
Subject: Support Federal and State Veterans' Employment Services.

Whereas it has been the long-established policy of the American Legion to promote a maximum employment program for all veterans; and

Whereas, title 38, U.S. Code (P.L. 85–857), as amended, and the Veterans' Readjustment Benefits Act of 1966 provide for an effective job counseling and employment placement service for all veterans; and

Whereas, the U.S. Department of Labor has promulgated policies for carrying out provisions set forth in title 38, U.S. Code, as amended, and the Veterans' Readjustment Benefits Act of 1966; and

Whereas there is a growing need for increased employment services for veterans. It is estimated that approximately 3.8 million veterans were separated from the armed services between January 31, 1955, and March 3, 1966; and

Whereas, the Armed Forces are separating an increasing number of post-Korean conflict veterans. Some 750,000 of these veterans will be separated during the current fiscal year. While an estimated 900,000 will return to civilian life in fiscal year 1969; and

Whereas, over 50,000 military retirees are returning to civilian life annually; many of whom require specialized assistance from the employment service in resolving their employment problems and in obtaining suitable gainful employment; and

Whereas, many veterans of World War II, who are now in the older worker category, encounter resistance in their efforts to obtain suitable employment because of their age; and

Whereas, the disabled veteran finds it more and more difficult to obtain gainful employment, due to both age and disability; and

Whereas, title 38, U.S. Code, as amended, provides that all State Employment services shall designate one or more employees, preferable veterans, in each full-functioning local employment office to carry out the duties prescribed by law for local veterans' employment representatives; and

Whereas the American Legion is concerned over the effects of the diversion of the local VER's away from their primary responsibility, to other local office programs, resulting in decreased services to veterans in obtaining employment.

It is considered imperative that this matter, coupled with the existing practice by the U.S. Employment Service of subordinating services to veterans, be brought to the attention of the Secretary of Labor: now, therefore, be it

Resolved by the American Legion in National Convention assembled in Boston, Mass., August 29, 30, 31, 1967, That the American Legion go on record as favoring and requesting the Congress to provide adequate funds for the U.S. Department of Labor, the Bureau of Employment Security, the Veterans' Employment Service, and the State employment services to adequately staff the program of services to veterans and to assure that the provisions of title 38, U.S. Code, as amended, and the Veterans' Readjustment Benefits Act of 1966 are carried out as contemplated by these laws; and be it further

Resolved, That the American Legion hereby petition the Secretary of Labor, the Administrator of the Bureau of Employment Security, Chief of the Veterans' Employment Security Agencies to take all necessary steps to insure that the designated veterans' employment representative in each local employment service office is allowed sufficient time to adequately perform all of this primary duties in connection with services to veterans; and be it finally

Resolved, That a copy of this resolution be sent to the Secretary of Labor, the Honorable Daniel J. Flood, Chairman, Subcommittee on Appropriations, U.S. House of Representatives and the Honorable Lister Hill, Chairman, Subcommittee on Appropriations, U.S. Senate.

Mr. KERBY. If I may I would like to comment on the testimony of earlier witnesses regarding the earmarking of funds. We refer to our resolution 371 in the brief memorandum attached which urges that funds be earmarked for the local VER. I did not emphasize it in the statement but would like to do so now.

Mr. SMITH. That will be considered at the time we mark up the bill.

Mr. LAIRD. Mr. Chairman, I have no questions. I would like to assure the gentlemen representing the National Economic Commission of the American Legion and the American Legion itself that the retainment of services in the Department of Labor is of concern to this committee. We have questioned them at some length about this at our regular hearings and have been assured by the Secretary of Labor that this will not in any way dilute or diminish the effectiveness of this program. But we are going to watch this very carefully to see that these assurances are valid and are carried through during the next fiscal year. The committee is aware of it and we are going to be watching it very closely.

Mr. KERBY. We appreciate it.

Mr. SMITH. Thank you, Mr. Kerby.

TUESDAY, APRIL 23, 1968.

MENTAL HEALTH PROGRAMS

WITNESSES

DR. LEONARD GANSER, DIRECTOR, WISCONSIN MENTAL HEALTH PROGRAM, REPRESENTING THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

HARRY C. SCHNIBBE, EXECUTIVE DIRECTOR, THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Mr. SMITH. Dr. Ganser, we will be happy to hear from you now.

Dr. GANSER. Mr. Chairman, I am Leonard J. Ganser, M.D., administrator, Division of Mental Hygiene, Wisconsin Department of Public and Social Services.

93-994 O—68—pt. 7——4

I am here today representing the National Association of State Mental Health Program Directors, and I am accompanied by Mr. Harry C. Schnibbe, executive director of the association.

The members of our association are responsible for the administration of the major portion of the residential and outpatient public mental health programs in the United States.

We administer 1,161 treatment facilities, both residential and outpatient.

We have under treatment annually 1,500,000 persons.

Last fiscal year the State mental health program directors administered programs funded at $2.4 billion dollars, which is six times the size of the annual budget of the National Institute of Mental Health and twice as large as the entire Federal annual expenditure (including VA, the military, and HEW) for mental health and mental retardation.

It is with this experience as a background that we come before you today to talk about several items of interest to the States in the HEW appropriations bill.

I have divided my remarks into four principal categories:

Part I: Community mental health centers (NIMH) and Community mental retardation facilities (SRS);

Part II: Education of handicapped children (OE);

Part III: Hospital improvement grants (NIMH) (SRS);

Part IV: Hospital staff development grants (NIMH) (SRS).

Mr. Chairman, the community mental health centers construction program, initiated by the Congress in 1963 (Public Law 88–164) is grinding to a slowdown at a time when it should be approaching its peak of development.

The interest in the program is now growing toward its full zenith in the States.

Proposed projects are backlogging all over the country.

Our shared dreams (the Federal Government and the States) of developing a program for treatment of the mentally ill in their own communities are on the threshold of being realized.

And at this point we are encountering what can only be called a Federal roadblock of alarming proportions.

The executive branch has stalled the development of the centers program.

In dozens of States community mental health centers are ready to bloom into existence but are now held back by the "slowdown" clamped on by the administrative agencies.

Through fiscal year 1968 the Congress authorized a total of $200 million for construction of centers.

The Congress appropriated $180 million through fiscal year 1968.

At that point the program was $20 million off schedule on the basis of appropriations voted.

However, the program received a more severe jolt when the administration "froze" the $45 million appropriated for fiscal year 1968 and ordered it "carried over" to fiscal year 1969 and then instead of asking for the authorized $60 million for fiscal year 1969, it is asking you for only $15 million.

Thus, through fiscal year 1969, if you honor the administration request, the Congress will have authorized a total of $260 million, but appropriated $195 million—a slash in the program of 25 percent.

Mr. Chairman, over 280 communities in 50 States and territories have benefited from the construction and staffing grants for community mental health centers. These new programs cover one-fifth of our population. (As of today there have been 213 construction grants and 151 staffing grants.)

We have four-fifths to go.

It was expected that with the fiscal year 1968 appropriations for construction and staffing, about 100 new centers would be initiated.

We are now beginning to see the program gradually fall behind and plans for new centers are beginning to stack up in State after State.

We fully realize the intense and critical demand on the Congress for money for any number of vital programs from national defense to the war on poverty.

However, we are not in a position to depreciate or suspend the war on mental illness.

It continues as a major problem of our society whether Vietnam is at peace or war and whether the ghettos are burning or not.

Eric Starvo Galt, the alleged assassin of Dr. King, was a patient in a State mental hospital. With the country torn asunder in the wake of Dr. King's assassination how can we come before the Congress at this time and say to you that it is all right to slow the major Federal program designed to help American communities combat mental illness.

We ask that you consider thoughtfully the staggering need and the staggering backlog of planned centers and increase the fiscal year 1969 appropriation from the requested $15 million to at least $30 million.

Mr. LAIRD. You understand that there are funds available that are frozen by the executive branch now?

Dr. GANSER. Yes, sir.

Mr. LAIRD. Our problem right here is the executive branch tells our committee we overappropriated in this area.

Dr. GANSER. Yes, sir; I understand.

Mr. LAIRD. I do not think that is made very clear in your statement. The Congress cannot release these funds, that has to be done by the executive branch.

Dr. GANSER. I understand that.

Mr. LAIRD. We can appropriate these funds, as you know, but we can't make the executive branch spend them.

Dr. GANSER. Yes, sir; I understand that. We tried to make it clear in the statement, but we do understand it is the Federal agency, the executive branch that has carried over that amount of money.

With the release of the frozen $45 million from fiscal year 1968, this will pump $75 million of vitality back into a program that is now halfway strangled.

One hundred forty-nine applications are being developed.

The situation is similar with the program of community M. R. facilities, also authorized in 1963 by Public Law 88–164. Here the need for new community facilities is considered to be even greater than in mental illness.

This program is also $18 million off the pace originally intended and we request that the $16 million in the budget request of the Division of Mental Retardation of Social and Rehabilitation Services be increased to $25 million to help get the program back on schedule.

EDUCATION OF MENTALLY ILL AND MENTALLY RETARDED CHILDREN

Mr. Chairman, last year the States treated in State operated or State-financed programs about a quarter of a million emotionally disturbed and mentally retarded children.

All of these children are classified as "handicapped," and most participate in some form of State-operated or State-supported educational program.

These educational programs desperately need to be expanded, enriched, and strengthened.

For this reason the directors of State mental health and mental retardation programs have been deeply involved in and concerned with the Federal grant program initiated by the Congress under Public Law 89–313.

Public Law 89–113 amended title I of the Elementary and Secondary Education Act (ESEA), authorizing Federal aid to State operated and State-supported schools for handicapped children. The formula for determining how much each State is entitled to in grant money is as follows: (1) the number of eligible handicapped children, (2) multiplied by one-half the average annual expenditure per pupil for public education. The money comes out of the title I appropriations.

In the first fiscal year of this program (1966) the States receive $15.9 million as their share of the title I money for education of 65,440 handicapped children. This amounted to $230 per child.

Sixty-eight percent of that money (about $10 million) went to State education programs in the area of special concern of the State mental health directors—the mentally retarded (56 percent) and the emotionally disturbed (12 percent).

In fiscal year 1967 the handicapped children's allocation of the title I appropriation dropped to $15 million while the number of eligible children increased to 82,797. This reduced the grant by $48 per child to $182 per year per child.

In this fiscal year the rate per child would have fallen to $165 per child and in fiscal year 1969 it would have dropped to $160 as the allocations to Public Law 89–313 would have fallen to $14.5 million while eligible handicapped children would have risen to 95,000 as new institutions came in for coverage.

However, the Congress enacted last year an amendment (sec. 208 of Public Law 90–247) which establishes that, in allocating title I funds, HEW must award full entitlement to each State for education of its handicapped children. This will mean about $283 per child.

Our association, last year, strongly advocated that amendment in the House and Senate.

The amendment was needed because while title I appropriations were increasing slightly ($987 million in fiscal year 1966; $1.06 billion in fiscal year 1967; $1.19 billion in fiscal year 1968) the number of "disadvantaged" children being covered by title I was increasing at a much greater rate. All of this caused the relatively "stable" handicapped children program to get "shortchanged" under the "ratable reduction" system used by HEW in determining the allocations to the States.

We have relatively stable populations in our institutions for children who are mentally retarded or emotionally disturbed.

We are growing, but not nearly as fast as the "disadvantaged" groups that are becoming eligible under title I.

Thus, although we will now have 95,000 handicapped children under the ESEA program this coming year, if we didn't have last year's Public Law 90–247 amendment, the title I money would have gone in much greater sums to the "disadvantaged" groups, while the "handicapped" would have received less than in other years.

Public Law 90–247 stopped the decline and held the amounts to handicapped children at a fairly constant level.

If we had continued our programs in an atmosphere of uncertainty over per capita Federal grants our institutions would not have been able to make long-term contracts for staff, instructional materials, and so forth.

This is why we fought for the "Morse amendment" contained in Public Law 90–247 which guarantees us at least the same amount we had the previous years.

Now we hear rumblings of efforts to bypass the section 208 directive in Public Law 90–247.

Instead of $24.7 million going into the program (as was allocated this year) we hear the sum of $15 million, which means $160 per child—instead of the $283 we received this fiscal year.

We strongly oppose any such action by the Congress and we reassert that in order to hire and hold staff and in order to contract for space and materials we must have a stable, predictable level of grant per child for the education programs in State institutions.

The title 1 programs for "disadvantaged" children can absorb per capita reductions because their gross income increases. We cannot absorb such a per capita decline.

I reiterate and fully endorse a statement our association made to the Congress last year in regard to the decline in Federal support per child: In part we said:

> Action is needed to hold the line on bare minimum support. These few dollars per handicapped child are not enough, but please halt the decline.

Once again we come to the Congress and plead that there be no decline in support.

We hope that the House Appropriations Committee will understand the full impact on handicapped children of section 208 of last year's law (Public Law 90–247) and not take any action to reduce the allocation of "ful entitlement" grant money to States with eligible education programs for mentally handicapped chlidren.

Mr. Chairman, we are seriously concerned about the hospital improvement project—or HIP as it is more commonly called—grant program.

This program, which is designed to provide support for demonstrations of improved methods of care, treatment, and rehabilitation of the mentally ill and mentally retarded in public institutions, has been of substantial assistance to our hospitals.

It has provided us with a flexible and convenient tool with which to strengthen therapeutic services and to improve the quality of patient care.

The budget request for fiscal 1969 for this program is the same as it was for fiscal 1968: $10,610,000 for mental hospitals and $8,972,000 for institutions for the retarded. This means that at least 30 State

hospital applications which are ready for funding will not get any consideration at all because of the lack of funds, and 47 institutions for the retarded will still be without grants.

In order to take care of these requests, the NIMH program should have an additional appropriation in fiscal 1969 of at least $3 million and $1.5 million in mental retardation.

Let me give you an idea of how well the HIP program has worked for some of our hospitals:

(1) A hospital in a Northwest State used its HIP grant to develop a program for resident adolescents who were without a directed program, were intermingled in the hospital facilities with adults and who, in many cases, were becoming chronic patients. As a result of the grant, over a 2-year period 190 children were treated under the program and nearly 50 of them were sufficiently rehabilitated to return to the community and to lead constructive lives.

(2) Another institution located in the Midwest used a HIP grant to develop an intensive short-term active treatment program for geriatric patients. Where before these patients had been left alone, really, just to die, under the new program during the first 2 years, 140 out of 200 participants were rehabilitated sufficiently to return to the community and lead reasonably normal lives.

As you can see from these examples, the objective is to change a hospital's program so that it can get more of its patients back into the community. This, of course, is the goal of any mental health program.

I might also point out the modest nature of our requested $4.5 million increase.

When this program was initiated in fiscal 1964 it started off at $12 million.

However, the State mental health program directors—who administer all the State hospitals in the United States—supported the program having been advised that it was to be a major Federal effort to upgrade State hospital treatment programs.

It was our understanding that the Federal Government, over a 10-year period, would invest $100,000 per year per hospital in improving treatment programs.

This was essentially the sense of a recommendation made by the congressionally initiated and financed Joint Commission on Mental Illness and Health.

Thus, we have expected this program to pump $360 million into improved services at State institutions for the mentally ill and mentally retarded.

It was expected that State facilities for the mentally ill and mentally retarded would receive a total of $26 million per year for 10 years.

In the past 5 years we have received a total of $65 million in grants to State hospitals and about $33 million for institutions for the retarded

This program is already off schedule by $46 million.

Hence, you can see that our request for a $4.5 million increase is most modest.

It is our hope that you will give this whole HIP program a careful review in light of the findings of your Joint Commission on Mental Illness and Health.

Mr. Chairman, another area of concern to us is the hospital staff development grant program, for which an increase of only $120,000 has been requested for fiscal 1969 by NIMH.

The thrust of this program is to provide a special training to nonprofessionals working in institutions so that they can assume a more constructive role in the rehabilitation of patients. Another objective of the program is to provide updated training for the staff professionals so that they can keep abreast of the changes in their field.

The result of staff development programs is to help the hospitals constantly reorient themselves toward the newer concepts of treatment and training for the mentally ill and mentally retarded. We do not believe the request for fiscal 1969 is sufficient to maintain the forward thrust of this program. We believe there should be an additional appropriation of at least $2 million in the NIMH budget and $1 million in the SRS budget for this purpose.

The need for more funds for the staff development program is readily apparent.

Only two-thirds of the eligible hospitals have thus far received grants under the program.

Of the 100 hospitals constituting the remaining one-third, work is currently underway to assist them in preparing quality applications so that they can participate in the program.

The administration's request for fiscal 1969 will not be sufficient to fund these applications when they are presented.

The staff development grant program is, of course, inextricably tied to the whole medical manpower need problem, and, as you know, the need for trained mental health manpower is substantial.

There is only one psychologist for every 23 available positions.

There is only one nurse for every five available positions.

By 1972, in order to meet the projected demand, the mental health manpower pool of psychiatrists, psychologists, social workers and nurses must be increased by approximately 30,000.

The staff development program can help fill this gap.

For example, some hospitals use their grants to evaluate existing training programs and determine what additional training should be given their personnel and then to provide this training.

Others use the grants to help nonprofessionals deal more intelligently and comfortably—and thus compassionately—with patients.

Still others use the grants to change the focus of their overall treatment program in order to put into practice the most advanced techniques.

The result of this emphasis is, of course, to make it possible for the patients to return to the community faster as a result of better and quicker rehabilitation. And this, again, is the goal of every mental health treatment program.

We respectfully ask that you consider increasing the NIMH hospital staff development appropriation to a total of $7,338,000 for fiscal 1969, and increase by $1 million the hospital in-service training grants for the institutions for the mentally retarded.

Thank you, Mr. Chairman.

Mr. SMITH. Doctor, I think you have a very good statement. I only have one question really.

In view of the fact that the expenditure level is less than the appropriation level, do you think the expenditure ratio between different programs has been approximately right for that level?

Dr. GANSER. I do not quite understand your question.

Mr. SMITH. If you were to be required to fund at the level expenditures have been in this fiscal year, do you think the ratio between the four principal programs is approximately correct?

Dr. GANSER. Yes. I would think so. I would have no question about the ratio.

Mr. SMITH. Mr. Laird?

Mr. LAIRD. Thank you for your statement, Doctor.

Mr. SMITH. Thank you very much.

Dr. GANSER. Thank you.

TUESDAY, APRIL 23, 1968.

U.S. CHILDREN'S BUREAU BUDGET

WITNESSES

GEORGE J. HECHT, CHAIRMAN, AMERICAN PARENTS COMMITTEE, INC., AND PUBLISHER OF PARENTS' MAGAZINE

MRS. BARBARA D. McGARRY, EXECUTIVE DIRECTOR, AMERICAN PARENTS COMMITTEE, INC.

Mr. SMITH. Mr. Hecht, we are glad to have you before the subcommittee again.

Mr. HECHT. I have with me my associate, Mrs. McGarry, the executive director of the American Parents Committee.

Mr. SMITH. Do you claim to represent all of the parents in the United States?

Mr. HECHT. No, I reach an awful lot of them though. I was the founder of Parents' magazine and have been publisher of it for 22 years, and I am national chairman of the American Parents Committee, on whose behalf I am speaking today.

Mr. SMITH. I notice your statement heading says you represent 71 million children. That is a lot of important people.

Mr. HECHT. I did not say we are representing; we are working for Federal legislation on behalf of the Nation's 71 million.

Mr. SMITH. You may proceed.

Mr. HECHT. Mr. Chairman and members of the committee, my name is George J. Hecht, and I am the national chairman of the American Parents Committee and publisher of Parents' magazine.

On behalf of the American Parents Committee, I should like to invite your attention today to a HEW appropriation question that has disturbed many members of our board of directors and national council, since the issuance of the proposed 1969 Federal budget.

That question is the uncertain future of the U.S. Children's Bureau budget.

For the last two decades, our committee has supported adequate appropriations for the Children's Bureau. Over the more than 40 years that Parents' magazine has been published, many articles have described the various on-going programs of the Bureau.

This year, a budgetary innovation has resulted apparently from the August 1967 HEW reorganization plan. Under this HEW reorganization plan, all the welfare services of HEW were redesignated as social and rehabilitation services, and the 1969 budget has lumped all SRS salaries and expenses under a single heading.

As members of your committee are well aware, the Children's Bureau was created by a 1912 act of Congress, which directed that the new Bureau "shall be under the direction of a chief, to be appointed by the President" and "shall investigate and report upon all matters pertaining to the welfare of children and child life among all classes of our people." The phrase "welfare of children" was clearly used in the sense of "the general welfare" because the purpose clause of the act goes on to specify a wide variety of matters to be investigated, including questions related to health, such as infant mortality, accidents, and diseases of children; employment; social problems, as orphanage, desertion; and legislation affecting children in the States.

I go into this at some length because the act of 1912 was and still is the base on which the Children's Bureau builds its far-flung program of consultation and services on behalf of mothers, children and youth, indeed the whole family. It was the imaginative leadership of the Children's Bureau taken together with the facts about maternal and infant mortality that finally resulted in the Maternity and Infancy Act of 1921–29 and the programs of grants-in-aid to the States for maternal and child welfare under title V of the Social Security Act.

Some 30 years after its creation, under the Reorganization Act of 1945, the Children's Bureau was transferred from the Department of Labor to the Federal Security Agency (the forerunner of the present Department). However, the Reorganization Act specifies that the Children's Bureau functions, as delineated in section 2 of the basic 1912 act, were to be administered through the Children's Bureau.

In view of this it would appear to be legally necessary that there be in the budget specific identification of salaries and expenses for the Children's Bureau including the position of Chief. Without such identification and substantial appropriations for the basic work of the Children's Bureau, it may well be that the half-century of solid accomplishments by this small Bureau will become past history.

Mr. LAIRD. How would you like to clarify it, by spelling it out in the committee report or making a line item appropriation for the Children's Bureau?

Mr. HECHT. Itemize it separately. Do not lump it along with the SRS. Just itemize it separately. By lumping it all in one lump sum, the administration can divert funds from the Children's Bureau to any other section of SRS.

Mr. LAIRD. If we put such a provision in our committee report, they could not do it.

Mr. HECHT. That is one way to do it. That would solve the problem. Although one cannot know unless it is specified what those salaries and expenses are.

Mr. LAIRD. How much would you like to have earmarked in the committee report for that purpose?

Mr. HECHT. $6,407,000. That is in the 1969 budget for "Maternal and child welfare." If this were specified as salaries and expenses for the Children's Bureau, that would solve the problem.

Mr. LAIRD. That is the figure, as I understand it, that is in the budget now.

Mr. HECHT. But now they lump it into one item of $27.8 million for all SRS salaries and expenses, and the administration could just juggle, take money from one section to another. We think the Children's Bureau is in grave danger of being starved to death and thus eliminated.

Mr. LAIRD. You think the Department wants to eliminate the Children's Bureau?

Mr. HECHT. This proposal might be the beginning of the end of the Children's Bureau. They would allocate the SRS appropriation to other sections of the SRS and starve the Children's Bureau to death. There is nothing in the appropriation that would specify the amount of money to go to the Children's Bureau.

What we are asking is a special item in the appropriation for salaries and expenses of the Children's Bureau; and as you suggest, that in your report the $6.4 million be definitely allocated as salaries and expenses for the Children's Bureau and not transferable.

Have I answered your question?

Mr. LAIRD. Yes.

Mr. HECHT. Congress is well aware that its official publications, among others, "Infant Care," year after year, are always at the top of the list as "best sellers" of all U.S. Government publications sought by the American people.

I respectfully urge—and as strongly as I know how—that the item of salaries and expenses of the Children's Bureau be set forth separately in the appropriation bill, and not lumped with those of the Social and Rehabilitation Service. If they are all combined in one figure, the needed money for salaries and expenses of the Children's Bureau could, without anyone noticing it, be used to finance other work of the Social and Rehabilitation Service. The Children's Bureau was created by an act of Congress and only another act of Congress should be able to kill it. The Social and Rehabilitation Service was created administratively and if its salary and expense appropriation and the Children's Bureau are combined, it will not be long, I fear, before the activities of the Children's Bureau will be curtailed to the point that, in effect, the Bureau would cease to function. I do not believe that this is what the great number of organizations and private citizens, who support the Children's Bureau, want.

The Children's Bureau has vitally important functions—to conduct research on the matters related to the needs of children; to issue publications for parents and for workers with children; to provide juvenile delinquency services; and by delegation of authority from the Secretary, to administer the maternal and child health, the child welfare, and the crippled children programs provided for in the Social Security Act as well as special maternal and infant care, and school and preschool health projects. The Children's Bureau needs to be continued as the Congress has for years intended, and its influence expanded as a "spokesman for children" and an innovator of new ways and means to meet the needs of children. It should not be absorbed and extinguished in the new administratively formed Social and Rehabilitation Service.

In the President's message on health, on March 5, 1968, particular tribute was paid to several Children's Bureau programs—maternal

and child health, crippled children's service, special projects for maternity and infant care, health services for school and preschool children. Grouping together the requested increases for these programs under the title of the "Child Health Act of 1968," the President has stated—

> I recommend a $58 million increase in appropriations for the maternal and child health care programs in fiscal 1969. $25 million of this increase will provide for the expansion of maternity and infant care centers and clinics. Our goal is to assure every needy American family:
>
> Adequate prenatal and postnatal care of the mother;
>
> A safe delivery by trained health professionals;
>
> Competent examination of the child at birth, and expert treatment when needed.

There are still persistent rumors that the Children's Bureau's programs of grants to the States for maternal and child health and crippled children's services are to be transferred from the Children's Bureau to the recently established Health Service within the Department of Health, Education, and Welfare, under Dr. Philip Lee, Assistant Secretary for Health. If this were to happen and the Children's Bureau itself left within the Social and Rehabilitation Service, the Children's Bureau would no longer administer the grants for crippled children's services as had been agreed to only last fall between former Secretary Gardner and the congressional conference committee that handled the 1967 amendments to the Social Security Act in H.R. 12080.

In the report of this conference committee (Rept. No. 1030) it is stated that Senate amendment No. 472, which made it mandatory for the crippled children's program to be administered by the Children's Bureau, was dropped after the conference committee had received assurances from the Secretary of Health, Education, and Welfare that the purpose of the amendments had already been taken care of administratively.

The Senate amendment (No. 472) had been included as a result of a great number of communications to the Congress and to the Secretary from pediatricians, orthopedic surgeons, and other professional persons, protesting against a reorganization order of Secretary Gardner in August 1967, transferring the crippled children's program out of the Children's Bureau and into the Rehabilitation Administration. The Secretary's assurance to the conference committee came at about the same time as the announcement to the press by the Administrator of the Social and Rehabilitation Service that the crippled children's program had been restored to the Children's Bureau.

The American Parents Committee respectfully requests the House Committee on Appropriations to make appropriate inquiries and take necessary steps to make sure that the Children's Bureau continues to administer the maternal and child health and crippled children's grants to States, including funds earmarked by the Congress for mentally retarded children. If the Secretary feels that it would be better for the maternal and child health and crippled children's grants to be administered by the Children's Bureau under the supervision of the Assistant Secretary for Health, it would then be our strong recommendation that the whole Children's Bureau intact be transferred to the Health Service.

This is saying if you have to transfer these programs to the Assistant Secretary of Health, it would be better to keep the Children's

Bureau intact and take the whole Children's Bureau rather than split it up and take part of its function one place and part another.

Mr. LAIRD. That is a surprise.

Mr. HECHT. It is only an emergency to salvage the Children's Bureau. We would much rather have the Children's Bureau continue just the way it is.

Mr. LAIRD. But you are willing to go along with the transfer over to the Public Health Service.

Mr. HECHT. Very reluctantly. If it is going to be split up, those two health grants go over to the Secretary of Health, we do this very reluctantly. We would much rather have it continue the way it is. The Children's Bureau needs to be strong and the Chief should report directly.

Mr. LAIRD. I would have to check that out with Kathryn Lenroot before I could go along with you. She is from my State of Wisconsin and had a great deal to do with building up the Children's Bureau. I am not so sure she would go along with that.

Mr. HECHT. I am not recommending this. I am saying rather than have the Children's Bureau destroyed, I would rather have it in Health.

Mr. LAIRD. Your suggestion might be well taken but I would want to withhold judgment until I talk with Kathryn Lenroot.

Mr. HECHT. I want to make myself clear. I am not recommending. I am saying rather than dismantle and split up the Children's Bureau between Health and Social and Rehabilitation Service, I would rather have it kept intact. In effect this would be a nullification of an act of Congress by Administrative process. We respectfully urge clarification of this situation. It is our understanding that any change from identifying a budget and appropriations, as such, for the Children's Bureau, would require either a further act of Congress nullifying the act of 1912, or else congressional failure to act within 60 days under a formal reorganization plan submitted by the President. An indication of the importance attached to this small but effective Bureau, is that its Chief is appointed by the President; also

The best of modern medical care for the infant during his first year to prevent disease, cure illness and correct handicaps;

An opportunity, on a voluntary basis, to plan the number and spacing of children.

To fulfill this objective, I propose the Child Health Act of 1968.

Regarding these programs, we should like to point out that, while the 1969 budget estimate for the Child Health Act totaled $237.3 million, the total authorized under Public Law 90–248 (Social Security amendments of 1967) is $250 million. The American Parents Committee applauds all these proposals, and strongly recommends the full authorization of $250 million.

The total authorized for Child Welfare Services is $100 million, although the 1969 budget adheres to the previous year's level of $46 million. We also support adequate appropriations for the National Institute of Child Health and Human Development, especially the $12 million requested for population control and studies that will assure that every child born will be wanted by his parent and society.

For the education of American children, we advocate adequate funding of the Elementary and Secondary Education Act, with special emphasis on the last three new titles for the education of handicapped

children and those from bilingual families, and the prevention of school drop-outs. We should also like to reemphasize our support of appropriations for the model secondary school for the deaf, at Gallaudet College, Washington, D.C. The justification for the 1969 budget has stated that the improvement of the elementary and secondary education of over 9 million children from low-income families can be accomplished through its recommendations.

For the sake of perspective, I should like to call attention to the fact that, of the $157 billion appropriated by Congress in 1967, only 10.7 percent went for all items in the vitally important health, education, and welfare category.

And finally I should like to point out that the future security and welfare of our Nation is dependent very largely on the health and well-being of our Nation's children. Hence our plea for maintaining the Children's Bureau as an effective instrument of our Government, and for supporting the various appropriations for programs that make for the health and well-being of children.

Thank you very much.

Mr. SMITH. Mr. Laird, any questions?

Mr. LAIRD. Mr. Chairman, I have no questions.

Mr. SMITH. Thank you, Mr. Hecht.

TUESDAY, APRIL 23, 1968.

FUNDING EDUCATION PROGRAMS

WITNESS

HON. FRANK E. MOSS, A U.S. SENATOR FROM THE STATE OF UTAH

Mr. SMITH. At this time it is our pleasure to hear from Senator Moss.

Senator MOSS. Mr. Chairman, I am Frank E. Moss, Senator, of the State of Utah. I appreciate this opportunity to appear before the subcommittee today. I appear in behalf of Gov. Calvin L. Rampton, of the State of Utah, who is also chairman of the Education Committee of the National Governors' Conference and chairman of the Education Commission of the States. The Governor has requested that I come here and read his statement into the record, and this I am proud to do.

The following is the statement of the Governor from Utah:

"One of the most serious difficulties experienced by school officials at all levels in making efficient use of Federal funds has been the timing of the Federal appropriation process, which has often caused grants of funds to be made after the start of the school year for which they are allocated and long after planning for the school year must be completed.

"Because the Federal funding cycle is based on a fiscal year which is not coordinated with the usual academic year, and because the Congress has often delayed in appropriating aid funds, federally supported education programs have experienced significant financial problems detrimental to program quality and effectiveness. School budgets have to be prepared 9 to 10 months ahead of Federal funds,

and frequently local commitments to spend occur 6 months ahead of funding.

"Late funding is complicated by the fact that aid distribution formulas have been changed frequently and expiring programs often have not been extended until just before—or even after—they expired. Serious problems have resulted:

"1. Inadequate utilization of increased Federal support and interference with both Federal-State coordination and State and local planning have developed.

"2. Short-term authorizations and abrupt changes create uncertainties for education agencies; schools don't know whether to expect Federal support at the same level—whether to accelerate, slow down, or stop.

"3. Program quality and achievement of program objectives are adversely affected.

"Late funding has accounted for by far the greatest number of complaints about Federal aid programs for education. The President and his administration, on the one hand, and the Congress, on the other, are to be commended for recognizing—and acting on—this very serious problem.

"You are familiar with the report of the task force headed by Assistant Secretary-Comptroller James F. Kelly, of the Department of Health, Education, and Welfare, entitled "Improving DHEW Support of Educational Programs," which stated the problems involved in late funding clearly and recommended that appropriations for Federal aid for elementary and secondary education be advanced by 1 year. I cannot improve on the task force's statement of the problem. I can only concur in its recommendation and express again my appreciation of the fact that the President included funds for title I of the Elementary and Secondary Education Act for fiscal year 1970 in his budget for fiscal 1969.

"You are also familiar with Report No. 1 of the House Special Subcommitee on Education, entitled "Study of the United States Office of Education. This report, as you know, liberally cited testimony before the subcommittee to outline in great detail the dimensions of the late-funding problem. You will recall, too, that the report of the Senate Labor and Public Welfare Commitee on the Elementary and Secondary Education Amendments of 1967 recommended provision for advance funding under the act.

"The response of the Congress to these reports, of course, was to authorize funds in advance for fiscal year 1970 under all titles of the Elementary and Secondary Act.

"I would like to call your attention to actions by two State-level organizations concerning advance funding. First, the steering committee of the Education Commission of the States, meeting in Boston last September, took note of the late-funding problem and endorsed the principle of advance funding for all Federal aid programs in education. The steering commitee reiterated its endorsement of the principle while considering the subject of block grants for education at its December meting in Hilton Head, S.C.

"Second, the National Governors' Conference Education Committee, of which I am privileged to serve as chairman, at the mid year meeting on Federal-State relations in Washington, D.C., February 28–March 1, made the following recommendation to the conference:

"That the National Governors' Conference commend the Congress and the administration for providing for advance funding of educational aid programs under the Elementary and Secondary Education Amendments of 1967 and for requesting advance funding for fiscal year 1970 under title I of the Elementary and Secondary Education Act and the proposed vocational and technical education legislation and higher education legislation of 1968.

"However, in the firm belief that late funding has been one of the most severe problems for the States and local education authorities under all Federal aid programs for education, the committee recommends that the National Governors' Conference call upon the administration and the Congress to extend the principle of advance funding to all such programs, beginning with fiscal year 1970.

"The report containing this recommendation was accepted by the full conference.

"I would like to add my endorsement to the many you have already received for the President's request for advance funding of title I of the Elementary and Secondary Education Act in the amount of $1.2 billion. However, I would like to stress that the amount requested and its limitation to title I must be considered the bare minimum, in view of the educational and administrative problems involved.

"Problems resulting from late and uncertain funding have occurred under all Federal education programs and, more specifically, under programs authorized by all titles of the Elementary and Secondary Education Act. It is true that title I programs are of the most direct and immediate benefit to disadvantaged children. But we must remember that programs were authorized to assist and improve education, in most cases for the primary benefit of pupils and their schools in less fortunate areas and in other cases for all schools and pupils, under all titles of the act because the Congress and the administration recognizes that such programs were necessary. Late and uncertain funding erodes the effectiveness of all those programs, not just those under title I.

"The problem of inadequate funding of Federal programs of aid for education is more serious and vexing than late funding. Let me cite again the report of the Education Committee of the National Governors' Conference:

"That we find the proposed funding of title I of the Elementary and Secondary Education Act, which provides for the education of disadvantaged children for the 2 fiscal years ahead at the same level as for the current fiscal year, actually constitutes a reduction, given the increasing number of children needing this assistance, rising costs, and the special costs involved in meeting the educational needs of these children. Further, we recognize the budget strictures operating during the coming year. But we question the advisability of budget cuts which have the effect of denying educational opportunity, and we therefore recommend substantially increased funding of title I of ESEA and restoration of funds for library resources and textbooks under title II of ESEA and funds for equipment and remodeling under title III of the National Defense Education Act to at least the levels of fiscal 1968.

"The Congress, after exhaustive hearings and consideration by education subcommittees in both Houses and by the conference committee,

authorized a grand total of $4.45 billion for fiscal 1969 under all titles of the Elementary and Secondary Education Act and $4.78 billion for fiscal 1970.

"In contrast, the budget request for those programs for fiscal 1969 is half the authorization, and the advance funding figure before you is limited to one program.

"My point is, that the American people—and particularly the millions of pupils in our schools—are the losers when their Government establishes educational programs and, further, authorizes their funding in advance in order to make them most effective, only to reverse itself later, drastically reduce the scope of those programs, and limit the advance funding to only one of their number.

"I am fully aware of the severe financial strictures under which the Federal Government must operate during the crucial year ahead. But I feel compelled to compare the Government with a typical American family in the handling of its finances. The modern American family, I believe, recognizes the overriding value of education; recognizes further that youth, at whatever age, are ready for a certain level of education at only one time and that education must be available to them then or it will have lost forever its ability to benefit them. The modern American family would only as its last resort scrimp on funds for education.

"The Federal Government should look on the financial problem in the same way. Something as priceless as educational opportunity and educational quality should not be denied to our youth in the name of economizing except in a case of dire fiscal peril.

"I would like to propose, therefore, two suggestions for your serious consideration. The first is to keep appropriations under the Elementary and Secondary Education Act for fiscal 1969 at least at their fiscal 1968 levels, adding a factor for growth in the number of young people we have to educate and for cost increases. The second is that, again applying the growth factor, you extend appropriations for all titles of the act where it is authorized to fiscal 1970.

"You have within your competence the authority to make a forceful recommendation on one of the most vital issues of our time: The question whether the Federal Government will keep its commitment to the young people of our Nation to assist with and improve their education. In full sympathy with the multitude of severe pressures upon you, I nevertheless urge you to make your decision a positive one. The generation of young Americans who are now in school will be forever in your debt if you do.

"Thank you."

Mr. SMITH. That is a very good statement, Senator. I assume he was speaking for all the Governors.

Senator MOSS. Yes. He is the chairman of their committee, and the Governors adopted the recommendations of the Education Committee. Our Governor has been very much involved in the problems of education since he came to the Governor's office and has taken a leadership role nationally in this area.

Mr. SMITH. The needs for advance funding for education is certainly a very important matter, and I am sure this committee is going to look very closely at it and do everything we can to try to resolve it, probably along the lines mentioned in the budget proposal. I am

sure you are doing everything you can on the Senate side to help with that.

Senator Moss. I am lending my voice to it to see if we can have it done in the Senate. I have school superintendents that frantically call me, not knowing where they are going to go on funding many times. This, it seems to me, is the logical answer to give them at least a year's lead to do their planning.

Mr. SMITH. Of course, we have a new dimension now, we have proposed limitations upon expenditures after appropriation and commitments have been made, regardless of how much was appropriated. If that becomes a custom around here, it would kill the advantages of advance funding and it wouldn't make any difference what year had been appropriated for.

Senator Moss. Right. Thank you.

Mr. SMITH. Thank you, Senator.

TUESDAY, APRIL 23, 1968.

LIBRARY PROGRAMS

WITNESS

MISS GERMAINE KRETTEK, ASSOCIATE EXECUTIVE DIRECTOR, AMERICAN LIBRARY ASSOCIATION

Mr. SMITH. We will now hear Miss Germaine Krettek. Go right ahead.

Miss KRETTEK. Thank you, Mr. Chairman. I know that you have a busy schedule. I will ask that the attachments to my statement be made a part of the record.

Mr. SMITH. That will be fine.

Miss KRETTEK. Thank you. My name is Germaine Krettek. I am associate executive director of the American Library Association, a nonprofit, educational organization of more than 38,000 librarians and laymen. For nearly a century, the association has been devoting its efforts to the improvement of libraries so that they may fulfill properly their services to the educational, scientific, and cultural programs of the Nation.

It is a privilege to testify before this committee on the need for adequate appropriations in fiscal year 1969 to carry out essential library programs. With your permission I will speak mainly about funds for the Library Services and Construction Act, and title II of the Elementary and Secondary Education Act, and also about the Higher Education Act not yet authorized for extension but which is in the process of amendment. In addition, I shall refer very briefly to library items in other HEW legislation.

We are fully cognizant of the stringent budget restrictions resulting from the tense war situation and certain factors in the domestic economy. Neverthless, we feel obliged to point out that the continued progress of the country is of paramount importance, and depends in a marked degree upon the prompt fulfillment of the essential needs of the people of the United States for library service in the fields of education, science, technology, business, culture, everyday living, and the requirements of the disadvantaged.

In order to give this committee some definite facts about the effects of the budget recommendations on libraries, the American Library Association sent out questionnaires to the States on the library programs funded in part by HEW appropriations.

This act, which started in 1956, aims to assist the States helping their public libraries meet the urgent and essential needs of all the people in the United States. The program covers all ages, all levels of education, and all stages of economic well-being. It provides for the cooperation among all types of libraries in the interest of the users. It encourages the States to make possible library services to persons living in State institutions; and to those physically handicapped, such as the blind and the visually handicapped.

Library Services and Construction Act	Fiscal year 1969 budget recommendation	Fiscal year 1969 authorization
Total	$49,894,000	$140,000,000
Title I, public library services	35,000,000	55,000,000
Title II, public library construction	[1] 9,185,000	60,000,000
Title III, interlibrary cooperation	2,281,000	10,000,000
Title IV-A, State institutional library services	2,094,000	10,000,000
Title IV-B, library services to the physically handicapped	1,334,000	5,000,000

[1] The remaining $9,000,000 of the fiscal year 1968 appropriation is to become available after June 30, 1968.

The effects of the reductions proposed in the budget below the authorizations approved by the Congress for fiscal year 1969 are tragic. They will deal a crippling blow to the States which have been struggling to expand and improve their public library services and facilities to all citizens.

Although progress has been made, there are still urgent, serious deficiencies. The association would like to note that 14 million persons in the United States are still without access to public library service (approximately 8 percent of the population) and that there is a particular lag in the development of public libraries which serve the disadvantaged segments of our populations of all ages.

The book shortage in public libraries is estimated at 100 million volumes, and the operating expenditure gap is estimated at $1.1 billion, the difference between what the amount should be and what is actually being expended.

Despite 997 construction projects in fiscal years 1965–67 under title II of LSCA, there is today still a startling backlog of public library buildings in relation to current needs.

Just a beginning—and that only through planning funds—has been made in the fertile area of cooperation among public libraries, college, university, school, and special libraries—title III.

Little has been done to date for persons living in State institutions, such as prisons, orphanages, residential schools, and so forth; and for the phyiscally handicapped, such as the blind and the visually impaired—titles IV–A and IV–B.

I have prepared some statements on the particular States, which you might like to have for information. This one is on Iowa, Mr. Smith.

The questionnaire which the American Library Association sent to all the State library extension agencies regarding the effects of the limited fiscal year 1969 budget brought significant responses. On the

basis of returns from 44 States, we were able to draw up a tabulation which shows what the States had in fiscal year 1968, and what is actually needed to give adequate public library service to all the people in the States reporting. It should be noted that these figures do not include all of the States, the District of Columbia, or the territories.

We have taken the total that is being received from all sources: Federal, State, and local, in fiscal 1968 (a) and then what is available from Federal sources only. This gives you a good idea of the amount of money that the State and local communities are putting into the programs in addition to the Federal funds. Then under (b) in each of the titles is shown the amount that the States say that they actually need if they are to give the kind of adequate service that the people need.

STATE LIBRARY AGENCY REPORTS ON AMOUNTS UNDER LSCA

[(a)—amount available in fiscal year 1968; (b)—amount needed in fiscal year 1969 to give truly adequate public library service to all the people, including those who do not have any public library service, those who have only inadequate service and those who do not now make use of the service which is available]

	Total from Federal, State, local sources	Federal sources only
(a) Title I	$331,117,974	$31,390,515
(b) Title I	704,819,414	138,045,533
(a) Title II	87,581,928	19,527,521
(b) Title II	321,477,596	116,807,665
(a) Title III	3,843,266	1,842,852
(b) Title III	42,745,842	13,037,516
(a) Title IV-A	3,420,068	1,634,000
(b) Title IV-A	17,737,160	8,057,407
(a) Title IV-B	2,835,101	1,002,235
(b) Title IV-B	15,720,483	5,536,449

If we examine the gaps between what is required to give adequate service to all the people and what the proposed budget recommendation for 1969 actually is, we can see the startling effect of the reduction. In view of the foregoing facts, the ALA feels that the reduced budget requests for fiscal year 1969 are a distressing setback for public library development, and urges that increases be made in each item.

This 5-year program, initiated in fiscal year 1966, authorized making grants available through title II to the States to acquire school library resources, textbooks, and other printed and published instructional materials for the use of children and teachers in the public and private elementary and secondary schools. The legislation is aimed primarily at remedying some of the deficiencies existing in these materials in disadvantaged areas of the Nation.

This measure, in the short period of its life, has accomplished much, but there is still much to be done for the children and teachers of the United States. To fail to support this basic program adequately, will be to endanger the educational progress and development of large numbers of our schoolchildren.

The budget recommendation for title II of the ESEA is only $46 million for fiscal year 1969 as compared with the final budget allocation of $99,234,000 in fiscal year 1968, a decrease of 53.6 percent in a vitally needed program for the pupils and teachers in the public and private elementary and secondary schools of the United States. It should be noted, also, that the authorization for fiscal year 1969 was set by Congress in December 1967 at $162.5 million.

To ascertain the effect of this terrific cut, the American Library Association sent a questionnaire to the 50 States, the District of Columbia, and the territories.

According to the reports from 47 States, the District of Columbia, and Guam, a total of approximately 21 million pupils eligible to be benefited by title II of ESEA were being so assisted in fiscal year 1968. The percentage of the eligibles was 94.7, this representing the average.

The 47 States, the District of Columbia, and Guam reported that the cut in title II funds would cause an estimated reduction in books purchased for the children of approximately 8.5 million volumes at a cost of nearly $26 million.

In view of the significance and essentiality of title II provisions for the pupils and teachers of the United States, the American Library Association strongly urges that the appropriation for fiscal year 1969 be set at the same amount as allotted for fiscal year 1968. To allow only the small amount recommended would be calamitous.

Samples of replies from the States are attached. (See attachment A.)

I do have some additional figures on Elementary and Secondary Education Act title II for each of you, that may be useful also for your information. I am sorry I don't have the full LSCA breakdown on Texas, Mr. Casey, but I will give it to you later. The USOE representative in the region had a death in the family.

HEA amendments of 1968 are currently being considered by both House and Senate committees. The purpose of title II of this act is to improve college libraries and the quality of library service throughout the Nation by providing grants for: (1) Acquisition of books, periodicals, and other library materials by colleges and universities; (2) training of all types of librarians—school, college, university, public, and special; (3) research and demonstration projects, including the development of new ways of processing, storing, and retrieving the information; and (4) aiding the Library of Congress to acquire and catalog additional scholarly material, not only for itself, but for the benefit of other research libraries who serve the scholarly community.

Higher Education Act	Fiscal year 1969 budget recommendation	Authorizations not yet established
Total	$42,300,000	
Title II—College library assistance and library training and research:		
Pt. A—College library resources	25,000,000	
Pt. B—Library training, including institutes	8,250,000	
Research	3,550,000	
Pt. C—LC acquisition and cataloging	5,550,000	

It should be noted that college and university enrollments have increased by 45 percent from 4,800,332 in the fall of 1963 to 6,963,687 in the fall of 1967. By 1972, the enrollment is expected to rise 25 percent, to about 8.6 million.

To obtain facts about the working of this program in fiscal year 1968, the American Library Association sent out a questionnaire to a sample of 150 of those institutions of higher education which had received grants under the law previously. Replies were received from 39 universities, 49 4-year colleges, and seven junior colleges, a total of 95. (See attachment B.)

The importance of title II to the improvement of the quality of higher education cannot be overestimated. It is hoped the authorization bill will be enacted shortly so that this committee can include adequate funds for fiscal year 1969 in the regular HEW appropriations bill.

In view of the increasing enrollments in junior colleges and other institutions of higher education, we deplore the tremendous reductions in the budget request for fiscal year 1969 as compared to the authorizations for the construction of needed buildings.

Higher Education Facilities Act	Fiscal year 1969 budget recommendation	Fiscal year 1969 authorization
Construction of academic facilities, including libraries:		
Title I—Undergraduate	[1] $200,000,000	$936,000,000
Title II—Graduate	[1] 25,500,000	120,000,000
Title III—Loans	150,000,000	400,000,000

[1] This combines new fiscal year 1969 obligational authority with funds carried over from fiscal year 1968.

The American Library Association also urges this committee to consider favorably the adequate funding of this vital act. We believe that this program, designed to improve and expand the basic resources and facilities of health science libraries, as well as to train medical librarians, help compile scientific knowledge, and develop a national system of regional health science libraries, is essential to the general health and welfare of the Nation.

Medical Library Assistance Act	Fiscal year 1969 budget recommendation	Fiscal year 1969 authorization
Construction	$1,250,000	$10,000,000
Training	[1] 1,433,000	1,000,000
Special scientific projects	200,000	500,000
Research and development	2,288,000	3,000,000
Resources	2,800,000	3,000,000
Regional medical libraries	2,415,000	2,500,000
Publications	300,000	1,000,000

[1] This combines new fiscal year 1969 obligational authority with funds carried over from fiscal year 1968.

In these troubled times, information and understanding of other nations is of paramount importance to the security and advancement of the United States. It is a matter of very real regret, therefore, that the Congress has not yet appropriated funds to carry out the purpose of this act which is to provide for the strengthening of the educational resources in the United States in the areas of international studies and research. The American Library Association urges this committee to include in the appropriations bill at least the budget recommendation of $10,820,000 for fiscal year 1969.

The American Library Association greatly appreciates the opportunity to present to this committee our reaction to the drastic reductions in the fiscal year 1969 budget recommendations for various library programs under HEW. These cuts, if put into effect, will severely curtail and damage library programs which are so fundamental to the development of the Nation.

(The attachments to Miss Krettek's statement follow:)

ATTACHMENT A

SAMPLES OF REPLIES FROM STATES ON ESEA, TITLE II (STATE SCHOOL SUPERVISORS AND TITLE II COORDINATORS, FEBRUARY 1968)

FLORIDA

Title II funds have enabled some of our systems to supplement local efforts enough to insure real progress toward excellence in materials program. With the drastic reduction for fiscal year 1969, we shall be obliged to curtail assistance to these schools.

IDAHO

Most elementary schools are just starting library programs. Secondary schools are beginning to update their collections. Individual instruction would have to be dropped, and go back to textbook instruction.

KANSAS

Allotments to schools will be cut. Small schools would need the help the most. Dollar-for-dollar in value received, this program has done more for all the children than any we have ever had.

LOUISIANA

It will stop work in closing the gaps, (1) reaching the standard of 10 books per pupil, (2) establishing elementary school libraries, (3) purchasing audio-visual aids, as State aid is for books only.

MARYLAND

The cut will hinder the attack on * * * delinquency; 90.4 percent of all schools fail to meet State standards for size of book collection.

MICHIGAN

The cut will sabotage it (the school program). We have to cut out works, meetings, printing, etc. Visits to individual schools would be greatly curtailed.

NORTH CAROLINA

Will affect effort to close the gap in purchasing materials of all types, all grade levels, and subject fields.

OHIO

Reduction of 50 percent in our program.

OREGON

The funds in title II have been meager—$2 a child doesn't buy much (in the way of library materials). But Oregon has used these funds to stimulate a lively interest in and appetite for improved library service.

PENNSYLVANIA

We have increased the number of library books per child from zero to at least four in many districts. The private schools have been encouraged to increase their collections.

SOUTH CAROLINA

In 1965-66, South Carolina had 143 elementary schools accredited in the Southern Association of Colleges and Schools. In 1967-68, the number increased to 480. Improved library facilities were the leading factors.

TEXAS

Too many schools are still without elementary school libraries.

WISCONSIN

A drastic reduction in funding would probably make it necessary to restrict the number of schools that could be served.

ATTACHMENT B

EXCERPTS OF REPLIES FROM REPRESENTATIVE INSTITUTIONS OF HIGHER EDUCATION IN RESPONSE TO AMERICAN LIBRARY ASSOCIATION QUESTIONNAIRE OF FEBRUARY 26, 1968

Statements on what has been done, or is planned, include the following:

Alabama College Library

Used it to purchase titles listed in a selection guide that otherwise we would not be able to buy.

California, Humboldt State College

Provided a backfile of the New York Times. The library did not have a substantial backfile of a major newspaper.

California, University of, Davis

Purchased the printed catalog of the U.S. Geological Survey, which is the most important bibliographic resource for materials in geology and related fields, such as paleontology, geography, etc.

Colorado, Loretto Heights College

Our present problems are: (1) lack of funds; (2) lack of availability of many standard out-of-print books; (3) high price of reprinted books and periodicals.

Florida State University, Tallahassee

There are several impediments in our library which prohibit the reaching of maximum standards; (1) lack of resources in the major indexing and abstracting media; (2) basic materials for new graduate and undergraduate programs; (3) necessary funds to buy primary source materials for current research on campus.

Illinois, Northeastern Illinois State College

Specialized material on the disadvantaged for the nucleus of a library in the Center for Inner City Studies.

Kentucky, Murray State University

Deficiency: size and quality of book collection.

New Mexico, East New Mexico University

Programs in higher education are expanding more rapidly than library collection to serve them.

Minnesota, Bemidji State College

Lack of funds—we would need a million dollars to achieve the national standard.

Nevada, University of Nevada

Title II–A funds are a great help to all their recipients. The amount should be increased dramatically.

Ohio, Central State University

More money is needed to fill large gaps in undergraduate collections and to build a firm, solid graduate collection.

Pennsylvania, Millersville State College

1. To meet national standards.
2. To meet requirements of accrediting agencies.
3. To meet needs of graduate programs.
4. To provide materials for serious research projects.
5. To provide materials for independent study and honors programs.

Texas, Trinity University, San Antonio

Inadequate book budgets to do restrospective as well as current purchasing. Inadequate binding and serials budgets in light of the publication explosion.

Virginia, Lynchburg College

There are not enough Federal grants and other financial resources to purchase library materials.

Wisconsin State University, Oshkosh

To assist libraries in continued involvement in depth in the social order, and to help libraries make an impact in the community.

Miss KRETTEK. Thank you.

Mr. SMITH. That was a very good and full and detailed statement.

Under title I, of course, the major reduction is in facilities.

Miss KRETTEK. Library Service Act under title II, yes.

Mr. SMITH. Do you think facilities are really crucial this year as compared with waiting a year if there is to be a cut? If there is to be a cut, is that where it should be?

Miss KRETTEK. That is right. If there must be a cut. Of course, I can't agree that any cut is possible or acceptable, even——

Mr. SMITH. I understand.

Miss KRETTEK. Because you cannot operate a program if you don't have the facilities in which to operate them. In the States we know that the (as you know, all the programs are matching) local library boards in many cases have gone to great effort to get the communities to agree to bond issues and appropriate the matching funds. But nevertheless I think title I services is the most important.

Mr. SMITH. If there is to be a cut, do you believe it might better be made in some other part of title I than facilities?

Miss KRETTEK. I think title II funds might be delayed rather than title I, if a reduction is inevitable.

Mr. SMITH. In other words, you would prefer facilities in title I over the other types of expenditures in title II?

Miss KRETTER. Under the Library Services and Construction Act, title I is for services, title II is for construction, title III is interlibrary cooperation, and title IV–A is for aid to institutional libraries, title IV–B for physically and mentally handicapped and the blind. Title I is the basic program; this provides the services. This is without any question of doubt the most important element in the Library Services Act.

Mr. SMITH.You refer to Higher Education Facilities Act where there is a substantial cut in facility funds. There is at the same time an increase in fellowships. I take it from your statement that you would prefer, if there has to be a cut, that fellowships be cut instead of facilities.

Miss KRETTEK. No; facilities. We were only speaking to the library element of the program.

Mr. SMITH. I understand. Thank you.

Mr. Laird?

Mr. LAIRD. I have no questions. That was a very good statement.

Mr. SMITH. Mr. Casey?

Mr. CASEY. I have no questions. Thank you.

Mr. SMITH. Thank you very much.

Miss KRETTEK. You are welcome.

TUESDAY, APRIL 23, 1968.

VOCATIONAL-TECHNICAL EDUCATION

WITNESS

LOWELL A. BURKETT, EXECUTIVE DIRECTOR, AMERICAN VOCATIONAL ASSOCIATION, WASHINGTON, D.C.

Mr. SMITH. Mr. Burkett?

Mr. BURKETT. Yes, sir.

Mr. SMITH. Please proceed.

Mr. BURKETT. I am Lowell A. Burkett, Executive Director of the American Vocational Association of Washington, D.C., which is a professional organization of some 45,000 vocational educators in this Nation.

Mr. Chairman, thank you for this opportunity to appear here in support of appropriations for programs of vocational-technical education. We are grateful for the consideration that members of this subcommittee have given to our needs in vocational-technical education. We are most especially appreciative of the fact that last year, by action of this subcommittee, vocational educators were permitted to continue the very successful work-study programs for vocational students by transferring $10 million from the funds requested for the Office of Economic Opportunity. In fiscal year 1967, with the same amount of funds, 49,000 students received assistance to stay in school and acquire a marketable skill.

In view of this year's restraints on the national budget, we are also appreciative of the fact that the Budget Bureau recommended the same level of funding for grants to the States that was approved by this subcommittee last year. We respectfully urge that you again appropriate the funds recommended for vocational-technical education, and we support also the modest increase recommended this year for vocational education research.

The following table compares the amounts appropriated last year for vocational and technical education with the sums recommended for fiscal year 1969.

FEDERAL FUNDS FOR VOCATIONAL TECHNICAL EDUCATION

	Amount authorized	Fiscal year 1968 (funds appropriated)	Fiscal year 1969 (funds proposed in budget)
Smith-Hughes Act	$7,161,455	$7,161,455	$7,161,455
George-Barden Act	49,991,000	49,991,000	49,991,000
Vocational Education Act of 1963:			
Grants to States, secs. 4 (a) and (b)	225,000,000	199,309,000	199,309,000
Research section, sec. 4(c)	[1]	13,550,000	15,700,000
Work-study program, sec. 13	[2] 30,000,000	[3] 10,000,000	----------
National Vocational Student Loan Act		3,600,000	[4]
Total		283,611,455	272,161,455

[1] Ten percent of amounts authorized in sec. 4(a).

[2] Also available for residential vocational education facilities. This provision of the Vocational Education Act of 1963 expires at the end of the current fiscal year.

[3] This amount was transferred from the Office of Economic Opportunity to fund the vocational work-study program.

[4] Act is to be merged with other higher education loan programs. No specific funds are identified in the fiscal 1969 budget.

The House Committee on Education and Labor and the Senate Committee on Labor and Public Welfare are now considering amendments to the Vocational Education Act of 1963. One proposed amendment would make permanent the vocational education work-study program, and would raise the authorization to $30 million for fiscal year 1969 and 1970. The funding level would go to $55 million in fiscal year 1971. If this amendment is approved, Mr. Chairman, we are hopeful that funds will be appropriated before Congress adjourns, though we recognize that such appropriations perhaps will not logically be a part of the bill you are now considering.

One of the most significant developments in education during the past 5 years has been our Nation's commitment to providing occupational education "for all persons of all ages in all communities." We are gradually implementing this mandate given us in the Vocational Education Act of 1963, though we still have a long way to go before we actually achieve our goal for a permanent, universal, continuing program of vocational education, readily available to all persons of all age groups and levels of ability, wherever they may live. Such programs are needed to help all individuals make occupational choice, to provide appropriate instruction, and the programs should be available to the individual at the time they are needed.

We believe, Mr. Chairman, that vocational education has made much progress since the passage of the Vocational Education Act of 1963. For the information of this subcommittee, we would like to leave with you a publication, "New Designs in Vocational, Technical, and Practical Arts Education in the Public Schools." This document highlights some of the growth and change that has occurred in the States since 1964.

Even since this bulletin was prepared there has been much progress made but we felt that this would be helpful to you in order that you might see some of the developments that have taken place.

There is no question that the primary domestic issues of our time include education, unemployment, civil rights, the problems of crime, housing, inner-city tensions, and poverty. It is also crystal clear that these are interdependent issues—no one of these problems will be solved without solving all the others. The common thread running throughout is the needs of people: their need for dignity in work, and in equal opportunities to partake of the benefits of our society.

We of the American Vocational Association believe that one of the keys to the solution of these problems of education, unemployment, civil rights, crime, and poverty is to adequately educate and prepare our people—both youth and adults—for the demands of employment in our technical society. Vocational education must not be viewed simply as a program, but rather as a system or process for preparing people for work.

Our schools are a unique public institution. They have custody of all youth until they reach well into their midteens. Therefore, our schools must be the institutions through which we seek to close the credibility gap between promises and prospects. Youngsters must be made to see that education can be truly meaningful and can lead to real career opportunities. On the other hand, our school systems must be prepared to make good on their promises, and to justify such beliefs. Too many of our schools are resigned, if not content, to be mere custodians of our youngsters.

Our manpower training programs, important as they are, are nonetheless an eloquent testimony to the failure of our schools to meet the challenge of educating youth for the world of work. The cost of welfare for the Nation's unemployed is another measure of our failure. Still another is seen in the crisis of the ghettos where there is 30 percent unemployed. Perhaps the most eloquent testimony to the inadequacies of our schools is the alarming dropout rate. Youngsters do not, in my judgment, drop out of school because they do not want to succeed; they do drop out because too few schools have persuaded them that they have something meaningful and useful to offer, and all too often the schools do not have such programs. Hence, every dropout is not only a personal tragedy but an indictment of the system.

With the ever-increasing demands for education and training which our society places on our young people, still approximately one-third of our youngsters will drop out of school before they finish 12 grades, and the rate does not seem to be declining appreciably. Eight out of 10 of our elementary school children will not complete 4 years of college, and all too few of those who complete high school will be adequately prepared for the world of work.

I believe that our Nation cannot afford the economic and human losses that result from inadequate education, nor should we afford a school system that rejects one-third of its students each year and provides inadequate occupational training programs for the vast majority who are not going to complete four years of college normally required for employment in professional fields.

Unfortunately, there are no national studies to show the costs of vocational education in terms of the benefits that it brings to people and to our economy. We do, however, have some figures that would indicate that vocational education can be considered an investment that pays dividends rather than a cost that brings no return to the economy.

For example, in 1967, there were approximately 5,000 youngsters enrolled in vocational cooperative education programs in the public schools of the State of Ohio. The costs for this program from local, State, and Federal sources, amounted to approximately $300,000 for the year; $250,000 going to pay salaries of the teacher coordinators, and $50,000 for instructional materials. The youngsters, enrolled in this vocational training program, actually earned $5 million during the year. These earnings were, of course, subject to Federal income taxes, and the estimated return to the Federal Treasury alone was almost $350,000. This more than paid the costs of operating the program.

I should point out, however, that the cooperative program is only one technique for providing vocational education. There are other programs where heavy and expensive equipment is needed; where materials and personnel are more costly. Not all vocational education programs provide as quick a return as does the cooperative program, but there is some evidence that strongly indicates that vocational training is an investment rather than a cost when you consider the costs to our Nation of unemployment and welfare.

Dr. Garth Mangum, who is a labor economist, in his study, "Contributions and costs of manpower development and training" points out that studies which have been of MDT and related projects "leave little doubt that the program has been a good economic investment."

Dr. Mangum cited studies made in Massachusetts of State-sponsored retraining which concluded that the savings in unemployment compensation alone from the reemployment of the trainee would repay the training costs in a little more than 5 years. Studies of some 900 trainees in the same State estimated that the public investment of $600,000 in training would return more than $3 million in benefits over the working lifetime of the trainees. A study by the Department of Health, Education, and Welfare, estimated a return in gross earnings of $2.24 per year for each dollar invested and repayment of training costs in 5 years from Federal income taxes alone.

Despite significant increases in Federal appropriations since the passage of the Vocational Education Act of 1963, the amounts provided are too small to meet the needs for occupational training. Appropriations for vocational education are also small in comparison with other Federal programs which are remedial in nature and which, hopefully, can be avoided through proper utilization and direction of additional resources into vocational education.

The following figures reflect the fact that we are spending more Federal funds to relieve "symptoms" than we are to prevent the "diseases" occurring from unemployment.

COMPARISON OF APPROPRIATIONS FOR VOCATIONAL EDUCATION WITH OTHER FEDERALLY SUPPORTED PROGRAMS FOR FISCAL YEARS 1961-67

[In millions of dollars]

Program	1916	1962	1963	1964	1965	1966	1967
Manpower development and training			$70	$130	$197	$435	$421
Health, Education, and Welfare vocational education	$50	$54	57	57	187	260	283
Office of Economic Opportunity:							
Neighborhood Youth Corps					132	272	325
Job Corps					183	310	211
Work experience					112	150	100
Other OEO manpower (estimated)					(1)	80	143
Adult basic education					18	35	[2] 30

[1] Not available.
[2] The 1966 amendments to the Economic Opportunity Act transferred funding of adult basic education to the Department of Health, Education, and Welfare.

In conclusion, Mr. Chairman, let me again urge this subcommittee to appropriate the funds requested for vocational education by the Budget Bureau. While this is not sufficient for all our needs, we do believe that these funds are highly significant in terms of the meeting the needs of some 7-million-plus students who can now be accomodated at present levels of funding.

Thank you for the opportunity to present this statement.

Mr. SMITH. What can you tell us concerning the counseling in high school of students for post-high-school technical and vocational and occupational training?

Mr. BURKETT. There is a great need to strengthen this particular program.

Mr. SMITH. It is true all over the country?

Mr. BURKETT. It is spotty, as many programs are in education, but it needs considerable strengthening.

Mr. SMITH. How do you strengthen it? I have been told that where they have counselors, they don't sufficiently counsel students who are not going to college.

Mr. BURKETT. Frankly, I think our major problem is that our counselors are people that are academically trained and not attuned to the world of work. They need some work experience and some relationship to the outside world, to the work world, in order to qualify as a counselor, particularly the vocational aspects of counseling. I don't think we pay enough attention to the preparation of counselors in helping them to prepare occupational information for the students. I think these are major problems. I think there is a need to change the public schools so that there is more attention given to the world of work in the total curriculum of the school.

Mr. SMITH. Is your association working on this counseling problem?

Mr. BURKETT. There is an organization called the American Personnel and Guidance Association that has responsibility for the guidance field. However, we have the vocational guidance people who are members of our organization. This is a small number of those people. We have, on two occasions, held national conferences with State supervisors and teacher educators of guidance services to point out this deficiency and assist in improving their competencies. One was done in Northern Michigan University at Marquette, one was done with the teacher educators at the University of Missouri last year. We had people from all over the Nation trying to focus on this problem.

Mr. SMITH. I am told that the counselors will talk to students and as soon as he finds out which student is not going to college, that is the end of the conversation.

Mr. BURKETT. In many cases they have nothing to offer the student.

Mr. SMITH. Mr. Laird.

WORK-STUDY PROGRAM

Mr. LAIRD. How are you coming on your amendment to the Vocational Education Act concerning the work-study program?

Mr. BURKETT. This is pending before the House General Education Subcommittee.

Mr. LAIRD. I understand that; but what is your progress on it?

Mr. BURKETT. I think that the support is fairly good in the field.

Mr. LAIRD. In the field?

Mr. BURKETT. I hope it is in Congress.

Mr. LAIRD. It is not very good in the executive branch. The administration is against the amendment. I wondered if you are giving any support to it.

Mr. BURKETT. We are working very hard on this. It is not in the administration bill. There is a bill currently before the committee that does not have it in, as I mentioned in my testimony.

Mr. LAIRD. The Department testified against it?

Mr. BURKETT. Yes.

Mr. LAIRD. I was trying to find out how you are coming.

Mr. BURKETT. I firmly believe that the Congress of the United States will respond to this need because I think the need has been proven in the field. I think that if the Congress is receptive to the needs of people, they will undoubtedly put it in.

Mr. LAIRD. I think you have to do a little bit more than that. I put in an amendment to the appropriation bill last year to take care of the program and there really was not great support for the amendment.

As a matter of fact, I do not think I heard from a vocational educator any place in the country in support of it.

Mr. BURKETT. I received several letters sent to various Members of Congress on this point.

Mr. LAIRD. I recommended the amendment and we passed it here in this committee. We earmarked funds to be transferred from OEO to keep the program going. It was my hope your association would become active so we could get the program extended last year in the authorization bill. Instead of working hard for extension, your association just dropped the ball and did not do anything on it.

Mr. BURKETT. We asked for legislation to extend the authorization beyond June 30, 1968, last year. We could not get the committee itself to act on any amendment in the House.

Mr. LAIRD. I thought this was a significant program. If the vocational educators would have gotten together we could have gotten an authorization through for this next year. I made it very clear when I offered that amendment transferring those funds over for fiscal 1968 that your time was running out.

Mr. BURKETT. We realize that.

Mr. LAIRD. Now time has run out.

Mr. BURKETT. We realize this. We petitioned and asked the General Education Subcommittee in the House to hold hearings on amendments to the 1963 act, but were not able to get it done.

Mr. LAIRD. This is one program that I feel has to be funded.

Mr. BURKETT. That is exactly right. That is the reason for my statement today stated that if this is enacted this year I hope there will be supplemental funding.

Mr. LAIRD. We seem to be putting the vocational work-training function all over in the Department of Labor program instead of continuing a going program that has brought us very good results over a long period of time.

Mr. BURKETT. Very fine results.

Mr. LAIRD. Are you familiar with the report that has been released on vocational education?

Mr. BURKETT. Absolutely.

Mr. LAIRD. It is a very disappointing report.

Mr. BURKETT. Many parts of this were very good.

Mr. LAIRD. They are bound to have a few good parts in a report of that size.

I do not know who wrote the report, but if I have ever seen bureaucratic gobbledy-gook, that report has it. Just as an example this sentence:

> Now, while rapid innovations in program content are occurring, new target clientele being designated, and various administrative lines of authority being tested, it appears preferable to focus the expertise of the specialized Federal agencies on distinguishable tasks, and observe the results.

Beautiful verbiage.

That is all I have, Mr. Chairman.

Mr. SMITH. Thank you, Mr. Burkett.

Mr. Casey?

Mr. CASEY. No questions.

Mr. SMITH. Thank you very much.

Mr. BURKETT. Thank you very much.

TUESDAY, APRIL 23, 1968.

MYOPIA

WITNESSES

MRS. SYLVIA N. RACHLIN, EXECUTIVE VICE PRESIDENT, MYOPIA INTERNATIONAL RESEARCH FOUNDATION
MISS BARBARA ZIEGLER
RABBI AARON DECTER, GARMENT CENTER CONGREGATION, NEW YORK, N.Y.

Mr. SMITH. Mrs. Rachlin, we will be pleased to hear from you.

Mrs. RACHLIN. We are happy to report much progress since our last visit, not only in this country but particularly in Europe, South America, Asia, Australia, and Africa.

May I introduce two trustees: Rabbi Aaron Decter, Garment Center Congregation, New York City, and Miss Barbara Ziegler.

Miss Ziegler is going to read our statement.

Mr. SMITH. Thank you.

We will place the names of all of your trustees in the record.

(The list follows:)

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Mr. SMITH. Congressman Flood wanted to be remembered to you. He intended to be here, but they have a primary in Pennsylvania today and he is unable to get back here this fast.

Rabbi DECTER. Much to my regret. I am originally a Philadelphian. This is my first year out of Pennsylvania.

Mr. SMITH. You may proceed.

Miss ZIEGLER. More than a million American schoolchildren with progressive nearsightedness are destined for blindness or near-blindness unless the riddle of the causation and treatment of this condition is solved. Countless adults have suffered loss of employment and become financial burdens to their families and the community because of pathological or degenerative changes in myopia. There is presently no known cure for this blindness.

According to the U.S. Bureau of the Census the population of the United States has passed the 200 million mark. It is generally estimated that more than a third of the population has myopia in one form or another. At least 1 to 3 percent have progressive degenerative or pathological myopia. These figures speak for themselves.

Certain eminent ophthalmologists estimate that about 18 million myopes are the patients of ophthalmologists. Leaders in optometry compute the number of myopes involved with their discipline to be about 45 million.

For centuries, myopia has been considered a hopeless affliction. We know that this need not be true. However, in order to effect a breakthrough and halt the alarming increase in myopia, a crash program is urgent.

To accomplish this, the Myopia International Research Foundation recommends the establishment of a National Myopia Center under the egis of the U.S. Public Health Service to make possible nationwide, organized and comprehensive interdisciplinary research into the causes, treatment, and prevention of nearsightedness. Doctors, institutions, colleges, and universities with particular interest in, and facilities for, research and treatment of myopia and its related problems would participate in a coordinated approach.

Among the areas in which research is urgently needed, in addition to specific eye research, are:

General health (including circulo-vascular and other studies in the realm of internal medicine; neurology; biochemistry; and the many other disciplines which should be involved in myopia research), heredity, environmental factors, nutrition, psychology, lenses (including contact lenses), vocational surveys, living habits of nearsighted children and adults, and many other facets involved in comprehensive research.

The National Myopia Center would encompass:

1. A myopia service program under the neurological and sensory disease control program of the U.S. Public Health Service.

(a) Collaborative study permitting the creation and development of service programs for myopes throughout the United States, and a standardization of records and reporting forms.

(b) Grants enabling myopia service programs:

1st year	$1,000,000
2d year	1,500,000
3d year	2,000,000
4th year	2,500,000
5th year	3,000,000

2. Myopia research projects in the National Institute of Neurological Diseases and Blindness, National Institutes of Health, Bethesda, Md.

(a) Establishment of statistical and analytical procedures by the Biometrics Branch of the National Institute of Neurological Diseases and Blindness.

(b) Grants to the National Institute of Neurological Diseases and Blindness, enabling myopia research projects and establishment of statistical and analytical procedures:

1st year	$1,000,000
2d year	1,500,000
3d year	2,000,000
4th year	2,500,000
5th year	3,000,000

3. The national registries of myopia pathology, a myopia eye study bank, should be developed under the U.S. Public Health Service. All universities, hospitals, other laboratories involved in eye research

and eye banks throughout the United States could participate in coordinated clinical research. Participating laboratories would receive eyes of myopes and their families, which have been donated for the purpose of research into the pathology of myopia from its incipience through its advanced stages. Findings would be correlated with other research.

The plan for the national registries of myopia pathology, originated by the Myopia International Research Foundation, has received the enthusiastic support of many individuals and organizations across the Nation.

A National Myopia Center structured upon this three-phase program would stimulate nationwide interest and participation by myopes with their families and friends in research under public and private health facilities.

The Myopia International Research Foundation pleads for your favorable consideration of this program so necessary if our young are to enjoy all the blessings of life.

I have another statement I will read from the Myopia International Research Foundation, Inc.

Mr. Chairman and Members of the House of Representatives Subcommittee on Appropriations for Labor, Health, Education, and Welfare: Greetings.

The Myopia International Research Foundation, Inc., 415 Lexington Avenue, New York, N.Y., is rapidly strengthening its crash program intended to save the eyesight of more than a million American children doomed to blindness because they have progressive, degenerative or pathological myopia.

Increasing numbers of American doctors are expressing interest in a comprehensive research program as outlined in our petition.

Since our last appearance before your honorable committee, interested doctors from over 60 nations have expressed their willingness to participate in an international research structure in myopia.

More and more health, civic and educational groups have offered to cooperate in our all-out program.

Dr. Clifford H. Cole, Chief, Neurological and Sensory Disease Control Program, National Center of Chronic Disease Control, U.S. Public Health Service, Arlington, Va., has shown great interest in helping the myope in every way in which his service program can possibly be involved.

For further details, I refer you to the attached petition and letters from: Robert H. Bedrossian, M.D., Vancouver, Wash.; Mary C. Fletcher, M.D., Houston, Tex.; Merton C. Flom, O.D., Richmond, Calif.; Abraham L. Kornzweig, M.D., New York, N.Y.

As a myope, in behalf of the more than a million children similarly afflicted in this country alone, I implore the attention and interest of your honorable committee in this vital project.

Respectfully submitted (Mrs.) Sylvia N. Rachlin, executive vice president, Myopia International Research Foundation, Inc., 415 Lexington Avenue, New York, N.Y.

Mr. SMITH. Mr. Laird?

Mr. LAIRD. No questions.

Mr. SMITH. Mr. Casey?

Mr. CASEY. I have no questions.

Mr. SMITH. It is a very good statement. I think it is rather self-explanatory. Thank you very much.

STATEMENT OF RABBI DECTER

Do you wish to say something, Rabbi?

Rabbi DECTER. Yes; if I may.

I am a recent newcomer to the problems of the Myopia Research Foundation and I am not a doctor, but rabbis and ministers and priests, of course, are interested in helping to heal people of every kind of ailment, not only spiritually.

I have noticed amongst my congregation, which is in the garment center area, that some of the top leaders of the International Ladies Garment Workers Union and of industry are themselves suffering from it, and no amount of tremendous research that has been done by the health program has been able to help them, simply because there has not been developed on a large enough scale the opportunity to utilize all of the interdisciplinary activities whereby people could be healed. This requires the cooperation of the biochemists and ophthalmologists and optometrists and so on; the others who are working in the field and perhaps the research in this area may help others suffering from diseases that are related. This is the reason for my own personal concern and interest aside from the fact that Mrs. Rachlin is a member of my congregation and I like this kind of dedication on her part to help relieve so many sufferers; and the 1 million children is only a minimum number by comparison with the many millions of adults.

It is estimated that about one-third of the American population is suffering from myopia in one form or another, whether degenerative of pathological or simple myopia, but suffering in such a manner that some of them are prevented from being at their best in service to the country or in their businesses or in any other fashion. There are many people whose activities have been limited because they wear glasses and their work has been limited because of very strong lenses and whose entire lives may suffer from these limitations. This is only a small group by comparision with those others who will never be able to be helped. It is only by the kind of help that government can give, not only to support great scientists and give a little bit of encouragement to the outstanding scientists in the field, but on a large scale to utilize all of these interrelated disciplines and the scientists working in a team effort, utilizing the great Public Health Service that has done so very much at this moment to help in discovering or trying to discover those great killers of America, the diseases that maim and kill.

This is not such a dramatic thing. Yet we are a nation that is suffering more and more from bad eyesight and degenerative diseases of the eyes.

Mr. LAIRD. I would like to interrupt the rabbi for one moment. I am sure he is aware of the favorable attitude of the committee in this area and that the committee has increased the funding of these programs quite considerably. When I first went on this committee we were funding this activity at the $500,000 level. Then we went up, just in research in the blindness and eye-related areas to $14,342,000 for research grants in 1965. We worked this up to the point now where in 1968 we are at the level of $22,698,000.

I did want you to know this committee has been aware of the problems of the eye and blindness. I think we have made progress, considering the growth of the funding from several hundred thousand dollars up to the point where this committee recommended over $22 million for research in this area last year.

Mrs. RACHLIN. But there is very little money being spent on specific research in myopia.

Rabbi DECTER. Thank you for interrupting and calling this to my attention. We are aware and gratefully so of the fact the committee has increased the responsibility of government for continued research. You were addressing yourself to blindness and problems of the eye.

It is precisely because the committee is sensitive to this problem and is increasing the appropriation I humbly petition you that you give greater concern to Mrs. Rachlin's appeal and petition for a program specifically geared to the myope and his problems, with the possibility of discovering what causes myopia and what can be done more than just giving people lenses. That in itself is not even a solution because Mrs. Rachlin herself is one of the examples of what happens, and what can happen, because of myopia as a degenerative disease, and there are millions of people equally afflicted.

I think it is a wonderful thing when people can feel they want to help others, as well, precisely because they have been the victims of this kind of disease.

So precisely because this committee is composed of great public-spirited individuals, not only great Members of Congress, and because you are increasing Government's responsibility for it, I would like to suggest that you, if at all possible, earmark some kind of grants for precisely this kind of program, even if it is only a small beginning so that a great scientist here and there, or a team at Bethesda or wherever it might be, would be able to do the kind of work that is necessary; and as time goes on it is quite possible that many of us or our children or children's children will be the beneficiaries of precisely such a program.

So I respectfully urge you gentlemen—I regret my friend Dan Flood is not here, I hope to be in touch with him as well—in the hopes that all of you together will be able to utilize and collaborate with your intelligent understanding of this problem so that the petition as presented by Miss Zeigler will have some kind of beneficial result and you will be able to act on it in an appropriate fashion.

Mr. SMITH. Thank you very much.

Rabbi DECTER. Thank you very much.

Mrs. RACHLIN. Thank you.

Mr. SMITH. We will place the other four statements in the record.

(The statements follow:)

STATEMENT OF MERTON C. FLOM, O.D., PH. D.

Mr. Chairman and members of the committee, because my life's work is teaching and research in vision, it might be assumed that I would automatically favor any proposal for expansion of research in vision. This is not the case. My life extends beyond the research laboratory. I am aware of other vital problems besides those of health, of many health problems besides those affecting vision, and of numerous vision problems besides myopia. In fact, my own research at Berkeley is not on myopia. And I do not have myopia. So it is not automatic that I favor a proposal to support research on myopia. But I do.

About one out of seven (or about 25 million) Americans has clinically significant myopia. What is myopia? If we were to ask a typical myope to describe his condition, he would tell us of indistinct vision whenever he looked at distant things and relatively clear vision for close things. If his nearsightedness were extreme, he would tell us that near objects had to be held within a few inches of his eyes to be discerned. In spite of clearness of objects at close range, he might volunteer having headaches or double vision which forced him to close one eye continuously when reading. His history might bring out the fact that neither of his parents had myopia and that his own condition was discovered in grade school after he had silently suffered through not being able to see the chalkboard and not being able to see well enough to participate in sports. After an eye examination he received glasses which allowed him for the first time to see distant things clearly.

But now there was almost surely a new problem: in spite of being careful in his play, he would regularly break his glasses, bringing financial hardship to his parents and educational and social hardship to himself. His parents inquired about curing his myopia and found someone who promised that his glasses could be thrown away if he did special exercises. He was diligent for months, but his myopia nonetheless worsened and each year or so he needed a new pair of glasses to see clearly. He recounts his limited military duty, restricted driver's license, and being denied certain jobs because of his myopia. In adulthood, his myopia finally stopped progressing, but he is still entirely dependent upon his glasses to see clearly at distance and to see comfortably at near.

I have chosen to describe myopia in this fashion to emphasize that it is people who are afflicted with this condition and that myopia affects far more than a person's eyes. Myopia affects their educability, physical development, choice of career, social maturity, safety, and productivity. Not every myope fits this picture. Some are as unaffected by their myopia as if their vision were normal. And in other people, the effect is so profound that it may impair their mental health.

Moreover, there are different kinds of myopia. There is a "transitory myopia" associated with use of many drugs, with changes in blood sugar level, and with menstruation. There is "night myopia" which quickly develops at low levels of illumination (as in night driving) and reduces the distance vision or normal as well as already myopic eyes. There is "traumatic myopia" which often follows impact to the head as is common in many accidents. In this type, there is often detachment of the retina resulting in blindness. There is an "acquired myopia" which affects a proportion of people only in later life. "Degenerative" or "pathological" myopia is a type that usually begins in infancy and runs a progressively worsening course into adulthood. Even with lenses, the vision in degenerative myopia is characteristically subnormal and, not infrequently, blindness ensues in what is generally considered to be a diseased eye. When myopia develops to a much greater extent in one eye ("anisometropic myopia") the vision of that eye tends to deteriorate to a form of blindness called amblyopia.

But, the commonest form of myopia is the one I described at the beginning, the so-called "simple myopia." The modifier "simple" is used to connote that it is the most common type of myopia; there is no implication that we know what causes this myopia, or that we know how to prevent it or cure it. Like the "common" cold, we can only treat myopia's symptoms, in this case, by means of lenses. Unlike the "common" cold, however, myopia does not run its course and disappear; once myopia begins, it practically never vanishes.

As a matter of fact, "simple" myopia is a complicated disorder. Testimony to this is the observation that what we do most for myopia in today's technological society; namely, prescribe spectacle lenses, was done similarly in the Ming Dynasty. Considering the prevalance of myopia and the intervening centuries, one can only conclude that myopia is not uncomplicated. With our present state of scientific knowledge, why are we unable to cure or prevent myopia? Perhaps myopia is incurable and cannot be prevented. But have we really tried? There is only a small body of solid scientific evidence on so elementary a question as, "which structural elements of the eye contribute to myopia?" And nearly all of this evidence has been done by workers in other countries, principally England and Sweden. Myopia seems to be a phenomenon of uncoordinated growth of various elements of the eye, but we know virtually nothing of what regulates their growth. We are similarly ignorant about possible environmental factors that might influence the development of myopia.

Scientists now have the tools to study and potentially solve the problem of myopia; controlled X-radiation, ultrasound, lasers. Further optics, electrophys-

iology, electron microscopy—to mention several. A little encouragement to a handful of widely scattered scientists would help. But a lot of encouragement and financial support to one or more interdisciplinary groups would almost certainly give us the answers we need. It is imperative that we call upon all disciplines that can contribute: biochemistry, genetics, physiology, anatomy, physiological optics, biophysics, pathology, endocrinology, ophthalmology, optometry, and many others.

Not to be overlooked in a financially supported team effort on myopia is the great probability that one or more fundamental problems in other areas will be solved. Just as solving the genetics of human color blindness was instrumental in understanding a general phenomenon of inheritance, so is it possible that general knowledge can emerge from research on myopia.

The topic that I was asked to comment upon was, "the need for research on myopia." I have spoken specifically to that question and no other. I would like to close with an important related point on vision research.

People are attracted to research that is dramatic. Thus, in the health fields we observe agencies and researchers being occupied with diseases that kill and maim. This is understandable and justifiable. But looking ahead, the day is not far off, if not to a large extent already here, when we will be obligated to direct our attention to the less dramatic human disorders. I refer to the multitude of health problems that impair the well-being, comfort, safety, and productivity of people. Myopia, and indeed most of the vision problems with which the optometrist is concerned, fall in this category.

Biographical Sketch of Merton C. Flom

Born in Pittsburgh, Pennsylvania in 1926.

Public school education in Los Angeles.

Two years in U.S. Navy (electronics), 1944–46.

Preoptometry education at UCLA, 1946–48.

Optometry education at University of California at Berkeley; B.S., 1950; M. Opt., 1951.

Education in Physiological Optics: graduate student at University of California, Berkeley, 1951–57. Ph.D. in Physiological Optics in 1957.

American Optometric Foundation research fellow, 1952–56.

Appointments at University of California School of Optometry:

Clinical instructor in Optometry, 1951–57.

Instructor in Physiological Optics and Optometry, 1957–58.

Assistant professor of Physiological Optics and Optometry, 1958–62.

Associate professor of Physiological Optics and Optometry, 1962; vice chairman, 1962–63.

Chairman of curriculum committee, 1962–63.

Member of executive committee, 1962–64.

Director of Orthoptics Clinic, 1951–61.

Director of Strabismus Clinic, 1954–64, 1965.

On sabbatical research leave in residence, 1964–65.

Other positions:

President of University of California Optometry Alumni Association, 1963–64.

Member of editorial council of American Journal of Optometry, 1963 to present.

Member in charge of Orthoptics Subcommittee of American Academy of Optometry, 1961 to present.

Member of A.O.A. Committee on Orthoptics and Visual Training, 1964–65.

About 100 oral presentations and outside lectures on vision.

Published 21 original papers on vision and the chapter on "Treatment of Binocular Anomalies," in the book "Vision of Children," by Hirsch and Wich (1963).

Membership: American and California Optometric Associations, AOA, American Academy of Optometry, Optical Society of American Association for the Advancement of Science, Sigma Xi, and American Association of University Professors.

Private practice of optometry in Richmond, Calif.

Principal investigator of two U.S. Public Health Service supported research grants:

(1) On the "Nature of Anomalous Retinal Correspondence," 1960 to 1962.

(2) "Fixation Tremor and Contour Interaction in Amblyopia," 1962 to 1967.

NEW YORK, N.Y., *March 19, 1965.*

(Attention Sylvia Rachlin, Executive Director.)

MYOPIA RESEARCH FOUNDATION,
New York, N.Y.

DEAR MISS RACHLIN: I understand that you are to speak before a congressional committee on the subject of "The Myopia Research Foundation," and its needs for financial support. As a practicing ophthalmologist of 30 years standing, I am very much aware of this problem and of the difficulties associated with its management, especially the need to preserve sight and prevent complications.

Strangely enough these individuals are very often bright persons who apply themselves to close work very diligently. But because of this need for constant reading, they have a tendency to develop degenerative changes in the retina and choroid which can drastically reduce their sight; also the high myope is a person very prone to get retinal detachment because of the stretching of the tissues associated with progression of myopia.

I think this problem is very widespread throughout the country and one that deserves considerable investigation and research. I want to wish you success in your efforts to help this severely disabled individual and prevent, if possible, its complications.

Sincerely yours,

A. L. KORNZWEIG, M.D., FACS.

VANCOUVER, WASH., *March 19, 1966.*

Mrs. SYLVIA N. RACHLIN,
Myopia Research Foundation,
New York, N.Y.

DEAR MRS. RACHLIN: I should like to compliment you and encourage you for your efforts in behalf of the Myopia Research Foundation. The problem of myopia is multiple. The complications that can result from extreme myopia are many. The severely myopic person has a much greater incidence of retinal degeneration and retinal detachments than that which is found in the normal population. Such diseases can lead to markedly decreased vision and even total blindness.

The great majority of people under 35 who wear glasses, wear them because of nearsightedness. Though it is true that most of these individuals do not suffer from any blinding complications of their nearsightedness the need for glasses or contact lenses to enable them to see better is a factor which is important in the general cost of medical care. There is also the inconvenience of having to wear glasses and the dependence on them.

Since a great majority of the nearsighted people do not have a dramatic loss of vision like that which occurs in other diseases, research in myopia has been somewhat limited and less glamorous than that of other eye diseases. The importance of myopia in the overall incidence of eye conditions is however very great. Any research which is done on a scientific basis that could lead to a decrease in the amount of myopia would be of considerable significance. In a great majority of incidences, myopia increases rapidly during the grade school and high school years. My particular efforts to date have been directed along the lines of attempting to discover some of the factors which may be present in causing this increase in nearsightedness and also, what can be done to prevent it. Adequate and scientific studies to determine some of these factors have been very limited. It is oftentimes difficult to obtain research funds to study diseases which are not dramatic or acute in their progress or do not produce many obvious symptoms. Increased funds for research for reducing or eliminating the progress of myopia and to help prevent myopia and the complications of severe myopia would be of great benefit in analyzing and solving some of the problems accompanying these conditions.

I believe that the Myopia Research Foundation has goals and ideas which are worthy of considerable support on a national level.

Yours truly,

ROBERT H. BEDROSSIAN, M.D.

HOUSTON, TEX., *March 14, 1966.*

Mrs. SYLVIA N. RACHLIN,
Myopia Research Foundation,
New York, N.Y.

DEAR MRS. RACHLIN: I am pleased to hear that your Myopia Research Foundation is to appear before the Subcommittee on Appropriations of the House of Representatives.

My particular field of interest is the pathogenesis of simple or school myopia. This disease does not result in a handicap such as those produced by cancer, heart disease, or stroke, but it is significant. Approximately 20 percent of our adult population is myopic; the cost of one eye examination and one pair of glasses is approximately $1 billion.[1]

In addition, there is the inconvenience of wearing glasses, the job limitations, eye injury hazard, and retinal detachment hazard. The reduction or elimination of school myopia would be significant.

I am currently endeavoring to conduct careful clinical investigation as to the etiology, treatment, and prevention of school myopia. One of my greatest problems is obtaining funds for this research.

I do feel your organization will help stimulate interest in myopia, stimulate and support good research, and foster better communication. I wish you success in your endeavor.

Sincerely,

MARY C. FLETCHER, M.D.

TUESDAY, APRIL 23, 1968.

EMERGENCY HEALTH SERVICES

WITNESS

DR. ROBERT H. KENNEDY, DIRECTOR, FIELD PROGRAM, COMMITTEE ON TRAUMA, AMERICAN COLLEGE OF SURGEONS

Mr. SMITH. Dr. Kennedy, you may proceed with your statement.

Dr. KENNEDY. Thank you very much for the opportunity to be with you this afternoon. I am Dr. Robert H. Kennedy, who was a practicing surgeon in New York from 1915 to 1960 and during the latter years professor of clinical surgery in New York University. In 1960, the John A. Hartford Foundation made a 3-year grant to the American College of Surgeons to try to improve the care of the injured in this country and Canada. I accepted the position of full time director of this field program and am now half way through the third 3-year grant. Our major aim in the first 3 years was to try to improve hospital emergency department treatment, in the second period we added the ambulance problem and in the present grant we include education of the public in emergency care. I have filed a statement.

Accidents kill more persons annually between the ages of 1 and 37 than any other cause. This includes the years of our most active and imaginative production. Only heart disease, cancer, and stroke kill more during life as a whole. They are largely diseases of later life, after one has made his major contribution. So in injury we are losing our greatest potential.

Many are working hard in accident prevention but, once the accidents happen, these leave millions with injuries and hundreds of thousands with permanent disabilities, not to mention thousands who are not immediately killed but die at the site or on the way to the hospital, often unnecessarily.

We must do better at saving life, diminishing hospital stay and lessening permanent disability, particularly when the victim will commonly be you or I. What can we do?

(1) I urge everyone to take standard and advanced first aid courses, and take them ourselves. These should be required in our schools from

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[1] Estimated population 14 years and over, 1965—127,000,000×20 percent estimated myopic×$30—cost of glasses and examination (estimated) =approximately $1,000,000,000 yearly.

at least the fifth grade on. I have known of a 9-year-old child saving a buddy by giving mouth-to-mouth breathing. Many adults should take instructors' courses and volunteer their services to educate others.

(2) The ambulance situation needs our intense interest. In the majority of communities its condition can only be described as chaotic. Five years ago not a State knew how many ambulances it had nor who was responsible for them. Since then we have learned something about 20 of these. This has been done largely through the efforts of the Emergency Health Services Branch of USPHS. The main need is adequate training of the ambulance personnel. In a survey of one State no attendant or driver was found who had gone beyond the eighth grade in school and several could not read nor write.

In 1960 Kouwenhoven, Jude, and Knickerbocker published their work on external cardiac compression, for relief of arrest of heart action. This made the ambulance system much more valuable, since a trained layman can restore heart action in many patients who will do well afterward, if accomplished within 4 minutes. This is useful not only after accidents but following heart attacks with many hearts "too good to die." I would like to feel that, in whatever State I get my cardiac arrest, an ambulance will come promptly with personnel so trained that as a physician I shall be glad to have them give me mouth-to-mouth breathing and educated external cardiac compression. This is far from being true now in cost communities. Should we expect that we, our wives, and our children will receive the required trained care in the next town or county or State if we would not get it from laymen in the home town? This is not a matter of medical attention. To the best of my knowledge no physician mans an ambulance in this country and he should not do so. A trained paramedical person can do practically equally as well almost all the time.

Ambulance equipment is lacking or the men not trained in its use. The vehicle needs to be longer, higher, and broader. How much? Not enough interest has been shown yet to obtain basic research to learn the precise needs of the vehicle, the equipment or the training of personnel.

(3) Much improvement is needed in communications. For example, Waller's[1] study of traffic accidents shows that persons injured in rural counties (under 50,000 people) were almost four times as likely to die of their injuries as those injured in urban counties (over 500,000 people). There were one and one-half times as many persons injured in these accidents per 1,000 population in the rural as compared with the urban counties. This is due mainly to longer time before the accident is discovered, longer period before the ambulance is notified and under way, and longer distance to travel. In other words communication must be improved to save life and limb. The past year has seen the start of several possibly valuable pieces of research in communications and some of them have been stopped already because they seemed too expensive.

(4) A fourth project needed intensely is to acquaint the general public with their situation in emergency care. They are not aware that in a great many communities the ambulance service and the hospital emergency department are not furnishing an adequate or even a similar quality of care to that rendered as soon as one becomes an in-patient. There has been definite improvement in the past 10 years, but not

[1] Waller, J. A., Traffic Deaths, Calif. Med. 101, 272, (Oct.) 1964.

enough to show yet in totals of deaths, hospital stay, permanent disability, and costs. We believe the public would want their own lives saved, as well as those of their wives and families, if they were aware that ways are known to accomplish this in many instances, that it cannot be done by issuing directives from on high, but by finding interested leaders in every community to spark and nourish interest in emergency care. There should be an advisory council in this field in communities of all sizes. It should meet regularly to discuss suggestions, complaints, and so forth, so that improvements may be made promptly.

The American College of Surgeons has committees on trauma in the States and Provinces and in many cities, counties, and so forth, to a total of more than 300, with more than 3,000 members of these committees interested in the field of injury. From the start the field program and these committees on trauma have worked closely with the USPHS, particularly the Emergency Health Services Branch since its organization in 1963. We know their aims and desires, but their work is circumscribed by the limited personnel and the number of hours in the day, the same as it is with our small unit of 4½ people.

The Emergency Health Services Branch has plans ready for action if they can get the wherewithal to proceed. For example, one most necessary project is to place a representative of Emergency Health Services in each State health department and in many counties and cities to consult, to advise, to survey, to live with these dilemmas. This cannot be done from any ivory tower. The problem is different in every emergency department and ambulance service I have seen and I have seen a great many. This work must be done at the community level and is needed predominantly in the less populated ones.

The emergency health services branch has the plans ready for making first aid training widely available, for reducing the chaos in ambulance services and other portions of emergency care, for improving communications and for developing advisory councils widely. They have cadres of trained men who can indoctrinate others. They have enthusiastic friends in various strong organizations to back up their efforts.

The benefit to our citizenry of using known methods of emergency care, and developing others in practice, is being lost because of too small a budget being sought and then too little appropriated. I know of no more important vacuum in this country than in knowledge of the value of emergency care resulting in apathy of the public, indifference of the powerful and woeful lack of means of support.

Thank you, gentlemen.

Mr. SMITH. Doctor, what do you think of the training programs now underway for ambulance drivers?

Dr. KENNEDY. Where there is one, it is excellent in many instances. I might say I am aware in the United States and Canada of about 112 different courses that are being given. We need one in every community.

Mr. SMITH. Do you think it needs to be speeded up?

Dr. KENNEDY. We are losing a lot of lives in the meantime.

Mr. SMITH. What I mean is, are you critical of the program?

Dr. KENNEDY. The quantity of it.

In a great many of our communities an ambulance is still only a means of transportation. In New York City the manual of the am-

bulance department says the ambulance is a means of transportation. It says nothing about what care should be given while that person is being transported or before he is put in the ambulance.

Mr. SMITH. Mr. Laird?

Mr. LAIRD. Mr. Chairman, Dr. Kennedy made a very good presentation. It seems to me we are going to have to apply not only the techniques familiar to the Emergency Health Service Branch, but we should start applying some of the lessons of the Vietnam war to Emergency Health Services.

Dr. KENNEDY. You would get better treatment there today than we could give you in most places here.

Mr. LAIRD. You do get better emergency treatment in Vietnam than you do in New York City today?

Dr. KENNEDY. The is no question about it. I practiced there for 45 years.

Mr. LAIRD. That is all.

Mr. SMITH. Mr. Casey?

Mr. CASEY. I want to commend you on your statement. It sounds like you are talking about my State and the lack of trained personnel or lack of knowledge of how many ambulances and so forth. It is only recently in most of our major cities I think they have even started limiting the number of companies that may get into the ambulance business or setting any standards at all.

Dr. KENNEDY. Most of them are not licensed at all.

Mr. CASEY. They used to race to see who could get there first. It is usually run by a mortuary.

Dr. KENNEDY. The majority of the services in this country are.

Mr. CASEY. I was always suspicious whether they were really anxious to save the victim or have first claim on the body. I am serious.

(Off the record.)

Mr. CASEY. I agree with you, we are very deficient and it cannot be done by just directions here, it has to be done at the community level with everybody getting interested. Of course the funding is something we might assist with. But until the public themselves get aroused you are not going to see the local government move even if you had the money waiting there.

Dr. KENNEDY. I think one of the best things that has been done is the law that requires that 40 percent of the funds that are furnished, the grant to the States, matching funds, has to be used in the local counties or municipalities.

I think that gives us one of the largest opportunities there is to do good in this field.

Mr. SMITH. I happened to have the experience about 12 years ago of discovering a heart attack patient. I did what little I knew how to do, which was not enough, and when the ambulance arrived, neither one of the people with the ambulance had the first idea of what to do except to roll them in on the stretcher.

Dr. KENNEDY. That would be true of most of our ambulance personnel in this country at the present time. It is unnecessary. We are just losing thousands of lives I believe every year because of the fact we have not given sufficient training.

Mr. CASEY. Some want to be ambulance drivers because they like to be able to drive fast with a siren on. As you say, most of them in the past have been poorly educated and do not get much pay.

Dr. KENNEDY. As you say, they often go in for it as an exhibitionist driver.

Mr. SMITH. Thank you.

TUESDAY, APRIL 23, 1968.

NATIONAL LABORATORY IMPROVEMENT PROGRAM

WITNESS

DR. BRADLEY E. COPELAND

Mr. SMITH. Dr. Copeland. Is this all part of your statement?

Dr. COPELAND. Part is the appendix, but the statement is previous to that.

Mr. SMITH. You may proceed.

Dr. COPELAND. Mr. Flood and members of the committee:

I am Dr. Bradley E. Copeland of Brookline, Mass. I am a physician practicing pathology at the New England Deaconess Hospital and the New England Baptist Hospital in Boston and at the Harvard University Health Service in Cambridge, Mass. I am assistant clinical professor of pathology at Harvard Medical School. The opinions which I will present today are my own, and I do not represent any of these institutions in this matter.

My purpose in appearing before this committe is to supply information with respect to questions asked by this committee about medical laboratories during the 1966 and 1967 hearings on the national laboratory improvement program of the National Communicable Disease Center of the U.S. Public Health Service.

I believe certain statements and information which have been presented are incorrect. For example, some statements supposed to represent the actual current situation prevailing in the medical laboratories of the United States today were based on information and cases 15 to 30 years old.

The statements appear in these parts of this committee's records.

1. A study requested by this committee in 1966 and submitted to this committee by the Department of Health, Education, and Welfare, February 6, 1967, entitled: "A Report on Laboratory Performance and Methods for Improvement."

2. In the justification for expenditure of the appropriation for the national laboratory improvement program of the National Communicable Disease Center, 1966 and 1967.

3. In the 1967 testimony in support of this appropriation.

I should like to submit to this committee as part of my statement the detailed report which 22 pathologists, including myself, from 17 States prepared in 1967 (Congressional Record, Dec. 14, 1967, H17065–17067). This report documents in detail at least 15 erroneous statements which have alarmed the Congress and the American public.

(The appendix follows:)

Pathologists' Review and Evaluation of Statements on Medical Laboratory Evaluation, Made to the Congress of the United States in 1966 and 1967—With Presentation of Additionally Documented Information

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STATEMENT

In 1966 and 1967, a number of reports and statements were presented to the Congress concerning the evaluation of work done by medical laboratories in the United States.

The most highly publicized of these was a report[1] made to both houses of Congress early in 1967. Because it has since been viewed with alarm by Members of the Senate and House of Representatives, by the press, by the general public and most recently by the President of the United States during signing of a bill (H.R. 6418) providing for Federal licensure of laboratories in interstate commerce, it is important to present additional information not available in the Congressional Record concerning the source of certain allegations that we have found to be based on incorrect as well as insufficient data.

Some were based upon small surveys of unrepresentative laboratories such as those of State health departments, Indian Bureau hospitals, Federal prisons, and New York City. Although "the Nation's laboratories" were criticized, "the Nation's laboratories" were not studied. Not one cited reference was a survey of a true cross section of laboratories. Although the aim was well intentioned to press for a greater degree of responsibility in laboratories to safeguard the general public, these allegations have unfortunately performed a disservice to responsible laboratories by raising fears as to their reliability. The Report on Laboratory Performance and Methods for Improvement," which had been requested from the Department of Health, Education, and Welfare—Public Health Service by the label HEW Subcommittee of the House of Representatives Committee on Appropriations was prepared in consultation with an ad hoc panel of 17; but in final form it contained material not seen or approved by all members of the panel. The panel consisted of: 8 members of the Department of HEW, 4 State and city health department officials, 3 practicing pathologists, 1 bioanalyst, 1 M.D. clinical chemist.

Appendix A of the Report entitled "Examples of Misdiagnosis, Prolonged Illness and Death Resulting from Laboratory Error," contains errors in fact which should be corrected. They are as follows:

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[1] A Report on Laboratory Performance and Methods for Improvement, Department of Health, Education, and Welfare, Public Health Service. Presented to the Assistant Secretary of HEW on Jan. 20, 1967; to the Subcommittee of the House of Representatives Appropriation Committee on Feb. 6, 1967; and to the Subcommittee on Antitrust and Monopoly of the U.S. Senate Judiciary Committee on Apr. 4, 1967; revised for printing in June 1967.

Error: A misplaced decimal point (page 1, par. 4):

"It is estimated that 5 million pints of blood were administered in 1963. Of these it is judged that the incidence of mismatched blood (Wintrobe—Textbook of Hematology, 5th edition, 1961) is 0.1–0.5 percent. This indicates that between 50,000 and 250,000 serious reactions of the type illustrated above occur each year in this country."

This calculation error resulted in a 1,000 percent overestimate of transfusions of mismatched blood. With the decimal point placed to indicate one-tenth of one percent, the figures should be 5,000 to 25,000—not 50,000 to 250,000. In addition, the textbook reference contains data collected between 1933 and 1937 and 1943 to 1944 and reported in 1938 [2] and 1945 [3] before significant advances in blood banking had been developed for general use.

Comment: The Irwin Memorial Blood Bank of San Francisco reports that in 1966 a total of 65,191 units of whole blood were transfused with one reported and verified hemolytic transfusion reaction, an incidence of 0.001 percent. Dr. Rosser Mainwaring of Dearborn, Mich., former president of the American Association of Blood Banks and current president of the American Society of Clinical Pathologists, reports a 14-year experience, from 1953 to 1966, of 27,916 units of blood transfused without a major hemolytic transfusion reaction.

Other recently published reports, in 1964 and 1966, show a hemolytic transfusion incidence of 0.03 percent [4] and 0.01 percent.[5]

Error: Source inaccurately quoted (page 2, par. 2):

"In a recent study of 328 neonatal deaths from hemolytic disease, it was found that a death could have been 'definitely prevented' in 23.3 percent of the cases, and 'probably prevented' in an additional 36.9 percent of the cases by correction of either patient factors, physician factors, or laboratory factors."

This paragraph contains two errors in transcription from the article, "Hemolytic Disease of the Newborn," California Medicine, August 1966, pp. 81–88. The 36.9 percent "indeterminate" stated in the original article is transcribed as "probably preventable," and the 23.3 percent "possibly preventable" becomes "definitely preventable."

Error: Not relevant—Laboratory not consulted (page 3, par. 1):

"Phenylketonurics constitute a large portion (some say 10 percent) of those confined to mental institutions. Many States have recognized this problem as being of sufficient magnitude to justify requiring all newborn infants to be tested. If the infant is promptly placed on a special low phenylalanine diet, the mental defects due to high serum phenylalanine may be avoided.

"Karen, the first child of healthy parents, is an example of a phenylketonuric. Her development up to 12 months of age was apparently normal. Development during the next 12 months, however, was less satisfactory, and evidence of mental retardation appeared. Laboratory studies at this time indicate that she was suffering from phenylketonuria, and treatment with low phenylalanine diet was instituted. The dietary regimen prevented further mental regression. This child should have received a routine screening test as a newborn which would have detected the problem before brain damage had occurred. This is an example of how lack of appropriate laboratory testing can result in permanent mental retardation."

In this case, no test for PKU was ordered so there was no laboratory measurement to blame.

Error: Not relevant—laboratory not consulted (page 3, par. 3):

"A married woman has a biopsy of a small breast mass. A staff physician examined the tissue slide and advised her that it was malignant and that the breast should be removed. At a famous clinic in another State, without further tissue tests, a radical mastectomy was performed. It was then discovered that the lump was not malignant." (*Bugg* vs. *Security Ben. Assn.* 153 Kan. 522 supreme court Kansas, Apr 12, 1941.)

This misdiagnosis which occurred in 1938 cannot be attributed to a "laboratory error" because the "staff physician" who examined the tissue slide was the surgeon who performed the initial biopsy and not a qualified person. The tissue was not processed by a qualified pathologist or a qualified laboratory.

The above errors in fact or interpretation suggest that more such errors may be present in the other undocumented statements of appendix A.

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[2] DeGowin, E. L., Annals Int. Med., 2 : 1777, 1938.
[3] DeGowin, E. L., J. Lab. Clin. Med., 30 : 99, 1945.
[4] Poley, R. W., U.S. Naval Med. Newsletter, 44 : 3, 1964.
[5] Reece, R. W., and Beckett, R. S., J.A.M.A., 195, Mar. 11, 1966.

In view of the cited errors, we would like to see appropriate documentation for all cases cited. It should include the data when the case occurred as well as type of laboratory in which the error was committed, i.e., Federal, State, city, or general community hospital (over or under 100 beds).

The generalized charges of laboratory unreliability in the opening and closing sentences of appendix A are not substantiated by the evidence offered. Furthermore, three members of the ad hoc panel—Doctors Arthur Rappoport, Thomas Laipply, and John T. Godwin—state that this appendix was never seen or discussed by the panel before its publication.

Comments on sources of statistical generalizations (par. 2 of introduction).

Incorrect conclusions and defective documentation are also to be found in paragraph 2 of the introduction to "Report on Laboratory Performance and Methods for Improvement":

"It has been demonstrated that serious deficienies exist in the Nation's clinical laboratories. Studies indicate that unsatisfactory performance is demonstrated in 10–40 percent of laboratories in facteriological testing; (1, 2) by 30–50 percent in various simple clinical chemistry tests; (3, 4, 5, 6, 7) by 12–18 percent in blood grouping and typing; (8) by 20–30 percent in hemoglobin meausrements; (9, 10) by40–80 percent indifferential characterization of blood cells; (11) and by 20–30 percent in measurement of serum electrolytes (12, 13). In addition, there has been considerable variation in results from laboratory to laboratory. This information indicates that erroneous results are obtained in more than 25 percent of all tests analyzed by these studies. The results cited above have been derived from performance evaluation programs, and thus may represent the best which laboratories can do, rather than routine performance."

The following references [6] were provided to document the general statement that the Nation's laboratories are in serious trouble:

1. USPHS, CDC, Laboratory Evaluation Service (1960–65). Unpublished data.

2. Schaeffer, M., "Health Department's Role in Improving Operations of Clinical Laboratories. Published Health Reports, volume 81, No. 1, January 1966, pages 71–74.

3. USPHS, CDC, "Clinical Chemistry Evaluation Program—Glucose Evaluation—Part IV." May 1965, page 19.

4. Tonks, D. B., "A Study of the Accuracy and Precision of Clinical Chemistry Determinations in 170 Canadian Laboratories," Clinical Chemistry, 9:217–233, April 1963.

5. Snavely, J. G., Golden, J. G., "The Accuracy of Certain Chemical Determinations in Connecticut Laboratories," third survey, Connecticut State Medical Journal, 16:894–899, 1952.

6. Belk, W. P., and Sunderman, F. W., "A Survey of the Accuracy of Chemical Analysis in Clinical Laboratories," American Journal of Clinical Pathology, 17:835–861, 1947.

7. College of American Pathologists, "The 1966 Small Hospital Laboratory Survey Report."

8. Schaeffer, M., loc. cit.

9. USPHS, CDC, "Clinical Hematology Evaluation Program—Hemoglobin Evaluation—Survey IV," April 1965, page 16.

10. College of American Pathologists, "The 1965 National Comprehensive Laboratory Survey: Hematology, Blood Banking, Clinical Chemistry," (Kit 2 report).

11. USPHS, CDC, "Cytohematological Evaluation Program: Summary of Results Reported in Cytohematological Survey" (4). Unpublished report—Atlanta, Ga. 1965–66.

12. USPHS, CDC, "Electrolyte Evaluation. 1966," parts I–IV.

13. Skendzel, L. P., and Hoffman, R., "1963 National Comprehensive Laboratory Survey," report of the Standards Committee of the College of American Pathologists.

Most of the references given represent a very limited scope of laboratories which are not at all comparable to the active community hospital medical laboratories in the United States. Although the poor results are attributed to "the Nation's clinical laboraories," all "the Nation's clinical laboratories" were not studied. Analysis of these 13 references, given to support paragraph 2 and its subsequent quotations is important. Three are inapplicable to the present laboratory situation in the United States: Reference 4 contains information from a foreign country (Canada). Reference 5 contains information 15 years old. Reference 6

[6] References were added by the June 1967 edition of "A Report on Laboratory Performance and Methods for Improvement."

contains information 20 years old; its use to evaluate laboratory performance in 1967 was protested to the AMA annual meeting in June 1967, by Dr. F. W. Sunderman, one of the authors of the paper. Six were from surveys principally limited to laboratories in New York City, State public health departments, Federal prisons, Indian Bureau Hospitals, and Public Health Service hospitals. Five are NCDC surveys that do not specify the distribution of types of medical laboratories studied. An example of the scope of NCDC surveys was the one used in explanation of a budget request at the Senate Appropriations NCDC budget hearing on March 9, 1965 (p. 390, printed report, pt. 1, hearings on H.R. 7765):

"Test specimens of 43 known agents or sera were sent to 55 State and territorial public health laboratories for diagnostic accuracy evaluation. Ten Public Health Service hospitals and 57 out-patient clinics of the Bureau of Medical Services are participating in the program in 1965 * * *."

The scope of the NCDC surveys has included the following types of institutions: Public Health Service hospitals, State health department laboratories, Indian Bureau hospitals, Federal prisons.

It is not reasonable to extrapolate data from these limited surveys and to apply it to all laboratories in the United States. Nor is it correct to imply that an error rate has been established for such common tests as urinalysis, blood hematocrit, serum calcium, or cytology when no survey has been done on these tests.

Documentation of error statements for three major laboratory areas—blood banking, microbiology, and cythohematology—are entirely taken from NCDC–PHS surveys and New York City laboratories, and the blood typing figures from New York City are applied to all medical laboratories in the United States. In contrast, Dr. Ernest Simard, then president of the College of American Pathologists, presented the following information on blood typing to the Subcommittee on Health of the Committee on Labor and Public Welfare (September 25 and 26, 1967):

Blood typing surveys from Minnesota—9,200 tests—0.3 percent to 3 percent error; Massachusetts—1,500 tests on five samples—100 percent, 100, 97, 99, and 92 percent accurate; and small hospital survey (CAP 1966)—ABO, 98 percent accurate. (Congressional Record, Sept. 21, 1967), and Rh, 96 percent accurate.

Of the three references related to active community general hospitals (Nos. 7, 10, and 13), one was a survey of hospitals under 100 beds. The only valid problem mentioned is the finding of the small hospital survey, 1966 (reference 7) that while most of the urea measurements (over 90 percent) were medically useful, there was a technical problem with urease methods that gave lower values than the referees by seven milligrams at the 50-milligram level. This problem was remedied in 1967 as is reported in the New England Journal of Medicine by Drs. Skendzel and Muelling, July 27, 1967, volume 277, 180–185.

Evaluation of paragraph 2:

1. Its documentation is inadequate to justify extrapolation of limited surveys of unidentified medical laboratories to the Nation's clinical laboratories.

2. Its documentation is inadequate to support the generalization for all tests when many common tests were not evaluated.

Furthermore, paragraph 2 is not justified by any of the information and documentation presented in "A Report on Laboratory Performance and Methods of Improvement"; and its documentation does not support the "premature death, extended hospital stay" statement cited under the following section, "Incorrect Statement—Premature Death."

Three members of the ad hoc committee—Drs. Rappoport, Godwin, and Laipply—have stated that they questioned the statements in paragraph 2 prior to publication during the panel discussion. Dr. Rappoport's letter (Jan. 10, 1967, to NCDC) in this regard reads. "None of the quoted figures are true and should not be permitted to pass for the truth." Other members of the ad hoc panel have indicated that the error statements of paragraph 2 are not representative of the general performance in all medical laboratories in the United States.

Additional statements on this subject have been made as follow:

Dr. Ernest Simard, past president, College of American Pathologists, statement to U.S. Senate hearing, September 25 and 26, 1967, Subcommittee on Health of the Committee on Labor and Public Welfare, pages 215–217. Congressional Record, September 21, 1967, pages 13414–13416—insertions by Senator Hruska of Nebraska, of a letter from Dr. C. A. McWhorter, professor of pathology, University of Nebraska, and an article "The Reliability of Laboratory Tests in the

United States," by Dr. B. E. Copeland. The American Society of Clinical Pathologists at its annual meeting, September 28, 1967, adopted a resolution stating that the statistical information was incorrect.

WHERE ARE THE HALF-BILLION TESTS DONE?

The question has been raised as to whether the 25-percent error rate charged includes tests done in physicians' offices. The report itself says "No." 270 million tests, or more than 50 percent of the 500 million estimated tests are done in the 700, or 10 percent, of the hospital laboratories that have accredited pathology residency training under the Council on Education of the American Medical Association.[7] It is reasonable to assume that the other 6,100 hospital laboratories account for the remaining tests.

OTHER INCORRECT STATEMENTS—PREMATURE DEATH

In view of the errors of fact, deficiencies in documentation, and unsubstantiated statements in "A Report on Laboratory Performance and Methods for Improvement," the following statement submitted to the Congress three times[8] during 1966–67 can be safely regarded as incorrect:

"Premature death, extended hospital stay, unnecessary suffering, and loss of productivity as well as tremendous economic losses are consequences of inaccurate laboratory results. It is conservatively estimated that at least 430 million tests are performed annually with an approximate error rate of 25 accurate laboratory results. It is conservatively estimated that at least 430 million annually to the Nation in payment for erroneous laboratory diagnostic results. The cost in human life and suffering is beyond monetary measurement." (No documentation presented.)

Neither the economic loss, nor the allegation of premautre death was established. In view of the fact that a gross calculation error was made in estimating mismatched transfusions and the fact that this information is 20 years old, the premature death statement is especially misleading.

The Nation's laboratories were not studied.

INCORRECT STATEMENT—QUALITY CONTROL AND SURVEY PARTICIPATION

In the course of congressional hearings in 1967, errors of fact were made with respect to (1) the use of quality control techniques in the clinical laboratories of the United States and (2) the participation of pathologists in national surveys.

(1) Quality control: On April 4, 1967, before the House of Representatives Subcommittee on Appropriations for the Departments of Labor and Health, Education and Welfare (pt. 4, PHS, p. 340, line 34). Dr. Sencer said: "Quality control is something that industry has adopted but medicine has not."

This is an incorrect statement. Quality control was inaugurated in medical laboratories in hematology, histopathology, and serology in the 1920's and 1930's; in blood banking in the 1940's; and in clinical chemistry in 1950 as shown by an article by Levey and Jennings entitled "The Use of Control Charts in the Clinical Laboratory," Am. J. Clin. Path., 20:1059, 1950.

Since then, thousands of pathologists and medical technologists have been trained in quality control in chemistry, hematology, blood banking, and bacteriology. The College of American Pathologists requires it for its laboratory accreditation program, and the Commission on Continuing Education of the American Society of Clinical Pathologists has conducted workshops and published manuals and instruction film strips on each of these quality control areas.

It is of interest that the 1967 budget of the Standards Committee on the College of American Pathologists is $256,000, and that recently it purchased a $19,000 recording spectrophotometer to carry out international standardization of the U.S. National Research Council hemoglobin standard and other standard materials.

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[7] Directory of Approval Internships and Residencies, JAMA, 198: 192–206, 1966.

[8] A. Feb. 11, 1966, hearing before a subcommittee of the House of Representatives on Department of Health, Education, and Welfare, pt. 3, p. 273. Testimony of Public Health Service, Department of HEW from written material presented to support the budget request for the National Laboratory improvement program.

B. Apr. 4, 1967, published hearing, subcommittee of the Committee on Appropriations of the House of Representatives on Departments of Labor and Health, Education, and Welfare, pt. 4, p. 365.

C. Apr. 11, 1967, published hearings, Subcommitte on Appropriaions of the U.S. Senate, Department of Health, Education, and Welfare, p. 1309.

The expenditures entirely for teaching by the American Society of Clinical Pathologists' Commission on Continuing Education for 1967 will be $500,000. A $2 million ASCP National Teaching Center is currently being designed, and half the money has already been subscribed.

These efforts in external and internal quality control are important, and significant, and prove that quality control is extensively used in the Nation's clinical laboratories.

(2) Pathologists' Participation in Survey: Correction is also in order for another erroneous statement at the same hearing. H.R. Subcommittee on Appropriations, Departments of Labor and Health, Education, and Welfare, April 4, 1967 (page 340, line 19):

"Representative Flood: Why wouldn't the various medical societies have been concerned about this for the past 25 to 30 years, . . .

"Dr. Sencer: Only 2,000 members of the 6,000 (CAP members) subscribe to this proficiency testing program."

This statement is in error. Since the subscription of the College of American Pathologists survey is by the individual hospital laboratory, a hospital with four pathologists takes only one survey. This means that, where applicable, almost every one of the 6,000 pathologists in clinical laboratory work participates in the National Comprehensive Laboratory Survey conducted by the Standards Committee of the College of American Pathologists. In 1967, 3,300 medical laboratories including Veterans' Administration Hospitals, will receive more than 97,000 samples for analysis.

SUGGESTED CRITERIA FOR FUTURE STUDIES

1. That a large collection of data be made covering all tests.
2. That clinical laboratories of all sizes should be represented.
3. That the data be current—not more than 2 years old.
4. That all statements be scientifically documented.

We believe that the thousands of dedicated workers in medical laboratories who are providing 24-hour coverage 365 days per year should not suffer the stain of these undocumented and incorrect statements about the quality of their work. We believe that suitable corrections should be made in the record.

Dr. COPELAND. Because of its length and degree of detail, I will summarize several representative errors:

1. ERROR OF FACT

Statement: 50,000 to 250,000 mismatched transfusions per year in the United States.

Fact: This estimate is a mistake in arithmetic resulting in a 1,000 percent overestimate. Also, this information upon which the charge was based was collected from 1938–45, before 90 percent of current blood bank knowledge was discovered.

2. ERROR OF OUTDATED STATISTICS

Statement: 30 to 50 percent of clinical chemistry examinations are in error.

Fact: The following items were included to support this statement: "A Pennsylvania survey of 1947"; "A Connecticut survey of 1952."

3. ERROR OF ATTRIBUTION

Statement: A woman's breast was removed when no cancer was present due to an erroneous biopsy diagnosis.

Fact: The breast biopsy tissue section was not performed by a qualified laboratory nor was it interpreted by a qualified pathologist. This case occurred in 1938.

4. ERROR OF RESTRICTED GEOGRAPHIC REPRESENTATION

Statement: 12 to 18 percent error in blood grouping.

Fact: To secure these figures only New York City laboratories were tested. This is not typical of the United States as a whole.

It was also stated that there is no quality control in medical laboratories. The fact is that internal quality control has been a part of medical laboratories since the 1920's. Quality control was in use in medical laboratories in hematology, histopathology, and serology in the 1920's and 1930's; in blood banking in the 1940's; and in clinical chemistry in 1950 as shown by an article by Levey and Jennings entitled, "The Use of Control Charts in the Clinical Laboratory," Am. J. Clin. Path., 20:1059, 1950.

Since then, thousands of pathologists and medical technologists have been trained in quality control in chemistry, hematology, blood banking, and bacteriology. The College of American Pathologists requires it for its laboratory accreditation program, and the Commission on Continuing Education of the American Society of Clinical Pathologists has conducted workshops and published manuals and instruction film strips on each of these quality control areas.

In addition, at least 96,000 samples were used for external quality control in 1967. In 1965, four U.S. companies were producing over 20 different kinds of quality control samples. By 1965 there were at least 10 quality control manuals, kits, and film strips available from professional societies.

Some of the 15 misstatements have received wide publicity in the public press. At the present time they are being quoted in good faith by other agencies such as the President's Commission on Health Manpower. The result is to frighten the American public needlessly.

To those of the American public who face hospitalization, the alarm and anxiety caused by repeating these statements will retard the delivery of needed medical services. Furthermore, action programs based on erroneous and outdated information can hardly result in meaningful changes.

In view of the mathematical errors, the errors of fact, the outdated statistics, the anecdotal evidence not related to medical laboratories, and the restricted samples used to predict general performance, the information presented to this committee in the "Report on Laboratory Performance and Methods for Improvement" does not represent the actual performance of medical laboratories in the United States in 1968.

We in the United States have the courage to acknowledge our failures publicly; we need accurate and up-to-date information in order to evaluate our successes.

Mr. SMITH. Why would statements have been made that were as much in error as you allege they were?

Dr. COPELAND. I think it was poor checking of data.

Mr. SMITH. They were not all made in the same day or by the same person. They were made from time to time.

Dr. COPELAND. Most of them relate to this report, and the extrapolation that is most commonly used, that 25 percent of all laboratory tests are in error, have been applied to the total figure for laboratory tests in the United States coming up with the allegation that there are some $430 million wasted in the United States on laboratory tests. But that is I feel a derivative from the report.

Mr. SMITH. You think that it mostly has its roots in this report?

Dr. COPELAND. Yes; I do.

Mr. SMITH. Mr. Laird?

Mr. LAIRD. Doctor, in some States the outside laboratories have to be licensed, the laboratories within hospitals do not require any licensing or certification. Do you think this is a problem?

Dr. COPELAND. It was until Congress acted last December and passed the Partnership for Health Act, which covered all interstate laboratories whether inside or outside hospitals. That is item No. 1.

Mr. LAIRD. That has not gone into effect as of this date.

Dr. COPELAND. I think the target date for interstate laboratories is the first of January 1969.

Mr. LAIRD. I know it is not in effect yet.

Dr. COPELAND. I think as of that date they have to have an accreditation either from the College of American Pathologists, which was accredited as the accrediting agency, or the Department of HEW.

The second point is that hospitals which have accreditation from the joint commission on accreditation have been exempted from licensure proceedings, but I have been talking at some length with the joint commission on accreditation and they now are going to adopt a very strict set of regulations that is coming out in August or thereabouts, which will be at least equal to the interstate requirements.

Mr. LAIRD. Doctor, your statement does not have much impact on the budget. You do not seem to be for reductions or increases, you are just making the statement to sort of set the record straight as far as your side of this controversy is concerned.

Is that a correct interpretation of your appearance here?

Dr. COPELAND. Yes; this has been repeatedly in the press. As a matter of fact, one of the witnesses before the Senate committee yesterday again used the figure that 12 to 18 percent of blood typing is erroneous in the hospitals of the United States. I have collected data to show that this is way off the correct figure, and the figure is probably been one in 50,000 transfusions and one in 100,000 transfusions instead of the 12 to 18 per hundred.

We know from surveys, for instance, that in Massachusetts, in Minnesota, and in the small hospitals of this country their performance on blood typing is roughly between 96 percent accurate and 100 percent accurate, which again bears very little relationship to the 12- to 18-percent figure.

Mr. LAIRD. Thank you, Doctor.

Mr. SMITH. Mr. Casey?

Mr. CASEY. Doctor, as far as correcting the record, do you, with your findings and knowledge of the situation, suggest that we have accurate, up-to-date tabulation and survey made as to the accuracy and the effectiveness of our laboratory tests.

Dr. COPELAND. I think that at the present time we have no up-to-date information and that it would be a very useful thing to have. I think in relation to appropriation, as I mentioned in my statement, to appropriate money for the purposes stated in the report is to tackle problems which do not exist.

Mr. CASEY. They have not been properly identified. If they exist partially, they have not been accurately identified as to the extent, if any?

Dr. COPELAND. Yes.
Mr. CASEY. Thank you, Doctor.
Mr. SMITH. Thank you, Doctor.

TUESDAY, APRIL 23, 1968.

COOPERATIVE SHELLFISH SANITATION PROGRAM

WITNESS

MRS. DAVID H. WALLACE, EXECUTIVE DIRECTOR, OYSTER INSTITUTE OF NORTH AMERICA

Mr. SMITH. Mrs. Wallace, do you wish to read your statement?
Mrs. WALLACE. Yes.
Mr. SMITH. You may proceed.
Mrs. WALLACE. Mr. Chairman and members of the committee, my name is Elizabeth Wallace, director of the fishing trade association, the Oyster Institute of North America. I am here to represent the oyster and clam growers and dealers and processors in their earnest desire to preserve and continue our cooperative shellfish sanitation program.

Some of you may be unaware of the history and evolution and involvement of the three partners in complying with the regulations governing the growing, harvesting, and processing of shellfish—meaning oysters, clams, and mussels.

Here is the three-part manual that regulates our industry. This all began when the 54-oyster producers pictured here, and I could not bring the picture. It is at my hotel room because Public Works called me up and said hurry over here, and I had to bring them the testimony on oil pollution. I will have to show you the picture at another time. Fifty-four of industry leaders came down in 1925 to establish this program. They requested that the Federal Government assist the States to promulgate regulations to assure safe molluscan products.

Mr. SMITH. That is a voluntary program?
Mrs. WALLACE. Yes.

Thus, this was the genesis of a unique partnership between the producing States, the Public Health Service, and the industry members. The States have the prime responsibility of testing the growing waters, the molluscan meats, patrolling the closed areas, and supervising all processing of clams and oysters. Parts I and II sets forth these regulations.

The third part is the Public Health Service evaluation of each State's performance. If a total score of 70 is not achieved, a State is removed from the certification list and none of its producers and dealers can ship in interstate commerce. This certification list is published biweekly.

For example, let us choose Mr. Casey because he comes from a seafood-producing State.

If you were the producer of shellfish, dependent upon your type of business you would be assigned a number comparable to one over here and that number would be your entry into interstate commerce.

Mr. SMITH. He could sell in interstate commerce?

Mrs. WALLACE. Yes. Our members have operated surprisingly successfully for so long under this system (43 years) that the certification number has taken on an aura and is cherished, being synonomous with one's name or identity and certainly with one's reputation and integrity in the market among one's peers.

In order to indicate how involved and interlocked the States programs are, we sent questionnaires to each shellfish producing State. The receiving States are involved, too, but not to such a degree. We have tried to indicate how much effort is put into water quality surveys, the patrolling and management of the producing grounds, the number of persons who are the primary harvesters, the acreage involved and the investment of each of the States in the shellfish sanitation program. These data are for 1967 and were supplied by responsible State officials.

The Public Health Service's record for State expenditures for 1966 is enclosed.

This is the data for 1967. I summarized it for you State by State.

In the various conservation departments 459 boats are involved in the water quality surveys and surveillance, 668 men with seven planes. Under the health departments—each State is a little different—14 boats, 161 field men, 69 laboratory technicians. Other people who are inspecting this food in the total program are 611.

I chose the total acreage from the 1966 shellfish survey because, as you see, each person gave me an answer in a different form of reference. So I took the total from the National Shellfish Register. The total value of shellfish I took from the preliminary figures of the Bureau of Commercial Fisheries for 1966.

Mr. SMITH. You have Maryland for 2 million acres and 18,000 have been out of commission.

Mrs. WALLACE. Yes. We say "closed."

Mr. SMITH. Where did the hepatitis cases come from, the 2 million or 18,000?

Mrs. WALLACE. The hepatitis came from nowhere. There wasn't any.

Mr. SMITH. You mean that was all just a story that people got hepatitis? I know somebody that got it. They did not think it was just a story.

Mrs. WALLACE. Did they get it from eating shellfish?

Mr. SMITH. Yes.

Mrs. WALLACE. Could they prove it?

Mr. SMITH. They have no doubt.

Mrs. WALLACE. No, because the virus has never been identified.

Mr. SMITH. Can't they by process of elimination figure it couldn't have come from anywhere else.

Mrs. WALLACE. I accuse the Public Health Service of asking every person who has a recognized case of hepatitis, "When did you eat shellfish?"

They say, "When did you eat shellfish? You did eat shellfish, did you not?"

I think we are going to find out shellfish does not cause hepatitis. Europeans do not think so. They think it comes from the water. We are going to learn the same. Shellfish have antimicrobial and antiviral properties. In the grossest polluted water in the United States in the wintertime, you cannot find bacterium number one in clams.

Mr. SMITH. I am not going to eat raw oysters, but if I go with somebody who is going to eat them in my presence, how can I tell him how to identify one that came from one of these persons in this voluntary program instead of from a supplier who chose not to enter into it?

Mrs. WALLACE. You are assuming the program does not work and I am assuming it does. I am asking for a continuation of our program. A contaminated area is patrolled. It is closed. You cannot take the shellfish from it.

Mr. SMITH. How can we identify the producer?

Mrs. WALLACE. It has his number on it.

Mr. SMITH. You mean each oyster is going to have a number on it?

Mrs. WALLACE. Each container of oysters has a certification number on it.

Mr. SMITH. If we go out to eat, how do I know whether or not——

Mrs. WALLACE. Ask the management the certification number of the shellfish and he has one. If it is "AL" meaning Alabama, 90–SP, you know it came from the Alabama Fisheries Association, which is in Mobile. I know the people and they are shellfish packers.

Mr. SMITH. In other words, you ask the place where you are eating?

Mrs. WALLACE. Or the store and each container has to have a tag on it with the number, and that number can be traced right back to the producing area.

Mr. SMITH. There is a tag on each basket?

Mrs. WALLACE. Yes, sir. It is a terrific program, and important to keep the appropriation coming.

Mr. SMITH. If it is a good program, and I am not saying it is not, why should we not have a compulsory program that extends that program to people that have not come into the program?

Mrs. WALLACE. We do have a compulsory program in effect.

Mr. SMITH. You are not testifying against that?

Mrs. WALLACE. Heavens, no.

It is a compulsory program to our people. To them there is no difference. In order to have an "open sesame" into the market they have to have a shellfish number; that is compulsory. If they can't sell their produce, they can't eat it all. It is compulsory.

In Georgia, for example, they will say—you know, Georgia withdraws from the Union whenever they are confronted with anything—"We will just keep our wonderful shellfish here. We won't share them with anyone." But they can't, they have to ship out of the State. There are no States that are not a part of this total program. Texas was the last to come in. We had dual standards at one time—intrastate and interstate. Every State has one standard now, an interstate standard.

I tried to document the effort that goes into this program. In the Public Health figures, they have over $3 million that was spent by the States, but in the chart the States do not show the administration and legal costs. I wanted to bring out this small discrepancy.

We urge you to continue our cooperative certification program by appropriating the budgeted estimates of $1,730,000 for 152 positions for fiscal years 1968–69 as listed by the water supply and sea resource program (exhibit VI).

It is contained in this chart. The PHS broke down how the money would be spent. This is a minimum program right here [indicating].

It is essential that the evaluation of the States' programs continue at the current minimum level to motivate State legislatures to provide funds for the monitoring and surveillance services listed and, therefore, assuming a nutritious, safe source of seafood.

In our hazardous world, needful of marine protein—today in the Philadelphia paper I noticed on my way down here that we are unaware of how much hunger we do have in our country, and it is a protein hunger—the States require the motivation of the regional staffs of Public Health Service and the research of the three laboratories. The latter are adding substantially to our country's knowledge of the content of the marine waters, such as the heavy metals, radionuclides, and pesticides. Hopefully, we can be made aware of and counteract the deleterious effects of the injurious chemicals that are adulterating our environment.

Our producers have always known that the great riches of the sea are in the estuaries in the form of food. The oyster and clam are foods that can be cultivated and managed. Our species lend themselves better than any other to farming or agriculture.

We earnestly request that you continue to assist us to qualify for our customers' confidence in the safety of raw oysters and clams by continuing the shellfish sanitation program which is a model of a successful Federal-State-industry cooperative worthy of emulation by other comparable groups who need such programs.

I think it is a great success story. We are happy with it. Now, I don't mean that our people like regulations. They naturally do not. Maybe some of you know James Coulter, who is deputy commissioner of health for Maryland. He said that the shell fishermen have a number of natural predators and then the health boys.

Mr. SMITH. Then we have this problem of water pollution which makes things more difficult.

Mrs. WALLACE. We are working very hard to retrieve our "closed" waters and enhance them so that we can have more food production.

Mr. SMITH. Mr. Casey?

Mr. CASEY. I have no questions. Thank you very much, Mrs. Wallace.

Mr. SMITH. Thank you, Mrs. Wallace.

(The attachments to Mrs. Wallace's statement follow:)

EXHIBIT III

State agencies	Personnel and equipment for— (1) Enforcement (conservation)	(2) Water quality (health)	Acreage	Value	Individual shellfishermen	Total budget, shellfishery sanitation program
Alabama:						
Conservation	6 boats, 13 men		[1] 7,000	$607,000	850	$155,000
Health		3 field, 3 lab	403,000			
Other food inspectors	95		255,500			
Connecticut:						
Conservation	4 boats, 8 men		46,000	775,000	150	50,000
Health		3 boats, 8 field, 7 lab	[2] 3,000			
			[3] 15,000			
	(assisted by 190 part-time local officers)					
California:						
Health		3 boats, 5 men, 3 lab	27,034	200,000	100	56,000
Market inspector	1		[3] 23,007			
Delaware:						
Conservation	6 boats, 11 men		20,000	182,000	300	20,000
Health		1 boat, 2 field, 2 lab	[2] 100			
Other food inspectors	12		[3] 5,000			
Florida:						
Conservation	139 boats, 127 men, 1 plane		105,000	1,345,000	850	125,000
Health		6 field, 5 lab (PT)	[2] 57			
Other food inspectors	15.					
Georgia:						
Conservation	11 boats, 11 men		[4] 119,100	66,000	57	[5] 90,000
Health		2 boats, 2 men.				
Agriculture	72 inspectors.					
Louisiana:						
Conservation	5 boats, 6 men		1,289,000	1,945,000	1,500	75,000
Health		9 lab (PT)	[2] 28,600			
Other inspectors	3		[3] 3,400			
Maine:						
Conservation	26 boats, 37 men, 1 seaplane		352,900	967,000	3,183	152,000
Other inspector	2 field, 1 lab		[3] 70,000			
Maryland:						
Conservation	88 boats, 122 men		200,000	9,615,000	4,000	163,000
Health		7 field, 4 lab	[3] 18,958			
Other	8.					
Massachusetts:						
Conservation	20 boats, 70 men		39,100	1,950	2,400	600,000
Health		3 boats, 3 men	[2] 3,200			
			[3] 8,000			

Mississippi:						
Conservation	7 boats, 17 men		[6] 7,500	597,000	1,000	26,160
Health		2 field, 2 lab.				
Other	3.					
New Jersey:						
Conservation	22 boats, 45 men		392,852	5,730,000	3,500	500,000
Health		10 field, 5 lab	[3] 77,221			
Other	8.					
New York:						
Conservation	15 boats, 35 men		390,155	6,348,000	3,500	250,000
Health		4 boats, 8 field	[3] 142,450			
Other food inspectors	74	10 lab.				
North Carolina:						
Conservation	25 boats, 42 men, 2 planes (radar and radio)		500,000	610,000	921	80,000
Health		9 field, 1 lab	[3] 45,107			
Other food inspectors	295.					
Oregon:						
Conservation	1 boat, 3 men		1,100	55,000	200	39,000
Health		4 field, 6 lab	[2] 1,000			
Other food inspectors	1		[3] 2,000			
Rhode Island:						
Conservation	10 boats, 19 men		20,000	223,000	106	67,000
Health		1 field, 3 lab	[3] 4,000			
Other food inspectors	16.					
South Carolina:						
Conservation	6 boats, 6 men		7,000	1,075	400	50,800
Health		6 field	[3] 1,250			
Other agencies	2.					
Texas:						
Conservation	20 boats, 3 aircraft, 28 men		1,040,000	1,608,000	750	84,000
Health		2 boat, 4 men	[2] 16,200			
			[3] 225,000			
Virginia:						
Conservation	47 boats, 65 men		1,411,000	7,786,000	3,300	168,000
Health		3 boats, 19 men, 10 field, 8 lab	[2] 1,100			
Other food inspectors	7		[3] 54,800			
Washington:						
Conservation	1 boat, 3 men		45,100	1,125,000	461	48,000
Health			[2] 570			
			[3] 650			
Total			[7] 10,189,700	[8] 40,443,000	28,158	2,798,960

[1] Used.
[2] Conditional.
[3] Closed.
[4] ½ of estuaries closed.
[5] Approximately.
[6] Productive.
[7] Shellfish acres (National Shellfish Register, 1966).
[8] Dockside value (1966, BCF, exclusive of mussels).

Note: Total for all States—Conservation: 459 boats, 668 men, 7 planes. Health: 14 boats, 161 field men, 69 lab technicians. Other inspectors, 611.

SUMMARY—STATUS OF STATE SHELLFISH SANITATION PROGRAM EXPENDITURES, APRIL 1966

STATE EXPENDITURES ON SANITARY SHELLFISH CONTROL ACTIVITIES—ESTIMATED CURRENT EXPENDITURE, FISCAL YEAR 1966

Region and State	Administration	Legal activities [1]	Laboratory examination	Sanitary control	Patrol	Total
Region I:						
Maine	$27,000	----	$33,000	$9,000	$50,000	$119,000
New Hampshire	2,300	----	----	----	----	2,300
Massachusetts	31,000	----	20,000	86,900	80,000	217,900
Rhode Island	8,000	$1,300	10,000	20,000	104,474	143,774
Connecticut	10,000	----	5,000	19,000	7,990	41,900
Region total	78,300	1,300	68,000	134,900	242,374	524,874
Region II:						
New York	16,900	----	33,800	118,300	200,000	369,000
New Jersey	15,600	----	3,900	58,500	354,000	432,000
Delaware	300	----	300	4,400	21,000	26,000
Pennsylvania	2,000	----	----	4,130	----	6,130
Region total	34,800	----	38,000	185,330	575,000	833,130
Region III:						
Maryland	8,000	----	102,000	70,000	76,300	256,300
Virginia	10,000	----	58,000	77,600	75,000	220,600
North Carolina	6,000	----	50,000	20,000	55,000	131,000
Region total	24,000	----	210,000	167,600	206,300	607,900
Region IV:						
South Carolina	5,400	----	10,000	9,000	17,500	41,900
Georgia	3,000	----	10,125	15,000	63,000	91,125
Florida	14,000	----	19,000	52,000	516,000	601,000
Alabama	6,175	----	6,175	5,500	17,000	34,850
Mississippi	3,000	----	9,000	16,300	71,000	99,300
Region total	31,575	----	54,300	97,800	684,500	868,175
Region VII:						
Louisiana	11,650	----	35,000	34,850	25,000	106,500
Texas	8,596	----	35,000	22,950	38,212	104,758
Region total	20,246	----	70,000	57,800	63,212	211,258
Region IX:						
California	7,250	----	[2]	21,850	[3]	29,100
Oregon	3,500	----	2,000	8,500	[3]	14,000
Washington	25,230	----	13,350	24,544	4,188	67,312
Region total	35,980	----	15,350	54,894	4,188	110,412
U.S. total	224,901	1,300	455,650	698,324	1,775,574	3,155,749
Percent allocation of funds	7.2	[4]	14.4	22.2	56.2	100

[1] Legal activities are usually covered under costs of administration.
[2] Other program.
[3] Not available.
[4] Less than 1 percent.

EXHIBIT VI

MARINE HEALTH SCIENCE

	Operations	Laboratories	Research
Headquarters	$37,800	----	$30,700
Regional offices: [1]			
Region I	70,100	NEMHSL	562,700
Region II	75,500	NWMHSL	105,500
Region III	72,200	GCMHSL	283,500
Region IV	77,900	----	----
Region VII	58,900	----	----
Region IX	53,200	----	----

[1] WS and SR combined—All funds accessible for program needs as are personnel.

Note: Marine health science total budget: 1968, $1,747,000; 1969, $1,730,000.

WEDNESDAY, APRIL 24, 1968.

HEART INSTITUTE AND REGIONAL MEDICAL PROGRAMS

WITNESSES

DR. MICHAEL E. DeBAKEY, PROFESSOR OF SURGERY, BAYLOR UNIVERSITY SCHOOL OF MEDICINE, HOUSTON, TEX.
DR. JOHN KIRKLIN, CHIEF, DEPARTMENT OF SURGERY, MEDICAL SCHOOL, UNIVERSITY OF ALABAMA
DR. JOHN M. WEINER, ASSISTANT PROFESSOR IN MEDICINE, SCHOOL OF MEDICINE, UNIVERSITY OF SOUTHERN CALIFORNIA, LOS ANGELES

STATEMENT OF DR. MICHAEL DE BAKEY

Mr. SMITH. How do you wish to proceed, Dr. DeBakey?

Dr. DEBAKEY. Whatever is your pleasure. We are ready in whatever way you would like to proceed.

Mr. SMITH. Do you have a statement?

Dr. DEBAKEY. I said just beore you came in, both Dr. Kirklin and I have been on the road now for a week or 10 days. We have not had a chance to put this in final form and wanted your indulgence to send it in in the next few days.

Mr. SMITH. You may proceed extemporaneously and we will place your statement in the record when it arrives.

(Dr. DeBakey's statement follows:)

STATEMENT OF MICHAEL E. DEBAKEY, M.D., PROFESSOR OF SURGERY AND CHAIRMAN, CORA AND WEBB MADING DEPARTMENT OF SURGERY, BAYLOR UNIVERSITY COLLEGE OF MEDICINE, HOUSTON, TEX.

Mr. Chairman and members of the committee, it is indeed a privilege and a great pleasure to come before your committee again to testify in support of the medical research needs of one of our most important national health problems, namely, those sponsored by the National Heart Institute.

I realize, Mr. Chairman, that I need not emphasize the great importance of diseases of the cardiovacular system to this knowledgeable committee. You are fully aware, of course, that it has long been one of our leading causes of death, accounting for more than a million deaths in this country alone each year, and that approximately half of these deaths are caused by arteriosclerotic heart disease alone. While there are reasons to believe that we are making encouraging progress in the various approaches to the problem and that some reductions in the overall death rate have taken place in the field of cardiovascular disease, the fact remains that it continues to be our No. 1 cause of death. It is important, too, to recognize that the declines in death rates that have taken place in recent years are in those categories of cardiovascular disease where significant improvements in management of the condition have come about as a result of previous intensive research efforts. It is for this reason that I emphasize the importance of the research effort and the support obtained through the National Heart Institute in these developments. It is also important to recognize the fact that the research support provided through the National Heart Institute constitutes the major support of all research in cardiovascular diseases today. Indeed, I would estimate that it constitutes more than two-thirds of the total research effort in this country. It is for this reason too, Mr. Chairman, that I am greatly distressed by the unfavorable effect on the research effort that will take place if the budget remains as it is being proposed for the coming year. Indeed, Mr. Chairman, this overall budget will only provide an increase of about 2 percent over the previous year, and this can be translated into an actual cut in the budget since this will not even maintain the increased cost in operation since it has been shown that to maintain the research effort at the present level would require

an overall increase in the budget of nearly 15 percent. In my opinion this would have a most unfortunate and unfavorable effect upon many research programs that have developed vigorous and encouraging impetus in seeking solutions to some of these problems and would undoubtedly cause some of these programs to be abandoned. I realize, Mr. Chairman, that we are in a difficult period, and I can only urge you to give this matter your most serious and thoughtful consideration.

I should now like to discuss certain specific programs that I consider of great importance. The first of these is the artificial heart-myocardial infarction program, which this committee had the foresight and interest to establish and which is currently being supported at the level of $13,392,000. As you know, Mr. Chairman, this program is directed toward seeking solutions to one of our most important causes of death, which I have previously indicated accounts for more than half a million deaths per year. The program seeks as its objectives to provide various mechanical devices that will meet clinical needs for mechanical circulatory assistance both for short- and long-term use, including a permanently implantable assist device and ultimately the development of a totally implantable artificial heart. The second objective of this program is related to the effort to reduce mortality and morbidity in patients with acute myocardial infarction. Great progress has been made in this area since this committee established the funds to support this program, and we are now in a period of intensive research with the opportunity to expand this program considerably in the hope of accelerating the research effort to seek solutions more rapidly. I have been closely associated with the development of this program both through personal involvement in my own research efforts in my own institution and also through my association with the advisory committee to this program. I can assure you that there is great enthusiasm and vigorous developments are taking place across the country in our best research institutions toward this development. The urgency of the development of mechanical devices to provide circulatory assistance and to maintain viability has been further emphasized by the recent development of human cardiac transplantation. Thus, we have reached the point where we now need for clinical purposes an artificial heart to support viability in much the same way that we now have an artificial kidney to support patients with kidney disease that require kidney transplantation. Accordingly, Mr. Chairman, I would urge that you give serious consideration to increasing this aspect of the budget to the level of approximately $30 million.

The next important program that I wish to specifically discuss is that concerned with the cardiovascular research and training centers. You will recall, Mr. Chairman, that this program was initiated by this committee 2 years ago by a supplemental grant derived from the recommendations of the President's Commission on Heart Disease, Cancer, and Stroke. The amount allocated for planning grants for this purpose during the past 2 years amounted to $800,000. I believe that up to the present time 10 of these planning grants have been awarded and, as I indicated to you last year, several of these are now ready for operation. These centers may be defined as an organizational unit established for the specific purpose of advancing knowledge and developing the most effective techniques and methods for the clinical management and prevention of cardiovascular disease through research, teaching, and patient care. Strongly oriented toward the problems of human disease, with the primary focus on the patient, the center should be provided with all the resources, facilities, equipment, and personnel essential to modern biomedical research and to the conduct of the most sophisticated diagnostic and therapeutic procedures. Since the center will be concerned with the total spectrum of cardiovascular disease problems whose solutions will require the collaborative skills and talents of individuals from the various disciplines, it should be staffed by a corps of scientists representing the biological, engineering, physical, and social sciences, as well as the clinical disciplines. The center should be housed preferably in a discrete geographic area to permit staff members to work in sufficiently close proximity with one another and with sufficient integration of their activities in order that ideas and technical advances can be continuously exchanged and critically evaluated and research opportunities immediately recognized and exploited. The center should provide for the most effective interface between the fundamental sciences and clinical investigation, thereby permitting the rapid advancement and application of knowledge derived from the various scientific disciplines toward the solution of cardiovascular disease problems. The center should provide for the most favorable environment for attracting high-quality trainees in a wide spectrum of clinical and fundamental scientific disciplines and for training and equipping

them with the most advanced skills and techniques of current biomedical research and clinical cardiovascular investigations. The cardiovascular research and training center grant would provide funds to support salaries of all categories of personnel, purchase of equipment and supplies, alteration and renovation of existing space, care of research patients on both an inpatient and outpatient basis, and for other expenses that are considered essential to support the research and training program of the center.

I think, Mr. Chairman, it would be most unfortunate if we lost the momentum which has now been generated toward development of these cardiovascular research and training centers by further delaying their implementation. I would propose, therefore, for the year 1969, a line-item addition to the current budget of $10 million in support of cardiovascular research centers, which I feel certain can be put into operation this coming year.

Finally, Mr. Chairman, I should like to express my grateful appreciation for the privilege and the pleasure of appearing before your gracious committee to give some of my views on the needs of some of our health programs.

Dr. DEBAKEY. My name is Michael DeBakey. I am professor of surgery at Baylor University College of Medicine, Houston, Tex.

Dr. John Kirklin and Dr. Weiner will follow me in that order, if it meets with your approval, Mr. Chairman.

We are primarily here to testify in support of the National Heart Institute budget, following which I would like to say a few words about the regional medical program budget. First in regard to the National Heart Institute budget. The main concern we have is with the budget as proposed by the administration which would provide only an increase of a little over 1 percent. We feel that this will constitute a severe restriction on the approach to the heart disease problem.

Let me begin by reiterating that I think it is of great importance to understand the approach to the solutions to the heart disease problem.

I need not say to this committee, which has heard this many times, how important the heart disease area is in terms of disability and death. It accounts for more deaths than all other diseases combined, constituting disabilities estimated to range in this country anywhere from 12 million to 15 million people and estimated to cost the economy something in the neighborhood of $20 billion, at a conservative estimate.

There are other means of support in terms of research activities to attack the heart disease problem and have been for many years, but the National Heart Institute is the primary support and it is of growing importance in terms of its major activities.

Without the Heart Institute support we would not have many of the things we have today in dealing with the heart disease problem.

Indeed, I think it may be said that over the past 25 years the National Institutes of Health have had greater impact and more force in the movement of medicine in this country in advancing the whole field of medicine than all other factors combined, in my opinion. So you get some idea of the great importance of the National Institutes of Health and, of course, in that sense, the heart disease problem, the Heart Institute.

More specifically, I would point out that within the past few years, because of the very small increases in the Heart Institute, the impetus in this area has been greatly slowed. Indeed, it is being felt in a number of different ways, but primarily in restricting the numbers of people that can be trained, the numbers of laboratories engaged in research, and this year many ongoing programs have had to curtail their activities. Among these are our own.

For example, within the past month we had to completely abandon certain research programs because of lack of funds. We will not be able to start them again at the same level because we lose personnel when we stop a program.

If, indeed, we can start them again in July and in one other in October, when the renewed funds may become available.

Mr. SMITH. Where did that personnel go?

Dr. DEBAKEY. They are going to other areas, technical personnel that are being hired and supported by research programs.

Mr. SMITH. Other areas of research?

Dr. DEBAKEY. No. Not necessarily; because there may not be other areas of research funds to support them. I am talking about medicine. For example, two people are going into industry. Two others are going to places that I don't know. We cannot pay them any more, so they are going somewhere else. These are technical personnel that are needed in these research activities.

Electronics monitoring technicians are a good example. This is personnel that not only have to have certain background but have to be trained in this area. You have lost all of this now. You have made an investment in the training of these people in our laboratory or in our clinic. Now you cannot pay them. You have got to start all over again to find people and train them again. You see that you lost money as well as time and the whole thing is slowed down tremendously. This is not only happening in our own case but, in fact, in some areas it is even worse than in ours.

There are specific programs that I would like to touch upon because they happen to be programs that are of great importance in attacking specific objectives.

One of these is what is referred to by the Heart Institute as the artificial hear, myocardial infarction program. One reason that these two terms are used for the total program is because hopefully the developments in each would support each other, would have an effect upon both objectives.

Indeed, in the artificial heart program, the development of devices that would be of temporary value in what is called assisted circulation rather than complete replacement of the heart to support the circulation by mechanical devices for varying periods, temporary purposes. One would be able to deal with certain types of heart failure problems, whether they be from myocardial infarction or other heart diseases.

Mr. SMITH. How many institutions have those devices available now to constituents?

Dr. DEBAKEY. There are about, I would say, five devices that are being tested clinically at the present time. Five different types of mechanical devices being tested clinically. These devices are available for testing purposes. They are not being used on a wide basis clinically yet. I would say something on the order of perhaps 15 to 18 institutions, in that neighborhood.

Mr. SMITH. How many of these insert the device into the veins of the leg rather into the heart area?

Dr. DEBAKEY. I would say that of the five I have mentioned, at least three of them are of that type. Hopefully, these will be perfected and in terms of easier clinical application, all of them, so that they can be applied on a wider basis. This is part of the problem. It is both

technical and, I would say, biologic and engineering, the problems involved.

Mr. SMITH. The question I had was: The question has arisen in some people's minds that perhaps it is time to begin to concentrate more on the use of this research. As I understand it, about 85 percent of the deaths of the heart patients who actually reach the hospital alive is from shock. Perhaps these devices would help to overcome that.

Dr. DEBAKEY. It has been variously estimated as to the numbers of these people that could be saved if we had ways and means of tiding them over this crucial period during which the circulation is inadequate to keep them alive, keep the heart alive, not only does the total body need the circulation to maintain viability to be kept alive, but the heart does, too.

The heart is supporting itself, too, in terms of its own circulation, and if it is inadequate, then it is like a vicious circle. It is unable to work even in a worse way.

Mr. SMITH. Isn't there enough that is known to be good to be concentrating on using it instead of sort of holding up until we get something better?

Dr. DEBAKEY. It is not so much that we don't have the knowledge. We do have a considerable body of knowledge in this area. From a technical and bioengineering standpoint, these devices have not been sufficiently perfected to be able to be applied on a wide basis. There is not enough knowledge about what they can do, so to speak. You have to, in addition to testing them out experimentally on animals, and one has to develop certain tests on animals. Once those tests have been completed, one can then be assured of their usefulness. Hopefully, they have to be tested on patients and one is still unable to develop the same model in animals that we find in patients in terms of certain diseased states. This comes about because these disease states are often very complex. They do not just involve the heart; the liver may be bad, or the lungs, or so on. Kidneys may be bad. All of these problems create a very complicated biologic state. You still have to test them on human beings.

This is why in a sense the funds we are asking for for this particular area are so important. It is because this is not the type of research project that can be done in the classical fashion by a research grant approach to a single individual. This involves an institution. It involves multidisciplinary efforts. It involves having disciplines of all kinds. This involves even the physical sciences. This is why the establishment of these centers that we are asking for, categorical centers, clinical research centers and cardiovascular and training centers, these categories are so important.

There is no other way that we can bring together the various people who are needed, who have the skills and talents and backgrounds and experience to do this kind of work. For example, to illustrate, in my own personal experience—and I hope these gentlemen will give you a few glimpses of their own experience which I know about—there are certain types of operations, for example, which are involved in certain types of research projects in which as many as 35 and 40 individuals may play a role in the team effort, a specific role.

It is very costly to do this. These people have to be supported. The hospitals cannot pay for this. They have to be done in the hospital.

The last patient that we operated upon and whom we put in one of these devices cost us $25,000. This is what it cost the hospital to do this. This was a hospital cost. In addition to this, it involved a 24-hour continuous survey on the part of the team of a minimum of eight people. This is a minimum we have. Most of the time we have as many as 15 people. This is 24 hours a day, minute by minute.

This is the only way that you can do this at the present time. Hopefully out of this ultimately will come information and knowledge and technical developments that will simplify this greatly. I hope Dr. Kirklin will have time to tell you a little bit about some of the studies that he is doing, which are directed toward just this purpose, how to replace technical personnel by equipment, by mechanical means to do the same job, and hopefully to do it better.

This is why we need these specialized centers. Yet, as you see in the budget, there is very little money for these centers. The Clinical Research Center budget includes something like, as you recall from your own committee work for planning grants only, about $800,000, a little increase of a couple hundred thousand dollars or maybe one more planning grant next year.

There are four or five of these that are ready to go into operation. You cannot just continue to plan. Once you planned it out you are ready to start operating.

Last year we had one I know about and Dr. Kirklin has one and he is ready to go. His center is ready to go. Ours has been ready to go. There are several others that are ready now to go. I would hope that we could seriously give consideration to a very modest increase in the budget for these centers. The increase of perhaps at least most of these centers would average between $2 and $3 million for operational grant. I would hope we could get several of these going this coming year.

Mr. LAIRD. Did you have a chance to make a presentation to the executive branch?

Dr. DEBAKEY. Yes.

Mr. LAIRD. They turned it down flat?

Dr. DEBAKEY. Well, not the people at the Heart Institute. Let me make that clear. They are strongly for this. I think in their professional judgment they have indicated this.

Mr. LAIRD. I am talking about the people that make the final decisions.

Dr. DEBAKEY. Yes.

Mr. LAIRD. There is no sense in our making money available that is not going to be released. As you know, there is quite a bit of money frozen this current fiscal year. Our committee can be said to have overappropriated by the amounts that have not been released. We can get ourselves into a position where we are accused of overappropriating as we did in 1968.

Dr. DEBAKEY. I am familiar with that technique, Mr. Laird. You are quite right about it. I assure you that as far as the sentiments of this committee are concerned, I have heard it many times and I know that your sentiments are along the same line as mine in terms of getting these programs on the road and going.

Mr. LAIRD. This current fiscal year there were funds appropriated that could have started these, but the funds are not being made available?

Dr. DeBakey. Yes. I am going to do my very best in every possible way to urge the individuals who, as you say, have the power to make the decisions about the use of the money to let these be used for this purpose. To me this is one of the most critical areas we have today in the heart disease area.

These gentlemen who follow me will indicate some of the other areas that are of equal importance in terms of moving this forward. They fall into this general sort of category of multidisciplinary effort. This is why I consider these centers of such great importance, and this myocardial infarction program is in the same area. This is a program that requires multidisciplinary efforts. We have a few of these going and Dr. Kirklin—both he and I are on the Advisory Committee of the Heart Institute that is in charge of this particular program. We are thoroughly familiar with what is going on and we have had the opportunity to engage with the Heart Institute staff and other members of the committee in the development of this program. I assure you, certainly in my opinion, as far as the heart disease area is concerned, and particularly the coronary disease area which is the biggest problem of all—it causes over half a million deaths in this country, that alone—and a number of disabilities in this area. You know they are quite tremendous. This particular program is directed directly at this.

I do want to say only one other thing. I recognize the most important development would be in the prevention of these diseases. Of course, there are numbers of programs of research projects that are going on to study and develop ways and means of prevention. Ultimately this will be the answer. There is no doubt about that. This is the answer to any disease: find the cause and find a way of preventing it.

At the moment we do not have the cause and we do not have an effective way to prevent this. Hopefully we will. In the meantime, we have a lot of patients to treat who have the disease. So this is why we have to pursue some of these other lines of approach, lines of approach that will give us effective ways of managing some of these clinical problems and dealing with them in a saving of lives that we otherwise wouldn't be able to save. That is why programs that you will hear about, these gentlemen will say something about, are of such importance. It is also why in a sense we would like to develop an artificial heart, because there are disease states at the present time that need to be treated and can be treated only by replacing the heart, whether it be a heart transplant or artificial heart. That is why we want to pursue both approaches, the transplantation approach and the artificial heart approach.

We are doing the same thing with valves. Over 8 years ago there was no way to really replace a badly diseased valve in the heart. Today we have perhaps—I will say we have almost too many valves. In many cases we do have many different types of valves. We are pursuing the transplantation of valves, too.

I was showing Dr. Kirklin earlier this morning the continued development and refinement going on. I brought along a couple of these valves, neither of which has been used in human beings yet. We have tested these in animals. There is nothing particularly new about the design of either one of these valves. From a design standpoint this

has been in operation for some time; but the only thing new here is the wall of the valve and the disk.

They are made out of new metal that has been developed by one of the industrial concerns that has to do with the development of atomic energy, industrial and heavy equipment. Hopefully, this new metal will solve one of the problems that is still with us in the artificial valve area.

This is the kind of effort that is continuously going on and requires continuous support.

Mr. SMITH. The body does not react to this kind of metal as much as to other metals?

Dr. DEBAKEY. Yes, sir. This particular metal in terms of its configuration and its surface relationship to the blood, and so on, will be a better metal.

Mr. MICHEL. What kind of metal?

Dr. DEBAKEY. It is carbon. It is one of the hardest metals known. By the process which they have developed this, for development of heavy equipment, industrial equipment relating to atomic energy, this particular process has been developed for that purpose recently. It was not developed for this but we have taken this knowledge and believe it may be one way to resolve this problem.

It illustrates how this work is going on and how it requires support. To test this in my own laboratory properly, something like 20 people are involved. These are people who are supported on a full-time basis in the research laboratory. In addition to that, we have to have animals, and this requires additional funds. To illustrate how this has been slowed down, our support for this particular activity ran out. I had to find support from another source. This delayed nearly 2 weeks the tests on this project.

You may say this is not very important, but it is a cumulative process. It adds to the other delays that are going on.

I have only one other thing, gentlemen, before I conclude the regional medical programs budget. As you know, I was fortunate enough to have the opportunity to chair the President's Commission on Heart Disease, Cancer, and Stroke. In that we initiated the regional medical program concept.

I think this program has developed in a very effective way in terms of the original concept. We now have something like 50 planning grants covering virtually the entire Nation. There are at the moment I think 11 operational grants and some 30 probably will be in operation by the summer.

I happened to be on the Council from the beginning, so I am thoroughly familiar with the activities that have taken place in this area.

It has caught the enthusiasm of most of the profession today.

The reason that I want to refer to it here is because the appropriations are important in the activities of this program for the future. As you know, if the program is extended by law this year by Congress, then there will be available some $30 million for next year's budget, which in terms of the budget restriction I think $65 million would give them something like $95 million for this coming year. This may or may not meet the actual needs particularly for the operational grants this coming year.

I would hope that the budget could be brought up to at least $140 million because I believe that otherwise there may be some restrictions

in the ability to carry out this program for 1970. I hope by that time almost all of them will be operational. It is when they become operational that the costs increase. During the planning period, the cost of the planning grants is relatively small. When it becomes operational, one can expect the program to range in the neighborhood of $3 to $5 million per regional program.

May I now ask you if there are any questions. If not, perhaps we could proceed with the next speaker, Dr. Kirklin.

Mr. SMITH. Perhaps we ought to listen to each of the witnesses first and then ask questions.

(Prepared statement follows:)

STATEMENT OF DR. JOHN W. KIRKLIN

STATEMENT OF JOHN W. KIRKLIN, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF SURGERY, UNIVERSITY OF ALABAMA MEDICAL CENTER, BIRMINGHAM, ALA.

Mr. Chairman, gentlemen, thank you for the opportunity of appearing before you as a witness to plead the cause of the National Institutes of Health. I wish to address my remarks specifically to the needs of the National Heart Institute.

I speak to you as an individual surgeon and doctor, committed these past 13 years to research, development, and application of new knowledge to the surgical treatment of cardiovascular disease, and as a teacher in this same area. Allow me to tell you of a few of the activities that are ongoing at the University of Alabama Medical Center, supported by a cardiovascular program project grant from the National Institutes of Health. These will serve as examples of the types of activities that are going on in this country today, directed at solving some of the health problems of our population. If these activities are to continue at their present levels, let alone be increased, it will be necessary that Congress appropirate at least those moneys requested in the proposed budget for 1969.

Dramatic improvements have been made in the ability to treat certain types of heart disease surgically, and I feel privileged to have participated in the development of many of these during my time as a member of the faculty and staff of the Mayo Clinic in Rochester, Minn., and more recently of the University of Alabama Medical Center in Birmingham, Ala. Specifically, you know that heart-lung machines have been utilized now since 1955 for certain operations upon the heart and great vessels. I was privileged to be the second surgeon in the world successfully to employ such machines, the first surgeon to do many of the operations within the human heart now done with these machines. Unfortunately, 13 years later there have been essentially no improvements in these heart-lung machines. Even today, an infant under 6 months of age has about a 50-percent chance of dying if he is on the heart-lung machine long enough to allow most complicated operations to be done. Unfortunately, patients with advanced forms of acquired valvular heart disease, requiring particularly long and complex operations, likewise have a significant possibility of dying as a result of the use of the heart-lung machine itself. The risks inherent in the use of this apparatus reside primarily in the subtle changes in the plasma proteins of blood produced by their exposure to blood-gas interphases and to foreign materials. Continuing investigation of methods of identifying and quantitating these changes and continuing methods for developing new materials and new oxygenators (or artificial lungs) are required for the design of improved heart-lung machines. These are urgently needed for the treatment of infants with serious forms of heart disease, for more complicated, and thus longer types of operations within adults, such as cardiac transplantation, and also for use and support systems to be used in patients who have suffered myocardial infarctions.

Another example of an area in which significant progress has been made, but in which present results leave much to be desired, is that of the replacement of human heart valves. Large numbers of patients have successfully been operated upon for diseased valves. In virtually all cases, this requires replacement of the valve, either with an artificial valve or a homograft valve removed from another individual. There is some reason to think that valves removed from other species, such as the calf, might be of value. Patients receiving either

artificial or transplanted valves are often markedly improved and on occasion cured, but certain imperfections in both methods still cause unsatisfactory results to occur in about 10 to 20 percent of patients. Further difficult work in the design and testing of artificial valves, and further intensive investigation concerning the procurement and processing of grafts is necessary to improve the results of this type of surgery. Such work is time cosuming and requires the interdisciplinary collaboration of many individuals.

It is well known that there are critical problems of health manpower in this country today. The ideal way of meeting these is to train more physicians by an enlargement of our facilities for educating physicians. However, even with the most strenuous efforts in this direction, it seems unlikely that we will in the foreseeable future have an adequate supply of physicians. Fortunately, considerable new knowledge has been generated by research and will continue to be generated by it if adequate support is forthcoming. This knowledge, plus the development of automated techniques in general, has allowed us to make a beginning in the development of automated techniques for observing and treating critically ill patients utilizing computer techniques. We are at present managing two critically ill patients each day after open operations on the heart by this technique. This results in the same number of nurses and doctors being able to care skillfully and well for a much larger number of seriously ill patients. Unfortunately, these automated techniques of observation and treatment are in their infancy and require enormous additional efforts to improve them and to make them broadly applicable. This kind of work is expensive and time consuming, and if it is to be carried forward in a proper fashion, will require considerable funding by the Federal Government.

These are merely several examples of the numerous activities going on in our university medical center and in those in other parts of the country, directed toward the solution of some of the problems in cardiovascular disease. Our own activities and most of those of others are virtually all supported by the National Heart Institute of the National Institutes of Health. Our own center has been built up slowly and painstakingly, and its most precious resource is the large number of skillful, well trained people. If adequate fiscal support for our own cardiovascular research and training program is not available to us, then we will lose this priceless resource of people. It will take a long time to gather these people again together and to generate the program that can make a significant impact on the health care problems of this country. Continuation of these programs can make further significant impact on the treatment of heart disease. It is urged then that adequate funding for the National Heart Institute and the National Institutes of Health be appropriated by your committee.

Dr. KIRKLAND. My purpose is to tell you, very briefly, what is going on in an institution that is an example of what is going on in other institutions.

My institution is the University of Alabama Medical Center. I emphasize again that I give that as an example of what is going on in other institutions.

Just to select a few things that might illustrate what some of the problems are. Heart and lung machines have been around and used in people now for 13 years and it is very true that there are a large number of people alive and well because of the use of these machines but they are terribly imperfect pieces of equipment. For example, if we put an infant 3 months of age on a heart-lung machine, he has about a 50-percent chance of dying today. If we operate upon a patient for 4 hours with a heart-lung machine, any patient, he has a significant chance—I don't think we know the number precisely—but he has a significant chance of dying, not as a result of the operation, not as a result of what we do, but only as a result of being on the heart-lung machine for 4 hours.

It is perfectly true that statistically, I suppose, we have overcome the biggest jump, most people survive. There is a question of whether this is good enough for the future or whether we have to do better so small infants and people needing complex operations can also survive in large numbers.

I would remind you that the operations being done, being contemplated, are progressively more complex with the introduction of artificial devices, cardiac transplanation, and so on.

This inherent risk of dying while on the heart-lung machine is really due to imperfections in our knowledge and imperfections in the development of new equipment. I think, as you well know, we talk about research in medical affairs really to cover research and development. We don't sharply distinguish between the two. Some are in research and some in development.

I could elaborate on the problem with heart-lung machines and what the difficulties are. We know a good deal, but it is an extraordinarily complicated matter involving basically the physical chemistry of certain constituents of the blood, the effect of moving blood across foreign surfaces, what it does to the physical chemistry of the blood. It is a complicated business. It is somewhat identified, but to further improve our knowledge of it and to overcome these problems is really a major difficulty.

Artificial valves are again an example of something that we do reasonably well. Quite a number of people survive because of them and really obscure the fact that they are really imperfect. Not only are they imperfect in terms of their immediate function at times, but I think if we think about 5- and 10- to 20-year survival in individuals with these artificial valves, we really are in very dangerous territory and materially handicapped by lack of knowledge. We don't know with any assurance whether or not artificial valves or a transplant valve is really best. I think this illustrates the need, at least at the present moment, in the field that I am knowledgeable about, for some parallel investigations.

Dr. DeBakey is working with artificial valves in our own institution and we have for some time been working with transplanted valves. Which is better is hard to say at the present time.

It is important that we acquire enough knowledge and enough experience and generate enough new methods so that we can determine which is better. In terms of transplanting valves, I don't think anyone really knows whether it is really necessary to transplant a human valve or whether a valve from another organism, from a pig, can be safely transplanted. These are all complicated matters.

Dr. Hume will discuss with you in more detail the terms of complex response of one organism in terms of the tissue of another. There has been a great deal of interest in replacing the heart and I think we are very sober in our approach to this. It is a very complicated matter. It is by no means self-evident whether this is best with a mechanical device or whether it is best done with a transplanted heart from another individual.

I think that in these cardiovascular centers efforts at cardiac preservation are an important part of the transplantation story. It is very difficult logistically to think of taking a heart out of a person and put it in another person on the spur of the moment.

A great many of the moral and logistic problems would be much easier if the heart could be removed at an appropriate time, banded, so to speak, preserved and used in an orderly fashion. This knowledge is terribly imperfect. Even if we had the knowledge, the application and the development of the technology would require an enormous effort.

One of the important ongoing things in these centers is the use of automation. I think that we would all agree the ideal solution to the medical manpower problem would be to have more highly skilled, well-trained doctors than we have.

Realistically, the chances of making any sort of impact on the health problems of this country by turning out more skillful, well-trained doctors in the next 5, 10, or 15 years is probably small. However, we certainly can make better use of the minds and abilities that are available by automation. For example, we are at the present time in our own institution caring for two new postoperative patients each day. We have an automated computer-based system which does many of the things that even many physicians still feel are human functions, such as deciding whether a patient should receive a transfusion, how much blood he should receive, whether he should have some drug to stimulate his urine flow. We are nowhere perfect but we can begin to do this now automatically with a mechanical device instructed by a computer, the computer having been trained in the logic and rules that are to be used. I think that this is really a superb example of the use of the research information that we have generated over the last 10 or 15 years. This computer is trained, so to speak, only as a result of the knowledge that we have based upon the investigations that have been supported by the National Institutes of Health. In fact, today this information and research and knowledge is being used to program a computer to replace people that are not available in the management of these critical patients.

Mr. SMITH. Dr. Weiner, we will hear your statement now.

STATEMENT OF DR. JOHN M. WEINER

Dr. WEINER. Mr. Chairman, I have prepared a statement that I would like to submit for the record.

Mr. SMITH. All right.

(The statement follows:)

STATEMENT OF DR. JOHN M. WEINER, ASSISTANT PROFESSOR IN MEDICINE, SCHOOL OF MEDICINE, UNIVERSITY OF SOUTHERN CALIFORNIA, LOS ANGELES

Mr. Chairman and gentlemen, I would like to recommend to the committee that a large scale clinical trial of Atromid-S, a promising drug in the primary and secondary prevention of heart attacks, be undertaken in the regional medical programs on a regional or interregional basis.

The clinical trial as a form of medical research is a carefully defined and financed by the United Airlines in San Francisco.

These tests, along with similar studies in the United Kingdom and small group studies in this country, provide strong evidence—on a limited basis—of the effectiveness of the drug. What is needed now is a concerted effort in the form of a carefully designed clinical trial involving a large number of men and women. Such a study would make it possible in a reasonable length of time to determine the precise value of Atromid-S in preventing heart attacks and deaths resulting from such attacks.

The clinical trial as a form of medical research is a carefully defined and controlled opportunity for the physician to supervise and treat large numbers of patients. The objective of such a program is to carefully document the effectiveness of the treatment used. In this way, it is of great importance to the practicing physician in the community and to his patient. The clinical trial is specifically designed to provide the physician with the facts he needs in order to choose the best treatment from among the many offered. It is the ultimate testing ground for the research efforts that take place in the laboratory with experimental animals and with small groups of human subjects. It is for these reasons that

the clinical trial is an important aspect of the total medical research picture in the acquisition and practical application of knowledge.

In designing clinical trial to prevent the occurrence of heart attacks, the known risk factors must be considered. A number of studies have shown that people with one or more of the following characeristics are more likely to have a heart attack: (1) abnormally high blood "fat" levels; (2) family history of heart disease; (3) a lack of regular exercise; (4) excessive cigarette smoking; and (5) emotional stress.

Careful consideration of these risk factors would suggest that the most effective and practical preventive program must focus on reducing the high blood fat levels. In addition to preventing the heart attack, normalizing the fat levels help to minimize the occurrence of heart failure and cardiac arrhythmia. This is especially important, as the heart disease picture in women most frequently involves heart failure and arrhythmia.

In order to prevent the second heart attack in patients with heart disease and to prolong the life of such patients, the following risk factors are important: (1) abnormally high blood fat levels; (2) heart failure; (3) arrhythmia; (4) diabetes; (5) abnormal thyroid function; (6) number of previous heart attacks; (7) complications during the acute course of the heart attack, such as shock; and (8) presence of other life-threatening disease. These factors are important, singly and in combination.

Specific treatments are available to combat the detrimental effect of a number of these conditions. However, in dealing with the patient with heart disease, the most important underlying factor appears to be related to abnormally high blood fat levels. Accordingly, a number of treatments have been investigated to correct this important defect.

One of the medications, Atromid-S, appears to be best suited for both prevention and treatment. This drug is safe and free of serious side effects. It effectively lowers the levels of blood fats. Initial studies in the United Kingdom have found survival of heart disease patients to be significantly increased with this drug. Dr. Louis R. Krasno's United Airlines study provides some new information regarding the efficacy of this drug.

Mr. Chairman, with your permission, Iwould like to submit a statement for the record from Dr. Krasno describing the experience of the last 3 years in the United Airlines study. In addition, I would like to read a summary of that statement now.

The United Airlines study began testing Atromid-S in April of 1965. A total of 1,400 men, age 41 to 60 years, were recruited and divided into two comparable groups—one group of 700 received Atromid-S, the other group received no treatment. Each individual was carefully examined at the outset in order to determine his risk status and is reexamined annually.

To date, 47 new episodes of heart attacks have occurred. Of these, 37 involved men not receiving Atromid-S, whereas 10 episodes occurred in men receiving Atromid-S. Thus, the incidence of heart attacks among the untreated men was 3.7 times higher than in the Atromid-S treated group.

Dr. Krasno further reports that the occurrence of new heart attacks in men with previous heart disease is 4.6 times greater in the untreated group compared to the Atromid-S group. He found that fatal coronary heart attacks occurred twice as often in the untreated men.

In October 1967, an additional 1,000 men were added to this study. These men range in age from 30 to 40 years and are being followed to test the protective aspects of Atromid-S before coronary artery disease begins or in its very early stages.

Dr. Krasno has found that the side reactions to Atromid-S are minimal and occur in only 2 percent of the patients. He concludes his statement by requesting support for additional studies of Atromid-S for the following reasons:

(1) To confirm the results obtained from the United Airlines study.

(2) To make possible the earliest use by the general public of an effective, safe drug in the prevention of coronary heart disease.

These research findings suggest that Atromid-S should be intensively studied in preventing heart attacks in normal men and women, as well as in the prolongation of life in the patient with heart disease.

In order to study the effectiveness of this drug, we propose the following clinical trial:

The research design is illustrated in table 1. A total of 16,000 individuals (8,000 men and 8,000 women) will be studied. Four thousand normal men and women and 4,000 men and women patients will be needed in the placebo group and in

the Atromid-S group, respectively. This design enables comparison of the effectiveness of Atromid-S, taking into account the normal subject's risk of acquiring the disease or the risk of early death in the patient with heart disease. One thousand individuals in each category is the minimum number required. It is possible to keep the size of the trial this small by making use of new techniques of analysis which enable the investigative team to evaluate the simultaneous effects of risk or prognostic factors on the outcome.

Men selected will range in age from 40 to 75; women selected will range in age from 45 to 75. While heart attacks typically have been considered to be a male disease, the occurrence of coronary heart disease in women increases with the onset of menopause. Hence, there is a need to develop an effective treatment program in female patients, as well as to evaluate Atromid-S in prevention of heart disease in the post menopausal woman.

Such a clinical trial is particularly feasible and practical to do at the present time. Because of previous research, we now know how to organize a community to support research in heart disease. We know how to educate a population in order to secure their participation in such studies. We know how to organize the many scientific disciplines required into an efficient team. We know how to communicate effectively with investigators in order to accomplish the standardization of research methodology needed in spite of great variations in local environments. We know the needs of the patient and how to meet them in order to insure his cooperation and continuing presence in a clinical trial. We are better able to define the types of information to be obtained from the patient. We have more efficient methods of analyzing the information procured.

The programs and organization of the clinical trial are shown in tables 2 to 4 and are discussed in the following. These activities are of the utmost importance in order to accomplish the goals of the research, namely, the prevention of heart attacks and death.

It is necessary to select a group of scientists knowledgeable in clinical trial research and heart disease to provide leadership. This steering committee is responsible for the scientific and administrative effectiveness of the trial.

A coordinating center is necessary to insure the standardization and correctness of the research procedures used in the participating clinics. This center is responsible for the development of the research plan, for the development of the educational programs, for the assignment of treatment, dispensation of drugs, and analysis of ensuing data. The analysis of data from these large population studies must be conducted by highly trained biostatisticians making use of modern high speed computers.

A central laboratory is needed to measure chemicals in the blood and urine shown to be important in heart disease. These analyses should include determination of the blood "fats" such as cholesterol, of endocrine substances in the blood and urine, of specific enzymes, of bloodclotting factors, and of trace metals such as potassium. These analyses will aid in understanding the mechanisms involved in the process and progress of heart disease in the normal person and in the patient.

Investigators from medical schools and large community health centers must be enlisted. These scientists are the key to the success of the clinical trial. They are responsible to their local community and to their patients for the conduct of the trial, for educational programs, and for the results of the trial. Their efforts in maintaining the patient in the trial, in maintaining the standard research procedures, as well as insuring good medical care of the patient, provide the base on which the results must stand. The problems of local professional jealousy, fear of losing patients, fear of Federal aid in medicine become less important when the local investigator is well respected and demonstrates that the clinical trial may be well integrated into the patient's total care under the supervision of his own physician.

Educational programs must be developed. Both voluntarily and governmental agency support must be secured in order to develop educational programs that will motivate normal subjects and patients to participate in the clinical trial.

Educational programs must be developed so that each investigator may best meet the needs of his participating group. These programs help to insure the long-term participation and cooperation of the subjects, the private physicians, the local hospitals, and the local voluntary and governmental organizations.

Clinic facilities must be established and personnel trained in order to insure the high level of accuracy necessary in research. These training programs of clerical, laboratory, and medical personnel are of utmost importance in the success of the trial and serve in numerous ways to increase the expertise of the personnel.

The screening of normal subjects and of patients must begin in the first year. This screening requires careful evaluation of each subject in order to insure that the so-called normal individual meets the established requirements for the classification—normal—and that the patient with heart disease meets the established requirements for the classification—heart disease.

The budget for the first year (shown in table 5) has been calculated to be $7,700,000, of which: (1) the coordinating center would receive $3,200,000 to develop the programs and procedures needed to recruit and process the 16,000 subjects to be studied; (2) the central laboratory would receive $1,500,000 for the equipment and personnel needed in order to develop the methods necessary to effectively process the large number of samples ultimately envisioned; and (3) the cooperating clinics would receive $3 million for the examination of subjects in order to insure that the normal persons are indeed normal and that the patients do have heart disease.

A program of this kind, Mr. Chairman and gentlemen, is uniquely suited to the structure of the regional medical programs. I believe that two or more regions, if properly motivated, can develop and conduct successfully this program.

I hope that you will see the merits of this clinical trial and will approve it in concept. It would help considerably if you were to express your approval of this program. I know that the men and women to be involved would be greatly encouraged knowing that the Appropriations Committee of the House of Representatives thought well of this study.

We would, of course, have the proposal originate in the local agencies according to law but those bodies would act with more direction and more assurance if they knew that the objectives were held in some esteem in Congress.

TABLE 1.—PROPOSED RESEARCH DESIGN FOR CLINICAL TRIAL OF ATROMID-S IN THE PRIMARY AND SECONDARY PREVENTION OF HEART ATTACKS AND DEATHS DUE TO HEART DISEASE

MEN

Primary prevention (normal individuals)				Secondary prevention (survivors of 1 or more heart attacks)			
Low-risk of heart attack		High-risk of heart attack		Low-risk of heart attack		High-risk of heart attack	
Placebo	Atromid-S	Placebo	Atromid-S	Placebo	Atromid-S	Placebo	Atromid-S
1,000 subjects	1,000 subjects	1,000 subjects	1,000 subjects	1,000 subjects	1,000 subjects	1,000 subjects	1,000 subjects
	Total normal males, 4,000				Total males with heart disease, 4,000		

WOMEN

1,000 subjects	1,000 subjects	1,000 subjects	1,000 subjects	1,000 subjects	1,000 subjects	1,000 subjects	1,000 subjects
	Total normal females, 4,000				Total females with heart disease, 4,000		

TABLE 2. INITIAL REQUIREMENTS FOR THE PROPOSED CLINICAL TRIAL OF ATROMID-S IN THE PRIMARY AND SECONDARY PREVENTION OF HEART ATTACKS AND DEATHS DUE TO HEART DISEASE

Organization of the study:
1. Establish steering committee.
2. Establish coordinating center.
3. Establish central laboratory.
4. Enlist investigators.

Educational program:
1. Recruit aid from national and local heart associations, medical associations, civic groups, State and governmental agencies.
2. Training programs for clinic, laboratory, and analysis personnel.
3. Educational programs in local communities.
4. Educational programs for volunteers (normal subjects and patients with heart disease).

Establish clinics:
1. Medical schools.
2. Community health centers.

Screening program:
1. Identify normal individuals.
2. Document the existence of heart disease.

TABLE 3. EDUCATIONAL AND PROCEDURAL REQUIREMENTS ASSOCIATED WITH THE CONDUCT OF THE PROPOSED CLINICAL TRIAL OF ATROMID-S IN THE PRIMARY AND SECONDARY PREVENTION OF HEART ATTACKS AND DEATHS DUE TO HEART DISEASE

COORDINATING CENTER: STATISTICAL MONITORING

Surveillance:
1. Subjects seen every 3 months.
2. Clinical evaluation.
3. Laboratory analyses.
4. Continuing educational programs to maintain enthusiasm of all pertinent parties (subject, local organizations).

Occurrence of heart disease:
1. Clinical documentation.
2. Laboratory analyses.

Occurrence of death:
1. Post mortem examination.
2. Clinical summary.

TABLE D. EDUCATIONAL AND RESEARCH CONSIDERATIONS IN THE PROPOSED CLINICAL TRIAL OF ATROMID-S IN THE PRIMARY AND SECONDARY PREVENTION OF HEART ATTACKS AND DEATHS DUE TO HEART DISEASE

Analysis of Findings:
1. Effectiveness of Atromid-S in prevention of heart disease.
2. Effectiveness of Atromid-S in prolongation of life.
3. Effectiveness of Atromid-S in prevention if second, third heart attacks.
4. Confirmation of risk factors in developing heart disease and in early death.
5. Evaluation of mechanisms involved in primary and secondary prevention.
6. Evaluation of techniques used in recruitment of subjects, in long-term treatment, in documentation of disease and death.

TABLE 5. FIRST YEAR BUDGET FOR THE PROPOSED CLINICAL TRIAL OF ATROMID-S IN THE PRIMARY AND SECONDARY PREVENTION OF HEART ATTACKS AND DEATHS DUE TO HEART DISEASE

Coordinating center	$3,200,000
Development of: Educational programs; reserach protocol; analytic techniques.	
Central laboratory	1,500,000
Development of: Facilities, procedures.	
Cooperating clinics	3,000,000
Presentation of: Educational programs to the lay and professional community.	
Selection of: Normal subjects and patients with heart disease.	
Total	7,700,000

UNITED AIR LINES ATROMID-S STUDY

Mr. Chairman, I sincerely regret that previous commitments deny me the opportunity of appearing before you and your committee. With your permission, Dr. John Weiner will submit the pertinent preliminary information and data obtained in the past 3 years during which the Atromid-S study at United Air Lines has been in progress.

The study on Atromid-S was initiated in November 1964. The first group of participants consisted of 1,000 men ranging in age from 41 to 60 years. An additional group of 400 male participants within the same age range was admitted to the study in order to cover such attrition as may occur among the first 1,000.

The following baseline data were obtained on 1,400 participants and repeated annually:

1. Serum fasting triglycerides.
2. Serum fasting cholesterol.
3. Electrocardiograms—resting and exercise.
4. Chest X-ray for cardiac size.
5. Blood pressure and pulse rate.
6. Fundoscopy.
7. Weight.
8. Smoking and exercise habits.
9. Personal and family histories.

The 1,400 men were matched according to age and risk factors predisposing to the development of coronary heart disease. The process of placing one-half of the group or 700 participants on the active drug Atromid-S began in April of 1965. The other 700 men remained untreated.

In October 1967 another 1,000 men ranging in age from 30 to 40 years were admitted to the study. The purpose of including a younger group of participants is to determine whether the protective action of Atromid-S against the development of coronary heart disease will be enhanced by the earlier administration of this agent. The assumption is being made that the disease process which eventually leads to coronary artery disease has not yet been initiated or that it is in the very early stages in younger men.

RESULTS

To date, 47 new episodes of myocardial infarction have occurred. Of these, 37 involved men not receiving the active drug whereas 10 episodes occurred in men on Atromid-S. The frequency ratio or incidence of coronary heart attacks among the untreated men was 3.7 higher than those being treated.

Of the 47 coronary heart attacks, 17 represented a second incident. Fourteen of the 17 attacks occurred in men not receiving Atromid-S while three took place in men on the active agent. This represents a 4.6 times greater frequency of a second episode of myocardial infarction among men not receiving Atromid-S. Fatal myocardial infarctions occurred twice as often among those who were not receiving Atromid-S.

The side reactions to Atromid-S appear to be minimal and encountered in only 2 percent of the participants. Most of these reactions are confined to the gastrointestinal system, causing symptoms of nausea or distension. One person reported a severe headache. Two participants indicated that the agent caused a mild dermatitis. In no instance were any serious systemic or generalized reactions noted.

SUMMARY AND COMMENT

The United Air Lines Atromid-S study includes 2,400 men. Of these 1,000 men are between ages 30 to 40 years whereas 1,400 range between 41 to 60 years. I believe it is premature to make any claims at this point; however, it must be noted that over a 3-year period involving 1,400 men, first heart attacks occurred with a frequency 3.7 times greater in the untreated group. This can certainly be considered presumptive evidence that Atromid-S is providing a "protective action" against the development of coronary artery disease. If these statistics are sustained during the next few years, it would become abundantly clear that we have a safe, reliable, and effective means of protection against this country's most challenging and serious medical problem—coronary heart disease.

In view of the significant and encouraging results obtained to date in the United Air Lines study, I urge that all the support necessary furthering studies on Atromid-S to be carried out by independent investigators be provided for the following reasons:

1. To confirm the preliminary and subsequent results obtained from the United Air Lines Atromid-S study.
2. To make possible the earliest use by the general public of an effective and safe drug in the prevention of coronary heart disease. The early initiation of a large-scale study to confirm the results of the United Air Lines program may well save thousands of lives through the early acceptance of this drug. Each year we delay in finding the answer to the enigma of coronary heart disease, over 500,000 individuals will die of this disease.

Mr. Chairman, I trust that at a subsequent time, it will be possible for me to personally submit to you and the committee further significant developments substantiating the preliminary results presented in this report.

Dr. WEINER. Mr. Chairman and gentlemen, I would like to recommend to the committee that a large-scale clinical trial of Atromid-S, a promising drug in the primary and secondary prevention of heart attacks, be undertaken in the regional medical programs on a regional or interregional basis.

This drug has been subjected to clinical evaluation in a project conducted and financed by the United Air Lines in San Francisco. These tests, along with similar studies done in the United Kingdom, provide strong evidence on a limited basis—of the effectiveness of the drug. What is needed now is a concerted effort in the form of a carefully designed clinical trial involving a large number of men and women. Such a study would make it possible in a reasonable length of time to determine the precise value of Atromid-S in preventing heart attacks and deaths resulting from such attacks.

The purpose of a clinical trial is to carefully document the effectiveness of the treatment used. In this way, it is of great importance to the practicing physician and to his patient. The clinical trial is specifically designed to provide the physician with the facts he needs in order to choose the best treatment from among the many offered. It is the ultimate testing ground for the research efforts that take place in the laboratory with experimental animals and with small groups of human subjects. It is for these reasons that the clinical trial is an important aspect of the total medical research picture. When well conceived and operated, it is the last step in defining the effectiveness of a new treatment and the first step in the practical application of the acquired knowledge.

In designing a clinical trial to prevent the occurrence of heart attacks, the known risk factors must be considered. These are: (1) High blood "fat" levels; (2) family history of heart disease; (3) lack of regular exercise; (4) excessive cigarette smoking, and (5) emotional stress. Careful consideration of these factors suggests that the most effective and practical preventive program must focus on reducing the high blood "fat" levels observed. In addition to preventing the heart attack, normalizing the fat levels may help to minimize the occurrence of heart failure and cardiac arrhythmia. This is especially important in women.

Atromid-S appears to be best suited for intensive testing as to its efficacy in both prevention and treatment.

Mr. Chairman, with your permission, I would like to submit a statement for the record from Dr. Louis R. Krasno, who has conducted the United Air Lines study of the drug. The statement describes the experience of the last 3 years in the study. In addition, I would like to read a summary of the statement.

The United Air Lines study began testing Atromid-S in April of 1965. A total of 1,400 men, aged 41 to 60 years, were recruited and divided into two comparable groups—one group of 700 received Atromid-S, the other group received no treatment. To date, the number of first heart attacks is 3.7 times higher in the untreated men than in the Atromid-S treated group.

Dr. Krasno further reports that second heart attacks in men with previous heart disease is 4.6 times higher in the untreated men. He found that fatal heart attacks occurred twice as often in untreated men compared to Atromid-S treated men.

These research findings of Dr. Krasno's suggest that Atromid-S should be intensively studied in preventing heart attacks in normal men and women, as well as in the prolongation of life in the patient with heart disease.

A total of 16,000 individuals (8,000 men and 8,000 women) must be studied, taking into account the normal person's risk of acquiring the disease and the risk of early death in the patient with heart disease. It is possible to keep the size of the clinical trial this small by using new techniques of analysis.

Such a clinical trial is particularly feasible and practical to do at the present time. Because of previous research, we now know how to organize a community to support research in heart disease. We know how to educate a population in order to secure their participation in such studies. We know how to organize the many scientific disciplines required into an efficient team. We know the needs of the patient and how to meet them in order to insure his cooperation and continuing presence in a clinical trial. We are better able to define the types of information to be obtained from the patient. We have more efficient methods of analyzing the information procured.

The budget for the first year has been calculated to be $7.7 million of which (1) the coordinating center could receive $3.2 million ($200 × 16,000) to develop the programs and procedures needed to recruit and process the 16,000 subjects to be studied; (2) the central laboratory would receive $1.5 million ($300 × 5,000) for the equipment and personnel in order to develop the methods necessary to effectively process the large number of samples ultimately envisioned; and (3) the clinics would receive $3 million ($600 × 5,000) for the examination of subjects in order to insure that the normal persons are indeed normal and that the patients do have heart disease.

A program of this kind, Mr. Chairman and gentlemen, is uniquely suited to the structure of the regional medical programs. I believe that two or more regions, if properly motivated, can develop and conduct successfully this program.

I hope that you will see the merits of this clinical trial and will approve it in concept. It would help considerably if you were to express your approval of this program. I know that the men and women to be involved would be greatly encouraged knowing that the Appropriations Committee of the House of Representatives thought well of this study.

We would, of course, have the proposal originate in the local agencies according to law but those bodies would act with more direction and more assurance if they knew that the objectives were held in some esteem in Congress.

I thank you.

Mr. SMITH. Is Atromid-S a brand name?

Dr. WEINER. Well, it is kind of grownup. It is a brand name and a technical name at the present time. Would you agree, Doctor?

Dr. DEBAKEY. Yes. I might say that I have had some experience with this type of study but in a more restricted way. We have in our own institution a special project we are carrying on, utilizing Atromid-S. Now, taking advantage of this particular model, we are studying other drugs that may have some other effect.

It seems to me that this kind of trial as suggested here by Dr. Krasno is desirable, and I must say that I think the regional medical programs provide a very good framework for this type of study on a wider scale. I would add my strong support of the recommendation here to include in your committee language clear approval of this particular program in the regional medical programs.

Mr. SMITH. Is Atromid-S peculiar compared to other drugs?

Dr. DEBAKEY. I would say, yes, it is peculiar in its effect. I don't think it is completely known, that is, all of the effects of the drug. We do know that it has a capability of reducing certain types of lipid elements in the blood and, hopefully, this would have some effect on the development of arteriosclerosis and atherosclerosis.

Mr. SMITH. In layman's language, how does it work on these fatty substances? Does it disperse them?

Dr. WEINER. I am not sure it is known exactly how it works. It is believed that it blocks the metabolic changes at a certain point—it blocks the production, so to speak, of some of these things.

Dr. DEBAKEY. Which lead utimately to the blood compound that constitutes the fatty acids.

Mr. SMITH. It reaches the blood stream but it is taken orally?

Dr. DEBAKEY. Yes.

Dr. WEINER. It is believed to have its primary effect inthe liver, in the blocking of the production of these fatty elements or in slowing down the production.

Dr. DEBAKEY. One important thing is that it has been used enough now to be able to say whether or not there would be any harmful side effects. Certainly, there have been absolutely no major side effects.

Dr. WEINER. Dr. Krasno reports that he has observed total side effects in 2 percent of his patients.

Dr. DEBAKEY. These are very mild.

Dr. WEINER. Yes. The kind of side effects he reports are some slight nausea or intestinal upset, which in our experience can be completely blocked by just having the patient take his pills with the meal. If you coat the pill with a meal you don't even get this minor nausea. That will tend to go away, too. It is a function of just getting used to the drug. If you are conscientious about taking your pills within the first week these kinds of symptoms would disappear.

Mr. SMITH. How long did he use this drug with this sample?

Dr. WEINER. He has been at it for 3 years. This is a 3-year report.

Mr. SMITH. You gave ratios there, but what about numbers?

Dr. WEINER. It has had a total of 47 new events. Ten of these have been in the Atromid-S and 37 have been in the untreated group.

Mr. SMITH. The sampling is so small that any other factor could have caused this; is that right?

Dr. WEINER. Well, it looks significant but it has to be substantiated by testing on a larger scale. As a matter of fact, he is unwilling to say categorically that this is the answer. He is in the process of continuing his study. He has also added another thousand men in the younger age group of 30 to 40, to see if it can be documented in terms of the effectiveness at this early stage, in quotes, of heart disease. That is why I am suggesting that we really get at it with a large enough clinical trial so that it can effectively decide the issue. Some of the issues are: Is this a good drug to use in prevention? Does it work in men?

Does it work in women? Is it a good drug to use in the treatment of a patient with heart disease?

Mr. SMITH. Is this a patented product?

Dr. WEINER. Yes.

Dr. DEBAKEY. The drug; yes, it is.

Dr. WEINER. It has been approved by the Federal Drug Administration.

Mr. SMITH. Has any attempt been made to compare it with others having a little different ratio of the ingredients involved?

Dr. WEINER. Yes. There is a study going on now, sponsored and supported by the Heart Institute, in men only, though, and in men who have had at least one previous heart attack. Atromid-S is being compared with five other drugs that are aimed at doing the same thing.

We have a clinic operating in that study. According to our agreements I can't really disclose the findings because we don't have the latest findings. At the last meeting, which was approximately a year ago, Atromid-S was one of the two. There are two drugs that very early, very preliminary stage, that looked good and Atromid-S was one of those. This coronary drug project is restricted to treatment of the man with heart disease. That is one important area, but we are also pursuing prevention, which is probably the more important area. We have the problem of heart disease in both men and women. That is why a part of the study we propose involves women, surprisingly enough, little studied in this country.

Mr. SMITH. One of the questions which is bound to come up here is whether the Government should spend large sums of Government money to develop a patented product that somebody else has the patent on, if in fact other products of similar or like nature could be involved in the sampling instead.

Dr. DEBAKEY. As you have indicated, the Heart Institute has sponsored a collaborative study, both diet collaborative study and drug study. This is only one of some five or six other efforts being made.

Mr. SMITH. After all, our final objective is to get this product, if it is proven effective whatever it is, distributed to the maximum number of people.

Dr. DEBAKEY. That is right.

Mr. SMITH. If it is going to be too high priced it is not going to be distributed to a lot of people.

Dr. DEBAKEY. That is right.

Dr. WEINER. There is a point I would like to make here, Mr. Chairman. In preparing for this particular testimony I again reviewed what we knew in terms of prevention and treatment in the drug areas, and selected Atromid as being the one that looked best to intensively try. To do that requires 16,000 subjects. If we decide that we again have to try to whole group of drugs, we either will have to restrict our consideration to a high-risk group such as the male with heart disease, as the coronary drug project is doing, or we have to add on to the number of people to be studied. Unfortunately, we will do about 8,000 at a time, which increases the cost.

Mr. SMITH. I thought you said you did not know at this point for sure whether Atromid-S was superior or inferior to these other two or three.

Dr. WEINER. At this point I can't say with absolute finality.

Mr. SMITH. Then how do you know which one to test?

Dr. WEINER. As I said, with all the indications we now have, Atromid-S is clearly the one that we should try. That is based on the findings in Great Britain, on Dr. Krasno's findings, and some very early findings from the coronary drug project. Taking all of these sources of information into account, Atromid does the things that you would ideally want a drug to do. It is safe, free of side effects, it lowers the lipid levels and it appears to be of use at least in terms of what we now have information on; it appears to be beneficial in terms of prevention in men and treatment of men.

Mr. SMITH. Do these other drugs fall down in one of those areas?

Dr. WEINER. They tend to be good in the lipid-lowering field, they don't tend to be as completely free of side effects nor as effective in the prevention-treatment area as does Astromid-S.

Mr. SMITH. What kind of side effects did they have that Atromid-S does not have?

Dr. WEINER. It depends on the drug. You have some that give greater intestinal problems, you have others that give some chest pain, which is a rather irritating side effect in patients with heart disease. Others produce a kind of a flushing, itching sensation of the skin. You think your skin is coming off. These are problems that in getting people to take pills you would like to eliminate, if we possibly can.

Mr. SMITH. It seems to me offhand that if a determination is going to be made that this kind of a project should be financed, that we should have a well-documented statement before us showing why it should be Atromid-S instead of the others. I think we just cannot say that, on incomplete analysis, you think Atromid-S is the one drug. It seems to me the statement ought to be something pretty substantial.

Dr. WEINER. Well, it is substantial. You do recognize, I know from the past actions of this committee, that the more we delay in getting preventive programs started, waiting for the definitive answer to come——

Mr. SMITH. I understood you to say there had been some experimenting going on, but you couldn't at this time say what the results were.

Dr. WEINER. In the one study, in the coronary drug project. That is the one that we do not have the latest report, and will not have until the 29th of this month, which is our next meeting. The studies in England of both prevention and treatment do show that Atromid-S is effective.

Mr. SMITH. The 29th is not very far off.

Dr. DEBAKEY. If you want the report made available, I am sure as soon as it is available it could be submitted to you.

Mr. SMITH. I think, for me as just one member of the committee, I would like, after the 29th of the month, to have you submit a very detailed analysis.

Dr. WEINER. That would actually have to come from the Heart Institute coronary project. I would not be in a position to furnish it myself.

The coronary drug project, let me repeat, is a study of men who have already had a hart attack. This program that we are suggesting goes beyond that to the men who have not yet had an attack and to women. So that the coronary drug project's findings are a piece of the problem, you see.

Mr. SMITH. Mr. Michel?

Mr. MICHEL. On this particular drug you mentioned there are probably five others that seem to be competitors. Is my assumption correct that these would all be produced by competing firms?

Dr. WEINER. I think there is another one being tested that is produced by the same firm, and I believe the others are by competing firms. I have really not paid much attention to that. I do not know.

Mr. MICHEL. My reason for asking is this: There are a number of competing firms under our system, but you are singling out one and asking for $8 million for this study, which for all practical purposes would promote one product over the other five. Am I not correct?

Dr. WEINER. I would say yes, in that sense.

Mr. MICHEL. Here is one private concern then, making one drug and you are asking for Federal funds to prove out its credibility——

Dr. WEINER. Right.

Mr. MICHEL (continuing). As against the five other firms who produce the same type of drug. They will no doubt ask, "How come you don't come up with the same kind of study for my drug?" This puts us in a rather embarrassing position.

Dr. WEINER. I don't think either one of us is concerned with who makes it, it is the underlying heart disease problem with which we are concerned. We want to determine which drug proves itself first in limited testing which Atromid-S has, then in large-scale testing which we recommend and then in general use.

Dr. DEBAKEY. I think, in all fairness, you are already supporting many different drug studies. I was just checking here. The budget for drug studies for fiscal 1968 is $4,600,000. They hope to be able for 1970 to have it go up to $6,313,000. Even that is going to restrict them considerably in their ability to do this particular cooperative study which involves, I think, something like five different agents. Now, this is aside from the diet study. This is the drug study, the coronary drug study. It is restricted in a way because it is only applied to the prevention of second attacks. The reason they have restricted it is because they don't have the funds to really involve a larger number of people statistically, and to include the individuals with perhaps lesser risk cases, you see, which is really what you are trying to find in this particular study in the way it has been designed. I don't know how you would get around it. After all, whatever drug you use is made by some firm.

Dr. WEINER. I was just thinking of a comparable problem in the new drug area, where they are undergoing testing. There is a drug now that is thought to be exceptionally beneficial in the treatment of chest pain, the angina problem, and I think in arrhythmia, too. It is the same problem. One drug looks good.

Dr. DEBAKEY. Perhaps you can look at it the other way, it is also desirable to find out as soon as possible whether they are any good or not so we can get rid of them if they are not any good, because they then become awfully costly.

Mr. MICHEL. How often does this drug have to be taken?

Dr. WEINER. It is taken daily.

Mr. MICHEL. One pill a day?

Dr. WEINER. Depending on the dose. We give nine pills a day, three pills at each meal.

Mr. MICHEL. Currently what is the cost of those pills? What does a day's dosage cost?

Dr. WEINER. If you went out into the open market?

Mr. MICHEL. Right.

Dr. WEINER. It is $10 per 100 pills at the present level of use.

Mr. MICHEL. Until we really have a broad-scale clinical study and produce the drug in large quantities, I guess you really couldn't get any bona fide cost figures.

Dr. WEINER. No; because these drugs are just of the experimental phase when the Food and Drug Administration allows them to be prescribed. You can get a prescription for this drug by your local doctor.

Dr. DEBAKEY. But they are not available in any other way.

Dr. WEINER. They are not available over the counter. The concept of how should he use this drug is still to be worked out. Should it be used as a secondary prevention agent? Shall it be used as a primary prevention agent? Should it be used just in men? Should it be used in women as well? Should these pills be given to people as soon as they reach the 35th birthday or the 40th birthday? This is the area that is really involved in deciding whether the drug is totally safe.

Mr. MICHEL. Was United Airlines this initial testing group?

Dr. WEINER. United Airlines.

Mr. MICHEL. Were these normal individuals or did they have incidences of heart disease?

Dr. WEINER. Of the 1,400 that Dr. Krasnow first picked up, they were all normals with the exception of 44. They were ages 41 to 60, well people with the exception of the 44 men who had had a heart attack previously. So he is essentially reporting on prevention. He is essentially reporting on that. And that phase of it looks good. He reports that the men are excited about the research program, that they are willing, and do take their pills daily. We have had the same kind of experience dealing with the heart patient. But I was glad to hear that he has this kind of experience in dealing with normals. I think we are up against the concept now that Americans are trained, through whatever mechanism the training takes place, to take pills. If you are going to tie into this training program in the prevention of a disease, then you must have a pill that does not give any side effects and which works.

Mr. MICHEL. Dr. Kirklin, with regard to your discussion of valve transplantation, does that also require the taking of valves from a person who just died? Is it similar to what we have witnessed recently with respect to the heart itself?

Dr. KIRKLIN. There is a major difference in terms of transplanting values on the one hand, and the entire organ, such as the heart or kidney on the other hand. The essential difference is that the valves can be reaped at any convenient time up to about 12 to 14 hours after death. Therefore, there is no special preparation. A second difference is that the valves can be sterilized after they are obtained and then stored, so that they are then taken in routine autopsies, at any convenient time after death; and it is really done as part of the autopsy. Then, once the valve is obtained it can be processed in an orderly fashion. So there is a major difference.

Mr. MICHEL. One final question: Are there any medically advanced countries pursuing the dual lines of research, as we apparently are, both on transplant and artificial hearts?

Dr. DEBAKEY. Yes, there are; I can tell you that in terms of the places that I know. For example, Russia has a major program of this kind going on. I know this not only from having visited their institutions where they are involved in, but they have been engaged in transplantation for some time. They have a major area of activity in transplantation. Also in the development of artificial organs. They have, as a matter of fact, a special institute for this purpose.

They have sent people over here to be trained, and I have trained two of their people in my own institution. In fact, another one is just getting ready to come over primarily concerned with the artificial developments.

France is a country that is involved in both areas. There are other countries that place more emphasis on one than on the other, depending on the interest in the sense of their individual people. I think the Japanese represent another place where there is considerable sophistication and knowledge and development.

Mr. MICHEL. Would you say we were the furthest advanced so far as the actual artificial heart is concerned?

Dr. DEBAKEY. Yes. I think we are more advanced, if you want to call it advanced, in the sense of having, let's say, centers and sufficiently well developed facilities in terms of the total resources; yes, I would say we are.

Mr. MICHEL. That is all, Mr. Chairman.

Mr. FLOOD. I would like the record to show that I came a bit late today and that I came directly here from the airport only because Dr. DeBakey was appearing.

Dr. DEBAKEY. Mr. Flood, if I may say, I want to again express my very grateful appreciation for the opportunity of being with you again. I, too, am sorry you weren't here this morning. It is always a great pleasure to be with you. I want to thank the other members of the committee for their attention and interest and concern with these matters. I want to say that I know the sentiments of each member of this committee are similar to ours. I know the pressures you men are under, I know the concern you have for the fiscal considerations here and the pressures that restrict it. I would only plead with you to give as much consideration to these matters as you possibly can in terms of the competitive forces involved, because I think that the future of the health of this country is dependent upon what you gentlemen are able to do.

Mr. FLOOD. Of course, Doctor, my surgeon is Dr. Hufnagel.

Dr. DEBAKEY. Yes, I know. He is a very good friend of ours. He is a colleague whom we respect and admire greatly, one of the pioneers in this field and continues to be. Here again, you see, is a man whose contributions have largely emanated from the support of the Heart Institute, the National Institutes of Health, beginning with the time when he was in Boston.

Mr. FLOOD. May I add this: Mr. Laird, who will now take the witness, is an oldtimer with the committee. He knows Dr. DeBakey well and long, and favorably.

Mr. LAIRD. Thank you, Mr. Chairman.

I was interested in the suggestion that the committee recommend a large-scale clinical trial of the drug Atromid-S.

I wrote to NIH and to Dr. Shannon about 3 years ago in regard to this particular drug. One of my concerns is the manner in which the committee would have to give direction to the regional program, by earmarking funds for a specific area of study. It would seem to me that this initiative should emanate from within the region where such clinical testing would be conducted rather than by direction from our committee. This bothers me a bit. I don't mind doing some earmarking now and then in the activities of the NIH, but I have been rather reluctant to move in and start earmarking here. I would like to hear you address yourself to whether you think we should start earmarking in the regional medical program. I think this is quite a departure from the way I look at the regional concept.

Dr. WEINER. I really don't believe I am asking you to earmark funds because I think that the regional medical program must start, as you gentlemen have indicated, at the local level and work its way there. What I am asking for, really, is a policy decision, help for us to motivate more than one region to develop this kind of a clinical trial because it actually cannot really be done in any one region. It will need at least two regions or possibly three to acquire the base group that we have to study. The idea that I am after here is that if you approve the concept of such a clinical trial then we can get the local organizations, local agencies, according to the law, to make a proper proposal, then have it come up through channels and the people in the regional medical programs here in Washington will give it its due consideration. But I think they will be guided to some extent by policy considerations that you in the House of Representatives enunciate.

Mr. LAIRD. But there is no policy decision that interferes with this kind of a project now, is there? Have you been turned down, or has any region or any group been turned down on a clinical test of any particular drug, as yet?

Dr. WEINER. I really cannot say. I know we have not been turned down because we have not yet submitted an application or plan. In fact no large-scale drug trials have been applied for. Most of the activities to date in the regional medical program have been of two sorts: the planning of programs and the development of educational programs.

Mr. LAIRD. We have several operational grants now.

Dr. DEBAKEY. That is right, Mr. Laird.

Mr. LAIRD. We haven't this kind of a drug program approved as yet?

Mr. DEBAKEY. That is true.

Mr. LAIRD. I had not realized that NIH had made a policy determination that would be in conflict with this kind of a clinical test on a regional basis. I would think your proposal would fit into the program. I am trying to get in my mind what you want this committee to do.

Dr. WEINER. What we would like the committee to do is to see the merits of this particular clinical trial and approve it in concept. Then the men and women to be involved in it would be greatly encouraged knowing that you think well of this study. Of course we would have the proposal originate with the local agencies according to the author-

izing law, but the local agencies need motivation and they would act with more direction and more assurance if they knew that these objectives were held in some esteem in Congress.

Dr. DeBakey. Mr. Laird, may I comment very briefly on what you are saying here? I think it is an important point. Let me say I think the important consideration here is rather the concept of utilizing the regional medical programs to achieve both its objectives and, let's say, the objectives sought here, which is a research program concerned with the evaluation of a drug on a large-scale basis. Now, this fits well into the regional concept because it engages the physicians and practitioners locally in evaluation of a drug.

Mr. Laird. This is one of the concepts discussed when the original program was set up.

Dr. DeBakey. Exactly; you are quite right.

Mr. Laird. That is why I don't understand the trouble on this one.

Dr. DeBakey. There isn't any trouble on it. I think what is needed here, though, is the impetus that could be obtained from a committee of this kind, the prestige of this committee to recognize that this fits into the regional medical concept.

Mr. Laird. Last year the executive branch froze $25 million in the regional program, as you know. The money was appropriated by this committee but not spent.

Dr. DeBakey. Quite right. It is expected that there will be available to carry over into next year's budget $35 million that would be available from this past year for the regional program.

Mr. Laird. I believe you are probably talking about the total carryover to 1969 rather than the amount that was unexpended in the 1968 appropriation.

Dr. DeBakey. Oh, yes, I am talking about the total carryover; that is right.

I think what would be worthwhile is really for this committee, Mr. Flood, to recognize this as a part of the concept of the regional medical programs, and that is the main thing that is needed. I think the same thing could be applied, for example, to antihypertensive medication in which the need is perhaps not as great but still great, when you think there are over 17 million hypertensives in this country and when the specific studies have clearly demonstrated that perhaps less than 20 percent of all the hypertensives in this country are being effectively treated.

Then it is possible to treat, I would say, the great majority of patients of hypertension in a far more effective way.

Mr. Laird. That is all I have.

Mr. Smith. Are you doubting that you have the authority to make this kind of investigation in the regional medical program?

Dr. DeBakey. No. The authority exists from the legislative standpoint, certainly. But I know that these discussions have come up before our council meeting and before some the study section meetings in relation to the regional medical program. That is, the utilization of funds for research programs relating, for example, to the study of drugs, hypertension, study of drugs of this kind for lipid reduction.

Mr. Smith. Do other people doubt it?

Dr. DeBakey. It is not so much that they doubt, it is more in terms of their not fully understanding. I think that this is a very good way to use the money because it does two things: it both gives us knowledge

from research and also extends the objectives and provides a means of reaching the goals of the regional medical programs in a very effective way. So that I am merely saying that it would be desirable for this committee through its prestige in terms of its pronouncements to have some impact upon extending this concept.

Mr. FLOOD. Mr. Hull?

Mr. HULL. I have no questions.

Mr. FLOOD. Mr. Casey.

Mr. CASEY. Thank you, Mr. Chairman. It is a real pleasure to have my good friend and constituent, Dr. DeBakey, here this morning with his colleagues. We are quite proud of Dr. DeBakey and his accomplishments, naturally. As you know, after Dr. DeBakey comes the dome stadium, you understand. A lot of people know Houston for its dome stadium but I think all over the world we are known as having the privilege of having Dr. DeBakey as one of our first-class citizens there, and a great scientist.

Doctor, how many of the centers now are actually operational?

Dr. DEBAKEY. Cardiovascular centers?

Mr. CASEY. Yes.

Dr. DEBAKEY. Actually, none of the cardiovascular research centers, as originally conceived by the Heart Institute and as conceived in terms of the money that your committee appropriated for planning, have yet gone into operation. Dr. Kirklin's center is one of those that received a planning grant and they are ready to go into operation, but I will let him speak for himself. We are ready to go into operation. We have been delayed in getting into our new building. We have a new building for cardiovascular research, called Fondren-Brown Building, which is supported in terms of construction by the local community, local foundations. The Brown Foundation which, of course, Mr. Casey knows about, and the Fondren Foundation gave the major portion of the money, but we also have a grant from the research facilities construction program.

This building is ready to be operated. I hope, Mr. Casey, next time you are down we can show you the new building. We have not gotten the money to operate it yet. Money has not been appropriated for the operational part of these centers. Next year's budget includes, I think, another planning grant. So that you have about $1 million-some-odd for more planning. You have had $800,000 for 3 years for planning. There are three or four of these that are ready to go into operation right now. Ours is ready to go. I will let Dr. Kirklin speak for himself.

Dr. KIRKLIN. I can only say, as Dr. DeBakey has, that there are planning grants that have been completed, and the only thing to do now is to become operational. Of course, the funds to do this are not available. There is an enormous need for it because we have a lot of rather well-developed activities that could be meshed now and make an effective program.

Dr. DEBAKEY. These are rather modest amounts. I see Mr. Laird looking at me rather curiously there when I say "modest," but I do mean modest. This is something on the order of between $2 million and $3 million, I would guess, to support each center. This to me is a way of developing these fields in a far more effective manner than by individual project grants.

Mr. CASEY. How many are in this planning stage at the present time?

Dr. DeBakey. I think there are eight.

Mr. Laird. There are only six, I believe, that could be funded, though, in fiscal 1969. At the outside, it would be six.

Dr. DeBakey. That is right.

Mr. Laird. Three are ready to go now?

Dr. DeBakey. That is correct. They have been ready to go, yes. Hopefully, there will be at least one more ready to go in the next fiscal year.

Mr. Casey. How is your research? Are you being financed sufficiently on your mechanical heart research?

Dr. DeBakey. No, we are not. As a matter of fact, Dr. Kirklin and I are both members of a committee, an advisory committee to the Heart Institute on the arificial heart-myocardial infarction study and at our last meeting we despaired our ability to do what needs to be done this coming year. This is well exemplified in our own research program—I had said earlier, before you came in—we have had to curtail the research activities in our own project. Some of these have had to be abandoned completely because there is no more money available.

Mr. Casey. Then there is going to be more need for looking toward the mechanical processes rather than the transplant. You can manufacture mechanical devices but sometimes it is a little hard to find a heart.

Dr. DeBakey. This illustrates the point we made earlier, that you proceed with approaches to a goal utilizing whatever appears promising toward that goal. Of course, in the meantime if we find the real solution to many of these problems and can prevent them, then none of this would be necessary. We could abandon all of this. In the meantime, as I said, there are patients that need attention, that need to be cared for. We must pursue whatever approaches we have and whatever knowledge is available at the present time. In this particular field the two major approaches are to develop artificial devices and to utilize transplantation methods. Both of these, however, require a considerable amount of research. In the transplantation—I am sure Dr. Hume will talk about that in greater detail in a moment because he is one of the world's experts in the field. The important thing is that we support both areas of development. I am ready to yield right now to him because it is important for you to hear him.

Mr. Casey. Thank you. I think we do want to hear from Dr. Hume.

Mr. Flood. Indeed.

Mr. Smith. Before we leave this, I think the record ought to show somewhere the cost of Atromdi-S. You say that they are prescribing Atromid-S. Could you easily get that figure for us?

Dr. Weiner. Yes.

Mr. Smith. The charge which most drugstores would make.

Dr. Weiner. Yes, I certainly could. The cost is $10 per hundred pills.

Mr. Flood. Thank you, gentlemen.

ALLERGY AND INFECTIOUS DISEASES

WITNESSES

DR. EDMUND KLEIN, CHIEF, DEPARTMENT OF DERMATOLOGY, ROSWELL PARK MEMORIAL INSTITUTE, BUFFALO, N.Y. (IMMUNO-THERAPY PROGRAM)

DR. DAVID M. HUME, CHAIRMAN, DEPARTMENT OF SURGERY, MEDICAL COLLEGE OF VIRGINIA HOSPITALS, RICHMOND, VA. (ORGAN TRANSPLANTATION)

DR. DENNIS W. WATSON, PROFESSOR AND HEAD, DEPARTMENT OF MICROBIOLOGY, UNIVERSITY OF MINNESOTA COLLEGE OF MEDICAL SCIENCES, MINNEAPOLIS (OVERALL PRESENTATION)

Mr. FLOOD. We certainly would like to hear this next group of witnesses who will discuss allergy and infectious diseases.

Dr. Watson is the one who is going to start off.

Dr. WATSON. Yes. I have a written statement. Mr. Chairman, I would like to proceed to it at this time.

Mr. FLOOD. Yes, please do.

STATEMENT OF DR. DENNIS W. WATSON

Dr. WATSON. Mr. Chairman and members of the committee, I consider it a real privilege to appear before you this morning as an educator and citizen, to speak to you in behalf of the outstanding program of the National Institute of Allergy and Infectious Diseases. As a member of its Council and administrative head of a large department in a State university, I am well aware of the contributions of this Institute, especially to the primary mission of improving the health of our citizens.

As president-elect of the American Society for Microbiology, I represent nearly 12,000 members whose contributions to the mission, range from the technical applied aspects to the most sophisticated basic molecular biological research. I should like to tell you something of the activities of this society because it supplements the mission of NIAID, and its continued success will depend to a large measure on your financial report of the Institutes.

One of our primary functions concerns the publication of scientific papers.

I bring this up primarily because you gentlemen recommend lots of money for research.

These, of course, are the products of your investment. Without such communication most of the rewards of research would be lost. Our society continues to have faith in the future, and by making significant investments and changes in publication procedures, it has been possible to increase journal pages from a total of 3,000 in 1961 to an estimated 8,000 in 1968. Because of a dedicated group of editors who contribute their time to this important work, we have increased not only the quantity but the quality of our publications. To those who question the quality of research in the face of greatly increased numbers of research dollars, I ask that they examine our publications over the past 5 years. We now publish five journals including the Journal of Bacteriology, Bacteriological Reviews, Journal of Virology, Applied Microbiology and Anti-Microbial Agents and Chemotherapy.

I do this because we are always accused of only being concerned with basic research. The last publication arises from a combined meeting of the ASM, Infestious Diseases Society of America, and the Society for Industrial Microbiology. The results of basic research, developmental research, and its clinical application work for the immediate welfare of the patient. The rapid publication of these results and their availability to the practicing physician makes this possible, which he can apply, of course, to his patients.

The second function of our society concerns scientific meetings. This year in Detroit there will be 135 sessions which include 1,152 regular papers, five major symposia, 25 round tables, and four major addresses. These meetings are invaluable to the scientific community, and they have been indirectly supported from research and training grants of the Institutes. Travel restrictions imposed by reduced budgets hamper the valuable contributions of such meetings.

As so often stated by Congressman Daddario, scientific societies should be used by Congress to assist in decisionmaking. Our society and the Academy are now organizing for the purpose of not only serving the science of microbiology but also to assure a proper concern for its application to the health and welfare of our citizens. For example, we have been particularly concerned about the lack of trained personnel in clinical microbiology. Many laboratories are not performing satisfactorily, as given in a report in Health Laboratory Science (vol. 4, No. 2, Apr. 1967, p. 72–89). The report concludes that the difficulty arises because of the lack of properly educated, trained senior personnel to supervise adequately the younger. unskilled technicians. Dr. Morris Schaeffer, author of the report, concludes, "A greater effort must be made to recruit and train more individuals capable of providing services so sorely needed in the clinical and public health laboratories across the Nation." As it impinges on the need for an expansion of the training program within the National Institute of Allergy and Infectious Diseases, I would like to plead for an increased appropriation in this area.

Mr. FLOOD. You would what?

Dr. WATSON. I would like to plead for an increased appropriation in this area of training.

I am sure that many of my colleagues would agree that the training grant program as administered under the National Institute of Allergy and Infectious Diseases, both in the basic and applied fields, has been highly successful. Curtailment of this program by failure to appropriate sufficient funds has been a real disappointment. At the March council of NIAID there was $75,000 for new programs. The $230,000 anticipated increase in the 1969 budget will not nearly meet the need which is the order of $2.5 million. The training grant program of NIAID would serve as an excellent prototype for an expanded "research-instruction" support program. There is an increasing awareness in the university community of the need for "institutional-type" support. Because the NIAID has done such an outstanding job in administering the training program, I suggest that the committee recommend an additional appropriation of $2.5 million to NIAID to introduce this education-research component into the program of the NIH.

I wish to emphasize that such support should not replace but rather supplement the individual research project system; this, indeed, could

relieve some of the insecurity and apprehension now apparent in the academic community.

Mr. Chairman, there is some apprehension in the academic community. I have a list which I call the educational component now.

The project-oriented research grant system has in the past contributed to the educational mission of the university; this has not always been admitted or appreciated:

Certainly, I don't know why this is so, but we always talk about training a research scientist, but you cannot put that much money into a university and not have something to do with education.

I believe it is now time to recognize that one cannot and must not separate research and education in this environment. It is indeed pertinent that as a member of the U.S. National Committee of the International Union of Biological Sciences, I was asked to bring to the attention of such committees as this the following resolution adopted by the XVI General Assembly of the IUBS in September, 1967.

Be it resolved—

(1) That research and education be carried on in the closest possible association;

(2) That trends toward divergence between the activities of advancing and of disseminating knowledge be vigorously counteracted;

(3) That talented research workers be expected to take an active part in the educational process, and that the exemption of research workers from educational functions be made an exceptional dispensation for a special cause, rather than a reward for excellence; and

(4) That teachers should be given opportunities for conducting research by means of grants and by liberation from full teaching duties.

Mr. Chairman, I contend that an extended training program applied to the basic microbiology department and other basic and applied science departments throughout the universities would go far to resolve the shortage of technicians and professional personnel so badly needed in the rapidly expanding health facilities of our Nation. Money appropriated as a departmental "institutional" grant stimulates not only graduate and medical education but all aspects including undergraduate education in the paramedical fields.

My enthusiasm for this supplemental institutional educational or training program does not preclude my support for the balanced program presently underway in the National Institute of Allergy and Infectious Diseases.

This program which places primary emphasis on the support of original research has been outstandingly successful as administered by NIAID. Its success should assure support in the future. Certainly, it should continue to be supported. The basic knowledge in immunology and microbiology now required by the surgeons to make practical the dream of successful organ transplantation will come from these programs.

There is still a tremendous amount of basic information required. Just tonight, Mr. Chairman, I am going to listen to Dr. Spiegelman over at the National Institutes of Health. He has been doing some basic research with ribonucleic acid. He has come up with a very fascinating piece of work which may have direct application in the leukemia-virus field.

Now, I will not belabor these essential matters. Certainly, we have some fine programs in antiviral substances; the streptococcal situation

is still with us; the slow viral infections are extremely important for possible etiologic agent in chronic disease.

Too, the support of selected special emphasis research in the important areas of antiviral substances, streptococcal diseases, and "slow-virus" infections should be supported. The intramural program of NIAID is doing outstanding research in these areas in collaborative efforts with universities and private industry.

Finally, the applied research aspects of the program, as manifest by development of vaccines, especially the respiratory disease vaccines, can save millions of dollars for the Nation.

These programs include development of vaccines, production of reference reagents, and the development of specific antisera used in the typing of tissues to assure the success of organ and tissue transplantation.

I regret that I have not had the opportunity to describe in greater detail the exciting areas evolving in the field of immunology and microbiology, which promise to bring greater rewards to the health requirements of our Nation. If I can answer questions or describe any of the program in greater detail, I shall be pleased to do so. Thank you.

(The attachment to Dr. Watson's statement follows:)

CITIZEN WITNESSES BUDGET FOR NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

[In thousands of dollars]

Activity	1968 appropriation	1969 President's budget	1969 estimated needs
Grants:			
Research	$52,936	$55,627	$65,000
Fellowships	4,267	4,362	5,800
Training	9,251	9,488	12,000
Total grants	66,454	69,477	82,800
Direct operations:			
Laboratory and clinical research	15,102	15,142	16,000
Collaborative research and development	11,025	12,034	13,000
Review and approval of grants	1,482	1,504	1,600
Program direction	359	405	400
Total direct operations	27,968	29,085	31,000
Total estimate	[1]94,422	98,562	113,800

[1]Cutback $1,422,000 from the 1968 President's budget required by H. J. Res. 888.

Mr. FLOOD. Thank you, Doctor.

STATEMENT OF DR. EDMUND KLEIN

Doctor Klein, we have been waiting to hear from you. Suppose you proceed.

Dr. KLEIN. All right, sir.

Mr. FLOOD. Where were you born?

Dr. KLEIN. In Vienna.

Mr. FLOOD. The great medical center.

Dr. KLEIN. Yes, sir.

Mr. Chairman and members of the committee, I am Edmund Klein, chief of the Department of Dermatology at the Roswell Park Memorial Institute in Buffalo, N.Y.

I appreciate this opportunity to report to you on the progress which has been made since last year when I presented to you a new approach to medical treatment, called immunotherapy of skin cancer.

Mr. FLOOD. We have heard you before. You are an old friend of the committee.

Dr. KLEIN. I would like to think so. These new advances will further provide benefits for millions of people. This recent progress is the result of the wide support which medical research has received in this country, to a large extent through your support of the National Institutes of Health. Of even greater significance than what has been accomplished in the immuno-therapy of skin cancer, the findings indicate that more important developments now lie in front of us.

As you may recall, the new principles and methods of medical therapy which I summarized for you last year were developed by utilizing the cause of one disease process, namely allergy, for the treatment of another disease process, namely cancer. These new treatment methods are based on entirely new concepts which have been translated into clinical effectiveness.

The new types of treatment were first used successfully by us for extensive skin cancers and precancerous skin conditions which were either very difficult or impossible to treat by other means. These new treatment methods, furthermore, are of importance to a number of other serious medical conditions. Since the principles of these methods are based on an allergic or immune reaction of the body, these are new forms of immunotherapy.

It is not entirely fortuitous that these principles were recognized in studies on the skin. When one deals with inherently complicated problems such as allergic diseases or cancer, it is easier to study them on the skin, because they are more readily accessible and more easily controlled, than to complicate matters further by studying them inside the body. For this reason we started some years ago to work on several generalized diseases which may affect the body anywhere and therefore manifest themselves on the skin. It became evident, first in animals, and then in man, that cancer located in the skin could be developed into a model system which may provide information of importance to disease inside the body.

In our studies on superficially located skin tumors we found that a number of chemicals produced allergic or delayed hypersensitivity reactions. Several of these chemicals, when applied to the skin after the patient had become allergic (hypersensitized), produced a marked inflammatory reaction. When such allergic skin reactions occur, they may be an indication of a very serious or even fatal process as in the case of penicillin allergy. The patient then should not have further contact with the allergy-producing substance.

Since, however, the allergic reaction took place on the skin we could see it and control it. We found that some of the chemical substances produced a much more intense allergic reaction in cancers and precancerous lesions of the skin than in the normal tissues. Had a similar type of reaction occurred inside the body, we may have missed it, since it would have been much more difficult to determine its nature.

The allergic reaction resulted in destruction of the malignant and premalignant tissues in the skin, while the normal skin was hardly or not at all affected. In fact, the normal skin grew and covered the areas

from which the cancers had been removed by immunotherapy. Healing proceeded with minimal or no scarring.

The principle of the immunotherapy methods consists of the following: A small amount of the drug which will produce an allergic reaction, is applied to a small area of the skin in the form of a cream or solution. Initially, there is no reaction. Repeated application of the drug, however, results in an allergic or hypersensitized state. This usually takes 2 to 4 weeks. Once the patient has become allergic or hypersensitized, the application of the sensitivity producing drug results in an onset of a reaction called the challenge reaction which may be of two types, an immediate and a delayed type of reaction.

An immediate hypersensitivity reaction is produced by soluble antibodies. This reaction may develop within minutes of exposure to the foreign sensitizing material.

In the delayed hypersensitivity reaction the allergy producing material causes white blood cells, believed to the primarily lymphocytes, to respond within several hours or days following exposure.

The challenge reaction results in severe damage to the skin cancers with minimal or no adverse effects on the normal skin. The cancerous areas turn red, become swollen and then blister. The blisters break and a crust forms which contains the dead remains of the cancer cells. In this way the cancer cells are destroyed and eliminated. After 4 or 5 days, the crusts begin to fall off, leaving normal skin in their place.

In patients with cancer involving large areas of the skin surface the challenge application of the drug is not limited to the sites involved by cancer. The drug is applied to the entire face, back, chest, or other large part of the body surface. Frequently, tiny areas which were not apparent before treatment, turn red indicating that small cancerous lesions are present. In this way it is possible to recognize these small cancers before they could otherwise be diagnosed. As a result of the reaction, furthermore, these early or small cancerous lesions also disappear. Similar reactions occur in patients with precancerous lesions of the skin. There is a large number of patients in this country with precancerous lesions resulting from sun exposure. These too, are benefited from the new forms of local treatment.

The new forms of treatment therefore result (1) in disappearance of extensive superficial skin cancers; (2) permit the early diagnosis of unrecognized cancerous lesions and consequently their removal before they become a clinically serious problem; and (3) allow the treatment of precancerous skin conditions thus preventing them from turning into cancer.

Since I appeared before you last year a number of further advances were made. We demonstrated that immunotherapy for skin cancer can be effectively carried out with chemicals which by themselves have no direct anticancer action. This observation is of fundamental importance, since it permits the conclusion that the body's own defense mechanisms may be induced to control a malignant disease. This is the essence of immunotherapy. It further has practical implications in that it permits us to use chemicals which may be less toxic to the normal tissues than most anticancer drugs.

Another new development is our findings that the induced capacity of the body to react against skin cancer can be transferred from one patient to another by injection of white blood cells which were obtained from the circulating blood.

During the past year we also found that another type of common skin cancer; namely, squamous cell carcinoma in situ, can be treated successfully by immunotherapy. The latter observation may be of particular significance in the treatment of squamous cell carcinoma which arises elsewhere in the body.

While these new findings are of substantial importance they represent a small number of the areas which require investigation in relation to the new principles and applications of immunotherapy. The lack of studies in other promising directions in this field is largely due to lack of funds.

I would like to suggest, Mr. Chairman, that the best mechanism for a program of immunotherapy research is a collaborative program in the Institute of Allergy and Infectious Diseases.

This view seemed to find acceptance last year. When the Labor/HEW appropriations bill was presented on the floor of the Senate, the chairman of the Senate Committee discussed the program and explained the addition of $500,000 to the bill to fund it. He said:

> The whole field of immunologic research is developing so rapidly that the Institute needs an additional sum above the President's request to take prompt advantage of the latest research findings. The new methods utilize allergic reactions which until now have been known only as the cause of disease. This new concept makes it possible to use the cause of one disease for the treatment of another. It is a challenging concept which calls for further exploration. The bill, therefore, provides $500,000 of the increase in immunology for the start of a collaborative program on immunotherapy. This program should extend current clinical studies, and it should examine underlying immunological mechanisms with a view toward applying the principles involved to other medical problems.

That was on August 2, 1967. The bill went to conference and while the increase was not agreed on in the conference, there was discussion of the item on the House floor and also a statement involving it on the Senate floor in the course of Senate adoption of the conference report.

In the House, on October 4, and again on October 26 of last year, members of the committee seemed to agree that $500,000 of the NIAID appropriation could be used by the Institute for funding the collaborative program.

And in the Senate, when the conference report was adopted, October 27, this statement was made by the chairman of the Senate committee:

> There was agreement * * * in the framework of the Institute of Allergy and Infectious Diseases on a $500,000 collaborative program on immunotherapy on skin cancer. I concur in the understanding expressed by the conferees in the House that this agreement still prevails and that (both these programs) can be funded within the funds now agreed on in this revised conference report.

I was informed, Mr. Chairman, that this indicated that the immunotherapy program would go forward. I am not familiar with the intricacies of the budget procedure so the only view I can express to you now is that the program has not been funded in this fiscal year which ends on June 30. There are 2 full months and a few days left of the fiscal year. I would hope that something might be done in that remaining time. Whether it is or not, I respectfully request this committee to fund the program in its fiscal year 1969 budget and in doing so to make it clear that the funding is to be done on a collaborative basis in the intramural program of the NIAID.

It is my judgment, and the judgment of the other 10 scientists with eminent qualifications in the various aspects of immunotherapy, that

this mechanism is the one which would yield the greatest results for an investment made by the Federal Government. It is true that any research financed by the Institute in support of the immunotherapy program whether it is done in the form of an individual grant or a collaborative project, will make some contribution to the ultimate end we are seeking. It continues to be my view that the most effective use of Federal funds can be made in the mechanism of the collaborative program. I therefore urge that this provision be made by the committee.

Thank you.

STATEMENT OF DR. DAVID M. HUME

Mr. FLOOD. We will now hear from Dr. Hume.

Dr. HUME. My interest is in transplantation and immunology, and I have prepared a little statement replete with typographical errors. I would like to paraphrase that and also tell you what happened to me last night, which I think illustrates some of the problems before us at the present time.

It may be of some interest to you to know that there have been at least 28 different organs or tissues transplanted through the years.

Mr. FLOOD. What happened last night?

Dr. HUME. What happened was we got a call from Norfolk, from a doctor down there, who said he had a patient, a young boy hit by a car and dying. His parents indicated their interest in donating the organs. He wondered if we could use the kidneys. We sent for some blood which he sent up to us.

Mr. FLOOD. Why would he call you?

Dr. HUME. He would call us, first of all, because we are known to be interested in transplantation; secondly, because we have been to Norfolk and had explained the problem there. We had appealed to them as another area where we might harvest cadaver organs, both Norfolk and Charlottesville, one 100 miles and the other 70 miles from Richmond. Each of these two areas has agreed to help us collect organs for transplantation.

He gave us a call. He sent down some blood on the patient. We carried out tissue typing on the blood he sent us and found this patient corresponded very closely to one of the patients we had on chronic dialysis in our unit. We then sent two of our men down there and when the patient died they took the kidneys out. They were brought back by a police car at I think about 120 miles an hour.

From the time the patient died to the time we had the kidneys in our operating room, 100 miles distant, was 1 hour, 40 minutes. We then carried out the transplant last night and the patient is doing well this morning.

This illustrates two or three things. First of all, it illustrates the importance of tissue typing because whether or not a transplanted organ is accepted depends on whether or not the donor and the recipient are similar to each other. The only way to find out is typing to see if they compare favorably. This has been a very important advance in transplants.

Mr. FLOOD. Did you ever do it yourself?

Dr. HUME. Yes, sir; I have done it myself.

Mr. FLOOD. Are you a surgeon?

Dr. HUME. Yes, sir; I am a surgeon. I am very much interested in transplantation. I have been working in this field for 20 years. I have spent at least 5 years full time in the lab, the first of which was with our colleague and surgeon, Dr. Hufnagel. The two of us were in Harvard 20 years ago. He was interested in blood vessels and I was interested in transplantation. We worked side by side at that time.

It illustrates a second thing, which is the problem in logistics and preservation of organs, both of which are important and expensive. It occupied the time of many people in Norfolk to collect this kidney. It occupied the highway department and the State police getting it down to us.

The preservation of the organ had to be carried out by two of our men who went down to preserve it in a living state until we had time to put it in. These are all areas of interest and important in transplantation at the present time.

The other thing that illustrated is the fact that the donor and recipient were both children. It has been of great interest to us that amongst all of the people that we have transplanted, and we have done 140 kidney transplants in patients, the best group of all have been the children. They have done better than any of the other groups. We have only lost one child out of the 16 transplanted. That child died of cancer 2 years after the transplant.

The other thing I would like to briefly go into is the fact that at the present time although clinical transplantation is carried out as something of a routine at the present time. As I say, we have done 140 of them. There are still many problems in transplantation not yet solved. I think at no time in history has there been a greater likelihood these problems will get solved than at the present time. The tools we have available to us are better than any we have had before, and the need for research in the field is greater than at any time in the past.

In addition to tissue typing, one of the other things that has been interesting has been the fact that once a kidney is rejected it is possible to transplant the patient again.

It has been possible to transplant. We have transplated 12 patients a second time. We have got a third kidney transplant, which is over 3 years from transplantation, after the earlier ones had been rejected. It is possible to retransplant somebody if the first transplant fails. The likelihood of failure of the first transplant is going to be less and less as we get better and better typing.

I would like to say a word or two about transplantation of the heart. I might say that since we did our first clinical kidney transplant it has been 17 years. At that time there was no television, newspaper, or radio coverage of the events. In fact, no doctors in the institution were very much interested in it. The only people really interested were the patients. We had a stake there, myself and my two colleagues. At the present time, transplantation has become very much better known, primarily through transplantation of the heart.

Heart transplantation obeys all of the laws of transplantation of any other organ. Tissue typing is just as important in heart transplantation as it is in kidney transplantation. This is a fact sometimes not recognized. Hearts are sometimes rejected and when they are, they stop functioning and the patient who bears the heart dies.

The rejection of the heart which has been worked out by my colleague, Dr. Lower, takes the form of narrowing the coronary arteries.

Gradually as times goes by, the coronary arteries get smaller and the blood supply becomes less and less and the heart fails. No clinical transplant can be thought of as a success until at least 2 years have gone by. The possibility of rejection can take place up until that time.

We know one fact: If at 2 years the organ is functioning very well and the test indicates there is no rejection going on, there is a 100-percent likelihood of success through the years up until 6 years, which is as long as we have done it. Up until 2 years you cannot really breathe easily until that period of time has gone by.

It has been demonstrated that hearts can be taken from people who are dead. In fact, my colleague, Dr. Lower, before the first clinical heart transplant could be done, demonstrated that you could take a heart out of a dog after the dog died and wait 30 minutes, wait and put it in the ice box for 6 hours, take it out of the ice box and put it in a second dog whose own heart can be taken out, shock the heart and the next day or a couple was running around.

I would like to say just a word or two about the fact that transplantation research has been somewhat unique in that it is an area developed in the laboratory, has then gone to the direct clinical application, saved patients' lives. Things which have then been learned from patient experience have gone back to the lab to improve our knowledge there. It is a thing which has moved back and forth between lab experience and clinical trials. For this reason I think the funds are needed to support both laboratory investigative work and clinical investigative work in transplantation. Clinical investigative work becomes patient treatment when it works.

Mr. FLOOD. Where do you get the money for your activities?

Dr. HUME. We get our money from the NIH. Before the NIH stepped into the picture, our hospital spent $140,000 for the first 6 months of our operation in clinical transplantation. Then we got a grant from the NIH which supported our work since this time.

The transplantation experimentation is very expensive because it does involve patient work. It does mean having patients in the hospital for long periods of time. It does involve having some kind of device to keep the patient living in. In the case of the kidney, an artificial kidney. In the case of the heart transplant it is a heart machine of some kind to keep the patient alive. There is no conflict at all between transplantation and any sort of organ, mechanical device to keep the patient living. You can not carry out a transplant on somebody who is dead. You have to keep them going with some kind of a machine. If the transplant begins to fail, you have to find some way to keep him alive.

One of the real problems in liver transplantation is there is no machine anybody devised to take the place of a liver. It is a very complex organ and for this reason we have——

Mr. FLOOD. The liver is a very large organ; is it not?

Dr. HUME. It is a very big thing and complex thing. It is a very difficult organ to replace. tI is sophisticated and complex. One of the ways we have been doing it is to exchange all the blood in the body. We take the blood out and replace it with other blood. Each time you do this it costs $500.

Mr. FLOOD. Can you transplant a liver?

Dr. HUME. Yes, it is done; and there are patients living now with liver transplants. It has not hit the 2-year mark yet, which is the key time to judge all transplants. One of the things that we have tried to

do and are doing—try to keep people living whose livers have failed until we can transplant them—is to take baboons, put them on a heart-lung machine, wash out their own blood, cool them down and then we replace their blood with human blood. Warm them up and the baboon temporarily becomes a human being.

One of the things I would like to say in conclusion is that first of all, transplantation experimentation is important, not only for its basic knowledge, not only for the fact it saves lives at the present time, but also for the fact that it gives us knowledge in the prevention of disease. For example, what we have learned about transplantation immunology and kidney transplant has helped a good deal in the understanding and prevention of kidney disease itself.

The second thing is that transplantation immunology is closely related to other fields, such as the collagen disease, arthritis, and cancer, which is in itself perhaps an immunological disease. Some of the things that we learned from that are maybe applicable to the treatment of rheumatic fever, arthritis, and cancer. I think it is very important from this point of view, too.

The final thing I would like to say, which is something I guess you hear every day, is the fact that money is needed in this field.

Mr. FLOOD. Yes. We hear that every day.

Dr. HUME. I would like to give you a couple examples.

My colleague, Dr. Lower, whose work is, I think, in experimental heart transplantation, is perhaps as good as any work that has been done in this field anywhere in the world. He had sent a modest grant request to the NIH for $45,000 per year. The grant was granted for a 3-year period, but the amount of money available to him was reduced to $25,000. At the end of the first year while applying for the funds for the second year of the grant, he made a request to up this to $31,000. Instead of that, they cut it to $17,000. This was not because they did not think the work was good, which they did, but there were not any funds available for it.

During this past year, our own work in kidney transplantation, liver transplantation, heart transplantation, has come to a virtual halt for lack of funds. Our efforts to expand our transplantation experiences into VA, where we want to build another transplant unit, at the present time are stymied because there are no funds available in the VA for this purpose.

Our own research has been severely damaged by the lack of funds.

Mr. LAIRD. I don't know who told you the NIH doesn't have funds available. They have funds available.

Dr. HUME. We have observed two grants in the last year—one I know got good priorities—which were granted by the study agency which we were told would be funded, one of which was reduced and the other no funds were forthcoming at all. I can document this for you.

Mr. LAIRD. The problem is that the funds may not be available to you, but they are available to the NIH.

Mr. FLOOD. That is right.

Go ahead.

Dr. DEBAKEY. I think it is important and ought to be clarified. This applies to many, many other areas. The point Dr. Hume is making is extremely important, and the point I referred to earlier; that is, that

we are not only being stymied but research is now coming to a halt in many very good labs where this type of knowledge and pioneering information is the place that it comes from.

The money is not available to him even though the procedure of grant approval has been gone through. It receives a high priority but whatever institute has it says "We are out of funds." What is important here is the distinction in the fact money has been appropriated for this purpose but it is not available to be spent for this purpose.

Dr. Hume. If you take the Heart Institute, my understanding is that their budget for the next year is a couple million dollars more than it was for the past year.

Dr. DeBakey. Less than a couple million dollars; it is $1,700,000.

Mr. Flood. Mr. Laird made the point, which is correct, about the availability of the funds. What about that?

Dr. Hume. All I can say is that they have not come through, as I understand it. I am on one of the study sections of the Heart Institute. We are constantly told that there are not enough funds to supply all the grants that we would approve. If the NIH wanted only to continue the support of the ongoing projects for the next year, they would not have enough money to do it because the cost of each project has gone up from the previous year. They did not get enough of an increase to even support the cost-of-living increase for the projects now going on.

They could not possibly take on any new projects if they continue to support the old projects. As I understand it, there are not funds available for new projects at the present time, if the old projects are supported. There are not enough funds to support even the old projects because of the increase in the cost of living. This lack of funds in this area is a very serious matter. It is something we hear about every day.

I think those are the points I would like to make. I think this is an important area for research, it is an important area for patient care and it is underfunded. The amounts of money available at the present time in NIH for transplantation research are insufficient to support the good programs in transplantation research now going on in our country. Our country is preeminent among all the countries in the world in transplantation research.

Mr. Flood. What about South Africa?

Dr. Hume. They are way behind us in transplantation research. In fact, they are novices in the field. The person involved in the transplantation came to our country to learn about it.

Mr. Flood. Minnesota?

Dr. Watson. Yes; he came to my institution, the University of Minnesota.

Dr. Hume. As far as their work in transplantation is concerned, it is way behind many other countries. As far as kidney transplants, they have done very few. Their knowledge in this field is way behind that of other countries. This country is preeminent to any country in the world. What we need are more funds. What I really would like are two things. One, more funds for the NIH in general, so that they can support good research projects in any field because there are a lot of good research projects that are not now getting support. Secondly, I think it would be of help——

Mr. Flood. How do you want them to allocate the funds?

Dr. HUME. I think the technique for giving funds now in NIH are very good, on a competitive basis, but I also would like to see some funds earmarked for transplantation because this is an expensive kind of research.

Mr. FLOOD. Well, you are a very refreshing and a very interesting witness.

Dr. HUME. Thank you, sir. I enjoyed coming, and I appreciate the opportunity.

Mr. LAIRD. I was glad you made the point in your testimony that NIH had helped in doing the basic research that was needed for the South African display. It just seems to me that we have failed to publicize the fact that the people of this country, through the taxes they have paid and the support they have given to NIH, made it possible.

Mr. FLOOD. Yes, that is a very good point.

Dr. HUME. Yes.

Mr. LAIRD. Their work wouldn't have been possible without the kind of work that you have done and the kind of work others have done under NIH grants here in the United States. We fail to communicate that very well. I think it is good that you made that point.

Mr. FLOOD. I agree. That is very well said.

Dr. HUME. The transplantation of two hearts into two patients hasn't really added a great deal to the knowledge of transplantation overall. There have been many places that have been ready to transplant hearts for a long time.

Our own institution has been ready for 2 years. We have had four instances in which we nearly transplanted a heart except that the criteria for selection of recipients has been a stringent one. Namely, they have to die before they transplant, they have to die within a matter of an hour or two. This is why we haven't done a dozen heart transplants in the last 2 years.

Mr. LAIRD. The work in research has made it possible. This work is more important than the transplant itself.

Dr. HUME. Right. Long before the transplantation it had been demonstrated that you could take a heart out of a cadaver and make it work. We have done it by taking a human heart and putting it in a baboon.

Dr. DEBAKEY. I think an important point is that NIH is really undergirding the field of medicine in this country.

Mr. LAIRD. And the world.

Dr. DEBAKEY. And the world. That is why I said that earlier.

Mr. FLOOD. Gentlemen, we are very pleased with your testimony. This was a marvelous presentation this morning. One of your very best, Dr. DeBakey, and you are an old hand. This young man here, Dr. Hume, is a fine witness.

By the way, I would like the record to show that we have present Col. Luke Quinn, who is an old friend of Dr. DeBakey, I understand.

Dr. DEBAKEY. Yes, he is.

Mr. FLOOD. And he is a highly respected friend of this committee. He has been of great help to the Congress during the past 20 years and is held in the highest esteem by its Members.

Dr. DEBAKEY. Thank you. Thank you so much.

Mr. FLOOD. We will come back at 2 o'clock.

WEDNESDAY, APRIL 24, 1968.

CANCER

WITNESSES

DR. SIDNEY FARBER, PROFESSOR OF PATHOLOGY, HARVARD UNIVERSITY MEDICAL SCHOOL, BOSTON
DR. HOWARD E. SKIPPER, VICE PRESIDENT AND DIRECTOR, KETTERING-MEYER LABORATORIES, SOUTHERN RESEARCH INSTITUTE, BIRMINGHAM, ALA.

STATEMENT OF DR. SIDNEY FARBER

Mr. FLOOD. We will now hear Dr. Sidney Farber.

We will place in the record his statement, which is as impressive as it should be from an old friend.

Dr. FARBER. Thank you very much, Mr. Chairman.

(The statement follows:)

STATEMENT OF DR. SIDNEY FARBER, S. BURT WOLBACH PROFESSOR OF PATHOLOGY, HARVARD MEDICAL SCHOOL; DIRECTOR OF RESEARCH, THE CHILDREN'S CANCER RESEARCH FOUNDATION, BOSTON, MASS.; PRESIDENT-ELECT, THE AMERICAN CANCER SOCIETY; MEMBER, NATIONAL ADVISORY CANCER COUNCIL

Mr. Chairman and gentlemen of the committee, once more I am grateful to you for this opportunity to testify before this committee. It is my privilege to appear before you in behalf of the American Cancer Society, and as a private citizen, to speak of the needs for cancer research throughout the country, and specifically to present to you the American Cancer Society's recommendation for an appropriation for the National Cancer Institute which we call the citizens' budget.

I am very happy to share this opportunity with a fellow member of the National Advisory Cancer Council, Dr. Howard Skipper, who is scientific director of the Southern Research Institute in Birmingham, Ala. His contributions to basic cancer research of greatest importance to the patient, particularly in the field of chemotherapy of cancer, are landmarks in the history of cancer research.

The citizens' budget we present to you today is in the precise amount we recommended 1 year ago. Permit a word of explanation for a recommendation at this time in the history of our country when talk of reductions in expenditures rather than increases are heard in many places. We well understand the enormity of the problems which face the President and the Congress. We understand fully that many grave needs for support from Federal funds are being examined by you at this critical time. We know that priorities must be established by you. It is our responsibility only to place before you as accurate an estimate of the amount of money which we believe can be spent prudently and effectively in and through the National Cancer Institute to permit the full utilization of our potential for rapid progress in cancer research in the country as a whole. We wish to convey to you our belief that the amount recommended can be justified on the basis of past accomplishment of the National Cancer Institute programs, as well as on the basis of pressing present needs. We want to make clear that when the great pressures upon our national economy are relieved hopefully in the near future, men and women in large numbers, expert in the various fields of basic research and clinical investigation in the field of cancer are ready to expand their programs in institutions from coast to coast. It is with this understanding that we present the citizens' budget for fiscal 1969.

The citizens' budget represents the recommendation of the board of directors of the American Cancer Society. It has the approval of members of the National Advisory Cancer Council who met as a group of citizens deeply interested in the progress of cancer research. We make this recommendation for the National Cancer Institute because of our special knowledge and interest in this field, with the hope that the many research programs of the several institutes comprising the National Institutes of Health will receive the support commensurate with the gravity of the problems with which they are concerned and the ability of the scientists and doctors of the country to solve them.

We shall divide this recommendation into two parts.

Part 1 includes the recommendation that $61,293,000 be added to the President's budget of $187,707,000 for a total of $249 million. This amount is for the support of expanded programs of the National Cancer Institute, both for grants and for the direct operations in the manner to be described below.

Part 2 is a recommendation for greatly expanded support of the present large centers of cancer research and clinical investigation in the United States and for the expansion or creation and support of similar centers in 20 sites in the country, in the amount of 41 million. In addition, we emphasize that an additional sum of $10 million is required for the start of a nonmatching construction program in such cancer research centers to provide facilities which are badly needed.

We include part 2 for information to your committee concerning what we regard as the most effective method of accelerating progress in the control of cancer when funds become available for this purpose.

Citizens' budget—Part 1

(An addition of $61,293,000 above the President's budget.)

The justification is made for additions in the following areas:

1. Grants

(*a*) Research, difference of $24 million.

1. Regular research projects: It is estimated that the President's budget would permit payment of only 60 percent of the research applications which will receive approval. Additional funding is needed also for the General Research Support Grants.

2. Specialized research centers: This would allow for a moderate expansion ($10 million) for clinical research centers, and radiotherapy centers to be distributed throughout the country for better geographical distribution.

3. Program support for patients with leukemia, Hodgkins' disease, and lymphoma under clinical investigation who can be treated as outpatients.

(*b*) Training grants, fellowships, research career development awards and other training grants for a total of $7 million above the President's budget.

There is critical need for support for the training of scientists and doctors in cancer research, and for the creation of more stable positions for scientists and doctors who choose cancer research as their field of permanent activity.

2. Direct operations

(Increase of $30,293,000 above the President's budget.)

Collaborative research and development in the areas of—

Immunology.

Causation of cancer (carcinogenesis).

Viruses and cancer.

Clinical trials of new anticancer chemicals.

Increased support for Cancer Chemotherapy National Service Center, which serves the country.

The special virus-leukemia program.

Special instrumentation development.

Expansion of biometry, epidemiology, and field studies in the identification of occupational hazards which may cause cancer, or

The study of special populations which have a high incidence of cancer in one or another part of the body, and finally

The increase in support for task forces in the fields of cancer of the lung, the intestines, the prostate, the bladder, and the uterus.

Summary of part 1 recommendations

Grant support	$24,000,000
Training grants	7,000,000
Direct operations for purposes stated above	30,293,000
Total above the President's budget	61,293,000

Total citizens' budget, fiscal year 1969

1. President's budget	$187,707,000
2. Increase for programs of National Cancer Institute (pt. 1)	61,293,000
Total	249,000,000
3. Part 2—Comprehensive expansion and creation of cancer centers as soon as funds are available	51,000,000
Total	300,000,000

Dr. FARBER. Mr. Laird, Mr. Smith, and members of the committee, I regard it a privilege to be here once more to speak as a representative of the American Cancer Society and also as a private citizen in behalf of the appropriation to be spent in and through the National Cancer Institute for the support of work carried out throughout the country, including the National Cancer Institute in Bethesda.

I am delighted at this time to have as my colleague, at your invitation, Dr. Howard Skipper, who is a professor of pathology at the University of Alabama and head of the cancer research in the Southern Research Institute in Birmingham, Ala. He is a member of the National Advisory Cancer Council, as I am, and we have worked together on committees and research enterprises for more than 20 years. He is one of the pioneers in the field of cancer chemotherapy, which has grown so rapidly since the end of World War II.

May I say a word before coming to the recommendation of the board of directors of the American Cancer Society? It is also the opinion of the National Advisory Cancer Council members who met as private citizens to discuss what we call the citizens' budget.

The magnitude of the problem of cancer is well known to this committee. There has been a tremendous development in the sciences basic to all medical research in the last 20 to 25 years, and cancer researcch has benefited from advances in all fields of medical research.

We are asked constantly whether there has been any progress in the last 20 to 25 years, following the beginning of real support given through the Congress of the United States.

Mr. FLOOD. Is a virus the cause of cancer?

Dr. FARBER. There is no question that a virus is implicated in the causation of forms of cancer that we find in the mouse and in the rat, in the chicken, and in other forms of life. In the case of leukemia, for example, so far there is great evidence that a virus will be implicated in an important way in the causation of leukemia in man, but the final proof is not yet at hand.

The largest program ever conceived and brought into being on the question if virology in the field of cancer has been underway for several years under the direction of Dr. Kenneth Endicott of the National Cancer Institute. I would say that a remarkable amount of progress has been made by him and his colleagues in the Cancer Institute and the many cooperative groups throughout the country in a study of the fundamental questions which will finally bring an answer.

There has been a reduction in deaths from those who do have cancer, as can be seen from the percentages which have been given over the years. When I entered the field in the 1920's, one out of six patients with cancer was being saved, mainly by the techniques of surgery.

In the 1930's, this changed to one out of five, when radiotherapy became more developed and used in addition to surgery. When finally in

the period since chemotherapy, the use of chemicals in the treatment of cancer, the percentage is now one out of three.

The statement is made, and this can be substantiated by experts in the field, if all the knowledge available today could be applied to every man, women, and child with cancer, we could raise this number of cures to one in two with the knowledge available today.

Mr. FLOOD. What do you mean by cure?

Dr. FARBER. By cure I mean something more than a 5-year survival. I mean cure.

Mr. FLOOD. Five years? What does 5 years mean?

Dr. FARBER. It means the yardstick which was used for many years, which was called cure, when patients with cancer survived without any evidence of cancer 5 years or longer. We would like to wait more years than that to speak with certainty of cure, except in the case of certain forms of cancer when we know that if a patient is alive with no evidence of cancer for 5 years, it is likely that he is cured.

Mr. FLOOD. How often should a pap test be done?

Dr. FARBER. I advise that this be done every 6 months. The usual advice is once every year.

Mr. FLOOD. That is the test to detect cancer of the uterus?

Dr. FARBER. Yes, Mr. Flood. It is the same test we now use for testing sputum to see if there is lung cancer.

Mr. FLOOD. Doctor, is it expensive to have a Pap test?

Dr. FARBER. No. About $5 in most cases.

Mr. FLOOD. Can you go to the family doctor?

Dr. FARBER. Yes; he can do it or in clinics that are set up for the purpose, a trained nurse specially trained in this procedure can carry it out.

Mr. FLOOD. This is not a difficult procedure?

Dr. FARBER. No; but there is a limiting factor. There are not enough technicians in the country trained to make the test available to every woman in the country over the age of 25, let us say. We hope that automation will soon bring a solution to this problem. It is something that if properly applied to every woman regularly once a year would cause a very marked reduction in the deaths caused by cancer of the uterus. This is one of the few diagnostic tests that we have. What we lack today and need very badly is a simple, inexpensive diagnostic test that is absolutely reliable, and inexpensive and one that we could carry out on the population as a whole at regular intervals. We do not have such a test for cancer, but if one could be devised, it would help to solve one of the important obstructions to progress that we have in the early detection of cancer throughout the country.

Mr. FLOOD. Do you think the cause is a virus basically?

Dr. FARBER. I think that a virus will be of great importance in some forms of cancer, if not in all. It will not be the only factor.

Mr. FLOOD. Can you develop a vaccine?

Dr. FARBER. That will depend entirely on whether the virus will cause changes in the body in the formation of antibodies so that the body can then have defenses against the virus. That may not be the case. It may be that we will have many different viruses as the cause of the many different diseases that we call cancer. It is possible that there will be found a biochemical factor which is responsible for the changing of the normal cell into a malignant cell.

If only we had the diagnostic test that could tell us when there is the presence of something within the body that is changing these normal cells to malignant cells, we could then apply a biochemical approach to the control of that cancerous process before it becomes an actual swelling or tumor, before the tumor destroys organs or tissues or spreads to other parts of the body.

There have been great developments even in the past year in the field of cancer research. Some of these have been in the basic science laboratories from which the final solutions must come; and Dr. Skipper will tell you about some of these, because the work that he is doing is in the field of basic science in cancer. His contributions have already been of fundamental importance to clinicians who deal with the problem of cancer in man.

I brought two photographs with me, Mr. Chairman and gentlemen, if you care to look at them, to illustrate what chemicals alone can do in the treatment of cancer. This first photograph is of a child with a tumor of the lymph node. You will see what chemicals have done when injected in the bloodstream or into the muscle or even taken by mouth within a 10-day period. You can see the disappearance of the masses.

Here is a photograph of a child with acute leukemia more than 10 years after the onset of disease. She looks like a normal child, but she is not cured.

Mr. FLOOD. Leukemia becomes progressively worse; doesn't it?

Dr. FARBER. It does if there is no treatment. It is still a disease for which we have no cure. We do have at least eight chemical discovered over the period of the last 21 years, which can temporarily destroy the lukemia cancer and cause the patient to return to an apparently normal state of health.

Mr. FLOOD. What is lukemia; something with reference to the bloodstream?

Dr. FARBER. That is a form of cancer which arises in the bone marrow and in the bloodstream, and in many organs and tissues of the body. It is a cancer which you can not cut out. The surgeon is of no help here because it is everywhere in the body.

Mr. FLOOD. It is not contagious?

Dr. FARBER. It is not contagious as far as we know at the present time. This is a disease which 20 years ago caused death in the vast majority of patients in a few weeks to a few months. Life has been prolonged by the use of chemicals so that 50 percent are alive now a year and a half after the onset, and 10 percent 32 months later are still alive. Of the children, only 1 percent are alive from 5 years to 15 years. We must not use the word "cure" as yet. There is great hope from the research not only in chemotherapy but also in the field of immunology that the two approaches together will finally destroy the last remnant of the leukemia which we are not able to destroy completely today.

Mr. FLOOD. How many forms of cancer are there, in round numbers?

Dr. FARBER. About 200 different forms of cancer. There are 20 which comprise, let us say, 90 percent of the forms of cancer. Six forms of cancer account for 50 percent of the total number.

Mr. FLOOD. Are they all killers?

Dr. FARBER. If we use the word "malignant" tumor, we mean the cancer will kill if it is unchecked or untreated. The only forms of treatment we have are surgery—when that is possible, and that is not

always possible—radiotherapy, and chemotherapy now; and in the near future, we hope, immunotherapy.

Mr. FLOOD. What do you mean by chemotherapy?

Dr. FARBER. The use of chemicals.

I would like to make a point about chemotherapy, gentlemen. For a long period of time before we were born, as a matter of fact, a few hundred years, there was great hope there would be found chemicals which would destroy cancer.

Mr. FLOOD. When was that? Who first though of that?

Dr. FARBER. It was at the turn of the century that the German Paul Ehrlich, who gave us the first treatment for syphilis, Salvarsan, developed a field which we call chemotherapy in the modern sense.

Mr. FLOOD. What would you say the prospects were for a vaccine for cancer?

Dr. FARBER. Mr. Chairman, I think that I have never indulged in either wishful thinking or in prediction except on the basis of solid accomplishments of research. I think that it is possible to say this and find agreement among men in the field of cancer research today: First, there are more experienced men who can carry out sophisticated research in institutions prepared for this task than ever in the history of medicine. Second, there have been great advances in the treatment of cancer and we are actually curing a few forms of cancer which were incurable just a few years ago. The choriocarcinoma of the uterus and cancer of the kidney, for example, even after spreading to the lungs, can be cured today, and these were incurable after spreading to the lungs 10 or 12 years ago.

Mr. FLOOD. What does "carcinoma" mean?

Dr. FARBER. That means cancer of tissues, such as the lining of the intestine, lining of the uterus, the lining of the mouth, lining of the stomach. I should have used it for the word "cancer" as a better term to cover all forms of cancer.

Mr. FLOOD. How do you get cancer?

Dr. FARBER. The causes are numerous.

In the case of most kinds of cancer in man, we do not know precisely. There are causes of cancer that are well known. For example, we do know that leukemia can be caused and has been caused by the use of radiation, as we know, from the atom bomb in Hiroshima and Nagasaki, or as we know from people accidentally exposed to large quantities of radiation, and so on. We know that we can get skin cancer from long and injudicious exposure to the sun. Also if X-rays burn the skin we can get cancer.

We know that in certain industries, workers exposed to certain chemicals can develop cancer.

Mr. FLOOD. In other words, you can get cancer by doing something wrong?

Dr. FARBER. Yes. Our greatest hazard today in the causation of cancer perhaps lies in the pollutants which enter the air or which may enter the food.

Mr. FLOOD. How do you produce cancer in animals?

Dr. FARBER. We can produce cancer in the mouse or in the experimental animals in a variety of different ways, including the use of viruses or chemical poisons or radiation.

Mr. FLOOD. Mr. Laird?

Mr. LAIRD. I have no questions, Mr. Chairman.

Mr. FLOOD. Mr. Smith?

Mr. SMITH. I have no questions.

Mr. FLOOD. Thank you very much, doctor.

Dr. FARBER. May I refer you to my prepared statement for the citizens' budget recommendation recommended by the American Cancer Society?

STATEMENT OF DR. HOWARD E. SKIPPER

Mr. FLOOD. Thank you again, Dr. Farber. Now we will hear from Dr. Howard Skipper, vice president and director of the Kettering-Meyer Laboratories, Southern Research Institute, Birmingham, Ala.

Dr. SKIPPER. Thank you, Mr. Chairman.

Mr. FLOOD. How long have you been in Alabama?

Dr. SKIPPER. About 25 years.

Mr. FLOOD. You are one of the Sloan-Kettering group?

Dr. SKIPPER. I have been working with them for many years. Dr. Kettering was a very dear friend of mine. He set up the institute. I will try to tell you something of our present basic understanding of the problem of treating disseminated cancer.

It has taken scientists and physicians—working in concert, with support made available by the Congress, the American Cancer Society, and a few foundations—20 long years to reach this point of basic understanding. I am quite certain that this knowledge will make future research on the treatment of cancer more efficient, effective, and rewarding.

I can best begin by relating to you some very simple experiments on a single type of cancer—transplantable leukemia in the laboratory mouse. In many respects this mouse leukemia behaves much like human leukemia but, as I shall point out later, it differs in one very important respect. The existence of this difference was a lucky break because the discovery of this difference has helped us define some of the major stumbling blocks to successful treatment of other types of disseminated cancer.

First, if one takes a drop of blood—which may contain 100,000 leukemia cells—from a leukemic mouse and, with the help of a fancy piece of equipment called a micromanipulator, picks out a single leukemia cell and carefully injects it into a healthy mouse, the following will happen:

(*a*) That single leukemia cell will divide and form two; these two will form four and four will form eight, eight will form 16, 16 will form 32, et cetera, until the number reaches 1 billion at which time the mouse dies.

(*b*) It will take about 15 days for that single leukemia cell and its progeny to proliferate to 1 billion leukemia cells—the lethal number.

What does this tell us?

(1) It means that, on the average, our single leukemia cell and all its progeny were dividing or doubling in number every one-half day—quadrupling in number every day.

(2) It means that in order to cure this mouse leukemia we must kill every leukemia cell in the animal no matter where it is; that is, bone marrow, spleen, liver, lungs, brain, et cetera. If there were 1 mil-

lion such cells in the animal when we started treatment and our treatment killed 999,999—leaving one living leukemia cell—we would have failed, because that one malignant cell would give rise to 1 billion (the lethal number) 15 days hence.

(3) It also means that if we are to cure this leukemia when it is widespread—which, of course, is impossible to do surgically—we must choose drugs which will travel to every organ and tissue of the body and, once there, selectively kill leukemia cells. Furthermore, we must choose dose levels and spacing between them which will kill leukemia cells faster than they are being replaced for long enough to reduce the number to zero—and without ever overdosing the animal.

Once we began to understand the criteria embodied in this simple principle and knew how fast our mouse leukemia cells were doubling, we and others rather quickly learned how to select dose levels and the optimal spacing between them that would kill leukemia cells faster than they were being replaced, and cure animals bearing 10 to 100 million leukemia cells spread throughout every tissue and organ in the animal's body.

So far, this principle of optimally matching drug doses and intervals with the doubling time of cancer cells has produced what appear to be "cell cures" in only two or three types of disseminated human cancer. It may prove useful in others in the future; we honestly don't know and won't know until we can learn how fast the many types of human cancer divide and can begin rational matching trials. At this time we anticipate one major hurdle which I will illustrate in a moment.

I told you earlier that our mouse leukemia cells have a doubling time of one-half day; human cancer usually does not grow so rapidly. Acute human leukemia has a doubling time of about 4 days and cancer of the breast in women about 30 to 60 days. Much nationwide collaborative effort is underway with funds made available by Congress through the National Cancer Institute to—

(*a*) Determine just how fast the cells of many different types of human cancer divide and how many are dividing at a given time, and

(*b*) Select the best drugs, doses, and spacing between doses for treatment of the most important types of human cancer.

Earlier I said that the mouse leukemia model behaves like human leukemia (and other types of cancer) in many respects, but it differs in one very important respect. Obviously, knowledge of this major difference is important because we would like to be able to do for all types of disseminated cancer what we can do for disseminated mouse leukemia—and, at the present time, we certainly cannot.

It is almost an axiom in science that once you know what your problem is and can define it in some detail, future research can be designed more rationally and meaningfully, and progress is usually more rapid and rewarding. I suspect that we can now define one of our major stumbling blocks in terms of the major difference between (*a*) our mouse model and those few disseminated and rapidly growing human cancers that can be cured by drugs today, and (*b*) those which respond much, much, less favorably.

More specifically, in almost any cancer cell population (tumor) we have three types of cancer cells:

Compartment A: Dividing cells (which are very sensitive to our best drugs and can be eradicated).

Compartment B: Temporarily nondividing cells which can revert to compartment (while these cells are not dividing, they are partially or completely insensitive to drugs).

Compartment C: Nondividing cancer cells which have lost their ability to divide—forevermore (these cells are of little concern to us since, in time, they will die and be resorbed).

If a cancer (like our model leukemia in mice, or choriocarcinoma in women, or Burkitt's lymphoma in children) has a high percent of cells in compartment A and a low percentage in B, our chances for chemotherapeutic eradication of widespread disease are good. However, if the ratio is reversed (low A, high B), the problem is quite different and much more difficult. The major problem which now faces us is to learn how to manipulate compartment B—drain it into A or C. I have faith that scientists and physicians will now be able to concentrate on this problem and learn how to circumvent it.

When control of disseminated cancer is achieved, history will probably relate that it wasn't done in a very dramatic fashion—in one quick stroke or "breakthrough"—but instead was done in a stepwise manner by many dedicated men building on each past failure and success.

Thank you.

Mr. FLOOD. Thank you very much Dr. Skipper. You and Dr. Farber were very kind to come here today and testify to this committee. We appreciate your testimony and we want to thank you for taking the time to come here to Washington to perform this public service.

CHILD HEALTH

WITNESSES

DR. ROBERT COOKE, PROFESSOR OF PEDIATRICS, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD.

DR. ALAN GUTTMACHER, PRESIDENT, PLANNED PARENTHOOD WORLD POPULATION, NEW YORK CITY

Mr. FLOOD. Dr. Cooke, proceed.

Dr. COOKE. Mr. Chairman and members of the committee, I am Dr. Robert E. Cooke, professor of pediatrics at the Johns Hopkins University School of Medicine and pediatrician-in-chief, Johns Hopkins.

Mr. FLOOD. One of the great medical schools.

Dr. COOKE. Thank you, sir.

I am a member of the President's Committee on Mental Retardation, a former member of the President's Panel on Mental Retardation, and chairman of the scientific advisory board of the Joseph P. Kennedy, Jr., Foundation.

Mr. FLOOD. Your field of interest is pediatrics?

Dr. COOKE. I have been interested in taking care of children for a long, long time. I became interested in that back in medical school. I went to Yale and eventually moved down to Hopkins. Pediatrics, as you know, is concerned with the care of children. Problems of the retarded have been a very great interest of mine because so many children suffer from this.

I happen also to be a parent of two severely retarded children, one of whom died 2 years ago at the age of 18, still unable to walk or talk

without support. I have taken care of problems such as this for almost 25 years. I have come to learn the enormous cost in human suffering and economic losses by the community that result from defects in human development.

I appear on behalf of the National Institute of Child Health and Human Development, in support of their budget as a citizen witness, and I think that you have my statement. I would like to informally, if I may, amplify certain aspects of that statement.

(The statement follows:)

STATEMENT OF DR. ROBERT COOKE

Mr. Chairman, member of the committee, I am Dr. Robert E. Cooke, professor of pediatrics at the Johns Hopkins University School of Medicine and pediatrician-in-chief of the Johns Hopkins Hospital. I am a member of the President's Committee on Mental Retardation, a former member of the President's Panel on Mental Retardation, and chairman of the scientific advisory board of the Joseph P. Kennedy, Jr. Foundation. I had the great privilege of conceiving and developing the concept of the National Institute of Child Health and Human Development and served as a charter member of its Advisery Council.

As a parent of two severely retarded children, one of whom died 2 years ago at the age of 18, still unable to talk or walk without support and throughout 25 years of medical experience I have come to learn from first-hand contact the serious costs in human suffering and economic losses by the community that result from defects in human development. Such defects come from viral infections during gestation, from chemical imbalances in the mother, from drugs taken during pregnancy, from hereditary defects of chromosomal origin beginning at conception. Just as important and far more common are aberrations in the developmental process occurring after birth such as inadequate mental stimulation and nutritional deprivation resulting poverty acting families burdened by a large number of children than they can care for and guide.

I know of no program within the National Institutes of Health or research programs in any nation in the world with greater importance for society than those of the National Institute of Child Health and Human Development. It is no exaggeration to state that there is at the present time a research capability which, if properly exploited can lead to a significant improvement in the physical and intellectual functioning of a significant part of our population.

All of us have been appropriately shocked by the mass display of aggressiveness, the revolt against authority, the wanton destructiveness which has boiled over in an ever-increasing manner in the last 2 years. Statistics clearly show that the major participants in our riots have been children—children whose development has been maimed and warped by early experiences, by inadequate family guidance, from mothers handicapped intellectually or educationally to meet the complex demands of rearing a family and earning a living.

It is within the research interest and within the research planning of the National Institute of Child Health and Human Development to bring to bear new methods of effecting social and intellectual maturation. Much of this work will be done in the mental retardation research centers now opening in major universities throughout the country.

We have also reached a level of scientific capability in the support of basic research so that the biological facts underlying aberrations in development can be identified and indeed modified, even though they be of genetic origin.

Mental retardation represents the largest single cause of disability of any condition known to medical science. Because this is a condition which persists throughout the life of the individual the cumulative man-days of lost productivity are enormous. The life span of the individual must be multiplied by the millions of retarded to appreciate the magnitude of the economic loss as well as the loss in human gain and advancement.

With assistance from systems analysts of the Department of Health, Education, and Welfare, we have looked in a cursory manner at the costs of one form of mental retardation—that of mongolism, one of the commonest single causes of severe mental retardation. Mongolism strikes in families, particularly the educated, who have waited some time before beginning their families. It occurs in one out of 650 births in the general population and rises to one in 40 or even

one in 25 babies born to older women above the age of 42. Indeed, as our population becomes better educated to compete in our technological society, the chances are greater that there will be an increasing number of such births in years to come unless preventive means are found.

Our costs analyses have indicated that the annual additional cost of care of the mongoloid child is conservatively $3,000 above that of a normal child. With current birth rates approximately 8,000 mongoloid children are born each year, with approximately 6,000 surviving. With the current trend continuing this number of 6,000 will rise to approximately 10,000 by 1988. The per annum cost is approximately $400 million in 1968 and will rise per annum to $1.2 billion by 1988. The cumulative total cost to our society for care alone in the next 10 years disregarding completely the lack of earning capacity of these individuals, will approximate $13 billion.

It is for these reasons that I speak in support of the budget which is submitted by the National Institute of Child Health and Human Development. I have reviewed this budget carefully and I am in wholehearted support of the small increases which are indicated over the 1968 budget. The largest single increment is for support of the mental retardation research centers which are now entering operation after the completion of the construction phase of the Mental Retardation Facilities Construction Act, dating back to the administration of President Kennedy and implemented by the Johnson administration. The $2 million of support for these mental retardation research centers will provide new approaches to the prevention of mental retardation of the social variety by the acceleration of human learning in the first months and years of life. These Centers will be involved in the development of new behavioral approaches that may avoid the aggressive attitude of the present teenagers in the next generation. They will also develop research programs concerned with the biological origin of learning so that nutritional as well as pharmacologic advances may be applied to the learning process.

Furthermore, the development of new knowledge on causation can lead to the development of vaccines for prevention. In the city of Baltimore alone over 500 cases of German measles in pregnancy occurred in the epidemic 5 years ago with a cost of care to that city alone being in excess of a half a million dollars per year. With the development of new vaccines, this catastrophe will be prevented. Have any one of you seen what havoc this virus can play in the unborn baby? The head is seriously reduced in size, the eyes are frequently grossly deformed and blind, the hearing almost absent, the heart defective, the body is physically retarded in growth, the child to be retarded mentally for life.

The burden of such children can break families apart and impoverish the young couple just starting a family. Thanks to research of this Institute and others of the National Institutes of Health this disorder will not be a problem in the future, but there are many other diseases occurring in pregnancy which may produce, though not frequently, equally devastating damage.

The second program with a major increment is that of collaborative research and development. This program is of equal importance if adequate control of population is to be effected so that families may be permitted to care adequately for their children, so that resentment of the inadequacies of life do not build into an early childhood, resentment of life from a mother too overworked, too tired, too poor to care. Ways must be found to reach out to such people so that family planning becomes practical and effective. Because the capability exists to bring such problems under control in an educated middle-class society does not mean that these methods are adequate for the poorer mother.

The increase of $3.5 million for increased research contract programs in reproduction and population and fertility control programs represent an investment which cannot help but have significant yield in control of problems in our ghettos as well as in other parts of the world that are overcrowded.

These increases are modest in keeping with the gravity of our times. I request respectfully, however, the consideration of the addition to this budget of $1 million earmarked for basic research in mongolism or Down's syndrome. Mongolism, as I have indicated, is the single, most common cause of serious retardation. I would estimate that the majority of the members of the National Association for Retarded Children are parents of mongoloid children. They represent the majority of the trainable children in classes in this country. This group alone, as I indicated, represents costs in billions for the next decade.

The reason for this request for $1 million is not simply to give a kind of pie in the sky approach that research might possibly make some difference in this problem. This request is based on hard scientific knowledge that the application

of basic science tools to the problem of mongolism can at this stage in our level of medical scientific achievement can yield significant results which will reduce the dire consequences of this disorder.

I hope you will bear with me while I attempt to explain why such an assertion is justified now and would not have been a very short time ago.

Mongolism is the result of a defect in the cleavage of chromosomal material or DNA in the process of the formation of the egg or sperm so that there is an uneven division of chromosomal material resulting in an excessive amount of DNA in the fertilized egg. Thus, there are three rather than the usual pair of chromosome #23. This additional chromosome, this excess DNA, leads to the alteration in function of every cell in the body from conception onward and to alterations in many tissues throughout the body producing particularly changes in the development of the brain, of the eyes, of the facial characteristics, of the heart, and of other organs.

Of great importance to medical science is the fact that this in a sense is a different species, with a different chromosomal number and it has for the human species enormous importance in understanding fundamental biomedical problems of concern to each one of us, who may never have heard of mongolism. For example, there are remarkable disturbances in the aging of the mongol. By the age of 35 there are senile changes in many mongols that do not appear in the normal until the age of 70 or more. Thus, this is an accident of nature which can shed much light on the problem of aging in the normal individual. Likewise, there is much more cancer, particularly leukemia in such children.

Of greater importance for the family of the mongoloid is the fact that there can now be detected early in pregnancy the presence of mongolism. This test involves the tapping of the uterus and removal of a very small amount of amniotic fluid, culturing the cells therein and studying these under the microscope to demonstrate the presence of an extra chromosome. With the identification of the mongoloid child in the first 12 to 14 weeks of gestation, the only recourse at the present time to prevention is abortion. I believe that much of society will find this an unacceptable approach and certainly it is only a last resort scientifically. Far more satisfactory will be the development of ways of modifying the expression of this extra chromsome.

Does this modification of expression seem in any way reasonable? There is now, through the study of microbial genetics, extensive information that chromosomes or DNA of chromosomes express genetic characteristics such as those of mongolism or of normal children through the elaboration of a somewhat similar chemical RNA. There are specific RNA's for the DNA of these chrososomes and it is now possible to begin to identify the RNA which comes from specific chromosomal material. It is also possible in microbes to suppress either the elaboration of specific RNA or indeed interfere with the elaboration of the product of the RNA, namely specific proteins.

The blocking of either of these two specific steps could lead to the total suppression of the action of these extra genes and thereby prevent the manifestations of mongolism from the time treatment is instituted. With prenatal detection now possible, prenatal modification becomes a possibility. Postnatal modification could lead to marked amelioration of the expression of mongolism, if the genes are active after birth and there is considerable likelihood that they are.

For instance there is another accident of nature, mosaicism in which some of the cells of the body have a normal number of chromosomes and the balance of cells have an additional chromosome. These cases in general are much milder, giving hope also that by the suppression of the action of this chromosome, one might have quite mild manifestations of the disorder with minimal or no mental retardation and relatively little in the way of physical stigmata. The search for suppressing agents would follow the studies of the basic biology of mongolism just as the search for antibiotics like pencillin has led to the eradication of so many serious infections.

The request for an additional $1 million earmarked for basic research in mongolism, usually over a 5-year period, would assure considerably greater chances for a solution to this problem rather than undirected research. The yield from this directed research would repay by several fold the original investment.

In conclusion, then, I would like to express my strong support as a researcher and physician and a parent for the budget as submitted with an additional $1 million earmarked for the solution of basic biological problems of mongolism.

Dr. COOKE. The National Institute of Child Health and Human Development has two increases within its budget this year as recom-

mended by the President. One is concerned with the development of programs in reproduction and human fertility, the development of better means by which family planning can be carried out, the development of better ways of applying this information. Dr. Guttmacher, who will be speaking after me, is a world authority on this problem. I will leave to him to a large extent discussion of this matter.

I would like to speak in terms of my own experience as a physician as the head of one of the largest clinics in the United States for poor children. We provide for full care for approximately 30,000 children with about 180,000 visits each year at Johns Hopkins Children's Center. We see the enormous problems of these families with larger numbers of children than they can care for.

Mr. FLOOD. This is outpatient?

Dr. COOKE. This is an outpatient center.

The problems of these poor children in part come from just too many brothers and sisters for the mother and father to care for. I think this is an important program of the Child Health Institute. What I have as my own major concern is the increment in the budget which is concerned with the financing of the research centers in mental retardation which have been established in several universities. I can speak fairly objectively because my own university has had support——

Mr. FLOOD. What do you mean by mental retardation?

Dr. COOKE. The definition which I like to use is mental development which is inadequate to permit an independent social adjustment in the existing culture. I use that definition.

Mr. FLOOD. This is a physical thing?

Dr. COOKE. Well, a certain percentage of these are and, in my statement I detailed one of the problems which is of special concern to us. For example, mongolism. I am sure that you have seen or heard of many families who have mongoloid children. These are among the more severely retarded. Then we have all gradations of children living in very poor circumstances who have had poor prenatal care, poor nutrition after birth, who have had many insults of one type or another of a physical nature.

Mr. FLOOD. It is not necessarily physical?

Dr. COOKE. It is not. It does not have to damage the brain. That is correct. The brain can look normal. The child can look normal and yet be retarded. It is in these instances there seems to be more evidence that it is the early experiences of the child that make a great deal of difference. The early stimulation.

Dr. Skeels, for example, a number of years ago in Iowa studied a group of children who suffered from severe, what he called at that time intellectual and emotional deprivation. They were left largely to fend for themselves. There was no adequate stimulation. There were inadequate attendants to care for them. They had no mothering. They were in orphanages, for example. These children grew up rather severely retarded. The control group which he took is really a fascinating study that started in 1937.

He followed up on these 25 years later. The children taken out of this deprived environment were put in homes where they received adequate stimulation, adequate experience, and they grew up to be perfectly normal. The children who remained in the orphanage in

deprived circumstances, out of the 15 or so, 14 of them are still in institutions for the retared. It is really a remarkable study that he did. He followed up on these 25 years later and showed these enormous differences.

Mr. FLOOD. Is there an age bracket?

Dr. COOKE. No; I would think that this is something that starts very early in life. The majority, I would say, before one is born and then insults that go on, for lack of experience that goes on after birth contribute very much to this. We know that premature babies have a greater tendency to be retarded. We know that.

Mr. FLOOD. Why?

Dr. COOKE. It is a good question. I wish we knew.

Mr. FLOOD. No economic strata?

Dr. COOKE. Yes, it is true that the poor have more prematures. The poor have more prematures that grow up to be retarded. Whether it is nutritional, additional infections and the like, we don't know. You were speaking to Dr. Farber about virus infections. We know a significant number of severely retarded come from infections in the pregnancy. German measles, for example.

Mr. FLOOD. We know that.

Dr. COOKE. We had over 500 cases in Baltimore of severe German measles 5 years ago. These cost the city half a million dollars.

I think the new vaccines are going to make a difference. There are other virus infections which produce damage in the baby. The so-called cytomegalo virus. VID is the abbreviation. It is a virus that produces a change in tissue culture that makes the cells balloon up and look like giant cells. That virus produces damage to babies and there are no vaccines for that.

What I would like to address myself to is a request for an earmarking of an additional sum of $1 million for basic research in the field of——

Mr. FLOOD. Earmarking in the report would be satisfactory, as far as you are concerned, is that right?

Dr. COOKE. That is correct. I was hoping there might be an increase in the appropriation for this Institute of $1 million that would be earmarked specifically for the study of the biology of mongolism.

Mongolism is a result of a defect in the chromosomes so that a baby is born with an additional chromosome. This is a hereditary defect. It is an odd number. The baby is born with 47 rather than the usual 46 chromosomes. This additional chromosome produces all the difficulties of the mongol. It produces the mental retardation, small physical stature, the congenital heart. I think it is worth remembering how common mongolism is. This occurs once in every 650 births in the general population. When a mother is around 40 years of age, it may occur as much as one out of 40 times.

Mr. FLOOD. How did you get here today; who paid your expenses?

Dr. COOKE. I paid my own expenses.

Mr. FLOOD. I think the record should show that. I guessed that.

Mr. SMITH. You are saying mongolism is what?

Dr. COOKE. The single commonest cause of retardation.

Mr. SMITH. Are you saying it is so distinguishable from other retardation that it ought to be completely separated?

Dr. COOKE. As I say, this is the single commonest cause of severe retardation. I would think that if you were to take the National As-

sociation for Retarded Children, the majority of the parents would be parents of mongoloid children. It is a disorder that strikes to a significant degree well-educated families.

Mr. SMITH. My question is, Should this research be completely separated from the research for the retarded generally?

Dr. COOKE. Why this directed research? That is the question you might ask me. Why do we want to concentrate, for example, in the direction of mongoloids? Let me say that this is such a large single problem, the systems analysis people estimated the cost of the mongol between now and 1978 will be about $13 billion in care in this country; $13 billion in care for this one group of individuals because it is of high frequency. These children never become productive.

Mr. FLOOD. What do you mean by high frequency?

Dr. COOKE. When we are talking about one in 500 or 600 births. This is a very large number of mongoloids.

This is a terrible economic as well as social problem. When you consider the frequency of divorce in families of mongols, it is several times more than it is in the regular population. Frequency of suicides is several times higher. You realize what a serious handicap a family has with such a child. To ask for additional money for a problem such as this without some chance of curing the problem, without some chance of prevention, that would be worthwhile.

Mr. FLOOD. Mr. Smith?

Mr. SMITH. You must feel that the research on mongolism is not getting enough attention in the overall appropriations for the retarded?

Dr. COOKE. That is absolutely correct. I also believe that the time has come now where there is the scientific capability. It is perfectly possible now to diagnose mongolism before a baby is born.

Mr. SMITH. At what stage can you determine there is an extra chromosome present in fetus?

Dr. COOKE. This can be done around 12 to 14 weeks now. The way it is done is by putting a needle into the uterus, taking a little bit of the fluid and then one grows the cells that are in this amniotic fluid, the fluid surrounding the baby.

Mr. FLOOD. You can do that?

Dr. COOKE. This can be done. Dr. Jacobson in Washington, D.C., has done 180 of these taps.

Mr. SMITH. Could the parent at this stage be advised that this is the situation?

Dr. COOKE. That is correct. Or they can be advised that the child is going to be normal, which can be also of great value. The point I am making is that at the present time all we can do is to prevent this. We can abort the baby. I believe in the next decade with adequate support it should be possible to modify——

Mr. FLOOD. Legally abort?

Dr. COOKE. Legally abort. That is correct. There are a number of States where this is possible now.

Mr. SMITH. Under those particular circumstances?

Dr. COOKE. Under those circumstances, correct.

Mr. SMITH. Are you saying, then, that in most cases the parents did not want to abort even though they knew that?

Dr. COOKE. No, this is not generally applicable as yet. These are new developments that have come actually out of the support of

programs of the National Institutes of Health where it has now been shown that you can diagnose this before birth.

Mr. SMITH. That is not generally available to parents. Maybe we should concentrate, somebody should concentrate on making their service available.

Dr. COOKE. This is actually being done. I met with the National Foundation people last week, people who have been in the birth defect business. We are actually going to be setting up a prenatal birth defect center at Hopkins with some private moneys.

Mr. SMITH. Is this detection something that the family physician could undertake?

Dr. COOKE. I would say that this is going to be some time before that is possible. I would think that with good obstetrical centers and gynecology centers in most parts of the country it would be possible.

Mr. SMITH. This service could become available on a widespread basis in a year or two?

Dr. COOKE. I think that would be correct. We would want to use it on a selective basis. Where there has been a risk before, where there has been a mongoloid child before.

Mr. SMITH. Why wouldn't you want to use it on all?

Dr. COOKE. This is still in a stage where we think the hazards possibly might be great enough so it would not be justified.

Mr. SMITH. What is the hazard?

Dr. COOKE. There have not been any accidents in the 180 taps Jacobson has done. I think there is always the possibility it could be damaging to the baby. I think it is not something that one would throw around indiscriminately.

The point is that I think if one properly supported basic research in this problem, instead of having to abort these babies it should be possible to modify the expression of this extra chromosome. You can not remove the chromosome, but a chromosome does not do anything except lead to a series of chemical reactions. If one can interrupt these chemical reactions by certain drugs, as one can put in penicillin which interrupts a series of chemical reactions in bacteria, you can then essentially stop the growth.

Mr. SMITH. Is it hereditary?

Dr. COOKE. We do know that there are some mothers who are carriers of this. One out of every three of her living babies will be affected, or the father might be in a similar situation.

Mr. SMITH. How do you determine which parent should not have this test?

Dr. COOKE. We know that the frequency of occurrence goes up very rapidly with older age; that is, if a woman is above 38, she has a much greater risk of having a mongoloid baby.

Mr. FLOOD. It is transmittable?

Dr. COOKE. In that sense, yes. It is hereditary material which is responsible.

Mr. FLOOD. Thank you, Doctor.

STATEMENT OF DR. ALAN F. GUTTMACHER

Dr. Guttmacher, we have your statement and we will place it in the record at this point.

(The statement follows:)

STATEMENT OF ALAN F. GUTTMACHER, M.D., PRESIDENT, PLANNED PARENTHOOD-WORLD POPULATION

Mr. Chairman and members of the committee, I appear today to recommend that you approve in full the requested appropriations for contraceptive research in the budget of the National Institute of Child Health and Human Development. Because, in this field, it is impossible to separate any improvement in technology from its application and its distribution, I want to urge the committee, as well, to give full support to the proposed expansion of family planning services in the Children's Bureau's and OEO's budgets.

The amounts of money requested are miniscule compared to the vast and urgent necessity. In fact, we can and must do more if the pressing problems of world population growth and the human and social problems resulting from unplanned, unwanted pregnancies are to be met.

Specifically, I ask you to—

(1) Appropriate the full $5 million requested for the National Institute of Child Health and Human Development for collaborative research and development which will enable NICHD, for the first time, to launch research in the development of new contraceptive techniques.

(2) Appropriate the full $55 million requested for the Children's Bureau maternal and infant care program, which includes an earmarked allocation of $21.5 million for family planning services to be provided primarily by health departments and hospitals. These funds, which will actually yield only $18.5 million for new projects, are the basic minimum needed to respond to applications already developed or in preparation throughout the country.

(3) Earmark or otherwise designate within the Office of Economic Opportunity appropriation, the $13 million projected in OEC's fiscal year 1969 budget request for family planning services to be provided by antipoverty agencies. This level will be barely sufficient to continue existing OEO-funded projects and to fund new applications which are already in the works.

These appropriations reflect the priority which Congress itself placed on family planning in the foreign aid, social security, and poverty legislations last year. After a period of long neglect, there is tremendous interest on the part of research scientists and public and private agencies in embarking on expanded family planning programs. This interest must be nurtured.

The National Institute of Child Health and Human Development

While NICHD's efforts in population research have become increasingly important, it is clear to all of us in the medical, scientific and family planning fields that much more needs to be done. The plan to establish a Center for Population Studies and Human Reproduction within NICHD is an encouraging sign that we will finally focus appropriate attention to this area. Yet we must contrast the total appropriation requested in fiscal year 1969 for this Center—$12 million—to the $150 million which Dr. Oscar Harkavy, the director of the population program of the Ford Foundation projected as necessary in his report last year to Secretary Gardner.

I should like especially to direct your attention to the request for $5 million for the collaborative research and development program—an increase of $3.5 million, the largest in the NICHD budget. The collaborative research has thus far been primarily confined to studies of contraceptive safety, but this year's increased budget will finally enable NICHD to begin an organized effort in development of new contraceptive methods as well as to initiate basic studies on the phychosexual factors which determine acceptance and sustained use by potential patients. This program has the highest potential yield of any area of research.

For most of my 45 years in medicine, we struggled with a contraceptive technology which was developed in the 19th century or earlier. It has only been since the introduction of the oral contraceptives in 1960 and the intrauterine devices in 1963 that we have witnessed what modern techniques can do toward the extension of family planning at home and abroad. The momentous advance presented by these two new methods is that they are our first effective, coitally independent contraceptive techniques, that is, birth control applied at a time wholly disassociated from the sex act itself, neither requiring its immediate anticipation nor interruption to achieve protection against impregnation. These new methods are

vastly superior to conventional techniques, but they have significant limitations and are not suitable for mass application in every country and among all who seek to avoid pregnancy. We must look forward to the discovery and introduction of a variety of new and improved family planning methods. To meet the need of all potential users we must offer the choice of many good coitally independent techniques, hopefully some to be used by the male.

The main burden of research in contraceptive development has heretofore been carried by foundations and pharmaceutical companies. But their resources are not adequate to the task. This year, the Ford Foundation, for example, will have to turn down at least $6.5 million in sound, developed projects for which it lacks funds. It is utterly essential that NICHD launch a major effort in this area.

The collaborative research program will enable NICHD to contract for studies which have a high potential payoff. Several areas have been delineated for immediate funding: studies aimed at the development of medication to be taken by a woman once a month just prior to her expected menses; studies of the activity and fate of sperm cells after their introduction into the female; studies of the chemistry and physics of seminal fluid, both hopefully leading to coitally independent male methods; studies of ovulation leading to a more efficient technique for the rhythm method and studies making use of hypodermic injections and depot implants, in my mind, are absolutely essential to successful mass programs overseas for the millions who prayerfully hope to curb their own excessive fertility.

Family planning services in the Children's Bureau and OEO

Turning to the appropriation for services, this committee should be aware that a significant number of American families at all income levels have more children than they desire. In the more affluent sector of our population, these unwanted births can be attributed to the shortcomings of current contraceptive methods which the new NICHD program would attempt to remedy. Among low-income families, however, most unwanted births occur because parents lack knowledge of how to control the size of their families or because they do not have ready access to medical services which provide modern contraceptive care.

For these families, living often at the edge of dependency, an unwanted pregnancy—or a succession of them—is likely to impose catastrophic consequences for the individuals involved and serious social and economic burdens for the community in which they reside.

It is estimated that approximately 5 million low-income American women who lack access to competent, medical contraceptive care have about 450,000 unwanted children each year, pregnancies which would be prevented through family planning. Women from low-income families also suffer disproportionately high rates of maternal mortality and morbidity, often due to attempts to end unwanted pregnancies by resorting to criminal abortion, and their children suffer from an inordinately high rate of infant mortality and mental retardation.

Yet, when family planning services are conveniently available and offered humanely, they are eagerly accepted and used by low-income women. Evidence is accumulating which indicates that these programs have a very significant impact on the rate of births, illegal abortion, illegitimacy and infant mortality, even in a short period of time. It has been estimated that it will cost at least $125 million to provide these services to the 5 million women who need them.

If we are to make a start toward giving individual families the opportunity to exercise their free and full choice in the matter of family size and child spacing and if the individual family and society are to reap the health, economic, and social benefits which would accrue, we must be certain that family planning services receive at least the appropriations projected for next year in the budgets of the Children's Bureau and OEO. These two programs, each with a different approach to the provision of family planning services to the poor, are equally necessary since they complement and do not compete with each other.

The proposed budget for maternal and infant care project grants includes an earmarked $18.5 million in new money to finance family planning services. These grants are channeled through the larger medical institutions, university medical centers and State and local health departments. For example, and this is only one isolated instance of the keen interest, representatives of 22 medical schools (or a fourth of all in the United States) met last week to plan program proposals and grant applications which are being readied this very week and will total nearly $3 million. To dampen this enthusiasm and impetus now would be shortsighted.

The family planning programs of the Office of Economic Opportunity have been unusually popular and successful. In contrast to the Children's Bureau programs

delivered through large and often impersonal medical institutions, OEO grants are more flexible in serving the population in need. Delivering services through neighborhood-based programs operated by anti-poverty agencies in 126 communities, they are uniquely effective in reaching the poor in areas where they live. In essence, the Children's Bureau and OEO present multidimensional programs which happily complement each other. Both programs are utterly indispensable in order to stimulate all the agencies which must participate in the expansion of family planning services. And the additional sums requested in both budgets for fiscal year 1969 are utterly indispensable to fund the programs which have already been developed in various communities throughout the country and which will extend services to about 1.2 million poor families.

Since the competition from larger and longer established programs will be fierce this year, it is incumbent upon Congress to earmark, or otherwise designate, the $13 million which OEO has projected to be spent on family planning in fiscal year 1969 to insure that these much needed funds will actually be used for family planning. This action would carry out Congress' mandate when it designated family planning a "special emphasis" program and would be consistent with Congress' recognition of the necessity to earmark family planning funds within the maternal and child health authorizations.

A mometum and a primacy for family planning has been created by recent legislation and presidential and departmental pronouncements. Your actions have precipitated a wave of enthusiasm. The response cannot be token, but requires continued interest and commitment. This can only be realized by approval of the budget request for an additional $3.5 million for vital collaborative research in family planning under the expert aegis of NICHD, and for $18.5 million in new family planning funds in the MIC programs, and by earmarking $13 million for family planning services in the OEO budget.

Dr. GUTTMACHER. I don't plan to read it, sir. I thought I would bring out some points for discussion between us that might clarify it. My interest is primarily in the $3.5 million increase which the National Institutes of Child Health and Development have asked.

I am president of Planned Parenthood World Population, which is a birth control organization. I am a physician of 45 years. I am an obstetrician, gynecologist. I graduated from the institution that Dr. Cooke represents. I am a Johns Hopkins man and taught there many years. I have now become president of the Family Planning Organization. I devote my life to the spread of birth control both here and abroad. I am chairman of the Medical Committee of International Planned Parenthood based here in London. I travel about 3 months of the year overseas.

This request by the National Institutes of Child Health and Development for increasing these funds, from my point of view, is wholly justified. The Congress and the people have certainly greatly increased their interest in regard to conception control both here and abroad. The cogency and necessity of it I don't think is germane to the discussion here, but I think it is obvious. The Congress seems to understand it fairly well.

The point is that we are making progress.

Mr. FLOOD. You have come a long way?

Dr. GUTTMACHER. We have done a lot in the years I have been with it. I have been president for about 6 years. We have made great progress. Fortunately, among all religious groups, I might add, I think the change in the Catholic point of view is most heartening because there has been a tremendous shift from the former difficulties which we had between groups that has now disappeared almost entirely.

So far you have got $1.5 million allotted to this research which is a thing very skillfully handled, $1.5 million goes only to searching out the safety of our newer contraceptive methods.

I am here to support the full $5 million which was asked by the Institute when it testified.

Mr. SMITH. What would a vaccine do that would be an improvement?

Dr. GUTTMACHER. I think it would be better, safer than a pill. It would be better.

Mr. SMITH. Why?

Dr. GUTTMACHER. Safer because I think the pill has certain inherent dangers in its administration. I think Dr. Goddard agrees with me. I think we are compiling sufficient evidence on that.

Mr. FLOOD. How would you administer a vaccine, by injection or oral?

Dr. GUTTMACHER. What we do is try to increase the immunity reaction on the part of the host animal. What we give is an antigen which is a substance that causes the reaction.

Mr. FLOOD. How does one administer the vaccine?

Dr. GUTTMACHER. Oral and injection.

Mr. FLOOD. What is the difference between an oral vaccine and a pill?

Dr. GUTTMACHER. An oral vaccine creates antibodies. What it creates within the organism is to prevent something from occurring. We would have to prevent the sperm cell from swimming up through the reproductive tract and impregnating the cell.

Mr. FLOOD. What would be the most effective way, oral?

Dr. GUTTMACHER. Yes. I think we are far away from that. The injection comes first. The Salk vaccine comes first and the oral later. I think we have to seek the injectoin first. There are many promising techniques.

Mr. SMITH. The pill then is quite different from the oral vaccine that you are referring to?

Dr. GUTTMACHER. Yes. The pill acts by interfering with the physiologic mechanism. The pill prevents ovulation. It prevents ovulation by keeping certain of the hormones from being secreted then at that particular point. That is quite a different thing than defense reaction on the part of the body. The sperm cell is a foreign invader, as it were, into the female body. If we would have the body react to the sperm cell as though it were a foreign invader, like bacteria——

Mr. SMITH. How much work has been done on the vaccine?

Dr. GUTTMACHER. There are several centers in this country where work is being done. The group at the University of Michigan, Dr. Tyler at California Tech worked on it, and the University of Pennsylvania. There are several centers in which vaccine is being worked on.

Mr. SMITH. Has it been developed to the extent that they are successful with guinea pigs?

Dr. GUTTMACHER. Yes. It has been in the male guinea pig.

We can deprive him of his spermatazoa for 8 months by a technique using what is called Freund's agulant, which dissolves the semen or testicular tissue in mineral oil to which is called Tubercle agulant. This is injected into the male guinea pig. He creates immune reaction to his own sperm cells and prevents their manufacture for about 8 months.

Mr. SMITH. That requires one injection each 8 months?

Dr. GUTTMACHER. One injection for the 8 months. Give him booster shots and keep his infertility for an indefinite period. That is restored

in the guinea pig after about 8 months. We have nothing that promising yet in the human. They are looking for that.

Mr. SMITH. Are you restoring it to him by injection of some other chemical?

Dr. GUTTMACHER. No; it restores itself. Like your immunity to typhoid after you have had a shot. The immunity disappears after *x* number of years or months.

Mr. SMITH. You don't have an antibody?

Dr. GUTTMACHER. Theoretically one could have that. It disappears on its own. There are other techniques. There is a lot of work going on in a once-a-month pill which would be taken perhaps by the woman on the 25th day of each monthly cycle. If she is pregnant, probably the egg would not plant. If she is not pregnant it would not do any harm.

Mr. SMITH. Is there considerable evidence of side effects from those pills?

Dr. GUTTMACHER. I don't know if it has side reactions. We are not that far along with it. This whole field is wide open with exciting prospects for research.

Mr. FLOOD. Thank you, Doctor.

Dr. GUTTMACHER. Thank you, Mr. Chairman.

WEDNESDAY, APRIL 24, 1968.

MENTAL HEALTH

WITNESSES

MIKE GORMAN, EXECUTIVE DIRECTOR, NATIONAL COMMITTEE AGAINST MENTAL ILLNESS

DR. FRANCIS J. BRACELAND, SENIOR CONSULTANT, INSTITUTE OF LIVING, HARTFORD, CONN.

VICTOR BUSSIE, PRESIDENT, LOUISIANA AFL–CIO, BATON ROUGE, LA.

MICHAEL FREELAND, ASSISTANT DIRECTOR, NATIONAL ASSOCIATION OF MENTAL HEALTH, INC.

Mr. HULL. The committee will come to order.

We have with us this morning, Mr. Mike Gorman.

You may proceed, Mr. Gorman.

Mr. GORMAN. Thank you, Mr. Chairman.

If I could, Mr. Hull, I would like to submit the recent article from the Saturday Evening Post, which you are probably familiar with, on progress in Missouri and some of the other State mental hospitals, which, I think, tells a better story than I can tell, and I would like to submit it for the record.

Mr. HULL. Without objection.

(The article follows:)

INSIDE THE INSANE ASYLUM

(By Harold H. Martin)

A dozen years ago the Post shocked America with a series of articles that broke through the walls of silence and neglect surrounding the nation's public

mental hospitals. Life for their inmates was a horror of degradation and despair. Today, however, a national survey shows that new techniques of treatment are bringing real hope that the mentally ill can be returned to the world outside.

A late sun filtered through the decorative iron bars on the Gothic windows. Dr. Liam O'Brien, a short, dark Irishman with a tongue like an adder and a soft spot in his heart for all people who are mentally ill, sat at his desk in the stately old administration building of State Hospital No. 2 in St. Joseph, Mo. Just outside the doctor's office a grand staircase with a red carpet and a fine carved-wood banister led down to an entrance hall floored in colored tile. In one corner a grandfather clock ticked away the generations. Here, in the past, anguished families would bring one of their poor deranged kinsmen and, reassured by the beauty and quiet of the entranceway, leave him forever, content that he would be cared for gently and with compassion.

"And if he proved unruly, they tranquilized him with this," said Dr. O'Brien, slapping a leather harness strap into his palm. "And here was his medication." He picked up a dusty ledger dated 1929, ran his finger down a column:

" 'Two ounces of whiskey every four hours,' " he read. "Prescribed for everything from melancholia to myocarditis."

He tossed aside the ledger and the strap. "Relics," he said, "but of not so long ago. It has been only about six years since my predecessor here felt the community had advanced in its thinking far enough so that he could free the patients who were chained to the walls."

He rose. "Come on," he said, and led the way along the corridors of his hospital until we reached a large room crammed with beds. They were placed head to foot, three rows deep, along each side, with only a knee's width between one row and the next. Down the narrow center passage, about 100 women, ranging in age from 16 to 80, sat in chairs or shuffled aimlessly about. There were old paretics, chronic schizophrenics, regressed psychotics, the demented senile: the whole sad spectrum of mental illness. Some seemed little more than vegetables, but if one paused to listen to their babble, one might sense a great awareness, and a hurt. "Tell my momma tell my papa came get me; tell my momma tell my papa came get me . . ." a dark-haired girl repeated over and over in a toneless singsong.

"Here are our worst," said Dr. O'Brien, standing in the midst of them. A young girl, sucking both thumbs, came up and nuzzled her head against his chest. He held her gently. "I get whitefaced with anger every time I come in here. These are our failures of the past. And what is there left to salvage here so late? God knows. But we are going to try."

Six months later the results of his efforts were spectacularly visible. The ward was empty. The women had been moved out to nursing homes, to foster homes, to better quarters that opened up on other wards as St. Joseph's bed-patient population, under the impact of a psychiatric staff increase from three to 16 doctors, began to drop from 2,000 to 1,450.

Dr. O'Brien's determination that the forgotten patients on his back wards shall become human beings again is a manifestation of a new spirit of confidence, a new approach to the ancient problem of the mentally ill that now prevails in a majority of the country's mental hospitals.

Until only a very few years ago the attitude of most hospital staffs toward a mental patient was that of the jailer toward a prisoner. The sick person was to be fed, clothed, disciplined—with straightjackets, handcuffs, chains and clubs if necessary—and kept until he died.

This was the situation when the *Post*, in a classic series of articles by John Bartlow Martin [INSIDE THE ASYLUM, October 6–November 10, 1956] exposed these dreadful facts of life as they affected the 750,000 men, women and children who were then hospitalized in the U.S. for mental illness. After months of research, Martin chose Columbus State Hospital in Ohio as a typical—and by no means the worst—example of the way rich, compassionate, generous-hearted America treated those of her mentally ill who could not afford the luxury of private care. There, in one of the country's wealthiest states, he found 2,700 patients served by 18 doctors, only 10 of whom (none a fully trained psychiatrist) gave daily psychiatric care on the wards. Some patients had been there for more than 60 years. On a daily budget allowance of $2.60 per patient per day, only about 400 were receiving any sort of therapy. The 2,300 others were merely there, in custody, helplessly awaiting death.

Martin's series stirred the conscience of the nation, but it was not until 1961 that a Joint Commission on Mental Illness and Health, appointed by the Congress, confirmed on a national scale what Martin had uncovered in microcosm

at Columbus. Its recommendations became the basis for President Kennedy's plea to Congress for a national mental-health program—"a wholly new emphasis and approach" to a problem that at one time or another will afflict one of every three American families. The legislators responded by passing the Mental Health Act of 1963. This authorized federal grants for the construction of a nationwide network of community mental-health centers, each to serve a population of roughly 200,000 people, and to provide a wide range of services, from around-the-clock emergency care for the person suddenly gone out of control to outpatient clinics, halfway houses, and follow-up support by social workers and psychiatric nurses. Of the $150 million provided, $60 million has now been awarded for the construction and staffing of 128 centers in 42 states, Puerto Rico and the District of Columbia. Construction, though, is the quick and easy part. The problem lies in finding trained professionals to staff these centers. The National Committee Against Mental Illness, Inc. estimates the country needs at least 10,000 more psychiatrists than the 18,750 now in practice (private practice, mainly), and psychologists, psychiatric nurses and psychiatric social workers are in equally short supply.

The National Institute of Mental Health says that despite these shortages 175 of the new mental-health centers will open their doors in 1968, and by 1970, some 500 will be serving their communities.

For the next few years, however, the old state hospital will remain the last refuge for those who cannot afford private hospital care, with its cost of about $35 a day, or the care of private psychiatrists, with fees ranging from $25 to $50 an hour. What, then, awaits the patient who still must turn to the public hospital for help?

The picture, formerly one of unrelieved darkness, is now one of mingled light and shadow. There are still areas—in the country as a whole and within individual hospitals, including the better ones—where the gloom is as deep as ever. But more and more the asylum is emerging from its apathy and despair. Traditionally a place of custody, it now is becoming a place of healing.

In the 10 years following World War II, according to the National Committee Against Mental Illness, the number of bed patients in mental hospitals increased at the rate of 13,000 a year. But in the next 10 years the number dropped by an average of 8,300 patients a year. Today the bed population in the nation's 302 public mental hospitals has fallen to an estimated 426,000, a new low.

The reduction in hospital population does not mean that the incidence of mental illness is dropping. The pressures and frustrations of life are no less abrasive than in the past, and the "social breakdown syndrome," manifested in a retreat from reality to a world of fantasy, is no less common. In consequence more people are entering mental hospitals today than ever before. Between 1955 and 1965, while the population of the U.S. was increasing by 17 percent, the number of admissions to public mental hospitals each year increased by 76 percent, to 314,500 in 1965, the last year for which complete figures are available. In this same period, however, the number of patients discharged each year more than doubled, reaching 287,000 in 1965—an increase of 127 percent.

Thus, more people are going into mental hospitals than ever before, but they no longer inevitably follow the dreary route of the past—from violent madness, to grim withdrawal, to the hopeless gray oblivion of the back wards. Instead, a new emphasis on getting the patient into the hospital early, and then getting him out again as quickly as possible, has resulted in a considerable reduction in length of stay. Today, between 85 and 90 percent of patients entering a mental hospital for the first time can expect to be discharged within a year. In most cases they are strong enough to face once more the terrors that sent them there, although frequently they regress and have to come back again—and perhaps yet again. Of the 314,500 persons admitted in 1965, some 115,500—more than one third—were returnees. But the important thing, nearly every expert agrees, is that those who enter need no longer abandon all hope.

No one factor can account for this dramatic change; rather, a combination of many factors is responsible. First, giving impetus to all the others, is a new tolerance of the mentally ill on the part of the community, a willingness to accept a discharged mental patient as just another sick person who has been to the hospital and has come home again. The community has begun to recognize what certain psychiatrists—the brothers Menninger, for example—long have recognized: That madness that destroys the personality is a madness that afflicts us all, only expressed in greater degree. And the fragmented personality is capable of being restored to some degree of dignity and pride.

Public awareness that this can be done—and must be done in a society that calls itself civilized and compassionate—has recently been reflected in the greater generosity of state legislatures in support of their state hospitals. In the U.S. as a whole the average daily expenditure per patient in a mental hospital, while still grossly inadequate, has more than doubled since 1955. As a direct result, so has the ratio of full-time hospital employees to patients—although there are still crippling shortages in the critical professional fields. Nearly a third of the country's state hospitals have less than five staff psychiatrists, and 21 have none.

But the single most important factor in the battle against mental illness, most doctors believe, has been the development of tranquilizers and the other psychiatric drugs. It has long since been proved that the drugs do have the power to soothe the anxiety-ridden, calm the manic, stimulate the depressed and, for a moment at least, call the hallucinating mind back to the world of reality. It is equally clear that, in most cases, the drugs can only control symptoms, not cure the deeper illness. But by temporarily suppressing the symptoms of the basic illness, they do permit the doctor to get through to a patient, so that more lasting forms of therapy can be applied. These may range from a simple word of kindness, through work and play regimes, to the most deeply searching forms of psychotherapy. In many cases almost any positive action helps, when applied with love and understanding, which is why equally significant results are being achieved at hopsitals experimenting with widely different techniques. They are simply different aspects of this quiet revolution.

Nowhere is that revolution more dramatically manifest than at Boston State Hospital. Behind a high iron fence, the sprawling hospital looks as it has for more than half a century. The huge brick-and-stucco buildings are shabby and run-down. But the patient population, which less than a decade ago stood at nearly 2,800, was down to 1,330 at the end of 1967 proof of Dr. William Menninger's assertion that it is brains, not bricks, that make a mental hospital a place of healing.

Ever since Charles Dickens visited Boston State in 1842 and found it "admirably conducted on enlightened principles," the ancient institution has enjoyed a reputation for zeal and skill in the treatment of the mentally ill. Its most rapid progress, however, began when Dr. Walter Earl Barton, superintendent from 1945 to 1963, took the bold step of throwing open the big iron gates that for more than 100 years had separated the hospital's patients from the world. Dr. Barton, who left Boston to become medical director of the American Psychiatric Association, was succeeded by Dr. Milton Greenblatt, a slender, tense, fiercely dedicated psychiatrist with the look of an intelligent, somewhat worried cockatoo. For three years, until he, too, moved on to higher things as commissioner of mental health for the Commonwealth of Massachusetts, Dr. Greenblatt sat like a nesting bird in a cluttered office in the red-brick administration building, hatching one scheme after another to convert Boston State into his vision of the mental hospital of the future—"a hospital without walls, no longer isolated from the community it serves, but an integral part of that community, drawing strength from the normal community patterns, and using its own special knowledge to keep those patterns healthy."

Beyond this community function, Dr. Greenblatt also visualized Boston State as a great laboratory for the study of all aberrations of the human psyche, a place not primarily custodial, but mainly concerned with developing new treatment techniques that could be applied in any mental hospital in the United States.

It was natural therefore that when Commissioner Greenblatt handpicked his successor at Boston State he chose a man highly distinguished in the fields of research and training. He was Dr. Jonathan Cole, rotund, balding and amiable chief of the psychopharmacology research branch at the National Institute of Mental Heath in Bethesda, Md. Dr. Cole, who masks an energy as fierce as Dr. Greenblatt's behind a façade of Buddha-like tranquilty, also shares his obsession that the main goal of the mental hospital today is to heal the patient and return his as soon as possible into a community educated to accept him.

One measure of a hospital's urge to heal is the number of different programs by which it seeks to create a therapeutic community both within and beyond the hospital walls. At Boston State there is such a variety of them that nearly every patient is involved in some sort of hopeful experiment. Moreover, treatment routines were greatly modified after a preliminary study showed that what often disturbed a patient and caused him to become unruly were small annoyances

nobody had thought about. Meal hours and bath hours, the use of certain forms of treatment, and restrictions on the patients' movements were planned for the staff's convenience, not the welfare of the patient.

"Seclusion of the disturbed patient once was routine," Dr. Cole says. "When he began acting up, the attendant didn't waste any time on him. He slammed him into a cell and locked him up and left him there. Finally we began to realize that most frequently the patient's agitation was not due to his basic illness, but to a breakdown of relations between him and staff. Behind nearly every episode of seclusion we found staff errors and staff weakness—ignorance, anger, intra-staff feuds, a jailhouse psychology. Knowing this, we reduced seclusion to the vanishing point."

The study of staff-and-patient relationships soon made it obvious that many staff members experienced stresses as severe as those that tortured the patients. Attendants suffered particularly: They stood at the bottom of the hospital pecking order—poorly paid, poorly trained and subject to social discrimination if not outright abuse from other staff members.

The attendant spent hours with the patients every day, yet the doctors never consulted him about his knowledge of a patient's progress or regression. The doctors even felt that it would be a violation of medical ethics to let him know specifically what was wrong with a patient. And, though it was his duty to protect the ward nurse from violence, he was strictly forbidden to have any social contact with her outside the hospital.

In recent years the attendant has been taught that his attitude toward the patients is as much a part of the healing process as the work of the doctor or the nurse. His opinion of his patients' progress or regression is sought at staff conferences. And if he wants to date a nurse after hours, that's up to him—and, of course, to the nurse.

When it dawns on the attendant that he is looked on not just as a custodian but as an important member of the treatment team, his morale soars and his effectiveness increases. Some attendants jump at opportunities to work longer and harder with the patients. Some supervise evening activities in their spare time; others volunteer as guides and drivers, taking patients to ball games, beaches and historic sites. Some have been invited patients home to dinner to meet and socialize with their families, the doctors report.

Whenever the doctors at Boston State describe the ideal hospital employee—a man with a healing touch that transcends all medical or psychiatric knowledge, they recall with nostalgia the genius of John Moskovites. Moskovites, a roly-poly young reek with an amiably irascible manner, was a male nurse at Boston until last year, when the Army Medical Corps commissioned him a lieutenant and sent him out to Tokyo, to practice his healing art in the military hospitals where American troops are being treated for psychiatric trauma suffered in Vietnam.

Moskovites, a doctor recalled, would go almost wild with joy when a patient with whom he had been working got well enough to be sent home. He would roll up the patient's mattress and throw it out the window. He would then tear down the iron bed and throw it after the mattress—a symbol that the patient would (he fervently hoped) never need the hospital any more.

Shortly before Moskovites left Boston for the Army, he drove me on a tour of the part of the hospital that lies to the east of Morton Street, the broad highway that divides the 200-acre grounds in half. Piled high against one building—mute tribute to John Moskovites' zeal—was a rusting tangle of old iron beds. He parked his little sports car beside a grassy square surrounded by ancient three-story buildings with iron-barred windows.

"They've been empty for months now," said Moskovites, nodding toward the two largest. "But on hot days you can still smell 'em." I remarked that the place was as quiet as a country churchyard. "It is quiet now," said Moskovites, smiling, "but just a few years ago it was bedlam—a wild confusion of people yelling and shouting and running around naked.

"A whole lot of things brought about the change. Drugs, in the first place. But mainly, I think, a lot of tender loving care. That's trite, I know. But I went over to Harvard and Radcliffe and Tufts and Northeastern and did some talking, and managed to get a lot of good kids to come in here and help us as volunteers. When I was out at Menninger's working with disturbed children, Dr. Karl used to tell us, 'Love cures people—both the ones who give it and the ones who receive it.' I think that's what happened here."

The college-volunteer program was started in 1954, at Metropolitan State Hospital in Waltham, Mass., by a Harvard student, Larry Dohan. Today student volunteers work as attendants in more than 100 hospitals and halfway houses

around the country. Nearly everywhere such volunteer aid has helped make the difference between success and failure, and Moskovites gave his eager young helpers full credit. In less than five years the population in the old chronic wards under his supervision dropped from 2,000 to less than 200, as the volunteers prepared them to go out to foster homes, nursing homes, or even to their own homes.

"We did it just by giving every patient something to do that he *could* do," Moskovites explained. "No matter how simple the task might be—even if it was just buttoning his own shirt—the fact that he could do it bolstered his ego. And we led them along that way, step by step. Not all of them responded, of course. But we didn't give up on anybody. We kept on trying. Come on."

We climbed the stairs of a half-empty building to the locked third floor. Here in a big dayroom women in various stages of undress sat staring blankly at the walls. Two nurses, watching television in the room, got up uneasily, as we came in.

"These people are just beginning to make a little progress," he said. "They are learning to dress themselves, to make their own beds. You see there are mirrors on the walls, and ashtrays, and vases of flowers. It means they're learning not to throw things. This used to be what is called a 'drag ward.' You had to drag 'em everywhere. Now they'll usually do what you tell them."

He stopped in the doorway of the long ward where the beds were lined up. Suddenly he shouted and began to run. In a corner of the ward a woman lay huddled between the beds. Moskovites ran to her, knelt down beside her, grabbed her arms and began to lift, yelling, "Up! Up! Up!" Her face began to crumple, contorting into the weird grimace of a woman weeping without tears. "Please," she begged. "Please! Please!" Moskovites tugged at her, almost manic in his anger—not at the whimpering woman, but at the attendants who had failed to notice her. "Get her up," he shouted, and they lifted her to her feet. Beneath her lay a crumpled dress. She had been on her way to the little ironing room in the corner of the ward to iron a dress—the simple task she had been assigned. The nameless horror that besets the schizophrenic had seized her and, unnoticed, she had lain down between the beds, curling into the fetal position, trying to retreat from the terrifying world into the silence and the darkness of the womb.

The nurses, taking her by the arms, led her gently to the ironing board. As they stood beside her, she straightened, looked about and calmly took up the iron. Moskovites smiled and patted her on the shoulder.

"Cruel?" he said, as we left. "No. The cruel thing would have been to let her lie there, which is what we'd have done in the past. Now I'll show you a room full of women who were once just as helpless and frightened as she is."

We drove to an old building where 34 women—all of them chronic schizophrenics, all of them once absolutely useless to themselves or to society—were busy sewing precut blouses on industrial sewing machines. Here, on a project called PROP (for Patient Rehabilitation Occupational Program), they were earning money while learning a skill. In a few months the more responsive of them would go to a home in the outside world.

Nellie, 43, gray-haired, brown-eyed, was a young and pretty woman when she came to the hospital 15 years ago. (This is not her real name; fictitious names are used for all patients mentioned in this article.) When Moskovites began his program of remotivating the chronic schizophrenics, she was foul, filthy and withdrawn. Now she lives outside in a foster home and comes back by day to work in the sheltered workshop. Neither she nor her companions could hold a job except in a "sheltered" situation. Here, though their sewing must meet a certain standard of quality, they can work at their own pace—which is about a third that of the normal outside worker. Nellie, in a week, will spend about 34 hours at her machine, and her piecework pay will average 98 cents an hour. The state supports her in the foster home. With her earnings she buys her clothes, cosmetics, cigarettes and other personal items. She goes and comes to the hospital on the bus, by herself. She is not "cured." There is no known "cure" for schizophrenia. But under mild sedation and in a protected environment, she can cope with the routine patterns of normal living. She is a useful person again. She will not die a howling lunatic on the back wards.

Katherine, white-haired at 51, with a smooth, placid face, came to the hospital when she was 22. Now she, too, was almost ready to leave, but whenever her departure was mentioned she would tremble and begin to whimper.

"She's still a little afraid," said John Moskovites. "It is a big step." He put his arm around Katherine, hugged her and patted her cheek. "She has been going out already, buying the little things she will need when she goes to a foster home," he said. "She went out the other day with Nellie and a staff

volunteer. She bought a blue washrag. Nellie bought a pink one. Katherine came right back afterward, because the crowds scared her. But that's all right. Now she knows that after she goes out to live, if she gets scared she can always come back."

At Boston, with its open gates, there is a constant going and coming of patients. Some go out to work by day and come back to the refuge of the hospital by night. Others sleep in foster homes at night and come to the day hospital in the morning. In the concept of the therapeutic community, the day hospital is as important as the 24-hour custodial institution. The very fact that it does not provide bed care is one of its great advantages, many doctors believe, for the bed is an invitation to the regressed and frightened patient to withdraw still further into his world of fantasy. There are also patients who are best served by not being brought to the hospital at all. Treatment teams from the hospital—a doctor, a nurse and a social worker—go to the patients' homes for periodic calls.

These house calls by the psychiatric team were begun under Dr. Greenblatt, on the theory that the visits would give the treatment team an invaluable insight into the problems the patient faces, the forces that are destroying him. Under Dr. Cole's administration, a young social worker, Dr. David Kantor, has pushed the theory one step further. He assigns medical students to live in the home with a discharged patient and his family, thus exposing themselves to the family pressures that the patient himself endures.

Even when patients are too sick to live at home, this need not mean the severing of all family ties. Visitors are sometimes startled to see a psychotic mother with her tiny baby in her arms—a form of therapy Dr. Greenblatt introduced at Boston State after seeing it tried successfully at the Massachusetts Mental Health Center. "This was a tough decision," Dr. Greenblatt says. "It is difficult to accept the idea of allowing babies to live in wards with seriously ill adults, whose actions might be unpredictable—particularly when the disturbed mother may have hostile feelings toward the child and to her marriage. There were other dangers, too. For instance, would patients get jealous of the baby for receiving so much attention and try to hurt it?"

He opened a brown-backed folder, "Let's take a look at a case and see what happened." He read:

"Mrs. P., twenty-two years of age, gave birth to a son the day before she received a college degree. This was a bitter disappointment to her because she had wanted to go on to graduate school. It meant that her husband, also a student, and with whom she was fiercely competitive, would continue his studies without her. She rapidly became inadequate as a housewife and mother, lost vitality and became depressed and suicidal, and was hospitalized. After two months of therapy she indicated her desire to have the baby with her, and the child was accordingly admitted at age eighteen months.

"At first, caring for the child was drudgery, for it was the coming of the child which had caused all this anger and frustration. Once she burst out screaming, 'I hate it! I hate it!' Gradually, however, she discovered that she actually enjoyed being a mother, and she was rewarded repeatedly for her growing confidence in caring for the child. After six months both mother and baby were discharged, with follow-up in the aftercare clinic."

The experiment confirmed what other doctors had discovered—that the presence of the baby on the ward tended to bring out the best in the other patients. Most of them welcomed it; others took its presence as a matter of course. Those who had aggressive feelings stayed away from it. Now it is not unusual to see babies, cheerful and contented, on the wards. Their presence, Greenblatt feels, adds warmth and gentleness to the surroundings.

Many patients, less fortunate than Mrs. P., have been in the hospital so long that they have no family left outside, no home to go to. Others cannot go back to their families, for it was the abrasions of family life that sent them to the hospital. Yet they cannot live alone. The answer, as Boston State Hospital has worked it out, is a highly effective system of family care, in foster homes chosen by the hospital for their friendly homelike atmosphere.

In Massaschusetts, as in other states, the change in hospital population has followed a curious and somewhat disturbing pattern. While the older patients are moving out, admission records show, more and more young people are coming to the hospital. For example, bed patients 35 to 44 years old—the age group in which most of the schizophrenics are found—have been decresing by three percent a year, but at the same time patients under 15 have increased by 16 percent a year, and 15-to-24-years-olds by six percent.

Recognizing this new trend, Boston State now lays particular stress on the treatment of the mentally ill adolescent. Under the direction of Dr. Anton O. Kris, some 40 to 50 disturbed youngsters 15 to 18 years old are now enrolled in the adolescent program.

They live on the wards with adults—"If you put all your adolescents on the same ward, they'll tear your hospital to pieces," Dr. Kris says—but they spend their days together, in a program of intensive treatment. Two old buildings left empty by the decrease in adult patients have been renovated with the help of the youngsters themselves into a community house with playrooms, workshops, a lounge and a place to dance. Classes are conducted by teachers from the Boston Public School System, and there is an active program of sports for the young patients.

"The main thing we do here," says Dr. Kris, "is to go deeply into the background of every disturbed child that comes to us. Many of our kids come from impoverished or broken homes. When we have finished our study, we know the pressures and distractions a youngster has had to endure and, by understanding him, we are able to teach him to understand himself. For instance, if a boy knows why he has strange angry moods of rebellion, he can begin to control them, and he will not let them wreck his life."

Teen-agers are among the most difficult mental patients to handle, and the professional attendants are not always as gentle and understanding with them as Dr. Kris would like. Dick Sullivan, a stocky, amiable student from Northeastern University, recently described his experiences with a schizophrenic 17-year-old named Betty:

"One thing about Betty was that she was a terribly strong girl. She got hold of some glass one day and cut up a few of the attendants. She also broke a chair over someone's head. They tried to tie her down in the ward, but she got loose and ran outside. They finally caught her in the reception building where I was and asked me to help bring her back. I tried to explain to her that everything would be OK, but that she had to be good and not try to run away. She was pretty scared, but did what I asked. I found out that if you could calm her down, she was really a sweet kid—but no one would take the time with her. When I finally got her back to the ward, they immediately put her in seclusion, in an empty room with a single window. I remember one of the attendants yelled at me from down the hall, 'Don't leave that damn girl in here—we don't want her.'

"Some of the attendants really care about the patients. Others . . ." he shrugged. "It's definitely not all good here by a long shot."

This of course is true. Despite its effort to recruit humane attendants and enlist the aid of volunteers with the dedication of a Dick Sullivan, Boston State, like every other mental hospital, is still desperately short-handed. Frequently on the wards at night one young and perhaps very frightened attendant will be looking after 100 patients.

Not only because of the multiplicity of its programs but also because Boston State is an open-door hospital, it needs a high staff-to-patient ratio. Many patients who behave very well when they go out in a small group under the supervision of an attendant get in trouble when they go out alone. One patient traveled across town by taxi-cab to punch her mother in the nose, and then asked her mother to pay for the cab. Another, who was in the hospital for shooting her mother, went home and took a potshot at her father. Men patients, after visting the nearby taverns, sometimes come back and take a swing at an attendant. Dr. Cole, however, has no intention of locking the gates that his predecessors opened, because he is convinced that the difficulties are more than offset by the good it does a patient to know that he is not imprisoned, that he is free to come and go. There are, of course, a few patients on every ward—roughly 200 in the whole hospital—who cannot be allowed to go out. As soon as additional help becomes available, Dr. Cole will bring these patients together in a special security unit where they will receive intensive treatment even though their freedom is restricted.

Boston is not unique in what Dr. Cole calls its drive to "jazz things up, to let a thousand things happen and to try to stimulate new ideas." All across the country the same ferment is taking place. New York, Connecticut, California and Massachusetts still lead the nation in the quality of the psychiatric care they provide, but with the help of a great increase in research grants, even the worst states are now showing considerable progress.

There are still some bad hospitals, and some bad wards in good hospitals. Across the country, though, the old snakepits are vanishing, as public compassion and concern have their effect on state legislatures. But there are still horrors aplenty, and by a tragic paradox one of the foulest of these, despite desperate efforts to improve, is located in the American city that was once the most humane and progressive in its treatment of the mentally ill. In Philadelphia in the 1790's. Dr. Benjamin Rush raised the treatment and study of mental illness to the level of a science for the first time in the United States.

The American Psychiatric Association was founded here in 1844, and the city today is the site of five of the leading psychiatric hospitals in the country. But they are for those who can pay for treatment. The remainder must look to the state hospital, known as Byberry, which over the years has been allowed to regress almost to the status of another Bedlam (the original Bedlam was St. Mary's of Bethlehem, a London asylum of the 16th century). After generations of neglect by a rural-dominated legislature. Byberry only recently has started to become again a place of healing, under the vigorous administration of a new superintendent, Dr. Daniel Blain, one of the country's outstanding psychiatrists.

Dr. Blain came to the hospital as the result of a survey conducted two years ago by the National Institute of Mental Health at the request of the Pennsylvania Welfare Department. The 12 distinguished psychiatrists and hospital administrators on the survey team looked into every aspect of Byberry, denounced it as medieval, and recommended as a first step that a top-flight psychiatrist and hospital administrator be appointed.

At first glance Byberry looks little like the pesthouse described in the confidential report. Located in an industrial section in the northeast corner of Philadelphia, with its 110 red brick buildings scattered over 1,100 acres of trees, shrubs and well-tended lawns, it could be the campus of a somewhat shabby New England prep school. At the time of the NIMH survey, however, 6,100 patients were crowded into quarters built for 4,200. They were tended by 1,800 employees, giving the hospital the lowest staff-to-patient ratio in the state. Of the professional staff, moreover, only 50 were doctors, and only six of these were psychiatrists certified by the American Board of Psychiatry and Neurology. Ten others had some training in psychiatry, and there were 85 registered nurses, though the number had decreased to 69 by the time Dr. Blain arrived.

As superintendent, Dr. Blain, a tweedy, quiet-spoken, vigorous man of 69, still faces an uphill battle. Byberry's inadequacies have been fully publicized—most recently an assault of a woman employee, a suicide, and an accidental death in the hospital, all of which might have been avoided if there had been more staff supervision, attracted wide attention. But the legislature at Harrisburg has been frugal in its support. When Dr. Blain took over in October of 1966, he made an immediate survey of the hospital's needs. He asked for 1,759 additional people—psychiatrists, pychologists, nurses, therapists, social workers and attendants—all of whom he needed desperately. He got 400 attendants. He asked for an operating budget of $25 million. He got $19.7 million. He asked for $33 million in capital funds to build new buildings and to remodel old structures that were falling apart after 18 years of neglect. He got nothing.

The shortages in professional staff still exist. Dr. Blain needs 150 psychiatrists. He has 20 doctors working in psychiatry. Only six of them are certified by the American Board of Psychiatry and Neurology, and three of these six are administrators who give no therapy. He has 7 clinical psychologists but needs 40. He has 70 registered nurses but needs 300.

These shortages still exist in spite of the criticism in the NIMH survey report, which said, in effect, that Byberry was a throwback to the snake-pit era.

Once the door slammed shut behind a patient, he was stripped, bathed, deloused, given a series of shots, issued drab hospital clothing and assigned to a ward where he might remain with only a modicum of treatment until he died. Most wards, the report noted, were so shorthanded that patients were often kept quiet by heavy doses of tranquilizers and by electric shock. There was little effort at group therapy and none at individual therapy. Due to the shortage of staff, seclusion was used extensively to control agitated patients, and it still is, though under Dr. Blain its use has been much reduced.

It is in the detention areas that the lay visitor feels the full impact of what it means to be a patient in a mental hospital. Here there is no furniture—just the oilcloth-covered mattress lying on the floor, the naked light bulb high out of reach in the ceiling. Only the eyes of the patient can be seen, at the little glass- or wire-covered peephole in the door of the tiny seclusion cell, and his voice comes through the locked door as a shrill scream or a mindless babble. When a

nurse opened one of these doors, a gray-haired woman was standing there completely nude. The nurse covered her with a blanket.

"How long have you been in the hospital, Mary?" she asked the woman.

"Six weeks," the woman said.

"She has been here ten years, the nurse said, closing the door. "She could go home if she had anyone to take her. Knowing that her family won't take her back sets her raving. For her own safety, we have to put her here."

No help was sought from, or offered by, the community, which in most other cities provides some small amenities for the patients in their nearby mental hospitals. In every ward at Byberry the surroundings were bleak. The dayrooms were cattle pens where blank-eyed men or women sat and stared into space.

A *Post* researcher, on a visit to the hospital a few days after Dr. Blain's arrival there, gave this description of a geriatrics ward:

"The thing that shook me was the noise. I somehow hadn't expected this wild babbling, jabbering, shouting, chattering and mindless moaning. For the first time I understood what the word 'bedlam' meant.

"All around us as we stood in the middle of the room were the old men, bony, withered of body, their skin yellow as parchment. Over the whole place the strong smell of urine hung like a cloud. The noise, the smell, the horrible sight of two old men, stark naked, huddled in their wheelchairs, stunned me. Involuntarily my mind shut out the dreadful scene. I turned desperately to a nurse. All I could think to ask was, 'How much do they pay you to work in this place?'

"She thought for a moment. 'We got a raise not long ago,' she said. 'Now I get one hundred and twenty-four dollars every two weeks.'

"As I was leaving the ward, a doctor asked if I had seen the old man who huddled in a corner with a sheet over his head. I hadn't. But I had seen the crippled man who came sidling toward me on his hands and knees with a hideous crablike motion, his hands slipping in the filth of the floor, his voice a strange gobbling sound.

"The old-women's ward was even more hideous, for it was their lunchtime and they sat about, some of them stark naked, dipping the soupy food—it looked like beans, rice, meatballes and ice cream—from their trays with their hands. A few could feed themselves with a spoon. Two attendants, harassed, impatient, their uniforms smeared with spilled food, were feeding others who spat and struck at the spoon like children.

By working his staff people almost beyond their endurance. Dr. Blain in the past 18 months has reduced Byberry's bed population from 6,100 to 4,850. He expects to move out another 1,000 to 1,500 in 1968 if federally supported social workers in Philadelphia find places for them in nursing homes, foster homes and geriatrics centers. By concentrating on new patients, the hospital has been able to send them out in three months, on the average, a creditable record.

"We have begun to function as a treatment center, not a warehouse," Dr. Blain said. "But I very much doubt that we can keep up this pace much longer without an increase in staff. The people we have are working twenty percent beyond their capacity.

"Also, the patients we have sent out were the easiest ones. We are getting down to the permafrost now, where it's like chipping ice with a spoon. Every tiny advance, from here on, will come only with tremendous detailed effort."

Shortchanging its mental hospitals is the poorest sort of false economy a state can practice, Dr. Blain feels.

"If we had been able to spend thirty-three million dollars to remodel this place, and if we had twenty-five million dollars a year to operate on for two years in a row, we could reduce Byberry's bed population to three thousand patients or less. When we reached this figure, the budget would begin to decrease. In fact, I would guarantee that I could reduce the budget ten percent a year for five years."

A custodial hospital obviously can be run more cheaply on a day-to-day basis than a treatment hospital, but in the long term it is vastly more expensive.

"A doctor told me that many of these people should never have been sent here at all. They could have made it very well in the protected surroundings of a nursing home. Here they have gotten worse instead of better.

"'There are two thousand geriatrics cases here out of six thousand,' the doctor said. 'It's a case of everybody's grandma being sent up to the Funny Farm to die. They don't belong here but in Riverview, the county home for the aged. But when Riverview fills up, some Philadelphia doctor writes on their

charts: Chronic brain syndrome with psychosis. When he adds, *with psychosis*, we have to take them.' "

The tragedy of Byberry is that, with a little money and a little help, many of these living vegetables might long ago have been transformed into human beings again, able to live under sheltered conditions outside. A small rehabilitation unit, functioning unden a federal grant, carries on within the hospital itself a program of intensive treatment which in eight years has returned some 800 patients to the community, where 550 of them have managed to remain for three years or more. But, with a hospital population of nearly 5,000, an average of 100 discharges a year is not much to shout about. Byberry's routine therapy is now doing about as well.

Unless the legislature comes through in the next few years with a strong transfusion of new money, Dr. Blain thinks, it is hardly likely that Byberry can improve much further. There is, however, one bright hope for the future. Philadelphia, working mainly with federal funds, has done what he considers the best job in the country of setting up community mental-health centers. Ten are planned, with six in operation now, and they inevitably will take some of the pressure off Byberry. Plans are underway to tie Byberry in with each of these centers. By special arrangement among city, state and federal governments, the centers will pay Byberry for handling patients from their "catchment areas" who need intensive care, and the centers in turn will provide aftercare for the patients Byberry treats and sends out.

Dr. Blain does not foresee that under such an arrangement Byberry will revert to its old custodial role. It will in time become a 2,000-bed hospital, he said—1,000 for patients in intensive care, 1,000 for patients taking part in an elaborate program of rehabilitation and vocational training. There is the strong possibility that, for all its unhappy history, Philadelphia will, through its mental-health centers, become once again a model for the nation in its treatment of the mentally ill.

The variations in the amounts different states spent on their mentally ill are fantastic. At the top is Alaska, which last year spent $32.37 per patient per day (with a total mental-hospital population of less than 250); at the bottom is Mississippi, spending $3.99. Kansas, the District of Columbia, Colorado, Utah, Iowa and California all spent more than $15. Alabama and West Virginia, along with Mississippi, each provided less than $5. The national average in 1967 was $8.84.

This is not to say that West Virginians, for example, are naturally less compassionate than Kansans. In nearly every case politics and a shortsighted view of economy are to blame. Moreover, a state's concern for its mentally ill is a cyclic thing. The pattern is always the same. A new governor comes into office and he calls for a crash program of hospital reform. The legislature catches fire and money is provided, the old superintendent is fired and a new one is hired. He builds up a top-flight professional staff, and all goes well for a few years. The bed population drops, and the papers are full of praise for the new programs. Then a new economy-minded administration comes in. The hospital budget is slashed, and the administrator is forced to cut back on his therapeutic programs. Staff morale is shattered. The administrator and the top people he brought with him scatter like frightened birds—to states where a new cycle is beginning.

It is not a bad system for the nation as a whole. Top professional talent in the field of mental health is in extremely short supply, and the recurring cycles help to diffuse it throughout the country. For the states that lose their good people, however, it can be a long term tragedy. When John Bartlow Martin wrote his series on Columbus State Hospital in 1956, Ohio was just beginning a period of hospital reform. But then in 1963 Gov. James Rhodes, taking over a nearly bankrupt state, announced that he was going to fire all hospital personnel hired by his predecessor after a certain date. He quickly rescinded the order, but the damage had been done. At the first hint of a political pogrom, many experts left Ohio.

Early in his term Gov. Ronald Reagan of California spooked many of his top people by announcing that about 3,400 mental-health personnel would be cut from the payroll. Immediately, every hospital administrator in the country, including Dr. Hulusi Tuatay, then superintendent at Columbus State, got on the telephone to California.

Dr. Tuatay, a soft-voiced, smiling, deceptively self-effacing man, had been at Columbus State for nearly 10 years before he was made superintendent; and he served only 2½ years in that capacity before he was promoted to the staff of the state department of mental hygiene as assistant commissioner in charge of research and training.

In his years at the hospital, he was responsible for introducing many of the therapeutic programs that were lacking when John Bartlow Martin visited the hospital in 1956. The bed population stood at 2,700 then. It is down to 1,819 today. The huge main hospital building is still rundown and shabby, and a doctor making his rounds will walk two miles from his office to the farthest ward and back again. But the per diem allowance is up from $2.60 ten year ago to $6.80—still not enough, but an improvement. Fifty doctors, 30 of whom are psychiatrists (though only four are Board-certified), are on the staff now, compared with 18—including three psychiatrists—12 years ago, and all new patients and half of the long-term chronics are now receiving some form of active therapy. There is also an effective program of altercare.

All across the country brilliant and dedicated doctors are using the new developments of the past 10 years—the new drugs, the new therapies, the new understanding of the needs of the mentally ill—in a massive assault on the old concepts of how a mental patient should be treated and a mental hospital should be run. These methods, though aimed at the same goals, are often surprisingly dissimilar. At Boston State the attitude is one of solicitude and gentle encouragement, a technique that works well with schizophrenics. At St. Joseph, Mo., Dr. Liam O'Brien uses methods much less tender to rouse depressed patients from their apathy. He admits that these methods may seem callous, even brutal, to an outsider, but he holds that nearly anything can be done to, or for, a mental patient if the patient recognizes that it is being done in a spirit of love and compassion.

"A depressed patient has a deep sense of guilt," Dr. O'Brien explains. "It may be real or imagined, but at any rate, it's there. And how do you expiate guilt? By penance, of course. You make up for your wrongdoing by accepting punishment. Thus, when the depressed person says to her best friend, 'I am worthless, I'm a no-good,' and the friend says, 'Now, now, that is not true. You aren't a no-good at all. You are a fine, sweet person, and we all love you,' the friend actually makes the person feel worse, not better."

When a patient says to Dr. O'Brien, "I am no good, I don't deserve sympathy," he says, "Very well. Take this brush and start scrubbing the floors." But, he points out, you must do this in a loving, not a sadistic, way.

"Depressed people," he says, "are also very dependent people—they go mooning about the house, one side of them saying, 'I'm no good,' the other demanding of all those about them, 'Gratify me—gratify me!'

"We help them get rid of their sense of guilt by putting them to scrubbing floors, and we gratify them by praising them for what they have done. But there is one more step—though we praise them as they deserve it, we are never quite satisfied, we keep pushing—'There's a bit of dirt there in the corner, there's a heel mark here'—until they begin to show signs of resentment. Then we set them to work at another task, more in keeping with their background than scrubbing floors. As we push, we watch for the first hopeful signs of hostility, because justified anger is healthy anger."

A young Cuban doctor, using Dr. O'Brien's "push 'em until they push back" theory, came to Dr. O'Brien's office looking puzzled. He was not sure he was making progress with a patient, he said. The patient had called him a name, but his English was not good, and he was not sure that this was a manifestation of healthy hostility.

"What did he call you?" asked Dr. O'Brien.

"He called me a horse's ess."

Dr. O'Brien suppressed a smile. "You are making good progress, doctor," he said. "Please continue."

A thousand miles to the south, at Central State Hospital in Milledgeville, Georgia, a blunt-spoken young psychologist, Dr. Robert Francis Heap, ex-paratrooper and Ranger, is experimenting with even more brusque and demanding techniques for remotivating old schizophrenics.

"It is the job of the psychologist," says Dr. Heap, "to assess and modify human behavior, and all human beings—even those who have been judged insane—willingly will modify their behavior in ways that pay off for them."

To test this idea, he set up, in an old ward of Milledgeville, what is in effect a small socio-economic community. On Dr. O'Brien's remotivation wards, when the patient learns to scrub a floor properly, the doctor praises him and immediately sets him a higher task. At Milledgeville, Dr. Heap not only praises him, he pays him. Originally Heap used little wooden tokens sawed from broom handles. Metal slugs have now replaced the wooden currency. With these tokens the patient is required to pay for his bed, food and recreation—everything but medicine.

The first 45 "citizens" of Dr. Heap's experimental community were chosen at random from 90 dull-eyed, foul and unresponsive men living on one of Milledgeville's most regressed back wards.

The remaining 45 served as a control group. They were sent back to a typical chronic ward, there to receive only the routine custodial treatment that is all this desperately shorthanded institution can normally provide. The 45 chosen for the experiment were moved into a special ward, physically as dull and drab as any other, but operated independently of the rest of the hospital. Here they were under the close supervision of a treatment team made up of the psychologist, a medical doctor, a psychiatric nurse, a social worker, a chaplain, and aides specializing in occupational, musical, recreational and vocational therapy.

"In the past," said Dr. Heap, "most of the care and handling of the mental-hospital patient has unwittingly encouraged passive, dependent, abnormal behavior. Our job is to stimulate him, to stir him out of his apathetic acceptance, to make him adaptive, independent, appropriately aggressive in the pursuit of worthwhile goals." One of Dr. Heap's patients immediately proved to be "adaptive, independent and aggressive in the pursuit of worthwhile goals." He got a broom handle and started counterfeiting tokens at such a rate that inflation threatened to wreck the whole project.

When the patient first comes to one of Dr. Heap's token wards—there are now five such wards—he is issued enough tokens to pay for his meals, his bed and his other needs for two days. After these are gone he must work to earn the tokens to pay for every service he receives. "The patient is taught that he must take full responsibility for his own behavior," Dr. Heap explained. "If he gets up in the morning, makes his own bed, shaves, participates in the morning exercises and shows up for breakfast, clean, neat and calm, he has automatically earned enough tokens to pay for his breakfast. If he doesn't do these things, then it is assumed that he does not want to eat. The choice is his.

We don't say, 'If you don't work, you don't eat.' We tell him, 'If you want to eat, you must work.'

Thus the patient must make a decision, and this, in Dr. Heap's theory, is the beginning of healing, for when the patient starts making decisions, he begins to make contact again with the world of reality. So far, Dr. Heap can recall no patient who has chosen to miss more than two meals in a row.

To a lay visitor, what Dr. Heap has accomplished in 18 months is impressive. To reach the T (for token) wards, the visittor must pass through a typical, old-time asylum dayroom where in the traditional moan and mutter and odor of madness, men sit like vegetables, numbed by drugs, or gabble, laugh and dance as their illness seizes them. On the other side of the locked door, in their clean, quiet, well-kept wards. Dr. Heap's patients move about busily at a dozen tasks as they work to earn their tokens. They have at least curbed the symptoms of their illness, and by controlling their conduct, they come nearer to the day when they can walk out of the hospital door. "No man," says Dr. Heap, "can help *being* crazy. He can help *acting* crazy."

Dr. Heap does not claim his patients are cured when they leave the hospital. No doctor who works with mental patients will use the word "cure" in the absolute sense. But his patients do show a remarkable capacity for keeping themselves under control, for adjusting to life in the world outside. The ward records tell a dramatic story: to date, 251 patients have been treated in the T-wards. Of these, 74 percent improved enough to be sent home, and only 19 percent of those discharged have come back. For the hospital as a whole, the relapse rate is 52 percent.

Techniques developed by Drs. O'Brien, Kris, Heap, by Mr. Moskovites and others experimenting with new approaches, will in time alter the pattern of patient population. Schizophrenics, with their withdrawal from reality, their inner fantasies, their delusions, hallucinations and bizarre posturings, now make up 20 percent of all the new admissions to mental hospitals and 30 percent of the readmissions. They are usually young—their average age is 34—and comparatively healthy. As a result, their death rate is low, and they tend to accumulate. Today, therefore, while half the beds in all U.S. hospitals are occupied by mental patients, half the beds in mental hospitals are occuped by schizophrenics.

The next largest segment of mental-hospital admissions is composed of patients suffering from such ailments as cerebral arteriosclerosis and senile brain disease. Their death rate is high, but their release rate is so low that they, too, tend to accumulate. They account for nearly one fifth of the present mental-hospital population.

Many of these patients should never have been sent to a mental hospital in the first place, for there is little that the psychiatrist or the psychologist can do for them. They need a medical doctor, a nurse and, above all, a friend. At huge Colorado State Hospital on the edge of the arid plain outside Pueblo, the senile patient may find all three of these in the person of one man. Dr. Augustus Davison is a short, tweedy, pipe-smoking man with steel-gray hair and sharp blue eyes, a harsh-voiced sentimentalist with a brusque manner, and a special talent for handling the troublesome and cantankerous oldster. Dr. Davison is an M.D., not a psychiatrist or psychologist—he pretends not even to understand their language.

"What do you mean by 'psychiatric treatment'?" he asks. "I don't know—unless it's a patient under the influence of Sodium Pentothal, lying on a couch dredging up memories of his childhood while a doctor listens and a tape recorder takes it all down. So, let us take a look at one of our geriatrics patients. He's an old man, nearly deaf, with swollen feet, a failing heart and an inability to control his bladder—plus, perhaps, a schizophrenic reaction of forty years' duration. What can a psychiatrist do for him? Nothing. The psychiatrist wants to treat a person perfect in health except for a touch of schizophrenia. He takes one look at my old guy and surrenders.

"Ten, fifteen years ago," Dr. Davison says, "I felt that way myself. I had the feeling that a geriatrics patient was hardly worth fooling with—no mind, no hope, no future, and a feeble body that was really no challenge to the doctor.

"Then, for some reason—maybe as I, myself, grew older—I began to understand that a day in an old man's life is as important as a day in the life of a child, and that there must be depth and breadth to life, as well as length of days. So, the challenge *was* there—to the doctor and the nurse and to everybody who had anything to do with the senile old—to bring some beauty, some joy, some usefulness back into the lives of these people who have, in effect, simply been stowed away to die."

Dr. Davison starts by trying to make his patients physically comfortable. "Some of them come in here as bedfast patients," he says, "complete with bedsores and catheters. I say to a man like that, 'Mr. Johnson, wouldn't you like this damned catheter pulled out of you so you can get up and try a walker, or a wheelchair, or get some strength back in your legs and arms? Wouldn't you like to try to put your own clothes on, and wouldn't you feel better getting up and going to the table with the others?' We let him know by our words and actions that we think he can do these things. And he does try. So, out of three hundred and ninety patients in our geriatrics division—and they range in age from sixty-five to one hundred and five years old—only six are bedfast. There is not a catheter in a single patient. I take a very dim view of any institution which resorts to this scurvy trick to keep the sheets dry."

Once his patients are made comfortable with the drugs and medicines that will alleviate their physical ailments, Dr. Davison tries to find whatever hidden reserves of strength they may have left. "We lay out programs for them in group therapy, in occupational therapy of various kinds," he says. "We keep them busy doing something that we hope they like to do. Every night there's something—church, movies, a party, a dance. We let them cook and serve their own meals.

"I know of no patient who cannot, if he tries, do something useful for himself, or for those about him," he explains. "The aged patients come in here with a great feeling of uselessness. They have a great wish to isolate themselves; they hope they'll soon be dead. We explain to them that it is natural and normal for people who have been busy all their lives to find it difficult to adjust when their working days are over. But we let them know that we think elderly people *ought* to be able to take things a little easier, to withdraw from responsibility, from crowds and rush and hurry. They have a right to a gentle disengagement from life.

"Then we try to create in them the feeling that they are still needed, are useful to somebody, that they are entitled to dignity and respect. And when they are cast in the role of a needed, useful, respected person, they rise to the occasion."

In 1961, when Colorado State formed its Geriatrics Release Program, there were 2,400 patients at the hospital who were past the age of 65. By the end of 1967 there were 390. Dr. Davison, who came to Colorado State in 1965, modestly says that his only contribution was fighting to bring medical care "to a level good enough for my relative or yours."

Pueblo, Milledgeville, St. Joseph, Boston—all are relics of the past insofar as physical plant is concerned, although using modern techniques. North of Pueblo,

in Denver, lies Fort Logan, a shinning new prototype of the mental hospital of the future. Only its spacious three-shaded lawns bring to mind the classic asylums of the past. New one-story buildings of glass and steel, with no bars at the windows, are scattered in clusters of "family units" around courtyards bright with flowers. In these separate cottages the mentally ill of all ages and both sexes live on wards separated only by a common dayroom.

With a staff of 720 employees and 1,336 patients—only 198 of whom are on 24-hour care—Fort Logan is one of the most heavily staffed state hospitals in the country. Even so, it makes much use of the patients themselves, and it allows them to know what illness afflicts their fellows. When the day patients arrive to join in the day's routine of therapy with those on 24-hour care, the nurse in charge of the resident patient reads aloud how each of them has passed the night —giving special attention to those who showed signs of anxiety and hostility. These briefings give the day patients a clue to how they should conduct themselves in the presence of the disturbed patients.

Trusted patients are used to guide those still needing help to the various therapy areas. The older people, particularly, help each other; it is a common and touching sight to see them walking together—old men, old women or old couples—hand in hand like children. A conversation I recently overheard between an older woman, very nearly ready to graduate to day-hospital care, and a younger woman, bovine and with drawn and still hallucinating, reveals how one patient may help another.

OLDER WOMAN: My voices are gone. I don't hear them any more. Do you?

YOUNGER WOMAN: Yes. And I am glad.

OLDER WOMAN: Why?

YOUNGER WOMAN: Because I like them. They keep me company.

OLDER WOMAN: Yes, but you are much better, for you don't scream back at them any more.

At Fort Logan, built and organized in 1961 in keeping with recommendations of the Joint Commission on Mental Health, there is a wide range of facilities for therapy—everything from basket weaving and basketball to the soul-searching agony of the psychodrama, in which the patient is induced to re-create, in dramatic form, the situations that drove him mad. There are no seclusion rooms. There are no restraints other than the sedative effect of drugs, and these are administered sparingly. The treatment team may consist of as many as 21 people, including a psychiatrist, a psychologist, two social workers, nurses, and occupational and recreational therapists. Each team will be responsible for approximately 100 patients, about half of whom the team will see and work with every day.

There are some patients whom Fort Logan, as an "open-door" hospital, does not take—for example, those committed under criminal charges. And in the beginning it would not take persons in crisis, though it now has a Crisis Intervention Service on duty around the clock which responds to calls for psychiatric assistance. The patient in crisis is treated with great gentleness. Some months ago as I was being shown through the immaculate wards and corridors. I heard a thin, wild screeching, like the cry of some tropical bird, coming from behind the closed door of an office. A tiny, wild-eyed, toothless little woman, her black hair flying, was struggling in the arms of a woman doctor, screaming in the toneless voice of the deaf: "Hel-l-l-l-p! Murdah! You are a thief. You want my money." She clawed with long fingernails at the doctor's eyes. A nurse came to help, and the two of them led her away, still screaming.

Her story, when it came out, revealed her as typical of the lonely old. Her husband, a successful businessman, had died years before, leaving her fairly well off. For a while she had lived well and pleasantly in her own apartment, then in a boardinghouse of the better class. As time passed, however, she became more and more convinced that her money would not last, that she would die a pauper. Though this was not true, she began a series of moves, from one cheap boardinghouse to another one cheaper still. When the police finally brought her to the hospital, she had been living in a tiny room in a Denver slum, going out at night to ransack garbage cans for her food.

Later that same day I saw her again. She was clean and quiet, under sedation. Her hair had been combed, and there was a ribbon in it. She was sitting in a chair with a restraining table, which prevented her from getting up, though she was free to move her legs and arms. Her eyes were glassy and unfocusing, but contact had been made. The woman doctor she had fought that morning stood beside her. When the doctor started to move away, a bird-claw hand reached out. "Don't leave me," the woman croaked.

Two days later, still in the chair, but under less heavy sedation, she took part in a group-therapy session in which the therapists were seeking to bring a mixed group of patients back to contact with their surroundings by passing around objects of various shapes and textures. For the women, there were bits of cloth—a bright print, a rough grained corduroy, a lush, soft piece of crimson velvet. As they put the velvet on the old woman's lap, her hands, all blue veins and bone, reached down to touch it. Her fingers caressed its softness, and in the drug-dimmed eyes there seemed to flicker a gleam of light.

"Maria likes the pretty velvet," the therapist said. The group sat silent, watching or dozing or staring blankly at something else. The toothless lips moved, and the neck muscles jerked with the effort of speech. The voice came harsh as a parrot's squawk—"I . . . had . . . dress . . . like . . . this . . ."

A psychiatrist, watching, smiled The old woman, wild with terror a few days before, was coming back to contact with reality. Her prognosis: pretty good. Within a few weeks she would probably be communicating as well as her deafness allowed. In time she would go out to a nursing home.

Would she return to the hospital? Would the old fears come back, that people were trying to rob her, that she would die a pauper? Perhaps. That is the risk an open-door hospital must take—that it may send some patient out before he is ready.

"Every time we let one go out, we know we are taking a gamble," said Don Snapp, administrative assistant to Fort Logan's director. "It really shakes up a team when it judges wrong and sends somebody out too soon. You see them leave, full of hope, strength and confidence—and you feel there's no job in the world as rewarding as this. And then you see them come back in, filthy, screaming and cursing, or dull-eyed, wooden, withdrawn. It breaks your heart. But you have to give them their chance, even if nearly a third of them do come back. There's no stigma attached to readmission."

The effort to get people out of the hospital and into the community is now being matched, in some areas, by a determination not to admit them in the first place unless they clearly require the special facilities of a mental hospital. For four years—until his recent assignment to other judicial duties—Judge Joseph Karesh of the San Francisco Superior Court stood as a watchdog between the patient and the mental hospital. A chunky, owlish, soft-spoken ex-South Carolinian with a crew cut, Judge Karesh was appointed Judge of the Psychiatric Court in 1963.

"At that time," he says, "the judge held his hearings in the ward at the county hospital. The poor sick people stood there in their pajamas while the doctor read the record to the judge. Whatever the doctor recommended, the judge so ordered, and nearly every time the order was a commitment to the asylum. The people being sent away didn't have any idea what was happening to them. Sometimes they didn't even know where they were, or who I was, or why I was asking all those questions. The first hearing I held, a patient socked me in the jaw."

Once during a visit by Judge Karesh's father, a rabbi from Charleston, the judge took him along to watch the commitment process.

"One of the patients to come before me was an old, old man," the judge says. "I remember now how pitiful he looked standing there, barefooted, in that old, blue-denim robe. After the hearing, my father didn't say much. But not long after that, he had to go to a hospital himself, for an operation. He was 83, and when I went to see him there, he called me to his bed. When I bent over him, he whispered, 'Son, what happened to that old man?'

"I realized then what a dreadful thing we were doing. I refused to go on the wards any more. I had a courtroom set up in the hospital, though the doctors didn't like that at all. And I said that when a patient was brought to me he was to be dressed. He was to have with him any witnesses he wanted, and a lawyer if he wanted one. I wanted him to know that, crazy or not, he was entitled to his day in court.

"I remember a guy they picked up downtown raising hell, and his record showed he had 'been in Napa' (site of a big state hospital) and that he was 'under the the delusion' that he was the manager of a prosperous business.

"Well, a little questioning showed he had 'been in Napa,' but not in the hospital. He lived there. And he managed a prosperous business there. He wasn't crazy, just drunk, but he came within an inch of being committed."

There is no danger that patients who get their day in a court like Judge Karesh's will be committed by accident. The judge listens to the doctor and then, with great sympathy and patience, questions the person brought before him.

"You need to understand what's going on," he says. "You'll find a woman trying to get her husband committed just to get rid of him, and vice versa. You'll find parents trying to get the courts to put away an unruly child. And you'll find children trying to turn the state into a baby-sitter for their aged and dependent parents.

"You don't have to be a psychiatrist to understand people," said the judge. "I know I take a terrific gamble sometimes, when I refuse to commit. I'll tell you this, though: If a man says he's afraid he's going to hurt somebody, I take his word, not the doctor's."

On the "bench" in his little improvised courtroom at the hospital the judge's manner was infinitely gentle.

A little black-haired woman, neatly dressed, came in on the arm of her father, a short, red-faced, well-groomed man who walked with dignity, as if he were giving a bride away. She seemed to be in her late or middle 30's, but there was something childlike about her. The record showed that she had been picked up late at night, barefooted, banging on the doors of St. Cecilia's church. She realized she needed help, her father said, and wanted to be committed voluntarily—meaning that she could leave the hospital after seven days, whether or not the hospital felt she was ready to go.

"I wonder," the judge said musingly, almost to himself, "if she has the capacity to make that decision."

"I have every capacity," she said. "You want me to tell where I first met you? You were on the corner dispatching cabs. I know everybody. I know all the saints by name, all the fallen angels, all the good angels."

The judge glanced down at the paper in front of him. "Your name is Barbara," he said. "Barbara means 'Blessed.'"

"Yes," the little woman said. "It also means 'strange.'" She grabbed her father's hand and kissed it. "I am a strange, blessed child. I want to go home now, to my mother."

"Her mother is dead, Judge," her father said quietly.

"You go out in the hall and talk to your father for a minute," the judge said. She went out with the little man, leaning on his arm.

The judge shook his head. "I'll have to commit her," he said sadly.

One after the other, the pitiful parade passed before Judge Karesh, 14 in all. Two patients were too ill to be brought into court. The judge went to them on the ward. One, an old woman with white hair turned stiff and yellow, was trying to draw a ragged stocking over a swollen, blue-veined foot. "I'll get ready, I'll get ready," she kept saying.

"Keep her a few days," Judge Karesh said to the nurse. "She doesn't need a hospital. She needs a nursing home."

Then the judge went out. "The pitiful thing," he said, "is their helplessness, their utter helplessness. . . ."

Americans have not always shown this deep concern for the "utter helplessness" of the mentally ill. Colonial America brought from Europe the false belief that insanity is incurable except by bleeding, beating, blistering and purging the patient to make the evil spirit that possessed him so uncomfortable it would go away. There was no attempt at gentler therapy. The wealthy insane were kept locked up in barns or attics by their families; the poor were left to roam the roads, harried from town to town like dangerous beasts, or were shut away in almshouses, or simply put in jail.

This attitude began to change in the early days of the Republic, again following the lead of Europe. In 1792 Dr. Phillipe Pinel unchained the madmen in the asylums of Paris. In England four years later William Tuke founded a Quaker hospital called York Retreat, where insane patients were housed in a family environment and treated as guests. No harsh treatment of any kind was permitted, except the occasional use of a straightjacket or seclusion, to control a maniac patient.

America for a time adopted and improved upon these humane methods, but the era of loving-kindness did not last long. A fiercely competitive industrial America soon forgot what a pastoral and rural America had discovered. Recognition of the madman as a human being had led to the building of the huge old asylums that still stand by the score all across the country. Their original purpose was to restore the mentally ill to health by compassionate and understanding treatment, but under the pressures of an increasingly complex and materialistic society, this goal was abandoned. The asylums became vast warehouses where the insane, the senile, the brain-damaged and the retarded were hidden away together and forgotten.

In the past decade or so we have started to realize again that the mentally ill person is a human being, and that—but for the grace of God—he might be any one of us. This realization, coupled with new therapeutic techniques, has brought a long-absent hope to those so afflicted—not everywhere, by any means, and not in every case, but more and more widely, more and more often.

Today hospital people estimate that one third of the nation's mentally ill, including nearly all those admitted to the hospital for the first time, are receiving good-to-excellent care. Of the remainder—the older, more difficult cases—about a third are getting moderately good care. The others, nearly half of the total, are still getting nothing much except token therapy and perhaps a somewhat more compassionate form of custodial care.

We have come a long way in the years since John Bartlow Martin wrote his classic INSIDE THE ASYLUM. There is still a long way to go. In 1956, when a doctor walked through the wards and a patient grabbed his arm, and, pleading, asked, "Doctor, when can I go home?" the doctor automatically answered, "Tomorrow," knowing that it was a lie. Today he can truthfully say it to thousands of patients, for, in the words of Dr. Charles E. Meredith at Pueblo, "Tomorrow comes more often now." But until we can hold out that hope to all those still hidden away in all the mental hospitals of the nation, the job is not finished. Until it is, each of us must bear in shame a share of the guilt.

Mr. GORMAN. Mr. Chairman and members of the committee, I suppose that it is appropriate to the field in which I am most interested that the report I bring you today is somewhat schizophrenic in nature—there are remarkable signs of progress in some areas of the fight against mental illness but also severe budgetary restrictions which, if enacted, will paralyze our efforts to replace the large custodial mental institutions with a network of mental health centers in the heart of the community.

The drop-in patients confined to our State and county mental institutions accelerates at an almost miraculous rate. As of June 30, 1967, there were 426,000 patients in these State and county mental hospitals, and there are about 300 State and county public hospitals. In the 12 years since the introduction of a variety of effective psychiatric drugs, we have cut the population of our tax-supported mental institutions by 132,000 patients. This is almost 25 percent below the national census of 558,000 patients in 1955—the last year before the introduction of the drugs. Even more remarkable, last year's reduction is the highest in history—a drop of 26,000, or approximately 6 percent below the comparable 1966 figures.

I do not think, Mr. Chairman, these statistics in any way convey the human satisfaction in a person restored to productivity, to a father restored to a family, to a mother restored to a family, to a young child who has been in trouble returned to a school. This has been a heartening development, and it is due in tremendous degree to the actions of this committee and to your sister committee on the Senate side.

I can well remember the skepticism and the derision which greeted our projection—contained in President Kennedy's historic mental health message to the Congress in February 1963—that by 1973 we could achieve a reduction of 50 percent in mental patients consigned to these State and county institutions. They thought we really were as crazy as some of the patients confined to the hospitals. If we can maintain the pace of the last 2 years—in which we have attained an average reduction of 25,000 patients a year—we will reach President Kennedy's goal and, much more important, we will bring new hope and new life to several hundred thousand mental patients and their sorely troubled families. So I think we are really on the way to achieving the goal. It is also an argument for Irish optimism. If you are optimistic, you do not have to be smart.

I have been advised by a few of my faint-hearted friends, both in and out of the medical profession, to be somewhat more conservative this year in asking for additional moneys for the National Institute of Mental Health. I reject such advice as unwise and immoral—I believe it is my duty and obligation to this committee, which has done so much over the past 20 years to further the fight against mental illness, to present a full and honest picture and then let the committee arrive at its own conclusions. I think that is our function here before this distinguished committee this morning.

You and I have no reason to be defensive about these increased mental health expenditures. Statisticians in the field have recently estimated that because we have 426,000 patients in our mental institutions today—as against 717,000 patients who would be there right now if the pre-1955 trend had continued; that is the upswing in patient population, we have saved State and county government approximately $8 billion in patient care expenditures and capital construction costs for new hospital beds. To quote the Madison Avenue advertising vernacular, no other organization can make that claim. I remind this distinguished committee, as I did a year ago, that this enormous and carefully documented saving is more than four times what the Congress has invested in the National Institute of Mental Health since its first appropriation in 1947.

In noting these significant gains, I do not want to delude this committee into believing that we have conquered the problem of mental illness in this country and all is sunshine and roses.

Far from it. Just 2 months ago, Secretary Cohen released the findings of the first comprehensive study of the economic costs exacted by mental illness. Covering the calendar year 1966, the study indicated for the first time the staggering price of mental illness to our citizens; more than $20 billion a year. Of this sum, $15.5 billion is attributed to losses in individual productivity; the remaining $4 billion is attributed to the single year cost of treating and preventing mental illness. Treatment costs hit hardest at thousands of families who literally went broke paying for psychiatric care for a loved one; the study estimates that patients, or their families, provide $500 million a year for treatment costs alone, a not inconsiderable burden on the middle income or low income groups.

Commenting on this study, Secretary Cohen said:

> The tremendous waste of mental illness revealed by the 1966 NIMH study shows the need for continuing efforts at every level of Government and by all citizens to help reduce further the cost of such illness.

Mr. Chairman, if the President's budget is sustained, the National Institute of Mental Health during fiscal 1969 will be permitted to spend less than $100 million in support of research which is the only way in which we can cut down the truly fantastic annual costs of mental illness. In other words, we have got to get more research going.

As one who reads the daily newspapers out of a sense of duty, and the Congressional Record to seek true enlightenment, I am aware of all the bromides about guns and butter, and the hoary premise that we can't have both. I am not terribly interested in butter, I have to watch Mr. Laird from Wisconsin. I am on a diet, I can't eat butter right now, nor am I interested in the billions of dollars we spend each

year for freeways, parking lots, and annual checkups for that most precious possession of 20th century American civilization, the automobile. But I am interested in people, and I respectfully remind this committee that this exotic disease called mental illness last year incapacitated more than 4 million people and filled close to 50 percent of all of this Nation's hospital beds.

In peacetime or in wartime, this is a savage indictment of our sense of values; I, therefore, confess that I cannot assume a mendicant posture in seeking desperately needed moneys from this Congress for these long suffering people.

Mr. Chairman, we therefore, propose a carefully documented budget of $327,485,000 for the National Institute of Mental Health during the coming year—an increase of approximately $48 million over the obviously inadequate budget recommended by the administration.

At this point I would like to highlight the major items in our proposed budget:

The administration contends that it is increasing the amount of money available for research grants by approximately $6½ million over last year.

In the first place, this claimed increase is somewhat specious—$2,300,000 more than last year is charged against the Institute's contribution to the general research support program administered by the National Institutes of Health, so that the actual increase is a little more than $4 million—less than last year's percentage increase.

When you read the fine print of the administration's background justifications, you discover that the claimed increase is really no increase at all. For example, according to these budget justifications, the NIMH will be able to support only 575 new research projects in fiscal 1969—58 less than last year—because the amount allocated to new research projects has been cut by $2.8 million. If this is progress, we want less of it.

Budget justifications alone do not tell the real story. I have served on the National Advisory Mental Health Council for 6 years, and no interlude in that time was more depressing than the recent March 25–27 meeting of the Council. Because of budgetary restrictions and the rising costs of research projects, we turned down more new research applications than at any previous meeting I have attended. In many significant areas of psychiatric research, we rejected more than 50 percent of applications which had been scientifically approved with high priorities by study sections composed of some of the most distinguished scientists in the country.

Time does not permit a full discussion of the really harmful consequences of these actions, but let me highlight just a few areas where this restrictive budget has forced us to hold down areas in which the Congress has expressed deep interest:

Two years ago the Institute, responding to professional and public pressure to develop a focal attack upon a disease which claims at least five million victims, established a National Center for the Prevention and Control of Alcoholism. To head this Center, the NIMH recruited one of the most distinguished research investigators in the field of alcoholism in this country. We gave him an impressive title, but we have never given him even a portion of the funds to mount a really effective research attack upon alcoholism.

For the coming year, the administration recommends less than $5 million for all of the research, fellowship and training activities of this Center—a magnificant increase of less than $300,000 over last year. This is hardly enough to support even one of the regional centers on alcoholism which the director of the Center is trying to establish.

There is more rhetoric and less money in this difficult field of alcoholism than in any area of which I am aware. There are magazine articles galore on the multibillion-dollar cost of alcoholism to industry, there are pivotal court decisions which proclaim that the chronic alcoholic is a victim of a disease and must be treated rather than jailed, and so on ad infinitum. Conversely, there is a tragic lack of realization that we can spend billions of dollars building detoxification units to dry up the alcoholics without answering any of the fundamental questions concerning the causes of alcoholism and its prevention.

We therefore recommend an additional $4 million over the administration budget for the research, training, and demonstration activities of the National Center for the Prevention and Control of Alcoholism.

We are plagued with the same credibility gap between rhetoric and performance in this field. The newspapers and the magazines are replete with articles on the drug problem; congressional committees hold seemingly endless hearings at which witnesses ventilate their frustrations about the absymal lack of any scientific answers to drug addicition and its consequences, particularly among the youth of our Nation.

The National Institute of Mental Health has tried valiantly to respond to these pressures. Its Director, Dr. Stanley Yolles, is one of the Nation's acknowledged experts in the field of drug addiction. In January, 1967 he set up, with strong congressional encouragement, a Center for Studies of Narcotic and Drug Abuse. Pulling together funds from various sources, last year he allocated approximately $4 million to this Center. This year, the administration recommends a paltry increase of approximately $600,000 to finance the Center's broad mandate.

This is obviously far short of what is needed to do the job; we, therefore, recommend an additional $2 million for the Center's activities during fiscal 1969.

It is reliably estimated that several hundred thousand patients are admitted to our mental hospitals each year with severe depression, and that anywhere from 2 to 3 million people are treated for milder forms of this disease in clinics and in the private practices of both psychiatrists and general physicians.

In the fall of 1966, the National Institute of Mental Health convened a task force of some of the most distinguished research investigators in this field and asked them to map out a broad research attack upon this most disabling illness. The task force reported early in 1967, recommending an initial yearly outlay of $4 million which would increase appreciably over the years. However, last year the administration recommended $2,725,000 for this activity; this year, it proposes a small increase of $3,155,000 to cover all of the research, fellowship and training activities of the Center on Depression. It is a most depressing recommendation.

We therefore recommend an increase of $1.5 million for this vital work during the coming year, realizing at the same time that this

recommendation does not provide the level of operation suggested by the 1966 task force.

Again, the story is the same weary and tedious one—the increased concern about the rising number of suicides in this country pressures the National Institute of Mental Health to move into this field. It is estimated that 50,000 people will take their lives this year, and that eight times that number will make one or more suicide attempts.

Responding commendably to heightening public awareness of the problem, the National Institute of Mental Health sets up a Center for Suicide Prevention, and it recruits a scientist generally regarded as the most brilliant investigator in the field of suicidology as its director.

In the first year of its operation, the Center was awarded $2,300,000 to solve the problem. For fiscal 1969, the administration provides a suicide-inducing increase of less than $300,000.

We, therefore, recommend an additional $2 million for the activities of the Center for Suicide Prevention during fiscal 1969.

This Center was created in July, 1966 in recognition of the growing mental health problems in metropolitan areas. It has a very broad mandate and is designed to work closely with the community mental health center program, the development of mental health components in the new model cities program, mental health problems connected with relocation of families uprooted by urban renewal projects, and in a host of other areas.

During the current year, this very important Center is operating on a skeleton budget of approximately $1 million to cover all of its research, fellowship and training activities. For fiscal 1969, the administration recommends an increase of $500,000.

It is obvious to those of us who serve on the NIMH Advisory Council that this is a most inadequate allocation. We therefore recommend an additional $1 million for this Center during the coming year.

In summary, Mr. Chairman, we recommend an additional $10.5 million over the administration budget to finance a modest increase in the research capabilities of the various centers whose work I have described. I assure this committee that if the current fiscal climate was just a little more salubrious, I would in good conscience feel it my duty to recommend at least twice the increase I have suggested.

Since its inception in 1964, this has been the most neglected of all the farflung activities of the National Institute of Mental Health.

As envisioned by President Kennedy in his 1963 mental health message, this program was to be an historic and unprecedented effort to lift the quality of care for hundreds of thousands of forgotten patients in every one of our publicly supported State and county mental institutions. Under the original Kennedy timetable, we were supposed to reach a funding level of $36 million in 1967, which would enable us to reach all of the 304 public institutions for the mentally ill.

A year ago, appearing before this committee, I warned that if the administration recommendation of $10,610,000 for this program was sustained, we would have to reject more than a score of scientifically approved applications. Unfortunately, the recommendation was sustained and the NIMH Advisory Council last year was forced to turn down 29 scientifically approved applications which would have entailed the small additional outlay of $2,348,000.

In that same appearance before the committee last year, I warned that if the fiscal 1969 recommendation of the administration did not provide a sizeable increase in this program, we would not be able to add one single hospital to this important endeavor. I regret very much, Mr. Chairman, that my prediction of a year ago has proved 100 percent accurate; at the March 1968 meeting of the Council we considered 18 new applications, many of them from severely understaffed mental hospitals in the smaller states. Despite the fact that these applications had very high priorities, and that an equal number had already been rejected by the appropriate study section, we were told that we could not fund a single one of these applications during the fiscal year beginning July 1.

Mr. Chairman, I do not want the committee to misunderstand me. I am very proud of what this program has been able to do with very limited funds over a 4-year period. Those hospitals fortunate enough to receive hospital improvement grants have used them to improve tremendously their treatment potential, particularly in developing new and exciting programs for children and adolescents, for the elderly patients on the back wards of the hospitals, for the alcoholics and for many other segments of our mental hospital population

However, the very lift that has been given to so many hospitals has been denied to many more which are equally deserving. I am an ardent proponent of the new community mental health center concept, but I cannot forget the 426,000 patients still resident in our public hospitals, nor the additional 350,000 patients who are admitted to these hospitals each year.

Since the inception of the hospital improvement grant program, we have reached less than 50 percent of eligible institutions. Over a period of 4 years, we have extended this program to 140 public institutions, but only 120 institutions are covered at the present time.

It is almost impossible to catch up now, but in order to keep faith with President Kennedy's goal, we recommend $6 million over the budget figure so that State hospitals can increase their treatment ability and discharge additional thousands of mental patients to their families and to the community at large.

During the last years of his life, the late John Fogarty—who chaired this committee for so many years and who will go down in history as one of the greatest benefactors of the mentally ill in the entire sweep of our civilization—became increasingly concerned with the fact that we were falling further and further behind each year in recruiting enough new psychiatric personnel to staff all of the new facilities we were building. He therefore inserted in the 1966 House Appropriations Committee report on Labor-HEW the following language:

> At next year's hearings, the Committee will expect a fresh assessment of the requirements for mental health personnel, by professional and sub-professional categories, five years hence and a realistic plan, including estimates of the funds required, for meeting these requirements.

As this committee knows, the NIMH responded to the Fogarty directive by coming up with a soundly documented report on its 5-year training goal. It informed this committee that a minimum of 100,000 mental health professionals in the four core disciplines—psychiatry, clinical psychology, psychiatric nursing, and social work—would be

needed by fiscal 1972, and it projected a funding increase of approximately $15 million a year to reach the necessary level of $187 million in training support by fiscal 1972.

Unfortunately, the administration acts as if the Fogarty report never existed. A year ago, it recommended approximately $100 million for all the training activities of the National Institute of Mental Health, as against the first year recommendation of the Fogarty report for $114 million. The consequences were predictable. The National Advisory Mental Health Council last year was more than $9 million short of being able to fund 106 training projects in state hospitals and university settings in all parts of the country. This is not just a cold statistical figure—we told 2,000 young people who wanted to enter one of the four key mental health professions that while we constantly proclaimed our need for them, we didn't have the money to aid them in any way in their chosen fields.

We will have to pull up the rhetorical welcome mat again this year. The administration proposes approximately $109 million for NIMH training activities in fiscal 1969. This compares with the $133,200,000 recommended as the minimum second step increase in the 1966 Fogarty report.

We faced the unhappy consequences of this restrictive administration request at the March meeting of the NIMH Advisory Council. We were told that we could not fund 138 scientifically approved training applications requiring a little more than $12 million. So the training backlog increases—$9 million last year in approved grants, and now $12 million more in approved grants in fiscal 1969 which we cannot pay. Furthermore, we were told that, in the new training projects area, we would be able to fund exactly two more projects than we did last year. If this is progress, some of us want out.

Mr. Chairman, we, therefore, recommend $133,200,000 for the training activities of the NIMH during fiscal 1969. This is the exact sum recommended for the second year of the 5-year plan ordered by this committee in 1966. It is estimated that we have about 72,000 workers in the four core mental health disciplines now. We will need the full amounts recommended in the Fogarty report over the next 4 years to come within whispering distance of the goal of 100,000 mental health professionals by fiscal 1972.

The administration recommends $10,641,000 to support fellowships in the research area during the coming year—an increase of only $500,000 over the level in the current year.

Under this restrictive proposal, we will not be able to add one single fellowship to the number supported last year. I don't think I have to belabor the committee on this point. We are standing still at a time when there is an enormous demand for increased numbers of research investigators in the burgeoning field of mental health.

We, therefore, recommend an additional $1 million for research fellowship grants during fiscal 1969.

The administration recommends an increase of only $1 million over last year for all of the direct operations of the National Institute of Mental Health, which include its growing intramural research program, the planning of its extramural research programs, the administration of a $100 million manpower and training program, the direction of a myriad of special mental health programs, the staffing of

regional offices and technical assistance to the States, scientific communication and public education, and all other areas of program planning, management, and service.

In the interest of brevity, let me just list a few areas where the administration budget guarantees no progress in the coming year:

The professionals in this area who work out of regional offices in all parts of the country are the lifeline of technical assistance and support to communities planning mental health centers, to State and county hospitals initiating hospital improvement and staff development programs, and to countless other institutions and agencies launching projects in all aspects of mental health. For the past 3 or 4 years, I have been complaining about inadequate appropriations for this activity. I am a little weary of State and county officials calling me and complaining about delays in getting their programs going; my only answer is that the NIMH budget does not provide enough professional hands and legs to cover 50 State programs and more than 3,000 county programs.

For the coming year, the administration proposes the magnificent increase of $97,000 for this vital grassroots technical help. We therefore recommend an additional $2 million so that the NIMH regional and local staff can catch up with the many technical requests for its services.

Last year, this committee noted that it was "encouraged by NIMH activities in scientific information and public education but feels there should be a more rigorous development."

You requested a report on current communications activities and projected plans, with particular emphasis upon the role of the National Clearinghouse for Mental Health Information. As you know, this report has been submitted to you. It is bold and imaginative; it contains a blueprint of how the NIMH can achieve its important goal of bringing to Government officials and concerned citizens the latest information on all of the activities in which it is engaged.

Again, Mr. Chairman, it is the same old story. We have a fine report, but we don't have the money to implement it. For the coming year, the administration proposes $2,555,000 for all of the communications activities of the NIMH; only $9,000 more than last year's recommendation. This paltry increase doesn't even equal the cost of the staff time devoted to the preparation of the congressional directed NIMH report on communications and education.

We therefore recommend an additional increase of $2 million so that we can more adequately tell our elected officials and the people who pay for our budget exactly what we are doing.

The administration recommends $17,325,000 for the intramural activities of the Institute during fiscal 1969; an increase of a little more than a million dollars over the current year's budget.

During the past year, research scientists at the National Institute of Mental Health have received national acclaim for their pioneering work in such fields as depression, alcoholism, sleep patterns, family therapy, and many other areas too numerous to mention. During the coming fiscal year, the Institute hopes to move into a new research building which it will share with the National Institute of Neurological Diseases and Blindness. In connection with that move, the Institute would like to expand its research programs, with particular emphasis upon setting up a special Laboratory on Depressions.

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We therefore recommend an increase of $2 million to accelerate the excellent work currently being done by scientists in the intramural program of the National Institute of Mental Health.

This division has the responsibility to plan and administer all programs directed toward specifically identified problem areas, such as alcoholism, narcotic and drug abuse, childhood mental illness, crime and delinquency, suicide prevention and a new program proposed by President Johnson in early child care demonstrations and evaluations.

Mr. Chairman, this is a very large order, but the administration requests only $4,205,000 for all of these activities; an increase of $675,000 over this year's level of operation.

We, therefore, recommend an additional $1 million over the budget request so that enough additional technical people can be brought on board to work effectively in these vastly expanding areas.

In summary, Mr. Chairman, we recommend an additional $7 million for the direct operations responsibilities of the National Institute of Mental Health. Our total recommendation in this area is $59,875,000.

Exactly 1 year ago, April 25, 1967, appearing before this committee, I noted that "enormous progress has been achieved in a very short span of time in launching the new era of community mental health centers."

Today, I must confess in all candor that I am most unhappy about the administration allotments for the community mental health center program.

The Federal matching funds for construction of new centers have been cut to the point where many States have been told that they must scale down their efforts in this area for the next several years. In many of these States the legislatures, city and county governments and the good citizens of the community have worked valiantly together to provide the matching moneys only to be told now that the Federal Government will not fulfill, for the foreseeable future, its statutory matching obligation in this great cooperative effort.

Last year I did present a number of case histories of States, of counties, particularly where millage levies had been presented to the people on a county ballot, and 85 to 90 percent of these referendums for increased taxes for mental health were passed. When school bonds were being defeated and other bonds for highways were being defeated, the people from North Dakota, Minnesota, Iowa, and many other States in the Midwest were passing bond issues, in other words, to levy additional taxes on themselves for community mental health centers.

Let me cite chapter and verse. A year ago, appearing before the House Interstate Commerce Committee on a 3-year renewal of the basic Kennedy legislation, I pointed out that the administration request of $50 million for the first year of renewal was $15 million less than the amount authorized for matching construction in the original 1963 bill. My testimony was not overwhelmingly persuasive; the committee authorized $50 million in construction moneys for fiscal 1968—the first year of the renewal authorization.

The appropriations history subsequent to the authorizing legislation was an even more crushing disappointment. I think this is important; I want to deal just in hard facts, and not in supposition.

The Congress voted only $45 million for the program. Then the expert slashers from the Bureau of the Budget moved in. In December, we were told that we could spend only $30 million—$20 million under the administration request. This is with all the matching money out in the field from the counties and from the States waiting and ready to go.

Then a month or so later, we were told that we could spend not 1 cent of the 1968 Bureau of the Budget apportionment—it would all be moved over to fiscal 1969. In other words, in one fell swoop we were cleaned out of 1968 money for that year. As if this was not bad enough, the President's recommendation for fiscal 1969 applied the final crusher. He requested only $15 million as the Federal matching portion for the construction of mental health centers in the coming year—$20 million less than the amount appropriated in the first year of the original Kennedy program. In other words, we are going backward but fast.

This terrific slash is supposedly ameliorated by the operation of an intricate shell game—you are allowed to carry over funds appropriated during the previous year in order to achieve a theoretically—and I emphasize theoretically—higher funding level. I respectfully submit that this is sheer budget sophistry. Judging from the experience of the past year, we have little assurance that we will be able to use any of these carryover funds. In other words, they have got the squeeze on us and if they decide we cannot use them, that is it.

Let me say this to the members of this committee, and all of you are experienced in this area: This budget shell game does not fool State and county officials, who know the difference between a theoretic dollar held in reserve and an actual fiscal commitment, and there is a great difference. If the fiscal 1969 recommendation of $15 million for the construction of centers is sustained, 28 States and the District of Columbia will be without current Federal matching money and will have to postpone or cancel mental health centers for which local matching funds have already been provided.

It is well to remember, Mr. Chairman, that before the first center grant was awarded, all 50 States had to complete an intensive, 2-year planning survey to convince the Department of Health, Education, and Welfare that they knew what they were doing and that they would guarantee that all of these centers provided five essential mental health services. As the plans came in, the States were allotted funds on the basis of population and per capita income, and that is the basis of the present allotment.

Permit me to bring the consequences of this budgetary shell game home to the members of the committee. I list the Department of Health, Education, and Welfare's own figures on construction allocations in fiscal 1967 and for fiscal 1969 by State:

State	Fiscal year 1967	Fiscal year 1969
Illinois	$2,349,631	$670,069
Iowa	708,080	192,081
Kansas	578,358	160,083
Kentucky	981,665	268,747
Missouri	1,097,446	325,999
Pennsylvania	2,820,735	798,754
Texas	2,888,542	830,577
Wisconsin	1,039,526	289,074

If you look at Missouri, it is over a million dollars in fiscal 1967, and that was a firm allocation, and the allocation for 1969 is $325,000. That is quite a severe drop. Missouri had the first mental health center grant awarded in the country. It has one of the leading programs in the country. When you cut it 66 percent, Missouri is in trouble.

In Texas, Mr. Casey, there was $2,888,000 for fiscal 1967 and if the 1969 figure is sustained it will be $830,000. Texas is on its way, as you know, in Houston and elsewhere in the State; they have projected 25 or 30 mental health centers. They are not going to do it with $830,000.

The situation in Wisconsin, Mr. Laird, is $1 million in 1967 and $289,000 in 1969, not a small cut even by a budget cutter's yardstick.

In Illinois, Mr. Michel, in 1967 it was $2,349,000, and in fiscal year 1969 it will be $670,000. And Illinois of its own self, with its own tax dollars, built eight of these mental health centers before we even got the Federal Government in the program. So it is not a question of saying Uncle Sam is doing it all; Uncle Sam is doing very little.

Mr. Chairman, among the large States, Pennsylvania currently leads the Nation in the number of centers per population. As a direct consequence of its superb 1964 mental health plan—in which 3,000 citizens were involved over a 24-month period—it has laid out a blueprint for 83 community mental health centers in the next few years. As a result of a model community mental health service law passed by the Pennsylvania Legislature in 1966, community mental health services are now mandatory in all counties in the Commonwealth. The counties will operate the centers, but the State will be responsible for up to 90 percent of the operational costs which the county cannot finance.

Things are really rolling in the Commonwealth of Pennsylvania, but they will come to a chilling halt if the fiscal year 1969 administration recommendation is sustained. The National Institute of Mental Health estimates that by June 30, 1969, it will be $4½ millions short of meeting its share of the cost of constructing these additional centers in Pennsylvania.

Among the medium size States, Kentucky leads the Nation with approximately 13 community mental health centers in various stages of planning and operation. A recent NIMH report submitted to the National Advisory Mental Health Council notes that "Kentucky appears to continue to be one of the Nation's leaders in mental health planning."

Since the inception of the Kentucky program, the Federal Government has fallen far behind in its matching obligations to that State. For example, in fiscal year 1967 the Federal allocation was approximately $2 million short of matching moneys available for construction of centers at both the State and local level. If the inadequate 1969 figure is sustained, Kentucky will have massive grounds for instituting a legal case of nonsupport and statutory default against the Federal Government.

Mr. Chairman, a year ago I stressed the fact that this was no handout program—that State, local, and private funds were providing support in a range of 2 to 3 dollars for every Federal dollar in the construction of these centers. This has held up right through the program. To date, 30 States have adopted community mental health service acts, and hundreds of counties are using local tax funds to help support these new mental health services.

As I said before, by referendum and by special balloting to help support these new mental services, the people have indicated overwhelmingly that they are ready to pay for this at the grassroots, out in the boondocks.

A breakdown of expenditures for center construction reveals that only 30 percent in the last 3 years has come from the Federal Government, as against 53 percent from county and private resources and 17 percent from State government. It is not easy to pull it out of the private sector. It is nice to make a speech on how you get the money out of the private sector, but let me present to the committee a breakdown of how it came out of the private sector.

Ten percent of the moneys are mortgaged. The good citizens had to go to the bank and say, Mr. President, lend us part of the money for a community mental health center—to get it started. Nine percent comes from the floating of local bonds, 17 percent is in cash contributions—contributions from pie sales, barn sales, and every other kind of affair. Auctions. I attended a few auctions and they were awfully good, very interesting.

Another 7 percent is in gifts and pledges. I feel there is tremendous grassroot support for these community mental health centers.

I am proud to note that more than 1,000 organizations—universities, social service agencies, clinics, community and State hospitals—have combined their energies and resources into the development of the 265 community mental health centers now in various states of being.

Mr. Chairman, this is a grassroots program. The good people all across the land have worked day and night to achieve the dream of John F. Kennedy. In 1963, I told this committee that our objective was the construction of 1,000 centers reaching approximately half of our population by 1972.

Again at this point, I think we were accused by many people of smoking opium or some other narcotic.

We have fallen badly behind this goal in the past year, and if the fantastically inadequate figure of $15 million recommended for this program in fiscal 1969 is sustained, we will be hopelessly behind.

We therefore recommend $60 million for the Federal matching portion of the construction of community health centers in fiscal 1969—the exact sum unanimously authorized by the Congress just a year ago. In other words, and very simply, the Congress a year ago authorized $60 million; President Johnson sent up $15 million. I get a difference of $45 million. I am not an actuary and do not own any banks yet, but I can subtract. I get a cut of $45 million, and it really hurts.

This program provides a decreasing amount of Federal support over a 51-month period to aid localities in providing staffing for community mental health centers.

It is again important to emphasize that this is not a handout program. The initial Federal grant for the first 15 months of operation is 75 percent of personnel costs, but it drops rather precipitiously in ensuing years. By the end of this year a number of these local centers will be receiving only 45 percent in matching monies, and they can look forward to a final matching figure of 30 percent next year.

Last year, we fell $2,660,000 short of meeting the Federal share for the operation of these centers. The National Institute of Mental Health estimates that if the fiscal year 1969 recommendation of $64,300,000 for Federal staffing is sustained, we will be $5,400,000 short of meeting our statutory obligations.

I also want to emphasize that the administration has constantly underestimated the unpaid backlogs in both the construction and staffing phases of the community mental health center program. This has happened over the past 3 years, and I have reason to believe that the backlogs for fiscal year 1969 will be 50 to 100 percent more than the administration estimates.

We therefore recommend $70,300,000 for the staffing of community mental health centers in fiscal year 1969.

I think that winds it up. I may sound a little emotional, but I do take my carpetbag and travel around most of the States each year talking to the local county commissioners and the good people at the forks of the creek, and in the last year I have seen this great uneasiness at the county level and at the State level and they say to me, "Okay, Mike, we raised this money, you told us we were going to build a thousand centers by 1973. Where is the Federal Government, where is its matching part of the money?"

This really bothers me. I do not think they have begun to hang me in effigy yet. I think there have been several threats to hang me in effigy. I do not mind that. I think if this keeps up a couple of years, they will hang me for real. I think we have to do something about it.

That completes my statement, Mr. Chairman.

Mr. HULL. Thank you, Mr. Gorman.

STATEMENT OF DR. FRANCIS J. BRACELAND

We will hear from Dr. Francis J. Braceland.

Dr. BRACELAND. I am Francis J. Braceland and I have been a psychiatrist for nearly 36 years. I graduated from Jefferson Medical College in 1930 and was an intern and chief resident at Jefferson Hospital. I began my psychiatric fellowship training at the old Pennsylvania Hospital in Philadelphia in 1932. I was then a Rockefeller fellow in psychiatry in Zurich, Switzerland, and at the National Hospital, Queen Square, London. I returned to be clinical director at the Pennsylvania Hospital until 1941, when I was appointed professor of psychiatry and dean of the School of Medicine, Loyola University.

I have since occupied the following positions:

Special Assistant to the Surgeon General, U.S. Navy, and wartime Chief of the Psychiatric Section (1942–46). I am a rear admiral, Medical Corps, U.S.N.R., retired.

Head of the Section of Psychiatry, Mayo Clinic, and professor of psychiatry, Graduate School, University of Minnesota (1946–51).

Psychiatrist in chief, the Institute of Living, Hartford, Conn. (1951–65); since 1965 senior consultant in that institution; also clinical professor of psychiatry, Yale University; since 1960, lecturer on psychiatry, Harvard Medical School.

I have been in the past:

President, American Board of Psychiatry and Neurology, 1953.

President, American Psychiatric Association, 1956–57.

President, Association for Research in Nervous and Mental Disease, 1957.

President, Board of Examiners for Certification of Mental Hospital Superintendents, 1955.

Chairman, American Medical Association, Section on Nervous and Mental Disease, 1956.

Chairman, National Health Forum, 1958.

Vice-President, World Psychiatric Association, 1961–66.

I am now editor of the American Journal of Psychiatry, the official organ of American Psychiatry, and am a psychiatric consultant to the Surgeons General of the Army, Navy, and Public Health.

Mr. Chairman and members of the committee, I am appreciative of your willingness to hear me. I appear before you as a representative of the American Psychiatric Association; the official body of American Psychiatry which numbers nearly 18,000 psychiatrists. I am here to express the support of that association for the citizens' budget for the National Institute of Mental Health, the budget just detailed for you by my respected colleague, Mr. Mike Gorman.

As a hardy perennial in appearance before you, I have risked boring you by repeating snatches from our early testimony spanning a period of 20 years. There are two main points I would like to emphasize in that regard. The first is that our initial appearances here followed rather closely upon the end of World War II and the early beginnings of the National Institute of Mental Health. This repetition is important this year for the reason that the funds which you appropriated in those early years have paid off handsomely insofar as psychiatric casualties in modern warfare are concerned.

In World War II, the number of psychiatric casualties was alarming, and the cause of great concern. Now, due to careful research and observation, the number of psychiatric casualties from the Vietnam war is remarkably small. The second point I would like to emphasize is that when we came before you 20 years ago, an unconscionably large number of our fellow citizens were confined to large State hospitals, and the prospect was that this number would increase markedly as the population increased.

Now, again due in great part to your help in supplying research and manpower funds, the appropriations have paid off and the number which was expected to be over 700,000 is down to 426,000. Fortunately, it even dropped by 26,000 in the past year. I am especially pleased to bring these reports to you.

In those early years of our reporting to you, and for some times afterwards, the attention of our medical specialty was focused sharply upon individual emotional problems and mental illnesses and, mostly, upon hospitalized patients. Our appeal to you encompassed an apologia and an explanation that our work was with some wonderful people who were ill temporarily and recovery was possible if the person was not isolated and forgotten. And we said, in fact, that if the person was properly and skillfully treated, recovery would be made by a large proportion of them. Our thesis was that these good people were really representatives of ourselves under different circumstances and the dif-

ferences between us were those of degree, rather than of kind. We were actually saying to ourselves and to others, with Lowell:

> Console yourself, dear man and brother; whatever we may be sure of, be sure at least of this: That we are dreadfully like other people. Human nature has a much greater genium for sameness than originality.

This is still true. The difference between us and sick people is one of degree rather than of kind. Fortunately, however, you are aware of the fact that the situation has changed markedly since those early days.

Not only has the mental health picture itself changed but, also our approach to it has changed. Steady advances have been made due to research and more enlightened attitudes, and also we have moved out from behind large stone walls and into the community at just about the right time to be of help with the general unrest which is evident all around us. Federal funds have helped bring this desirable situation about.

My only competence is that of a clinician; a psychiatrist for 36 years and, your permission I will confine my remarks to the Nation's mental health as a clinician sees it today, touching upon important segments with which the clinician deals, and accenting finally the widespread anxiety and depression which besets the population at the present time.

Our situation of general unrest is not altogether unique or unprecedented. There have been other times like this but, in my opinion, the Nation has not witnessed a time like the present with its widespread rioting, draft resistance, and violence, since that time more than 100 years ago when the Nation was at war with itself.

Basically, what is common to such periods, Dr. George Rosen says, is that:

> They are times when societies and their culture, or segments within them, are changing to something else; when the accustomed structure of order, power, beliefs, and meaning, disintegrate and man confronts the inscrutable future not knowing what is to come.

Well, there is no need for me to tell you gentlemen that the old order is changing rapidly and the new directions are not clear as yet. So people will react to the unprecedented changes in a fashion depending on their backgrounds and the weight of outside pressures upon them. Present day anxieties and turmoil will be used constructively by some people, and they will set about to do what they can to be of help to others. Other people will be overwhelmed by the rapidity of change and some will become sick and depressed. Another group will become angry and prejudiced. Still others will take matters into their own hands and be moved to violence. Each person will handle his anxieties in his own fashion.

It is obvious to use now as clinicians that societal factors, such as poverty, urban overcrowding, lack of education, and all factors which lead to despair and personal futility, are as important in populating mental hospitals as are the physical and emotional disorders which we heretofore have studied so carefully.

As yet there is no consensus on how violent behavior can be stopped. The only thing we can agree on is that it must be prevented. To paraphrase the late President Kennedy's apt phrase regarding war, and substituting the word "violence" for it, we might say that: "Mankind must eliminate violence or "violence will eliminate mankind." The

NIMH has been involved in research efforts to develop understanding of the forces of violence as they relate to behavioral sciences, but much more needs to be done, particularly research in the behavioral sciences and in mental health efforts to understand the factors which cause violence.

Behavioral research has already provided us with a relevant body of knowledge on motivation, emotion, attitude, and on individual group and social processes. This information can be collected and refined, but we need to know much more. Today we are face to face with various aspects of general unrest, including its mental health implications. At the level of prevention, there is already significant and useful information about the nature of the system which stimulates social disquiet and leads to mass violence. Some of this material was furnished to the Kerner Commission. The commission requested the data available from behavioral science research which might be of aid to them, and a staff paper was prepared in answer to that request. This material was assembled from various projects in universities and other diverse departments being funded by NIMH grants.

What is being done is to support the training of individuals to study and deal with the issues and problems thought to be related to riots. Thus, social institutions, economic forces, urban planning, human relations, family life, discrimination, cultural forces, and other factors affecting the lives of the poor and minority groups, all are receiving increased attention by mental health and related professionals.

At this point I should interject a note of caution. I, by no means, intend to imply that psychiatrists are soothsayers or, indeed, that they know how to settle the problems which beset unsettled nations. No one pretends that this is so. What I do intend to imply is that psychiatry and its coworkers do possess a body of knowledge gleaned from research and experience which might be utilized, among other things, in trying to understand what is going on. The Director of NIMH said on one occasion: "Much of this material is dispersed. It needs to be collected and refined and put in context with other findings, and then judged on the basis of field trials." One of the problems is that the scientific community appears to be talking to itself, since neither the public or the policymakers act very often as though the word had gotten through to them.

The point here is that this is not the time for budgets to be cut, especially those connected with manpower, research, community, and behavioral sciences. Rather, it is a time to increase them markedly and to encourage efforts to correlate all available material, for the mental health of the Nation is involved.

I am cognizant of the heavy demands for funds being made upon the Congress, and aware of some of the dilemmas you face. I have confidence in your wisdom in meeting these problems, however, and I know too that you will keep in mind the importance of sound mental health in communities, and know that there are large numbers of sick and distressed individuals who cannot speak for themselves in this regard. The mentally disturbed, the addicts, the alcoholics, all of them are poorly understood, and, sometimes, they are badly treated.

When you helped to bring us out of isolated mental hospitals, into the community, neither you nor we knew the extent of the demands which would be made upon us for services and for assistance. The old point of view that mental illness was chronic and refractory to treat-

ment is gone. The new point of view is that most mental illness serves its purpose and disappears, and it does so more rapidly and completely when it is well understood and skillfully dealt with. We see patients now, Karl Menninger says, not as much as persons afflicted with certain diseases, but as human beings obliged to make awkward and expensive maneuvers to maintain themselves. Isolated from their fellows, harassed by faulty living techniques, their reactions are intended to make the best of a bad bargain, and at the same time to forestall a worse one. In other words to insure survival even at the cost of suffering and social disaster.

While social change in the past was measured in terms of historical epochs, centuries, or generations, the rates of economic, social, and technological change move so quickly today as to impose a perpetual pressure upon every individual. Changes in the nature and distribution of the population of the nations have intensified the problems of mental health and have created a general awareness of concern about them. The disappearance of frontiers and the rapid shift from rural to urban living have reduced the opportunities for disaffected or nonconforming persons to escape close scrutiny. There is no longer a satisfactory place for them to migrate.

The increasing trend toward crowded dwelling units in cities has concentrated more people in situations which tend to intensify stress, and at the same time reduces both individual and social tolerance for the inevitable disturbing behavior which arises. We all know of the major social conditions which have stressful effects upon people's mental health. They are reported regularly, sometimes tragically, in our news media. In mentioning these events, please understand again that psychiatrists do not pose as oracles. We cannot change these social conditions, but we can make efforts to prevent illnesses arising from them and we must take care of the people who become disturbed as a result of them. Like Spinoza, we make ceaseless efforts not to ridicule, bewail, or scorn human actions, but to understand them.

We point out that harsh treatment, the feeling of being unloved, quarrels and insecurity, all bring out hostility and strengthen antisocial inclinations in individuals and groups. Emotional deprivation in childhood accounts for later antisocial and sometimes criminal behavior, as well as assorted kinds of mental disorders. Hostility and resentment may show up in defiance of parents and all authority—fathers, teachers, police, military officers, judges, God. It can remain covered up for a long time and emerge later tragically. In families where there is acute tension, children feel isolated and displaced and deformed characters can ensue which will be evidenced later as antisocial or emotionally distressed individuals. Just how do we propose to go about helping with these problems? By moving further into the community with the community mental health centers which you funded and which you have heard so much about. We will go into storefront clinics in underprivileged neighborhoods wherever necessary to really get to people who need help.

Realize, if you please, that the funds which you appropriate for research and for psychiatric manpower have vast implications for mental health far beyond the uses made of them in the purely mental health field. This once neglected discipline has now spread its influence and slowly attracted the help and the demand for help from the community. It began to make contributions to its sister medical

specialties and to military and industrial medicine, shortly after World War II. Its help has also been solicited by educational and religious institutions, and these contributions are slated to increase. I would just like to mention briefly our contributions to these varied disciplines. This will tell you of the company we keep, give you an account of our stewardship, and inform you of the widespread effect of the funds which you are asked to appropriate here.

As to the present day applications of our findings to general medicine, the work of psychosomatic research is well known. Though we have not satisfactorily solved the age-old body-mind problem, our findings are constantly becoming more important. Everything from the diurnal rhythm of our bodies, our so-called biologic clocks, the optimal time to administer drugs, the influence of rapidly changing time zones upon flyers and travelers, the phenomena of sleep, the various chemical and biological phenomena which underlie depressions—all of these have psychological and physiological components. These, plus the remarkable contributions of the sociologists and anthropologists regarding man's behavior, hold exciting prospects for future research in man's mental well-being and in his behavior.

As to the contributions made by psychiatric clinical observation and basic research to military psychiatry already mentioned, they are remarkable as evidenced by the fact that in the Vietnam conflict thus far there is a remarkably low number of psychiatric casualties. This is due to a number of factors, the most important of which are a more careful selection of men, and a more efficient and immediate treatment of emotional upsets at the front and close to the man's own unit.

The knowledge which we have gained from our researches also has helped us to be of assistance in industry. Psychiatry can make noteworthy contributions, and in some instances is already doing so. Its role is consultative and preventive. It can pinpoint causes of time lost and reasons for turnover of personnel. Obviously it is not the function of business or industry to act as nursemaid or psychiatric clinic, but it does seem wise in these days of manpower shortages to eliminate roadblocks to emotional satisfaction and to conserve skillful personnel wherever possible. This utilization of skilled psychiatric help in industry will grow. Unfortunately, however, at present there are not enough consultants to go around.

As to the contributions to education, with the personnel aided by funds from NIMH, I went into detail last year on the type of the problems encountered and their incidence. I shall not take up your time repeating those remarks. You know, however, of the importance of these young people in high school and in college. From them will come tomorrow's leaders. Fortunately, many of their problems are minor and transient. In general, these are basically admirable youngsters, even if they are occasionally difficult. Twice in the month of March 1967, our military leaders in Vietnam spoke of those young men whom they had encountered—mostly drafted men. They said of them:

> Let me tell you, they are the bravest, smartest soldiers we have seen in twenty-six years in the military. They are resourceful on a battlefield. They are giving of their all and doing a fantastic job.

It is evident that once committed, these young people acquit themselves creditably. The problem, of course, lies in the question, how to inspire them? More help in advising them and careful attention to

the mental health of these young people is essential. They represent the Nation's hope for the future.

All of this is by way of report to you and this fantastic array of needs and of efforts, of work being done in the mental health field is being offered to you in justification of the budget which Mr. Gorman has just presented to you. The preventive possibilities are evident. These budgets are not simply for mental hospitals though they, too, benefit from all that is going on in the field.

Mental health research and mental health workers were obviously needed to fill the breech in a number of pressing situations. So true is this that psychiatry, one of the major disciplines called upon for assistance, is having an identity crisis of its own. It must be careful not to spread itself too thinly in an effort to be all things to all people. Basically it has a medical mission. It did not seek these other tasks. They evolved as the specialty evolved in its modern dress. It cannot, however, under any circumstances, fail to respond to the call of the community for mental health is an absolute necessity to it.

Your committee has in the past communicated to the House its concern that mental health research efforts continue to expand. This is essential in these present times of great national unrest. We are in a period as brilliant and as violent as that which surrounded the period of the French Revolution. Mental health research today is providing some exciting findings which portend hope for the future. To interrupt investigators, to ask them to tread water and see their research teams disintegrate and disappear, would be calamatous in this period of great anxiety. I would urge you, therefore, to continue and increase the support of research funds both for internal and external NIMH programs and, like the Bank of Monte Carlo, one cannot guarantee a payoff, but when one occurs it is great in its extent.

With your permission, I shall not go into further detail regarding overall mental health research here, nor comment further on the dire results of any cutback in research funds. That has been ably taken care of by my colleague. Rather, I would like to comment upon several situations which are in need of continued and expanded attention.

We mentioned that in one major preventive approach to the general social unrest which is so evident nationally, the NIMH is supporting the development of community mental health centers throughout the land. When the concept of these centers was evolved, they were though of primarily as a means of group mental health services—mostly for the deprived—but, in general, as places that patients could be treated in their own communities. Now, however, they loom in addition to be centers with possibilities for research and training facilities for programs quite directly related to civil disorders, social unrest and violence; because, on the findings of this research and on our ability to train workers who can understand and influence deprived people, will rest our ability to give them the services they need in the places where they live.

Some 260 of these centers have received Federal grants to help finance construction and initial staffing, and almost 100 of them are operating today. Their staffs are treating mental illness and emotional disturbance but they are also beginning to meet many more needs in their communities than they originally expected to do. Communities are looking to set up and expand the use of these centers and it is certain that their preventive and consultative services will contribute

toward social changes that can ease the pressures and stress underlying violence. This will not be done by mental health workers alone. Rather, it will be a base where physicians, clergymen, and other capable professionals will pool their knowledge and apply their competence to the probems which are presently disturbing communities.

To neglect to expand the number of these centers, to cut budgets now, to fail to help bring these concepts to a broad fair trial, would be tragic. One fears a return of our dispirited group to isolated hospitals if we fail in our efforts to help broaden the base of community centers.

The capable Director of NIMH has told you, I am sure, of his plans to implement President Johnson's statement that one of the immediate objectives of his administration will be to develop "a child health program; to provide for families unable to afford it, access to health services from prenatal care of the mother through the child's first year." I shall not go into detail regarding the programs which have been worked out—in the interest of time—suffice it to say they are, indeed, well conceived and they merit your strong support.

I would like to discuss many more important clinical aspects of problems which face us, but I realize that your patience should not be tried. I would certainly talk about alcoholism and urge you to markedly increase the budget for research and training to help with that scourge. It attacks the high and the low, breaks up families, and distresses children in untold numbers. I would reiterate what I said to you last year, and earnestly seek your help in establishing laboratories to further the understanding of the phenomenon of depression, one of the most painful congeries of symptoms known to us. I say this because usually there is no visible symptom which accounts for the person's distress, and that makes understanding more difficult and the illness harder to bear.

Melancholy is a phenomenon as old as man. The question has been asked why so many great men have been melancholy. Some have lost their lives during periods of depression. I am sure you can recall the sad histories of some of them. Of all of the emotional illnesses treated by psychiatrists in the present culture, depressive phenomena are in the forefront. Depression is the psychiatric diagnosis made most frequently today.

The Medical World News, in a March issue, surveys the subject under the apt title "New Faces of Depression," and a subtitle, "An Old Syndrone With a 1968 Look." The article begins with a quotation from the Greek biographer, Plutarch: "When a man is depressed, every little evil is magnified by the spectres of his anxiety." Plutarch's observation is as apt today as when he made it 2,000 years ago.

I think we are justified in bringing this subject to your attention again for several important reasons:

1. The incidence of depressive phenomena.
2. The basic scientists have gone far in the past several years in determining many of the chemical and physiological accompaniments of the illness.
3. The condition is eminently treatable today. Often self-limited, the condition can be alleviated by drugs and other modern methods of treatment.

Feelings of sadness, hopelessness, or despondency, may arise due to adverse external circumstances in which the individual finds himself.

Whether the conditions be really overwhelming or whether for some reason the individual finds himself inadequate to deal with them, the resulting depression is the same.

Fortunately for most of us, our depressive feelings are only transistory and either disappear spontaneously or after we have worked out some type of positive solutions to the problem responsible. These depressions are obvious and easily recognized, but there are others which are masked to the point where no one but an expert can detect their presence until a full-blown deep depression appears. Here the situation is much more serious, the depressed mood becomes longer lasting, and the attitude of dejection and the train of symptoms which follow in its wake render the individual ineffectual. These depressions are the illnesses most difficult to bear, for unlike medical or surgical illnesses, there are no visible physical symptoms apparent to the sufferers or to others that might explain his distress.

These depressive episodes must be differentiated from grief, a normal phenomenon, and should not be confused with it. In grief the loss is personal, objective, external, and readily understandable. The response it calls forth is realistic and proportionate to what has been lost. Grief, which is the normal expression of sorrow and bereavement which follows the loss of a loved one, is self-limited and gradually subsides.

Psychotherapists call attention to the great effort expended by these individuals who feel that they do not deserve anything in their own right, but must continue to strive and achieve if they are to get someone to love them or to continue to love them. It has long been recognized that these good people are extremely vulnerable to loss of position or status or the loss of material possessions. They are vulnerable, too, to the decline of physical abilities essential to their continued achievement or even with advancing age the loss of certain future possibilities of achievement. Examples of these situations are plentiful today in our period of merges, strict rules for retirement, and the pressures of our economic situation.

Children and adolescents may become depressed and some of their destructive behavior may mask a mild depression as they search for meaningful relationships. They are not our concern here, but we should mention that much of the apathy, boredom, and willingness to enlist in almost any cause except study in college students is of the same genre. The complaints that they don't know what they want to do, the lack of interest in education in general, the feeling of the uselessness of it all, and the coupling of education and attainment with the older generations from whom they are separated, all may be due to underlying mild depressions. It is no longer easy for them to take a moratorium and drop out of college for a while to catch up with themselves, for the draft must be kept in mind. Some of the students deliberately arrange to fail, which fact distresses their parents and brings their plight sharply into focus.

Under these situations, the attractiveness of trying drugs in some form is apparent. They have heard of the pleasure of attaining a "high" and they are influenced to try it by the pressures of their peers. If they are fortunate, the experience will be disappointing or scary; if it proves attractive, they will have some serious decisions to make. While it is true that so-called "pot" is not addicting in the physical

sense, as are the narcotic drugs, nevertheless, there is a psychological attractiveness to it and it is not at all the harmless substance that enthusiasts make it out to be.

We have talked several times about depressions of middle life and earlier thought to be the exclusive property of women and due to the change of life. We decried both of these assumptions and noted the occurrence of depression in men a decade later, and suggested that the only relation to change which was present was the individual's inability to change in accordance with the surrounding changes which faced their age group in the present culture.

We noted, too, that persons who were rigid, conscientious, and inclined to perfectionism, were vulnerable to depression in this period, They were not easily influenced even though circumstances around them were changing rapidly. These are usually fine people but their rigidity becomes a hazard when their external circumstances call for marked change and they are unable to comply.

As to the reactions of older people to the present general unrest and rapidly changing cultural and economic environment, they are understandable. In the present era, with youth in the center of attention and in "children's crusades" in politics and the search for young people to occupy executive and top positions, men in the older age groups are understandably insecure. Very often they find themselves unable or unwilling to keep up with the pace and they withdraw, react in a depressive manner and become chronically ill.

Mr. Chairman, if I have become too clinical in this presentation again, I assure you that it is my only competence. I chose this method of presentation to you rather than repeat line for line the budget needs which has been done so ably by my colleague, Mr. Gorman. I do want to emphasize heartily, however, our agreement with him. The mental health field has opened up. It has great possibilities, and I know that you and your committee members will insist that it continue its activities. The mental health of the community depends upon the health of its individuals, and the mental health of the Nation depends upon the health of its communities.

(Attachment follows:)

NIMH FISCAL 1969 BUDGET INCREASES PROPOSED BY CITIZENS

	1969 President's budget	Citizens budget
Research	$81,159,000	$91,659,000
Hospital improvement	10,610,000	16,610,000
Training	109,046,000	133,200,000
Research fellowships	10,641,000	11,641,000
Early child-care projects	14,500,000	14,500,000
Direct operations	52,875,000	59,875,000
Total	278,831,000	327,485,000
Total increase requested, citizens budget	48,654,000	
Community mental health resource support:		
Construction grants	15,000,000	60,000,000
Center staffing	64,300,000	70,300,000
Narcotic facilities	8,000,000	8,000,000
Total, community resources	87,300,000	138,300,000
Increase for community resources	51,000,000	

Dr. BRACELAND. Thank you very much for hearing me.
Mr. HULL. Thank you, sir.

STATEMENT OF VICTOR BUSSIE

Our next witness is Mr. Victor Bussie, president of the Louisiana AFL–CIO.

Mr. BUSSIE. Mr. Chairman and members of the committee, my name is Victor Bussie. I am president of Baton Rouge, La., AFL–CIO and I have been since 1956. Rather than read my entire prepared statement, I would like to ask permission to have it included in the record.

Mr. HULL. Without objection.

(The statement follows:)

STATEMENT OF VICTOR BUSSIE, BATON ROUGE, LA.

Mr. Chairman and members of the committee, my name is Victor Bussie. I am a resident of Baton Rouge, La., and I am president of the Louisiana AFL–CIO.

I am appearing today in behalf of the National Association for Mental Health of whose board of directors I am a member. I have been a citizen volunteer in mental health association work for the past 10 years, and during 1965 and 1966 I was president of the Louisiana Association for Mental Health, an affiliated Division of NAMH. I deeply appreciate this opportunity of presenting our views before this subcommittee.

I am quite certain that most of the members of the committee, including your distinguished chairman, reside in counties in which there is a mental health association; I am absolutely certain that all of you reside in States in which there is a State mental health association. These are among the more than 800 affiliated chapters and divisions of the National Association for Mental Health. We are a volunteer, nonprofit, citizens organization with 1 million members and associated volunteers.

These are the concerned, informed citizens in towns and cities across the country for whom I speak; but more importantly, I speak also for the more than 1 million patients residing in the hospitals—both public and private—and the uncounted other millions receiving treatment as outpatients.

Mr. Chairman, it is our purpose and our fervent hope that by appearing here today we can help these unfortunate victims of mental illness and also the 1 in 10 of all of us who at one time or another in our lives fall prey to this serious, incapacitating illness.

As in years past, a representative of the National Association for Mental Health is appearing before your committee to testify in respect to the budget of the National Institute of Mental Health and again this year we are urging that the Congress appropriate funds in sufficient amounts to enable that agency to carry on and expand its vital work.

This year however, this task is more difficult than ever before because of the grave problems confronting our Nation. No one can ignore the fact that there are many pressing demands upon the Federal budget dollar and we citizens, comprising the membership and associated volunteers of the National Association for Mental Health, have considered carefully the position we ought to take this year in the face of the current situation. We have concluded that our primary responsibility is not to assess relative priorities among those many demands but rather to present, in behalf of the mentally ill of this countrry, our views as to the present unmet needs of these afflicted citizens among us, and our best judgment as to the Federal funds required to help in meeting those needs.

Basically, our position, outlined in greater detail below, is first, to recommond substantial increases for research and manpower training; and secondly, to recommend the appropriation of the full amount of $60 million for fiscal 1969 for construction of community mental health centers as authorized by the Congress last year.

Accordingly, we respectfully propose that the Congress appropriate for the fiscal 1969 budget of the National Institute of Mental Health the sum of $364,996,000 for its grants program and direct operations, an increase of $86,165,000 over the President's budget of $278,831,000 for these purposes; and for commu-

nity mental health resource support the sum of $138 million, an increase of $50,700,000 over the President's request of $87,300,000.

GENERAL INADEQUACY OF THE PRESIDENT'S BUDGET

The President's proposed budget, exclusive of community mental health resource support, totals $278,831,000, or about $30 million over the $248 million requested for 1967. This is approximately a 12-percent increase. Considering the magnitude of the problem, and the Government's declared commitment to a truly national program to combat that problem, a 12-percent increase is so modest as to be inadequate. As a matter of fact, that increase when shorn of budgetary "adjustments" shrinks to the point where barely enough is provided to maintain the program at its present level and certainly not enough to provide for urgently needed expansions.

With respect to the President's request for community mental health resource support, the total of $87,300,000 requested for fiscal 1969 is almost $13 million below the $100,168,000 requested for fiscal 1968. Moreover, in its $15 million request for construction grants, the budget requests are for $35 million less than the $50 million requested for fiscal 1968. The National Association for Mental Health regards this reduction as tantamount to a repudiation of the declared commitment to mount and prosecute a full-scale national mental health program.

Specifically, the major increases recommended by the National Association for Mental Health relate to research, manpower training, and community mental health resource support.

RESEARCH

The proposed budget allocates $81,159,000 for research. The National Association for Mental Health purposes that this amount be increased to $125,655,000. In making this proposal, the National Association for Mental Health is guided by the opinion of its Professional Advisory Council composed of distinguished professionals from the various mental health disciplines, and experienced knowledgeable laymen who have devoted many years, as volunteers, in working for improvement and expansion of services for the mentally ill.

Mr. Chairman, we believe that the amount requested in the proposed budget for research is wholly inadequate for an attack on a set of problems for which we acknowledge we have so few answers. While we have learned a great deal in recent years about better ways of treating the mentally ill, the fact remains that there are still wide gaps in our knowledge which can only be filled by research. We need basic research; we need research into the effectiveness of existing services, and we need to investigate thoroughly how to utilize research results.

MANPOWER TRAINING

We propose that this amount be increased from $109,046,000 to $125 million. It hardly seems necessary to cite for this committee the oft-expressed need for intensive and expanded training programs to meet the critical manpower shortages in the field of mental health. The pressing manpower shortages and the growing need for an expanded armamentarium of mental health workers demands a substantial increase in the training budget.

COMMUNITY MENTAL HEALTH RESOURCE SUPPORT

We recommend $60 million for construction of community mental health centers for fiscal 1969, an increase of $45 million over the $15 million requested in the proposed budget. Here we are recommending precisely the amount which the Congress authorized just 1 year ago.

This program is unquestionably the keystone of our national mental health program. The citizens of this country, and their State and county governments, have toiled hard to plan, and finance, and to create community mental health centers. They have done so relying on the declared commitment of the Federal Government, a commitment now in danger of being repudiated.

Mr. Chairman, let no one be unmindful of the possible consequences of the Federal Government's failure to abide by that commitment. We are still far short of the number of community mental health centers which all authorities agree are required. The establishment of hundreds of planned centers, now on the verge of actually coming into being will be deferred, some perhaps abandoned. We cannot afford any delay nor can we afford a loss of even one such planned center.

An item-by-item breakdown of our budget proposals is appended to this statement. This shows the various activities, including those discussed above, for which the National Association for Mental Health proposes increases over the President's budget. In singling out the items above, I do not intend to convey the impression that we are less serious about the need for the other increases we proposed, rather I simply do not wish to burden the record with cumulative testimony. We concur in and support the justifications for the increases, though not the precise amounts, which have been presented here this morning by Dr. Francis Braceland and Mike Gorman.

Mr. Chairman and members of the committee, it is a privilege for me to have had this opportunity to present this statement in behalf of the National Association for Mental Health and I thank you.

PROPOSED INCREASES, NIMH BUDGET, FISCAL 1969

	1969 President's budget	Budget proposed by National Association for Mental Health
A. GRANTS		
1. Research	$81,159,000	$125,655,000
2. Hospital improvement	10,610,000	14,141,000
3. Training	109,046,000	125,000,000
4. Fellowships	10,641,000	17,000,000
5. Early child care demonstrations	14,500,000	14,500,000
Total grants	225,956,000	296,296,000
Total increase proposed by NAMH for grants	$70,340,000	
B. DIRECT OPERATIONS		
1. Planning, development, and administration of extramural research programs	2,569,000	3,500,000
2. Intramural research	17,325,000	19,000,000
3. Manpower and training	1,727,000	2,200,000
4. Mental health services	1,641,000	2,000,000
5. Special mental health programs	4,205,000	6,000,000
6. Regional and field activities	7,302,000	10,000,000
7. Fort Worth and Lexington Clinical Centers	10,580,000	14,000,000
8. Scientific communication and public education	2,551,000	4,000,000
9. Program management and services	4,975,000	8,000,000
Total direct operations	52,875,000	68,700,000
Total increase proposed by NAMH for direct operations	$15,825,000	
C. COMMUNITY MENTAL HEALTH RESOURCE SUPPORT		
1. Construction grants	15,000,000	60,000,000
2. Staffing grants	64,300,000	70,000,000
3. Narcotic facilities	8,000,000	8,000,000
Total resource support	87,300,000	138,000,000
Total increase proposed by NAMH for community mental health resource support	50,700,000	

Mr. BUSSIE. Also that the contents of the pamphlets, which are new, will be included in the record too.

Mr. HULL. Without objection.

(The pamphlet follows:)

FACTS ABOUT MENTAL ILLNESS

"Further progress in the difficult field of mental illness and mental health will come only when millions of Americans know enough, care enough, and are willing to work together hard enough to make it come." William C. Menninger, M.D. (1899–1966).

A TOTAL OF 20,000,000 PERSONS AFFECTED BY MENTAL ILLNESS

One person in every 10 (a total of 20 million in the United States) has some form of mental or emotional illness (from mild to severe) that needs psychiatric treatment. There are more people in hospitals with mental illness than with all other diseases combined, including cancer and heart disease.

Doctors recognize mental illness to be an important factor in many physical illnesses, even heart disease. Over 50 percent of all medical and surgical cases have a mental illness complication.

OVER 1,700,000 PERSONS ENTER MENTAL HOSPITALS

Latest figures show that over 1,700,000 persons are registered in public and private mental hospitals, psychiatric services of general hospitals, and Veterans' Administration psychiatric facilities. (This includes patients in hospitals at the beginning of the year, plus those admitted during the year.) About 760,000 persons are under the psychiatric care of these hospitals on any one day of the year, including about 150,000 who are on a trial visit or a similar form of supervision

During the year about 800,000 persons are admitted to public and private mental and private mental hospitals and the psychiatric services of general hospitals. Of these, nearly 300,000 have already been hospitalized one or more times.

QUICK AND PROPER TREATMENT HELPS ASSURE RECOVERY

At least seven out of 10 patients admitted to a mental hospital can leave partially or totally recovered with prompt and proper treatment. Data from a number of states show that about 75 percent of those admitted for the first time leave the hospital within the first year.

With schizophrenia, the most prevalent mental crippler for newly admitted patients, the chances of release within one year have jumped from about 20 percent to about 80 percent since 1947. The higher rate occurs, however, only when proper treatment is promptly administered.

In the case of two other serious mental illnesses, involutional psychosis and manic depressive psychosis, the chances of recovery or improvement are about 65 percent and 75 percent respectively.

Recent research has shown that high readmission rates (about 35 percent of patients discharged within a year) can be reduced to about 10 percent with continuing and thorough rehabilitation service, including medical, social and vocational after-care.

MENTAL ILLNESS AFFECTS CHILDREN AND YOUNG ADULTS

Mental illness occurs at all ages, including childhood. There are about 500,000 mentally ill children in the United States classified as psychotic or borderline cases. Most of these children are suffering from the psychiatric disorder known as childhood schizophrenia.

Only a very small percentage of the total are receiving any kind of psychiatric treatment.

The latest annual figures show that 24,438 children and young adults were admitted to public mental hospitals for the first hospitalization for serious mental disorder. Of these, 3,247 were under 15, and 21,191 were between 15 and 24.

On any given day in that year there were 27,686 children and young adults with serious mental disorders in our public mental hospitals. Of these, 4,547 were under 15 and 23,139 were between 15 and 24.

In private mental hospitals, first admissions of children and young adults totaled 4,636, of which 243 were children under 12 and 4,393 were between 12 and 21 years of age.

An additional estimated 300,000 children under 18 are served in psychiatric clinics each year, for less severe mental disorders.

During a one-week period, psychiatrists in private practice saw about 49,600 children (under 12) and adolescents (12 to 17 years). This figure represents about 24 percent of all patients (207,400) seen by psychiatrists in private practice.

COMMUNITY FACILITIES FOR THE MENTALLY ILL

There were about 2,000 public and private out-patient clinics in the United States last year. Many of these are part time, and most of them have long waiting lists. An estimated 1 million children and adults are served in these clinics. Almost half of these clinics are in the Northeastern States, principally in urban areas.

The best-informed mental health professionals estimate that a full-time clinic is needed for every 50,000 people. This would mean 3,880, or twice as many as now exist.

EXISTING FACILITIES

There are 531 mental hospitals in the United States. They include 326 State and county hospitals, 41 Veterans' Administration neuropsychiatric hospitals, two other Federal hospitals, and 161 private psychiatric hospitals.

About one out of every 11 community general hospitals, approximately 495, have separate units for treating psychiatric patients. Another 495 community general hospitals admit psychiatric patients to their regular medical facilities.

QUALITY OF CARE FOR THE MENTALLY ILL

Only custodial care is received by the great majority of patients in State mental hospitals. A very small percentage receive intensive psychiatric treatment, even though research has demonstrated that some patients who have been in the hospital as long as 5, 10, or 20 years recover when they receive intensive treatment. The reason for this situation is that few State hospitals get the necessary funds to provide adequate staff and equipment for intensive treatment. A key index of this inadequacy is the amount which the hospital spends per day for the maintenance of each patient. (Maintenance covers the salary of all personnel, treatment supplies, plus equipment, food, clothing, and overhead.) Latest figures show that the average daily expenditure for maintenance in public mental hospitals is $6.74 per patient. One State spends as little as $3.18. By contrast, short-term general hospitals spend more than $44 per patient per day, private psychiatric hospitals, $33, and VA psychiatric services, more than $16 per patient per day.

PSYCHIATRISTS SERVING THE MENTALLY ILL

About 15,140 psychiatrists were practicing in 1966, providing approximately 729,000 hours of work activity per week. However, only 60 percent of work activity was devoted to direct services to patients, with the remaining time spent in consultation, teaching, administration, and research.

A recent comprehensive government survey of psychiatrists, in which 88 percent reported information about themselves, reveals that only 9 percent have child psychiatry as their major specialty.

Over half of the Nation's psychiatrists are located in five States: 21 percent in New York, 13 percent in California, 6 percent in Pennsylvania, 6 percent in Massachusetts, and 5 percent in Illinois; 13 percent reside in areas which represent 35 percent of the population. One State has as few as 11 psychiatrists.

COST OF MENTAL ILLNESS

According to a recent study published in The American Journal of Psychiatry, mental illness cost the United States about $20 billion in 1966. Half of this cost was borne by individuals other than the mentally ill. Cost of direct treatment was almost $3 billion—about 15 percent of this is expended by governmental agencies, and the rest is accounted for by private insurance carriers, private industry, and private philanthropy.

Annual expenditures for community mental health programs (including outpatient clinics) total $112,122,419.

COST TO INDUSTRY

Business authorities conservatively estimate that the annual loss to industry directly related to emotional disorders is staggering, amounting to $10 billion each year.

Mr. BUSSIE. I am accompanied this morning by Mr. Michael Freeland, assistant director of the National Association for Mental Health.

I would like to ask permission he be authorized to make a few statements.

Mr. Chairman and members of the committee, my name is Victor Bussie. I am a resident of Baton Rouge, La., and I am president of the Louisiana AFL–CIO.

I am appearing today in behalf of the National Association for Mental Health of whose board of directors I am a member. I have been a citizen volunteer in mental health association work for the

past 10 years, and during 1965 and 1966 I was president of the Louisiana Association for Mental Health, and affiliated division of NAMH. I deeply appreciate this opportunity of presenting our views before this subcommittee.

I am quite certain that most of the members of the committee, including your distinguished chairman, reside in counties in which there is a mental health association; I am absolutely certain that all of you reside in States in which there is a State mental health association. These are among the more than 800 affiliated chapters and divisions of the National Association for Mental Health. We are a volunteer, nonprofit, citizens organization with 1 million members and associated volunteers.

If all of these citizens were paid workers, I am sure the committee and the Congress would have a difficult time in meeting the payroll for these people who devote so much of their time to this effort.

These are the concerned, informed citizens in towns and cities across the country for whom I speak; but more importantly, I speak also for the more than 1 million patients residing in the hospitals—both public and private—and the uncounted other millions receiving treatment as outpatients.

Mr. Chairman, it is our purpose and our fervent hope that by appearing here today we can help these unfortunate victims of mental illness and also the one in ten of all of us who at one time or another in our lives fall prey to this serious, incapacitating illness.

As in years past, a representative of the National Association for Mental Health is appearing before your committee to testify in respect to the budget of the National Institute of Mental Health and again this year we are urging that the Congress appropriate funds in sufficient amounts to enable that agency to carry on and expand its vital work.

This year however, this task is more difficult than ever before because of the grave problems confronting our Nation. No one can ignore the fact that there are many pressing demands upon the Federal budget dollar and we citizens comprising the membership and associated volunteers of the National Association for Mental Health, have considered carefully the position we ought to take this year in the face of the current situation. We have concluded that our primary responsibility is not to assess relative priorities among those many demands but rather to present, in behalf of the mentally ill of this country, our views as to the present unmet needs of these afflicted citizens among us, and our best judgment as to the Federal funds required to help in meeting those needs.

Basically, our position, outlined in greater detail below, is first, to recommend substantial increases for research and manpower training; and second, to recommend the appropriation of the full amount of $60 million for fiscal 1969 for construction of community mental health centers as authorized by the Congress last year.

Accordingly, we respectfully propose that the Congress appropriate for the fiscal 1969 budget of the National Institute of Mental Health the sum of $364,996,000 for its grants program and direct operations, an increase of $86,165,000 over the President's budget of $278,831,000 for these purposes; and for community mental health resource support the sum of $138 million, an increase of $50,700,000 over the President's request of $87,300,000.

I do not want to touch on too many other aspects of my prepared speech. Rather, I would like to give you if I might in just a few minutes some of the personal observations I have had in working in the mental health field.

In 1948 I had my first opportunity to visit a mental health institution in my State of Louisiana. It was one of the most trying experiences of my life. When I left the hospital in Jackson, La., the first thing that I determined was that I was going to forget everything that I saw, that it simply was something that I could not comprehend, something I could not do anything about, and something that it was just best for me personally if I did not give any further thought to it. I am ashamed to say that I did for many years.

In 1959, Senator Russell B. Long and Mrs. Earl K. Long asked me as a friend of the Long family if I, after being advised by some eight or nine doctors, would consent to take Governor Earl Long to a mental institution in Texas. The reason for that, of course, being that he could not be confined in Louisiana under the Louisiana law.

I took Governor Long, who was a personal friend, to that institution and after having had him committed there, in accordance with the wishes of the family and the direction of the doctors, I began to realize as I sat in that hotel room that night that here was a man who had devoted all of his life to the political betterment of our State. He had served as Governor twice in elected position and once, because the position had come to him by virtue of the fact he was Lieutenant Governor and the Governor vacated the office. I began to realize that if this very learned man in politics, Governor of our State, highly respected and able man, could be affected by mental illness because of the stress and strain of the job that he had had practically all of his life, then certainly it could affect almost anybody. And since that time I have been actively interested in the mental health program in our State.

I was, for 2 years, president of the Louisiana State Association for Mental Illness, being appointed there by the legislature itself for the purpose of trying to assist in any way we laymen can to further the program in our States. We have made tremendous progress. No longer am I ashamed to go to the hospital in Jackson to look at people who are confined there.

Instead, we go with a great sense of pride and a great sense of satisfaction that we have done a great deal to help those people. But we in Louisiana have really not done that, gentlemen. It was done because of the efforts of this committee and of this Congrss and because of our President. If it had not been for that, I am afraid I would still be ashamed to go into that institution in Jackson, La. I would still have the same effects I had many, many years ago when I felt it was almost a hopeless situation and something I could do nothing about.

You have done a great deal; you can do much more. I realize, of course, that there are many demands on your time and on the funds that are available to this Government, but I do not believe that the money could be spent in any better form for any better program than to aid those people who are mentally ill who cannot do anything for themselves.

I talked to the commissioner of mental health yesterday in Louisiana. He advises me that if the proposed cuts or if the various inadequate increases go through as proposed in the budget, our hospital

improvement program in Louisiana will suffer tremendously and at central Louisiana hospitals and Jackson State hospitals, most of the hospital improvement program will have to be discontinued.

I talked to the officials of the Tulane Medical School in New Orleans, the department of psychiatry. They advised me that 85 percent of the research funds are Federal grants and that unless those grants are increased rather than decreased, it is going to seriously affect the ability of that department of psychiatry to provide the number of trained doctors and psychiatrists we need.

In-service training, the commissioner of mental health tells me, and this I know to be true, will be almost entirely eliminated under the proposed budget you are being asked to consider.

Construction grants—we have worked entirely with our State on this in an effort to raise the appropriation each year, and this year we have been allocated $1.6 million in matching funds in anticipation of receiving $2.4 million from the Federal Government for construction of facilities that we desperately need. But we understood that under this budget we would receive only half of the amount that we are hopeful of receiving, and this would be totally inadequate to permit us to go forward.

I say again that I realize the problems you have in trying to stretch the money, but I firmly believe that many of the problems that we have in this Nation are caused from mental and emotional disturbances. We are working very desperately with the families, the wives, the children, the mothers and fathers of servicemen today and we find, because of many of the other problems in our Nation, that this is seriously affecting their emotions. Many of them are having problems that during World War II my wife and perhaps your wife and the wives of other servicemen did not have. I can readily understand how they must feel from time to time.

But all of this is creating a problem I do not believe, gentlemen, we can adequately cope with under the amount of money that has been recommended, and I earnestly hope you will take into consideration the figures we present from the citizens' laymen group of the National Association for Mental Health, and that you will do everything in your power to increase those funds so we can carry on the work we are trying to do.

I would like to ask at this time if Mr. Freelund would be permitted to introduce into the record some of the letters we have received recently from citizens that are just beginning to be aware of the fact that the National Association of Mental Health, that the Governors, and others are really interested in their problems in trying to do something about it.

Mr. HULL. Without objection.

Mr. FREELUND. Very briefly, I would like to point out that Ann Landers of the national syndicated newspaper column, recently within the past 2 weeks in one of her columns indicated, in response to an inquiry from one of the readers, that persons interested in finding resources for psychiatric services should write to the National Association for Mental Health, 10 Columbus Circle in New York. We have been literally inundated by letters from these people.

I should like to point out that these are not letters from irrational persons. These are letters that prove conclusively that the hard efforts

we have been putting into the education of the public over the past years to make them realize that mental illness is not a disgrace but an illness and that it is important for them to seek early help are paying off. We are getting letters from people in every part of the country. I will just read one or two of them so you can understand the flavor of what we are getting.

This is from New York State, Babylon:

I am writing you because I feel that I need psychiatric help in solving some of my problems. I cannot afford to pay and I would like to know of the nearest clinic to where I live. Please answer as soon as possible.

We have a letter from a 17-year-old girl:

I am a 17-year-old girl who needs, or at least wants, psychiatric attention but cannot afford it. I have been told there are mental health facilities which supply this aid at reasonable rates. I would appreciate it very much if you would send me some information on such facilities which may be located in Albany, Schenectady, Troy, or some city in this area as we live just outside of Albany. Please reply as soon as possible.

The point I think made by these letters is that people are looking for help, that they have been led to believe that help is available and it would be tragic indeed if that help were not forthcoming when they seek it.

With your permission, gentlemen and Mr. Chairman, I would like to offer these with a statement of what the Mental Health Association is doing about it.

We are answering these letters and trying to provide help for these people.

(Letters follow:)

NORTH BABYLON, N.Y., *April 17, 1968.*

I am writing because I feel that I need psychiatric help in solving some of my problems. I cannot afford to pay and I would like to know of the nearest clinic to where I live. Please answer soon as possible.

Thank you kindly.

CARBONDALE, PA., *April 19, 1968.*

DEAR SIR: I have directed myself to your help.

I am in need of psychiatric help, but do not have the money to obtain it.

Please send me a list of clinics close to my home that I could attend.

I will appreciate any help you can give me.

Thank you.

RAVENSWOOD, W. VA., *April 19, 1968.*

HEADQUARTERS FOR THE NATIONAL ASSOCIATION OF MENTAL HEALTH,
New York City, N.Y.

DEAR SIR: Could you give me information as to whom to contact in my area for psychiatric counseling? I feel that I need this help and under present circumstances cannot afford it. I will be able to travel to Parkersburg, Charlestown, Huntington, or other nearby cities if this service is not available nearby. I would appreciate your help. Thank you.

LOUDONVILLE, N.Y., *April 2, 1968.*

DEAR SIRS: I am a 17-year-old girl who needs, or at least wants psychiatric attention, but can't afford it. I have been told that there are mental health facilities which supply this aid at reasonable rates. I would appreciate it very much if you would send me some information on such facilities which may be located in Albany, Schenectady, Troy, or some city in this area, as I live just outside of Albany. Please reply as soon as possible. Thank you.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.,
New York, N.Y., April 24, 1968.

We are inundated with letters of inquiry resulting from a recent Ann Lander's column. In an answer to a letter, Miss Landers stated "Almost every city has mental health facilities which are free or extremely reasonable. Some of these clinics have waiting lists and others are actively looking for patients. Write to the headquarters of the National Association for Mental Health, 10 Columbus Circle, New York City, N.Y."

Every letter has been acknowledged as per attached copy.

Many of the letters are desperate "cries for help," and should be answered as soon as possible. Many need special handling by a professional.

We are forwarding to you all but the most immediately serious letters which we will answer directly to save time in the emergency.

Please make every effort to respond quickly.

Mr. FREELUND. Finally, with your permission, Mr. Chairman, we request permission to file a supplemental statement on funds for education of handicapped children under title I of the Elementary and Secondary Education Act of 1965. We are concerned that funds authorized and appropriated for this purpose, for the education of handicapped children in State-supported schools and institutions, emotionally disturbed, retarded children may be reduced. We would like to file a supplemental statement.

Mr. HULL. Thank you very much, gentlemen.

THURSDAY, APRIL 25, 1968.

ARTHRITIS AND METABOLIC DISEASES

WITNESSES

DR. MILTON GRAUB, PRESIDENT, NATIONAL CYSTIC FIBROSIS RESEARCH FOUNDATION, NEW YORK CITY

DR. JOHN HERNDON, VICE PRESIDENT, NATIONAL CYSTIC FIBROSIS RESEARCH FOUNDATION, NEW YORK CITY (CYSTIC FIBROSIS PROGRAM)

DR. MORRIS ZIFF, PROFESSOR OF INTERNAL MEDICINE, UNIVERSITY OF TEXAS, SOUTHWESTERN MEDICAL SCHOOL, DALLAS, TEX. (ARTHRITIS CENTERS)

DR. LOUIS WELT, CHAIRMAN, DEPARTMENT OF MEDICINE, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, N.C. (OVERALL PRESENTATION)

STATEMENT OF DR. MILTON GRAUB

Mr. HULL. We have with us this morning Dr. Milton Graub. We would be glad to listen to the doctor. You may proceed in any way you like.

Dr. GRAUB. Thank you.

Mr. Chairman and members of the committee, I am Dr. Milton Graub, a pediatrician, associate professor of pediatrics at Hahnemann Medical College, Philadelphia, and president of the National Cystic Fibrosis Research Foundation.

Mr. HULL. You may give the names of the gentlemen who accompany you here.

Dr. GRAUB. Yes. I am accompanied by Dr. John Herndon, vice president, National Cystic Fibrosis Research Foundation, New York City. Also present are Dr. Morris Ziff, professor of internal medicine, University of Texas, Southwestern Medical School, Dallas, Tex., and Dr. Louis Welt, chairman, Department of Medicine, University of North Carolina, Chapel Hill, N.C

I would like to report to you today on the status of research in cystic fibrosis as the foundation did 1 year ago. We would like to bring the subject up to date and discuss with you what has happened in the intervening year.

Investigators in Pennsylvania have reaffirmed their initial finding that guanethidine administered intravenously to children with cystic fibrosis restores their adnormal salivary gland secretions temporarily to normal. Moreover, using this drug as a research tool, they have disclosed a possible relationship between calcium metabolism and the thickness of the mucus in C/F. Work at the NIAMD also suggests that abnormal calcium metabolism may contribute significantly to the extreme viscosity of mucus that plugs the glands of an individual with cystic fibrosis. Other drugs resembling guanethidine are now being studied for their effect on the gland system involved in this disease. The hope is that one will prove to have therapeutic action.

Another promising development mentioned to you last year, a clue to a possible test for carriers of the gene for cystic fibrosis, has fared well under further experimentation. The investigators working on it at Duke University expect to be able to refine and simplify the technique to the point where it will offer a reliable basis for mass screening. Meanwhile, they have managed to concentrate the factor which they discovered in the blood of cystic fibrosis patients and their parents. This has permitted a collaborative study to be undertaken between the Duke team and another at the University of Wisconsin, whose findings also were described to you. Tissue culture studies in progress at four locations offer another possible approach to a method of detecting carriers of the C/F gene. If recent work continues to prove out, we may soon have the simple, reliable marker we have been seeking. Testing of newborns would be feasible, letting us know immediately if the baby has cystic fibrosis or carries the gene for it. The same recent laboratory findings would provide us with a means of studying the basic defect in the disease—and without any burden being imposed on the child as an experimental subject.

At Wisconsin it was demonstrated that sweat and saliva of C/F patients contained a factor or factors capable of causing dramatic changes in the functioning of rat salivary glands. When injected with the sweat or saliva, the rat glands lost their ability to handle salt normally. This salt disturbance resembles that seen in cystic fibrosis itself. Now the Duke-Wisconsin study is seeking to determine whether the factors in the blood on the one hand, and in the sweat and saliva on the other, are similar. Preliminary studies suggest that these factors may indeed be related.

The rat, incidentally, is proving to be an extremely useful animal model for the study of electrolyte abnormality in cystic fibrosis. Finding such a model has been one of our high-priority research goals.

The Wisconsin workers, I might add, have made definite progress in elucidating the nature of the sweat and saliva factors. They have,

to begin with, located what they believe is one source of such a factor in the body. Further, they have identified certain positively charged molecules capable of inhibiting salt movement across membranes, and they have been able to relate these molecules to naturally occurring and synthetic substances with similar charges.

Even more exciting, a way has been found to neutralize the salt loss in the rate salivary gland. Negatively charged molecules, whether natural or synthetic, will restore the salt transport. Thus, the movement of salt through membranes can be turned on or off at will in these animal glands. One of the agents effective in controlling salt transport has also been found by investigators in Seattle to have mucolytic properties. That is, it thins out the mucus. This opens a whole new avenue to the management of cystic fibrosis, where the chief trouble is caused by thick, sticky mucus that clogs the lungs and interferes with and damages other organs.

It may be that the Wisconsin scientists have come upon the basis of the salt transport defect in cystic fibrosis. In any case, their studies are of the type that offer insight into the very fundamentals of the life process and there is strong indication that cystic fibrosis will serve as a model disease for the study of a number of membrane transport disorders.

Two unique factors demonstrated in the tissue of C/F patients by Miami workers have been further clarified and partially identified. Collaboration continues between the groups at Miami and Duke. A pattern for the defect in cystic fibrosis seems to be emerging.

The stimulus of all of this activity and ferment in connection with cystic fibrosis is beginning to be felt in related areas of biomedical science. More and more investigators now see this metabolic disorder as a challenge justifying their best interest and efforts. They discern hope where there was formerly chaos.

To hasten an understanding of the new leads and findings, a symposium was held early this year on "Cystic Fibrosis and Related Human and Animal Diseases." This was a landmark among conferences on cystic fibrosis; over a two-and-a-half-day period, 15 panels were conducted—as many as four or five simultaneously. The roster of participants was made up of the most eminent men and women in their respective fields, many from abroad. Submitted as an attachment for the record is a laudatory report on the symposium from the April 1 issue of the Journal of the American Medical Association. I daresay that out of this concentrated workshop meeting have come enough ideas to spark years of research—research which will illuminate other diseases as well as cystic fibrosis. In calling this conference, the foundation had the valuable support of the NIAMD, and also of the National Center for Chronic Disease Control of the Bureau of Disease Prevention and Control, Public Health Service.

The new directions that research will take promise to be many and will involve such matters as tissue and organ culture, membrane permeability and control of exocrine gland secretion. No doubt we shall find ourselves moving also into the realm of organ transplants.

In summary, early clues are holding up, new leads are developing, and new scientists from many disciplines are becoming interested in cystic fibrosis. As a result, the foundation has been receiving many more research grant applications than it has resources to fund.

This need for more financial support in the total research effort in cystic fibrosis is the reason we came to this committee last year. We made an urgent plea for funds for a research program including research and training in the NIAMD and clinical research in the Public Health Service outside the Institute itself.

As a result of our plea, three actions were taken by this committee and ultimately enacted into law, for which we have to express our gratitude to the committee and Congress.

The first of these was a program of two demonstration projects in clinical research to be conducted in the Bureau of Disease Prevention and Environmental Control. This program is in the process of being carried out and it is expected to yield singificant results in the course of its 3-year duration. The program has been funded to the extent of $438,000. The applications for funding received in this program amounted to some $3 million and consisted of 16 very sound, very well documented applications, 14 of which were turned away for lack of money. We therefore recommend that the committee provide for two additional programs this year, which would cost about $500,000. This would have sufficient work going on in clinical research to delineate clearly what the ideal kind of program is and how best we can approach the research problem on a clinical basis.

The second step of this committee was the allocation of $750,000 for pediatric pulmonary centers in the regional medical programs appropriation. This program necessarily is slow in its implementation, but it is progressing under the direction of Dr. Robert Martson, and we expect that it, too, will yield constructive dividends once it is in operation.

The third step of the committee was to provide for funds for cystic fibrosis research in the National Institute of Arthritis and Metabolic Disease. It did this first in its committee report when it addressed itself to the details of the Institute's appropriation. The report said on page 26:

> The committee therefore directs that $2 million of the appropriation for the National Institute of Arthritis and Metabolic Diseases be devoted to research on cystic fibrosis.

We were very heartened by that language and expected that, when the Institute funded that much for cystic fibrosis research, we would have a new and broadened approach to the solution of the disease. We sent word to our medical colleagues who are oriented to research telling them that, upon enactment of the law containing the appropriation, money would be available to fund new applications. They responded to the news and we were very pleased when the requests they submitted were reviewed by study sections and approved by the NIAMD Council. It appeared to us that these applications would be funded.

Early this year, we got in touch with Dr. Donald Whedon, Director of the Arthritis Institute, and asked him how the funding of the program was proceeding. After some delay we received fragmentary information, so, mindful of the fact that we would be testifying before this committee in late April, we sent a letter to him on April 4, 1968, asking for detailed data on which to base our testimony. We received a reply from Dr. Whedon dated April 9, a copy of which is in your hands, in which he said:

We are attaching a detailed listing of current active cystic fibrosis grants giving names of the investigator, institution where the research is carried out, title of the research grant, dates for which the grant is active, and dollar amounts per year. The list totals about $1,824,000 and constitutes currently active extramural research grants. In addition, in fiscal year 1968 the Institute is spending $190,000 in intramural research on cystic fibrosis and $4,000 from collaborative studies funds. Thus, the sum total of current expenditures in the Institute's cystic fibrosis program amounts to approximately $2,018,000 and meets the directive of the House Appropriations Subcommittee in its report for fiscal year 1968.

Now, Mr. Chairman, I would like to direct your attention to the list of funded grants which accompanied Dr. Whedon's letter. There seem to be two lists involved, the first entitled "Cystic Fibrosis Primary," and which consists of 15 projects for a total of $584,612. There is no doubt about these projects being cystic fibrosis and there is no doubt about the study section having approved them and the council having approved them. However, there is a second list entitled "Cystic Fibrosis Secondary," which consists of 37 projects with a total of $1,239,692. These, too, were approved by study sections and by the Council, but their relationship to cystic fibrosis, in some instances, is so remote as to go beyond the vanishing point.

In this compilation of $1,239,692 are grants of upwards of $500,000 which are either not cystic fibrosis research or are so distantly related to cystic fibrosis that it is not cystic fibrosis research in the terms we recommended to the committee last year and, it appeared to us, in which the committee directed that the funds be used. At the same time, five new cystic fibrosis grants and one renewal, totaling $140,000, which were approved by study sections and the Council, were not funded by the Institute. The reason for this as stated by Dr. Whedon in his letter to us, and in letters to the applicants, was that appropriations were not available to fund them. This, now, is something we cannot understand.

Dr. Whedon's letter says that five new applications and the one renewal had a "priority too low to pay." This is stated on a sheet attached to his letter to me which you have before you.

I would like to go into this "priority" matter briefly. The Department of Health, Education, and Welfare in February 1968 issued a document entitled "The Research Grant Programs of the Public Health Service." In a chapter entitled "Quality of Research," it says on page 40:

There is no valid basis for equating the 100–500 priority scores with such value words as "excellence," "very good," "good," "fair," and "poor." As nearly half of all new applications have already been discarded, even the applications receiving the lesser priority scores have been judged as meritorious and thus worthy of public support.

And it goes on to say:

The priority scores utilized in the review process are assigned to applications only after they have been approved by a study section. Thus, the scientific merit of a project and its eligibility of NIH support have already been established. The purpose of the priority score is less to quantify quality in an absolute sense than to provide a means of gaining a collective opinion of the reviewers for ranking the applications recommended for payment. This is not to suggest that priority rating is unrelated to scientific merit, but other subjective variables are reflected in these numerical indixes. To illustrate: Given two project proposals of corresponding scientific merit, one an epidemiologic approach, another a laboratory technique, one reviewer might assign higher priority to the former as a consequence of his conviction that the state of the art in that science-discipline calls for more emphasis on epidemiologic studies. Thus, priorities reflect scientific choice as well as scientific merit.

The significant thing here, Mr. Chairman and gentlemen, is that HEW says itself that priorities reflect scientific choice as well as scientific merit, and as we understand it, the purpose of your directing the use of the funds was to insure that at least $2 million went to cystic fibrosis.

It therefore seems that the Institute did not fund cystic fibrosis research as it was directed but, within the Institute, exercised arbitrary scientific choice of research projects contrary to the language of the report.

Mr. Chairman and gentlemen, this is the way it appears to us and this is what we explained to Dr. Whedon in a meeting we had with him and his staff in his offices on April 10, 1968. In that meeting, at which Dr. Herndon and I represented the National Cystic Fibrosis Research Foundation, we told him that we felt that if the language of the Congress were heeded, the five new grants and the one renewal grant approved by his own Council should have been funded. His reply to us was that this would have been done if this committee and the Congress had provided additional funds over the level of the executive estimate for fiscal year 1968, which was $143,954,000. Since only language was provided, and additional funds were not added, Dr. Whedon said that "the earmarking is not classic earmarking," which he says is a locution of the NIH reflecting NIH policy.

It was our understanding that, within the framework of the increase of $8 million provided to the Institute in the fiscal year 1968 budget over the fiscal year 1967 budget, the C/F funds were to be provided. Evidently, Dr. Whedon does not agree with this position.

We hope that our understanding of the congressional action is accurate, and we trust that this committee will see its way clear to take whatever action it feels should be taken to accomplish the purpose it had in mind when it wrote the language in its 1968 report.

We also recommend that, for fiscal year 1969, the funds for cystic fibrosis research again be at the $2 million level and that the Institute be governed accordingly.

Dr. Herndon, who is the vice president of the National Cystic Fibrosis Research Foundation for medical and scientific affairs, is here beside me, and we will both be glad to answer any questions you might have about the position of the Institute as it was explained to us by Dr. Whedon and his staff on April 10 and any other questions you may have on this testimony.

Thank you.

(The attachments to Dr. Graub's statement follow:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
NATIONAL INSTITUTES OF HEALTH,
Bethesda, Md., April 9, 1968.

Dr. MILTON GRAUB,
President, National Cystic Fibrosis Research Foundation,
New York, N.Y.

DEAR DR. GRAUB: I am writing in response to your letter of April 4, 1968, concerning cystic fibrosis grants supported by the National Institute of Arthritis and Metabolic Diseases.

We are attaching a detailed listing of currently active cystic fibrosis grants giving names of the investigator, institution where the research is carried out, title of the research grant, dates for which the grant is active, and dollar amounts per year. This list totals about $1,824,000 and constitutes currently active extramural research grants. In addition, in fiscal year 1968 the Institute is spending $190,000 in intramural research on cystic fibrosis and $4,000 from collaborative

studies funds. Thus, the sum total of current expenditures in the Institute's cystic fibrosis program amounts to approximately $2,018,000 and meets the directive of the House Appropriations Subcommittee in its report for fiscal year 1968.

Not included in the list, Dr. Weisiger informs me, are new awards to Dr. Alexander Spock at Duke ($67,710) and to Dr. Robert Schwartz of Rochester ($16,160) which have a primary CF assignment. Also excluded are the program projects of Roseman ($243,000) and Park ($250,000), since it is difficult to separate out the important CF components.

The following is in response to your other specific questions with particular interest in the number of cystic fibrosis grants approved but not funded. Ten new applications totaling $192,834 were approved in fiscal year 1968. Among these were three new research grant applications which had been approved but were assigned to another institute as well as to NIAMD. These three grants will be activated and funded by the other assignee institute. Of the other seven approved applications two will be funded by NIAMD in the near future and five others will not be activated because of the priority scores which were assigned to them by the reviewing study sections; these priority scores, between 275 and 373, are in the range in which, because of the overall budget limitation, the Institute is not funding. The procedure with respect to these five applications is in accord with long standing NIH policy to award in order of relative excellence.

In addition, two renewal applications were approved in fiscal year 1968. One of these, again, has a dual assignment and will be supported by the other assignee institute. The other renewal application received a very low priority and will not be funded.

In addition, 21 new applications totaling $888,179 were disapproved by the reviewing study sections in 1968.

As per your request, I am attaching a detailed list of names, institutions and dollars covering all the above mentioned grant applications. Please do not hesitate to call me if you need any other specific information.

If you have questions regarding NIH policy with regard to the system of payment of grants, I suggest that they be directed to Dr. James A. Shannon, the Director of NIH.

Kindest personal regards.

Sincerely yours,

G. DONALD WHEDON, M.D.,
Director, National Institute of Arthritis and Metabolic Diseases.

[Attachments.]

FISCAL YEAR 1968

Type of application, disposition, and number	Individual	Institution	Amount
NEW APPLICATIONS			
Will be funded by alternate Institute which was primary assignee:			
2105	Back	New York State University at Buffalo	$30,620
8504	Bartell	New Jersey College of Medicine and Dentistry	12,683
8505	Boring	Emory University	14,135
Assigned to NIAMD, priority too low to pay:			
A12199	Elliss	Brown University	23,974
A12399	Speisel	St. Christopher Hospital, Philadelphia	28,159
A12517	Halbert	Miami University Medical School	11,450
A12685	Green	Childrens Memorial Hospital, Chicago	17,550
A12709	Lee	Johns Hopkins University	17,337
To be funded by NIAMD:			
3420	Waring	Tulane	20,766
A12667	Schwartz	Rochester University Medical School	16,160
RENEWAL			
Assignment to another primary Institute: 2035	Warwick	University of Minnesota	29,820
Assigned to NIAMD, priority too low to pay: A12207	Barbero	Hahneman Medical School	42,000

CYSTIC FIBROSIS PRIMARY

Project No.	Study, researcher, and organization	Date	Amount
5 A 02856-10	Study of The Cystic Fibrosis of the Pancreas, Dische, Z.; Columbia University, College of Physicians and Surgeons, New York City.	January 1968-December 1968	$34,062
5 A 03563-09	Bronchopulmonary Obstruction in Cystic Fibrosis, Denton, R.; Pennsylvania University Medical School, Philadelphia, Pa.	November 1967-October 1968	67,992
5 A 06178-06	Glandular Cytochemistry in Cystic Fibrosis, Shackleford, J. M.; Alabama University, Medical College, Birmingham, Ala.	April 1967-March 1968	8,550
5 A 06278-06	Research Program on Cystic Fibrosis, Cooke, R. E.; Johns Hopkins University, Medical School, Baltimore, Md.	October 1967-September 1968	94,016
5 A 06339-06	Studies in Cystic Fibrosis, Shwachman, H.; Childrens Cancer Research Foundation, Boston, Mass.	April 1967-March 1968	60,731
5 A 06365-06	Development of the Human Sweat Gland, Lobeck, C. C.; Wisconsin University Medical School, Madison, Wis.	September 1967-August 1968	33,780
5 A 08305-05	Cystic Fibrosis and Pulmonary Disease, Matthews, L. W., Case Institute Western Reserve University, Clevelsnd, Ohio.	January 1968-December 1968	93,074
5 A 09067-03	Immunocytology of Cystic Fibrosis of Pancreas, Blanc, W. A.; Columbia University, College of Physicians and Surgeons, New York, N.Y.	September 1966-March 1968	12,608
C A 09067-03 S1	----do----	September 1967-March 1968	7,616
5 A 09468-03	Analysis of Sugars in Mucopolysaccharides, Stillwell, R. N., Baylor University Medical College, Houston, Tex.	June 1967-May 1968	12,120
5 A 10413-02	Pathogenesis of Cystic Fibrosis, Maxfield M.; Southern California University, Los Angeles.	January 1967-March 1968	25,703
1 A 10542-01 A1	Comparative Study of a Fibrocystic Glycoprotein, Pape, L.; Los Angeles State College Foundation.	September 1967-August 1968	15,252
5 A 10635-02	Exocrinopathic Metabolism in Cystic Fibrosis, Knauff, R. E.; Temple University Medical School, Philadelphia, Pa.	May 1967-April 1968	29,490
7 A 12207-01	Program projects in Cystic Fibrosis, Barbero, G. J.; Hahnemann Medical College and Hospital, Philadelphia.	July 1967-March 1968	75,618
1 J 12383-01	Symposium on Cystic Fibrosis and Related Diseases, Shwachman, H.; National Cystic Fibrosis Research Foundation, New York, N.Y.	January 1968-December 1968	14,000
	Total		584,612

CYSTIC FIBROSIS SECONDARY

5 A 00740-14	Biosynthesis of Sulfated Mucopolysaccharides, De Meio, R. H.; Jefferson Medical College, Philadelphia, Pa.	May 1967-April 1968	$17,403
5 A 00803-15	Protein Synthesis by Pancreas, Dickman, S. R.; Utah University Medical College, Salt Lake City.	May 1967-April 1968	21,912
5 A 02353-10	Development of Intestinal Absorption Mechanisms, Bogner, P. H.; Pittsburgh University Medical School, Pennsylvania.	September 1967-August 1968	19,322
5 A 02534-10	Intestinal Absorption in Malabsorption Syndromes, Clifton, J. A.; Iowa State University, Medical College of Iowa City.	September 1967-August 1968	46,133
5 A 02827-09	Water NA and K Fluxes Across the G I Mucosa, Code, C. F.; Mayo Foundation, Rochester, Minn.	April 1967-March 1968	27,487
5 A 04683-08	Proteolytic Enzymes in Cystic Fibrosis, Haverback, B. J.; Southern California University Medical School, Los Angeles.	January 1968-December 1968	27,600
2 D 05338-07	Comparative Studies of Salivary Mucoids, Draus, F. J.; Pittsburgh University Dental School, Pennsylvania.	September 1967-August 1968	23,554
2 A 05635-06	Ecorine Sweat Gland Function, Dobson, R. L.; Oregon University Medical School, Portland.	September 1967-August 1968	68,876
7 A 05678-07	Metabolic Pathways of Active Sodium Transport, Maffly, R. H.; Stanford University Medical School, Palo Alto.	December 1967-November 1968	27,027
3 A 05678-07 S1	Metabolic Pathways of Active Sodium Transport, Maffly, R. H.; Stanford University Medical School, Palo Alto.	December 1967-November 1968	14,062
5 A 05795-06	Aldosterone and Electrolytes in Sweat, May, C. D.; New York University Medical Center, New York City.	April 1967-March 1968	13,495

CYSTIC FIBROSIS SECONDARY

Project No.	Study, researcher, and organization	Date	Amount
5 A 06481-05	Active Ion Transport in Intact Frog Skin, Watlington, C. O.; Virginia Medical College, Richmond.	April 1967-March 1968	$10,246
2 A 06815-06	Study of Inborn Errors of Metabolism, Sidbury, J. B., Jr.; Duke University Medical School, Durham, N.C.	January 1968-December 1968	43,729
5 A 08293-05	Basic Gastrointestinal Investigations, Haverback, B. J., Southern California University Medical School, Los Angeles.	March 1968-February 1969	102,000
5 A 08445-04	The Biology of Skin of Man and Other Primates, Montagna, W., Medical Research Foundation of Oregon, Portland.	September 1967-August 1968	108,972
5 A 08778-03	Salivary Gland Endorcrine Interaction, Hilton, F. K.; Louisville University Medical School, Kentucky.	September 1966-August 1968	16,696
2 A 08844-04	Digestive Proteins in Human Pancreas, Keller, P. J.; Washington University Dental School, Seattle.	September 1967-August 1968	19,911
5 A 09022-04	Bicarbonate Secretion in the Pancreas, Hubel K. A.; Iowa State University, Medical College, Iowa City.	September 1967-August 1968	18,131
5 A 09090-04	Cell Secretion and Permeability, Farquhar, M. G.; California University, San Francisco Medical Center.	January 1968-December 1968	35,923
5 A 09247-03	Studies of Trypsinogen Deficiency Disease, Townes, P. L.; Rochester University Medical Medical School, New York.	January 1968-December 1968	16,857
5 A 09280-04	Transport of Ions and Fatty Acids by Epithelium, Stevens, C. E.; Cornell New York State University Veterinarian College, Ithica.	January 1968-December 1968	27,126
2 A 09323-04	Sodium Transport Energy Coupling in Kidney, Courtney, M. A.; Iowa State University, Medical College of, Iowa City.	February 1969-January 1969	19,394
5 A 10080-03	Mechanism of Action of Peptide Hormones, Schwartz, I. L., Mount Sinai Hospital, New York City.	September 1967-August 1968	90,948
5 A 10451-02	ZZ Enzyme Secretion and Its Metabolic Control,Schramm. M.; Israel Hebrew M.; University, Jerusalem.	June 1967-May 1968	26,794
5 A 10659-02	Effects of Cholinergic Agents on Turtle Bladder, Schilb, T. P.; Louisville University Medical School, Kentucky.	July 1967-June 1968	15,523
5 A 10928-02	Cell Secretion and Membrane in the Pancreas, Jamieson, J. D.; Rockefeller University, New York City.	August 1967-July 1968	25,350
5 A 10956-02	Electron Microscopy Experimental Pathology, Hennigar, G. R.; South Carolina Medical College, Charleston.	August 1967-July 1968	25,756
5 A 11028-02	Morphochemical Studies With Microscopy, Spicer, S. S.; South Carolina Medical College, Charleston.	September 1967-August 1968	40,444
5 A 11285-02	Electrolyte Physiology in Malnourished Infants, Nichols, B. L.; Baylor University Medical College, Houston, Tex.	January 1968-December 1968	21,153
1 A 11407-01	Histophysiology of Secretion, Munger, B. L.; Pennsylvania, State University, Hershey, Pa.	June 1967-May 1968	49,205
1 N 11412-01	Action of Hormones on Active Transport Processes, Sanders, R. B., Kansas University, Lawrence.	May 1967-April 1968	14,156
1 A 11940-01	Studies on the Bioactivation of Slaframine, Aust, S. D.; Michigan State University, East Lansing.	September 1967-August 1968	24,708
1 A 11982-01	Subunit Structure of Mucins, De Salegui, M., Mount Sinai Hospital, New York City.	September 1967-August 1968	54,267
2 A 12028-02	Ion Transport Across Epithelial Membranes, Curran, P. F.; Yale University Medical School, New Haven, Conn.	January 1968-December 1968	43,644
2 A 12032-02	Active Ion Transport and Cellular Structure, Zadunaisky, J. A.; Yale University Medical School, New Haven, Conn.	January 1968-December 1968	22,733
7 A 12188-01	Parathyroid Metabolism and Calcium Control, Costello, L. C.; Howard University Medical College, Washington, D.C.	June 1967-April 1968	32,471
9 A 12396-05	E M Studies Transport and Absorption Sites, Kaye, G. I.; Columbia University College of Physicians and Surgeons, New York City.	January 1968-December 1968	26,684
	Total (37)		1,239,692
	Total (52)		1,824,304

[From the Journal of the American Medical Association, Apr. 1, 1968]

ENCOURAGING APPROACHES SUGGESTED—EXPERTS "BRAIN-STORM" CYSTIC FIBROSIS

Recently, in New York City, some 250 medical investigators attempted to "brain-storm" a disease: cystic fibrosis.

The technique of drawing new data sources for cystic fibrosis worked well. Speculation was encouraged at the sessions, sponsored by the National Cystic Fibrosis Foundation with Public Health Service support. Thought bridges were tenuously erected between previously unrelated experiments in genetics, surgery, biochemistry, and even veterinary medicine.

Central to this cross-fertilization is the premise that cystic fibrosis is not a rare disease, as previously thought.

First reported in 1936 by a Swiss physician, Guido Fanconi, it is the most recent addition to man's major chronic diseases. For over 20 years true incidence studies were hampered by the lack of a reliable diagnostic test. Most affected infants died undiagnosed, of broncho-pneumonia and malnutrition.

Then came a New York heat wave in the early 1950's.

Clinicians at Children's Hospital noticed that many of their patients with cystic fibrosis were most severely affected. The children lost significant amounts of sodium chloride—far greater than those of similar age with other disease. This was the suggestion for the now standard "sweat test," developed by Paul A. di Sant'Agnese, M.D., Sc. D, and colleagues.

Although geographic differences seem to exist, and incidence of cystic fibrosis of 1/2,000 live births "now seems conservative and acceptable," Dr. di Sant' Agnese notes. Rare among Negroes and Orientals, the disease is the most frequent, lethal genetic disease of Caucasian children.

An estimated 10 to 12 million persons in the United States may carry the cystic fibrosis gene, which expresses itself as a recessive trait.

What are some of the encouraging approaches still open to investigators of cystic fibrosis? The majority were covered at the New York meeting.

Close to 50 percent of cystic fibrotics are now diagnosed before 18 months of age, said Harry Shwachman, M.D. conference chairman. "The mother frequently senses the disease before the physician," added the Boston pediatrician. Physicians must share this maternal suspicion, not "brush it off, as too frequently happens."

A number of tests are being developed for routine, newborn screening. These include determinations from neonatal hair and nail samples. As yet, however, these electrolyte values are not as reliable as the sweat test. Meanwhile, such neonatal signs as ileal atresia, intestinal obstruction, or late passage of meconium should be cause for a sweat test, Dr. Shwachman said.

Numerous laboratories are just beginning their examination of the exocrine glands and the abnormal mucus which accompanies the disease.

At Duke University, for instance, an abnormal serum factor was reported in 1967 by Alexander Spock, M.D. and colleagues. The factor found only from the serum of CF patients, disorganizes the ciliary beat when placed on tissue culture explants of normal rabbit respiratory epithelium. The mode of action of the factor remains unclear Dr. Spock commented.

However, the same substance also occurs in some parents of affected children, indicating a possible technique of detecting heterozygote carriers.

Current experiments into pathogenesis of the disease, nevertheless do not yet fit in "a rational pattern," noted Dr. di Sant'Agnese who is now chief of the pediatric metabolism branch, National Institute of Arthritis and Metabolic Diseases.

A reproducible animal model such as exists for most diseases, would be "the ideal situation," said Rockefeller University's Robert W. Leader, D.V.M. "To date, none has been found, but this may be because of a low index of suspicion about cystic fibrosis among investigators who deal with animals." He urged an international effort to find CF-like disease in animals, which may appear unexpectedly as a mutation of a single generation.

At this point, investigators use such diverse creatures as slugs and starfish, dogs, and dolphins to examine individual characteristics of cystic fibrosis. Recent findings by University of Virginia investigators that baboons will tolerate human blood suggested to conferees that they might serve to test in vivo the effect of the Duke serum factor.

While pathogenesis is a confusing and discouraging state, therapy is not, said Tulane's William W. Waring, M.D. In the first reported cases of cystic fibrosis, half were dead within a year. Thirty-one cystic fibrosis centers recently reported

over half of their patients still alive at age 12 to 15. Early and aggressive therapy, including prophylaxis against the invariable staphylococcus infections, has produced much of this improvement.

Typical of this approach is that taken by Carl F. Doershuk, M.D., and fellow pediatricians at Case Western Reserve University hospitals, Cleveland. "Although lung function may be normal at birth, early loss of function and damage is characteristic," he cautioned. "Once irreversible pulmonary damage occurs there is a steady progression, despite all therapy."

Once cystic fibrosis is detected in the newborn—including asymptomatic children of known CF gene carriers—a regimen begins, including use of the mist tent, postural drainage, physical therapy, and steroid and antibiotic therapy, as needed.

Among 349 consecutive patients treated between 1957 and 1965, there were only 25 deaths, Dr. Doershuk reports. Median age at death was 21 years; mortality under 6 was 5.4 percent. Improvement was noted in 82 percent of 96 consecutive patients carefully evaluated under a prophylactic program begun 7 years ago. None of the four deaths were in children under 5.

"The big point is that you no longer have to tell the parents of the cystic fibrotic, 'just take him home and love him,' " Dr. Doershuk said.

TOLAZOLINE AIDS PULMONARY FUNCTION IN CHILDREN WITH CYSTIC FIBROSIS

A two-decade-old adrenergic blocking agent appears to have beneficial effects on the pulmonary function of children with cystic fibrosis, Denver clinicians report.

Tolazoline was administered to 11 patients whose pulmonary involvement did not respond to conventional therapy, Ernest K. Cotton, M.D., told the New York conference. Although oxygen therapy continued, antibiotics were not used.

Vital capacity improvements of various degrees were seen in 10 of the patients, ages 3 to 17 years, during a 1-month preliminary trial. Each received tolazoline in a dosage of 2 milligram/kilogram, every other day. The 11th child was dropped from the study when antibiotics were again administered because of infection.

In addition to vital capacity changes, thoracic gas volume decreased and arterial oxygen tensions increased under tolazoline therapy. These parameters changed for the worse whenever the drug was discontinued temporarily.

In general, clinical improvement was "very obvious, exercise tolerance included," Dr. Cotton said. Radiologic changes indicating improvement of lung function were minimal, however. And these were seen in some patients only toward the end of the preliminary trial.

The drug's effect presumably is based on its role of increasing blood flow in the pulmonary vascular bed. Tolazoline has been used in peripheral vascular disorders

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[From the Medical World News, Mar. 29, 1968]

FACTOR LINKED TO CYSTIC FIBROSIS—WHAT TURNS BODY FLUIDS INTO GLUE?

Something about a cystic fibrosis patient turns the mucous secretions that normally lubricate his body ducts and airways into a sticky, obstructive glue. A seemingly unrelated anomaly that characterizes CF patients is excessively salty sweat.

Do the salty sweat and the sticky mucus have anything in common? Yes, according to the findings of three separate research groups. What they have discovered in the serum, sweat, saliva, and pancreatic secretions of cystic fibrosis patients is a factor affecting electrolyte transport.

Although the disease afflicts one in every 20,000[1] white children in the United States, and it is seen in virtually every country, its cause is unknown. Addressing more than 200 researchers and clinicians who assembled in New York for a brainstorming session sponsored by the National Cystic Fibrosis Research Foundation and the National Institute of Arthritis and Metabolic Diseases, Specialist Harry Shwachman conceded that physicians "can only recognize the complications of the basic defect and try to treat them." Dr. Shwachman is clinical professor of pediatricts at Harvard Medical School.

A serum factor affecting the movement of electrolytes was uncovered by Dr. Alexander Spock, associate professor of pediatrics at Duke University. The fact that it appears not only in patients but also in their parents suggests that the

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[1] 2,000.

factor is a primary manifestation of the disease, rather than a secondary effect. Dr. Spock and his associates found the same factor in the saliva of one patient.

The substance, a protein, may alter electrolyte transport by acting on cell membranes, the Duke pediatrician suggests. This action could produce changes that profoundly affect the cell's function. For example, when explants of rabbit trachea are exposed to the serum of cystic fibrosis patients for 2 to 5 minutes, the cilia of the mucosal cells begin beating in opposite directions. In contrast, serum from normal persons and patients with diseases that mimic CF have no effect on ciliary movements.

Another research team has found a factor in the sweat of cystic fibrosis patients that affects sodium transport. The patients form sweat normally. But when the fluid reaches the duct of the sweat gland, sodium is not reabsorbed, report pediatricians John A. Mangos and Nona R. McSherry of the University of Wisconsin. This factor may account for the reliability of the sweat test for cystic fibrosis.

A BRAKE ON REABSORPTION

The factor's physiochemical properties indicate that it may be a protein. Dr. Mangos believes it is present in the fluid produced by the sweat gland's secretory coil and that it inhibits sodium reabsorption by the duct, where sweat is made hypotonic. The Wisconsin researchers suspect that the factor may also be present in the saliva of CF patients.

Evidence of a substance that inhibits electrolyte transport in the pancreas has been discovered by Dr. Hans-Beat Hadorn, director of the pediatric clinic at the University of Bern, Switzerland. He and his colleagues studied ten children who had cystic fibrosis but no signs of pancreatic involvement. They gave the patients pancreozymin to stimulate enzyme output and secretin to stimulate water and bicarbonate secretion. Analysis of their duodenal fluid revealed very small amounts of bicarbonate but abnormally high concentrations of enzymes.

Dr. Hadorn says that children with cystic fibrosis have an impaired ability to produce the watery, bicarbonate-rich electrolyte secretion that characterizes normal duodenal fluid. "What we found was a disproportionate relationship of enzyme to electrolyte portions of the pancreatic secretion." He believes that in cystic fibrosis, some substance, possibly a humoral factor, interferes with the mechanism normally stimulated by secretion.

Secretin has a similar effect in the liver, says the Swiss researcher. "It stimulates electrolyte production in the biliary ductules, and the bile secretion consists of an organic fraction with a high content of bile salts and an electrolyte fraction similar to that of the pancreas."

NEEDED TO RETRIEVE SODIUM

The basic defect in cystic fibrosis involves the control of electrolyte transport, the Bern pediatrician suggests. "In isotonic secretions—produced by the pancreas, liver, and mucous glands—this control mechanism would be necessary for the formation of the electrolyte fraction. If the mechanism is inhibited, a reduced flow rate results. In hypotonic secretions, such as saliva and sweat, it would not be required for the formation of the primary secretion. But it would be necessary for the reabsorption of sodium that leads to a hypotonic end product. Therefore, if the mechanism were impaired, the flow rate would not be affected but the fluid would be hypertonic."

Although the role of an electrolyte transport defect in causing cystic fibrosis remains to be proved, the theory provides a hopeful start toward explaining this baffling disease.

Mr. HULL. Thank you, Doctor. We will have the questioning after all of you have testified.

Dr. GRAUB. Fine.

Mr. HULL. We have with us Dr. Morris Ziff, whom we will hear at this time. We would be delighted to hear from you.

STATEMENT OF DR. MORRIS ZIFF

Dr. ZIFF. Mr. Chairman and gentlemen, I am Dr. Morris Ziff, professor of internal medicine and head of the rheumatic disease group at the University of Texas Southwestern Medical School in Dallas. I am

also chairman of the research committee of the Arthritis Foundation and a past president of the American Rheumatism Association.

I speak to you as a representative of those physicians and scientists who are primarily concerned with the elucidation of the underlying causes and with the optimal treatment of arthritis. My testimony has the full endorsement of the Arthritis Foundation, its medical section—the American Rheumatism Association and its paramedical section of allied health personnel.

I endorse fully the needs of the NIAMD, as expressed in the President's budget, for continued support and steady growth of its present programs of research grants, training grants, research fellowships and clinical research centers. It is absolutely essential for continued progress toward solutions to the many problems of arthritis and the metabolic diseases that the physicians and medical scientists engaged in research and education with respect to these diseases have increasing opportunities to compete for the funds they require from the resources of the NIAMD.

A program of the Arthritis Foundation which I shall recommend to you in the remainder of my testimony will depend for its adequate sustenance in the future upon support from the research and training funds of the Institute.

Last year, the Arthritis Foundation recommended to this committee a program of arthritis centers to be administered in the National Center for Chronic Disease Control of the Public Health Service with an appropriation of $1.5 million. The committee and the House of Representatives, when it acted on the committee bill, did not fund this program. When the bill went to the Senate, $1 million was added to the appropriation of the Bureau of Disease Prevention and Environmental Control for the program. When the bill went to conference, the House conferees agreed with the Senate on the purposes of this amendment. As a result of the conference, a number of programs were shifted from the Bureau of Disease Prevention and Environmental Control to the regional medical programs, apparently including this $1 million for arthritis centers.

Amendment 31 of the conference report of the House deals with this shift of funds and reads as follows:

"Amendment No. 31: Appropriates $27,942,000 for "Chronic diseases" instead instead of $27,504,000 as proposed by the House and $32,692,000 as proposed by the Senate. In general, the conferees are agreed on the desirability of the purposes of the Senate increase but are also agreed that a large part of the activities for which the increase of over $5,000,000 was earmarked is so closely related to activities financed under "Regional medical programs" that they would more properly be administered by the National Institutes of Health under that appropriation. With this in mind, the managers on the part of the House agreed to $4,500,000 of the Senate increase for "Regional medical programs". It will be expected that the activities for which the Senate increase for "Chronic diseases" was earmarked be performed under the appropriation "Regional medical programs" to the maximum extent determined to be feasible by the National Institutes of Health.

After the appropriations bill had become law, the National Institutes of Health made the determination, in the light of the language of the report, that the arthritis centers could no properly be funded under the regional medical programs. This seems to be in accord with the regional medical program law, so it becomes apparent that the $1 million appropriation was swept into an inappropriate place in the budget.

The fact that I would like now to call to the attention of the Committee is that the program was intended to be funded, and we felt gratified that it was. But in the light of last year's experience we believe now that the logical place for these funds is in the National Institute of Arthritis and Metabolic Diseases, where they can be administered along with the existing grants in support of research and training in arthritis.

Mr. LAIRD. Mr. Chairman, these could have been funded under the language of the regional medical program authorization.

Dr. ZIFF. Does it extend to arthritis?

Mr. LAIRD. The language of the act includes the phrase, "and related diseases," and it has been broadly interpreted in the grants made under the regional program. I don't know what you were told about this, but the authorization language is very broad the way it has been interpreted.

Dr. ZIFF. This becomes a legal problem which I cannot really discuss very well.

Mr. LAIRD. The Congress cannot make them spend money in the executive branch of Government, you understand. We can appropriate, and evidently we overappropriated in this area, because $25 million is not being expended.

Dr. ZIFF. Well, if there is this complication, what I will suggest is that it go right into the NIAMD.

Mr. LAIRD. Regardless of what account the money is appropriated under, you can't force the Executive to spend it. That is my point.

Dr. ZIFF. I see.

I wish now to summarize our reasons for repeating this request for a specific increase in the appropriations for health research. Current estimates from the Health Interview Survey, conducted periodically by the National Center for Health Statistics, indicate that 16.8 million persons, or one out of every 12 individuals in this country, have arthritis or rheumatism. Of these, nearly 3 million suffer limitation of their ability to work, keep house or engage in school activities. Yet, even through the combined efforts of the Public Health Service and the Arthritis Foundation, not more than $15 million are being spent this year for research training and research into the causes and means of control of the major forms of arthritis—less than $1 per victim per year.

In order to promote more efficient expenditure of the available funds, from all sources, both private and governmental, the Arthritis Foundation makes grants to support arthritis clinical research centers in the teaching hospitals of medical schools. These grants assist a center director to develop and maintain a balanced program of research, professional training, and exemplary patient care, directed largely at ambulatory patients. They aim to facilitate the application of new knowledge derived from basic research to patient-oriented investigation of the underlying causes of arthritis, the mechanisms which produce disability, and the development and evaluation of better methods for treatment and prevention of arthritis.

This program was begun in 1959 under the auspices of the national foundation but since 1965 it has been carried on by the Arthritis Foundation. Fifteen such arthritis centers are currently supported directly by the foudation in the following cities: Boston (2), Los Angeles (2), San Francisco, Seattle, Salt Lake City, Denver, Dallas,

Buffalo, Rochester, N.Y., New York City, Baltimore, Birmingham, and Washington, D.C. An additional 10 applications are being reviewed this year and we estimate that at least 10 other institutions are eligible and would apply to the foundation if we could give them reasonable encouragement. The present availability of funds limits the maximum size of an annual grant from the foundation to $25,000.

The excellence and productivity of the centers currently supported by the foundation are not in question. Each of the 15 centers also has an arthritis training grant and one or more research grants from the NIAMD. Why then do we ask for additional Federal funds to support these activities? My answer requires a brief description of the ways in which arthritis differs from many other diseases. The major forms of arthritis are prime examples of chronic, long-term illnesses which usually take their toll, not through acute episodes of incapacity but rather through the gradual accumulation of progressive disability with increasing risk of crippling and deformity. The course of arthritis fluctuates—episodes of active disease, lasting usually for months and often for years, alternating with periods of relative remission. Research into the mechanisms of rheumatic disease and the evaluation of treatment require that patients be studied over long periods of time. During most of this time the typical patient is ambulatory. He is cared for in hospital-based out-patient clinics and related ambulatory facilities, but seldom spends much time in a hospital bed. It is presently neither desirable nor feasible to use large numbers of hospital beds for the clinical investigation of arthritis.

NIAMD would not now have sufficient funds to support the necessary care of patients who are the subjects of research in ambulatory clinic facilities.

The committee is aware of the extramural program of the National Institutes of Health which supports clinical research centers. In the NIAMD these funds are used largely, if not solely, for the cost of hospital beds. We are asking, in essence, for a similar program for ambulatory patients with chronic disabling disease.

For this reason, the directors of the clinical research centers of The Arthritis Foundation find it necessary to utilize 90 percent of the grant funds which they receive from the foundation for the support of medical and allied health personnel whose services are essential for the exemplary care of ambulatory patients who are currently being treated.

The foundation fully intends to continue and to increase its program of center grants, but feels obligated to turn increasing attention to the needs of those investigators who are not now funded and who urgently need assistance to develop the breadth and depth of their ambulatory patient care facilities to the level required for effective research and training.

So, Mr. Chairman and gentlemen, what we request of the committee is that it approve again the program of arthritis clinical research centers and that $1 million additional be provided to the administration budget for the NIAMD with directions for funding the program. We ask a reiteration by the committee and the Congress of its acceptance of the program in the appropriate budgetary structure.

Thank you.

Mr. HULL. Thank you, Dr. Ziff.

STATEMENT OF DR. LOUIS WELT

We will now hear Dr. Louis Welt. Dr. Welt, you may proceed in any way that you care to.

Dr. WELT. Thank you, sir.

(Dr. Welt's affiliations follow:)

Professor and chairman, Department of Medicine, School of Medicine, University of North Carolina; formerly assistant professor of medicine, Yale University School of Medicine; formerly consulant, Windham Community Hospital; formerly associate attending physician, New Haven Hospital; formerly chief, research section, Veterans' Administration Central Office; council member, American Society of Nephrology; chairman of scientific advisory board, National Kidney Foundation; member of National Advisory Council, National Institute of Arthritis and Metabolic Diseases; former member of program project committee, National Institute of Arthritis and Metabolic Diseases; member of an Advisory Committee of the National Academy of Sciences-National Research Council; formerly member of the executive committee of the renal section, American Heart Association; formerly chairman of the medicine test committee, National Board of Medical Examiners; former member of the editorial board of the Annals of Internal Medicine, and currently member of the editorial board of the American Journal of Physiology and Journal of Applied Physiology, American Journal of Medicine and American Journal of Medical Sciences. Member of numerous medical societies, including the American College of Physicians (fellow), the Association of American Physicians, the American Society for Clinical Investigation, the Southern Society for Clinical Investigation, the Society for Experimental Biology and Medicine, American Physical Society, the American Society for Artificial Internal Organs, and the Transplantation Society.

Dr. WELT. Mr. Chairman and members of the committee, first let me express my gratitude for the privilege of appearing before this distinguished committee on behalf of the National Institute of Arthritis and Metabolic Diseases. This committee has a superb record in terms of its response to the health problems of our Nation through its support of the programs of the National Institutes of Health.

I can assure you that your efforts are recognized with pride and with gratitude by the scentists of the biomedical community and by all scientists interested in the health of our Nation. The implications are far-reaching. The National Institute of Arthritis and Metabolic Diseases embodies a series of programs that touches on many areas of the biomedical sciences. These include arthritis, dermatology, diabetes, endocrinology, hematology, kidney disease, metabolism, gastroenterology and others. I would appreciate the opportunity of pleading of an increased budget so that this Institute can proceed apace with its mission.

I have prepared a statement for submission, sir.

Mr. HULL. Yes. Without objection, it will be inserted at the end of your statement.

Dr. WELT. The research supported by this Institute has met with considerable success and I have alluded to some of the exciting areas in the prepared statement which I have submitted. I will mention it briefly, and would be happy to be responsive to your questions relating to these and other matters. The items alluded to include studies in the field of arthritis. Arthritis almost certainly heads the list of chronic diseases in the United States in terms of its impact on the social and economic arena. There are in excess of 15 million of our citizens afflicted with this disease, or these diseases. In this past year there have been some interesting observations that there is a material in the joint fluid of inflamed joints of patients with certain forms of arthritis which represents a degradation product of joint cartilage.

Better understanding of the nature of this material may well lead to a better understanding of the disease and to improved care of patients so afflicted, which is our ultimate goal.

There is a new instrument using both direct light and also the principle of fiber optics with which the skilled physician can look inside the joint space, obtain material for examination, make observatons as to the course of the disease in terms of the various treatment regimens used, and make more precise decisions as to when certain operations might be indicated.

Gout is a form of arthritis that affects almost 1 million Americans. A specific biochemical defect, an impaired enzyme system had been found to be present previously in a rare metabolic disorder of early childhood. A similar disorder has now been found in gout and this provides the first discrete biochemical defect which we can put our finger on. This opens up a new avenue of approach which may very well provide rich rewards. There is a medicine that has been used for the treatment of gout for many years. We now for the first time have a few hints as to how this agent may work. If we understand this a little more carefully, we may well be able to synthesize new compounds which will be even more effective and have fewer side effects. As time goes on, we are learning more and more about diabetes mellitus and it is apparent that we are dealing with a multifaceted disease, a disease which is present today in over 4 million Americans. It is our belief that there are 5 more millions who will develop this disease during their lifetime. The clear recognition that it is not simply due to an absolute deficit of insulin permits the investigators to focus on other aspects of the problem which will surely lead to better insights, better care, and less disability.

During the past year it has been clearly demonstrated that a suggestion made 60 years ago is in fact true. There are at least three hormones produced by the gastrointestinal tract which trigger the secretion of insulin. Although an increase in the level of sugar in the blood promotes this secretion, it would appear that the gastrointestinal tract, by virtue of the fact that it has the first contact with what we eat, has a way of anticipating that there will be a rise in blood sugar and it triggers the secretion of insulin before the blood sugar becomes unduly elevated.

My particular efforts in research are related to the problems of kidney disease. The National Institute of Arthritis and Metabolic Diseases has supported work in this field which is providing us with a better understanding of the problems, and it is heavily involved in helping to develop the instrumentation that will permit us to care for these patients more efficiently, completely, and at a lower cost.

The role of dietary manipulation in connection with kidney disease represents another most important step. It has become clear that the employment of a diet which is low in protein but, very importantly, which uses rather special types of protein, those that have an unusually high content of what we refer to as essential amino acids can permit patients with advanced kidney failure to live longer and live more comfortable and useful lives despite marked impairment of kidney function. We are learning more and more about how to care for the patients with severe and life-threatening kidney disease, and we must contend with these unfortunate people with the tools that are at hand, but it must be emphasized that work must be supported that might prevent the progression of kidney disease so that the number of pa-

tients dying of end stage kidney disease can be reduced. Toward this end, this past year studies have begun to bear fruit which may tell us which patients are likely to recover from an acute episode of nephritis and which patients might not, unless we can intervene in an effort to minimize the damage that would otherwise obtain. This is a beginning and should lead to more intensive work in this and other areas.

One could recite many other accomplishments. I am confident that the Institute has administered the public's funds most effectively toward the end of gaining improved knowledge and with it improved care for the ill.

However, I must bring to your attention the facts that there are many areas where profitable work could be accomplished and there are talented investigators eager to undertake these tasks, but the fiscal constraints under which the Institutes in general, and this Institute in particular, must work, are most unfortunate. These opportunities for research, and the scientists available to attack them, represent the success of the entire program. If we do not support these young scientists now, there are areas that will lie fallow and young men and women who have demonstrated a talent for research and have been trained to work in these areas will go without support and their talents and motivation will be lost, to the detriment of our national health.

The budget which has been proposed by the administration for the fiscal year 1969 would make it imperative that there be a retrenchment from the previous scope and vigor of the Institute's program. I am a member of the National Advisory Council of the Institute, and in this capacity I have watched with great concern many approved grants—and by approval I refer to approval with high priority scores—that just cannot be supported owing to lack of funds. The implications of this situation are multiple, far reaching, and very serious.

Unless we can accelerate the pace and broaden the scope of investigation, there will be a damaging consequence not only today but in the future. Disorders that might become controllable and amenable to therapy 5 to 10 years hence may continue to ravage our citizens because we have been unable to continue at the appropriate pace which is both necessary and possible.

We will also lose those well-trained researchers, and our investment and theirs will have been for naught. We are establishing new schools of medicine and expanding existing schools. This is essential, as there is no argument whatsoever that we need more physicians, but the staffing of the new and expanding schools will become impossible unless we can continue to attract the faculty manpower, and that manpower needs and must have space and funds for research. Without it I am at a loss as to what to suggest in terms of helping to educate a significant increase in the number of physicians.

Good biomedical research cannot be turned off and on at will. It must be a continuing process. There will be tremendous waste if there is a significant slowdown even though 5 years hence there may be an acceleration once again. The losses involved in the time lag will be enormous in every perspective from which one can examine the problem.

Let me translate some of these problems into concrete values of funding. The Institution has been unable to fund in fiscal year 1968

$12 million worth of meritorious applications. These represent grants that have been considered meritorious after a stringent double review process. At present less than 50 percent of approved grants can be funded. The situation looks more bleak for the fiscal year 1969. Although the total figures might be higher by a few percent, one must realize there is an increased cost in research, not only in terms of the increased cost of personnel, equipment, and supplies, which obtains in almost all areas of our economy but, in addition, the instrumentation employed is more sophisticated, more elegant, and is capable of providing more reliable answers but, alas, it is more expensive as well.

Hence, with the proposed budget there will be, in fact, even greater constraints on the grants that can be funded. The situation with regard to training grants is of intense concern. Unless the budget for fiscal year 1969 is increased significantly, the Institute at the very best will be able to maintain a restricted core of research training grants instead of funding an expanded program.

These are programs that have been so successful in providing training for talented young men and women in the area of research.

Mr. Chairman, and members of the committee, the program of the National Institutes of Arthritis and Metabolic Diseases are familiar to me and I would like to suggest a budget for your consideration which is designed to begin to meet the requirements of the Institute for the fiscal year 1969. These revisions request $10 million more in research grants, $1 million more in the fellowship program, $2 million more in support of the research training grant program, and $1 million more in the area of collaborative studies. These sums would begin to meet, in realistic terms, the needs of the Institute for its extramural program. These are certainly not insignificant sums of money, but the rewards that society will reap from this investment are highly significant. Health is the individual concern of us all. The economic loss incurred by illness is not only felt by the individual but it weakens the economic structure of our society. The future of medical research can be brilliant. We must make certain that this potential is not blunted by undue fiscal restraints today.

Mr. Chairman, and members of the committee, I would like to make one more plea, namely, that the funds allocated to the National Institute of Arthritis and Metabolic Disease not have undue constraints placed upon them as to how they should be employed in terms of disease areas. Although it is understandable that some will make special pleas for isolated disease areas, I would like to make explicit that there are hidden pitfalls if one focuses too closely on what appear on the surface to represent single disease processes with the view that if only more money were invested in disease X we could quickly cure X. That is not quite how it all works. There is no doubt that as a first approximation certain areas legitimately represent points of departure, but it must be emphasized that it is difficult to be certain from what work, in what other general disease area, be it arthritis, dermatology, endocrinology, diabetes, hematology, there may come insights to problems that perplex those working in the field of disease X.

If you will permit me, I should like to allude to some of our own work which may illustrate briefly how there may be unanticipated links in the chain of research activity. Our personal preoccupations have to do with kidney disease. In particular, we are making an at-

tempt to understand what it might be that is ultimately responsible for death in these patients. If one could identify the toxic compounds that accumulate in a patient whose kidneys are too ill to excrete or modify these agents we might be in a better position to apply treatment programs more effectively. This work has led us to studies of the manner in which certain elements cross the envelope of the cell. This envelope is referred to as a membrane. So the work in this area would be spoken of as membrane transport. The cell we use is the red blood cell. Hence, one might designate this as work in hematology rather than kidney disease. Furthermore, the defect we have found in patients with end-stage kidney disease seems also to be present in certain patients dying with widespread carcinoma.

Thus, our work involves the problem of cancer. We have seen it in patients with severe, third-degree burns. This is in the field of surgery. We have had reason to look for such a defect in patients with cystic fibrosis. Hence, it can be said that we are working in that field. The point I wish to make is that the thread of a research problem intertwines within and amongst disciplines. Constraints placed on the researcher and constraints placed on the National Institutes of Health could lead to a constraint on discovery. Hence, I urge you to support excellence as well as individual disease programs.

The Institute interacts in a very meaningful way with many special groups. Among these are those concerned with chronic kidney disease, arthritis, dermatology with such diseases as psoriasis, gastroenterology with particular concern for problems of inflammatory bowel disease and acute liver failure, sickle cell anemia which affects such a significant percentage of the Negro population, cystic fibrosis, orthopedics, and urologic conditions. Such groups and voluntary organizations are making excellent contributions by arousing public opinion and by channeling private funds into efforts to deal with these diseases.

I am quite familiar with one such private organization, the National Kidney Foundation, of which I am the chairman of the scientific advisory board. In none of these areas, however, is there sufficient broad fundamental knowledge to mount a concentrated crash program which would be expected to lead to early elimination of the numerous problems. I believe, therefore, that in fulfilling its responsibilities of spending public funds as wisely as possible, the greatest eventual benefit to the American people, in this particular setting of financial constraint, will come by concentrating support on broad-based investigative programs. Such programs are more likely to open up meaningful paths leading to an understanding of these diseases than studies which appear superficially to be more directly related to the clinical problem. I firmly believe that at this point in time the wisest action is that of supporting the most meritorious relevant research projects across the many diseases of the responsibilities of this Institute.

Thank you, gentleman, for the privilege of appearing before you.

Mr. HULL. Thank you.

(Dr. Welt's prepared statement follows:)

PREPARED STATEMENT ON BEHALF OF THE ACTIVITIES OF THE NATIONAL INSTITUTE OF ARTHRITIS AND METABOLIC DISEASES, BY DR. LOUIS G. WELT

Mr. Chairman and members of the committee, I appear before you today to speak on behalf of the activities of the National Institute of Arthritis and Metabolic Diseases. My name is Louis G. Welt and I am a doctor of medicine, having obtained my degree at Yale University. I am professor and chairman of the

Department of Medicine, School of Medicine, at the University of North Carolina. I am a member of the National Advisory Council, and a former member of the Program Project Committee of the National Institute of Arthritis and Metabolic Diseases. I am a former assistant professor of medicine at Yale University School of Medicine, former associate attending physician at New Haven Hospital, and a former chief of the research section at the Veterans' Administration central office. I am a council member of the American Society of Nephrology, and chairman of the Scientific Advisory Board of the National Kidney Foundation. I am a member of an advisory committee of the National Academy of Sciences-National Research Council; a former member of the executive committee of the renal section, American Heart Association; and former chairman of the Medicine Test Committee, National Board of Medical Examiners. I am a former member of the editorial board of the Annals of Internal Medicine, and currently a member of the editorial boards of the American Journal of Physiology and Journal of Applied Physiology, the American Journal of Medicine, and American Journal of Medical Sciences. I am active in numerous medical societies, including the American College of Physicians, the Association of American Physicians, the American Society for Clinical Investigation, the Southern Society for Clinical Investigation, the Society for Experimental Biology and Medicine, American Physical Society, the American Society for Artificial Internal Organs, and the Transplantation Society.

Before proceeding, I would like to thank you for the privilege of testifying here today. This committee has a fine record of responding to the health needs of our Nation by supporting the programs of the National Institutes of Health. Your efforts are gratefully recognized by the community of biomedical scientists and by all people interested in the health of our citizens. By supporting significant research and training programs of this institution, you have displayed the humanitarianism which must always characterize our national efforts.

The National Institute of Arthritis and Metabolic Diseases has had a very stimulating influence in many fields of medicine. With its carefully conceived and competently executed programs of research and training, this Institute has formed an alliance of public and private biomedical resources into effective assault forces against some of man's most disabling foes. In my opinion, the meritorious way in which this mission has been discharged has fully justified the confidence which you have placed in the programs of this Institute.

To illustrate the heartening progress made during the past year all along the frontier of the war against disease, I would like to mention a few examples of recent research achievements.

Research in arthritis is entering a phase in which examination and reappraisal of the more fundamental research aspects should lead us closer to the cause of various arthritic disorders. This research has led to a reexamination of synovial, or joint lubricating, fluid by a number of investigators, with some provocative results. One Institute-supported study has uncovered an apparent degradation product of joint cartilage in synovial fluid obtained from patients with various joint diseases. The hitherto unknown factor appears to be heavily concentrated in acutely inflamed joints, and it is anticipated that further study of this material will yield valuable information about the effect of inflammation on joint cartilage metabolism.

Studies relating to the diagnosis of arthritis are also progressing. The use of the arthroscope, an instrument which permits direct visual examination and biopsy of intrajoint structures, has been found to be a 100 percent effective procedure. Until results of this study were reported, rheumatologists had to rely upon "blind" needle biopsies, which are not always satisfactory, or upon exploratory surgery with all of its consequences. Arthroscopy, it was determined, obviates the need for such a surgical approach and is superior to the needle biopsy technique.

Another important finding concerns gout, a form of arthritis which strikes between ½ to 1 million Americans. An Institute scientist in Bethesda, who earlier had pinpointed the biochemical defect in a comparatively rare metabolic disorder, Leach-Nyhan disease, has discovered that the same ensyme defect occurs in certain patients with gout. His work represents the first description of a specific metabolic defect, absence of an enzyme, in this disease. Although it was concluded that not all cases of gout could be attributed to this one specific defect, this work is significant in that it points to new avenues for research in gout.

Evolving knowledge of the nature of diabetes strongly suggests that we are dealing with a multifaceted disease, and not with a simple inability of the pan-

creas to produce insulin. Although the basic defect that results in diabetes remains unknown, there has been much progress in recent years in elucidating some of its many mechanisms.

During the past year an Institute-supported investigator has demonstrated that three gastrointestinal hormones are capable of triggering insulin secretion by the pancreas, thus verifying a 60-year-old theory. His work suggests that secretion, pancreozymin, and gastrin may play an important role in the priming of insulin secretion following food ingestion. This is an important concept, inasmuch as pancreatic insulin secretion currently is believed to be almost wholly dependent upon elevated blood levels of glucose.

In a subsequent study, the same investigator discovered a hitherto unknown intestinal factor, possibly a new hormone, which also acts to augment insulin secretion. He presently is purifying this material and is attempting to learn its chemical structure and its role, if any, in diabetes.

Another Institute-supported scientist has discovered a new type of diabetes in children, and has suggested that it may be more common than has been recognized previously. It is manifested chiefly by growth retardation, failure to thrive, and defective glucose transport in the kidney and intestine. Unlike juvenile diabetes, the disorder does not require insulin administration; instead, the children appear to benefit from a high-protein diet, vitamin D, sodium fluoride and salt. Studies of this new clinical entity are continuing.

My own research efforts have been related to one of the challenging fields of medicine with which this Institute is concerned—kidney disease.

The Institute's artificial kidney program continues to spur research in this area and has resulted directly in a number of significant advances. One of them is the development of a new and unique hollow fiber capillary kidney under a contract with the Dow Chemical Co. The design consists of small bundles of many hollow cellulosic fibers through which the blood is passed, and which are washed by a blood-purifying dialyzing solution. The advantage of his design is that it is compact, disposable, as efficient as dialyzers now in use, and would lend itself to mass production. This very promising new artificial kidney has already been tried successfully in a number of patients.

Institute contractors have also devised a technique for storing and reusing conventional artificial kidney equipment which reduces the cost and simplifies the work involved in performing hemodialysis (blood cleansing) in the home. Now, artificial kidneys can be used for at least three successive treatments with the new procedure; the equipment requires assembling and disassembling only once instead of three times a week, and affords an estimated savings of $800 per year.

In another significant study, it was shown that intensive intermittent dialysis for more than 1 year improves the decreasing peripheral nerve function which may be associated with chronic kidney failure. Also, measurements of anti-kidney antibodies in the blood of patients with glomerulonephritis, a severe kidney disorder, have shown promise of predicting, early in the course of this disease, which patients with this disease will eventually develop a more severe progressive form of the disorder. Early discovery of such patients may conceivably permit therapy which might revert the often severe course of this disease to a relatively uncomplicated one.

In connection with diet and kidney disease, I might add that the Institute this past year cosponsored a research conference on the use of special diets which have shown promise of prolonging survival in certain types of patients with chronic kidney failure. This type of diet, developed in Italy and England, has permitted moderate-term survival and rehabilitation in certain patients without recourse to kidney transplantation or artificial kidneys. As a direct result of this conference, a number of pertinent clinical studies will be undertaken by several of the participants.

In gastroenterology, a highly significant accomplishment this past year was a series of liver transplant operations. Four young girls were able to live for 3 to 6 months after receiving new livers. The scientist responsible for this remarkable achievement has received grant support from the Institute for a number of years. He attributes the successful grafts to judicious use of the relatively new anti-lymphocyte serum, and to improvements in organ storage, tissue typing, and operating technique. His accomplishments hold significant promise for the future.

I would also like to mention that the Institute cosponsored and hosted a digestive disease conference last year. The 2-day meeting drew about 70 gastroenterology experts to Bethesda to evaluate the importance of digestive diseases as a national health problem, and to formulate plans for intensifying research and

relevant training in this field. Conferences such as these serve to stimulate research, permit exchange of information, and often produce new directions for scientific investigation.

It is ironic that the remarkable progress which has been made against so many disease problems has been accompanied by problems related to a shortage of skilled talent in the health disciplines. The success of biomedical research programs depends on a diversity of human talents. It has become increasingly evident, however, that today such skilled manpower is in critically short supply. In this connection, I would like to call your attention to the farsighted programs of training grants and fellowships which have been maintained by the Institute. These programs of aid to promising talent are designed to help alleviate this serious shortage of scientific manpower which could eventually dilute the high standards of excellence and productivity now characteristic of those engaged in modern-day biomedical research. In the allocation of funds, prudent consideration should surely be given to this serious factor if the health needs of our people are to be met properly now and in the future.

At this point, Mr. Chairman and members of the committee, I would like to address myself to the extremely grave fiscal situation in which this Institute, as well as all of the National Institutes of Health find themselves. It is common knowledge that the biomedical research budgets have leveled off during the last year and that the vigorous and productive growth of this Institute has now been stopped because of a gradual diminution of its budget. The budget proposed by the administration for fiscal year 1969 in fact makes sure that the promising work of the Institute is not carried on in the previous scope and vigor but that retrenchment must take place instead.

In my capacity as a member of the National Advisory Council for the Institute, and in this capacity I have watched with growing frustration the tightening of the fiscal noose. Despite full awareness of the economies imposed on the Government by the current national and international situation, I feel compelled to speak out before this committee because it is important to illustrate to you what such a fiscal slowdown means not only in terms of research not done today because there is no money to pay for it, but in terms of the long-range results of such damaging neglect, tomorrow. This future damage will express itself in terms of disease and suffering for which there might have been a cure or prevention, in terms of biomedical research that should be carried out but cannot since the competent researchers of tomorrow, disappointed by inability to fund their work today, will not be available then. There is no doubt in my mind that today's competent young biomedical research workers, disappointed in their search for grant funds, will not wait indefinitely until a better tomorrow but will turn their attention to other fields where they can earn a living. Moreover, we are all aware of the fact that more physicians are needed in the United States because of a growing population and because of a gradual expansion of medical care on all levels. These new physicians must be created in expanded old and evolving new medical schools. The established schools are already having difficulty finding qualified teachers; the new evolving medical schools, for lack of available manpower must raid the old schools and, unless we provide generously today for the continued training, particularly research training of up and coming new teachers of medicine, there will soon be such a shortage of qualified academic scientific manpower that it is unlikely that we shall, in our lifetime, be able to saturate the strong demand for additional physicians for care of our population.

Good biomedical research cannot be turned on and off at will. Successful biomedical research requires a long induction time before it results in effective new methods of diagnosis and treatment. If we permit an interruption of such research today—and I am observing this interruption for lack of funds right now—then we must also recognize that we are turning off a process which is not easily turned on again a few years from now "when the fiscal situation looks better." At that point it will require much effort, recruiting and pump priming before the ongoing semistarved research process can again be made effective.

To be specific, as a member of the National Advisory Council of the Institute, I see before us a million and a half dollars worth of meritorious requests for research grant funds related to kidney and liver transplantation alone for which there simply is no money. Overall, the Institute has not been able to fund in fiscal year 1968 $12 million worth of meritorious grant applications which had been approved after a rigorous double review. At the present time less than 50 percent of all approved research grants can actually be funded; at present less than 25 percent of all research grant applications to this Institute

eventually see funding. The situation for next year looks even bleaker because of the proposed administration budget which does not even allow for a holding of the line. Even though the total figures might appear somewhat higher by a few percent, the increased cost of biomedical research, including annual inflation, is such that with practically the same amount of money in fiscal year 1969 we can do considerably less than we were able to do in fiscal year 1968.

The situation with regard to training grants is of even greater concern. Unless the budget for fiscal year 1969 is increased considerably, the Institute will at best be able to maintain a restricted core of research training grants rather than engage in a much-needed expansion of research training activities.

Mr. Chairman and members of the committee, the program needs of the National Institute of Arthritis and Metabolic Diseases are well known to me and I am hereby suggesting to you a budget which, I believe, represents a reasonable picture of the requirements of the Institute for the fiscal year 1969. The increases which I propose are custom tailored to specific needs in the field of health research and—considering the vast amount of knowledge which we must still acquire to alleviate suffering from disease—are highly justified.

FISCAL YEAR 1969 BUDGET PROPOSED BY CITIZENS FOR THE NATIONAL INSTITUTE OF ARTHRITIS AND METABOLIC DISEASES

[In thousands of dollars]

	1969 President's budget	1969 citizens' proposal
Extramural grants:		
Research grants	$97,546	$107,546
Fellowships	6,737	7,737
Training	16,109	18,109
Total extramural	120,392	133,392
Direct operations:		
Laboratory and clinical research	15,042	15,042
Collaborative studies	7,599	8,599
Epidemiology, biometry, and field studies	721	721
Review and approval of grants	2,311	2,311
Program direction	424	424
Total direct operations	26,097	27,097
Total	146,489	160,489

The rewards society has to reap from biomedical research are beyond our imagination. Health is the intimate concern of all of us. The economic loss incurred by illness, through the loss of manpower, time, wages, and welfare funds, is not only felt by the individual, but it also weakens the economic structure of our society. I have faith in the future of medical progress, and I am firmly convinced that efforts such as those of the Institute are leading us into a new and exciting era of discovery. We must make sure, however, that the doors to this future do not become partially closed because of an undue fiscal restraint today.

Thank you gentlemen for the privilege of appearing before you.

Mr. HULL. Mr. Laird?

Mr. LAIRD. Mr. Michel has several questions he wants to ask with respect to cystic fibrosis earmarking. I see that Dr. Welt is against earmarking. His statement is in opposition to earmarking any funds within the Institute by disease category.

Dr. WELT. May I expand on that just a little bit, Mr. Laird? I think that it is unwise to direct that funds be used in a given area independent of whether or not the grant applications for that area can compete effectively with other areas. I am not certain, sir, where the answers to some of the problems of a given disease are going to come from. That is one of the exciting things about research in any scientific field. Unless we have a continuous dialog among a group of biomedical

scientists we would easily be led down blind alleys. I think that the scientist who is permitted to work, fully recognizing the fact that he appears to be competent, has a well conceived protocol and new, innovative ideas, something that seems worthy of support, I think this is the best way to get the most for the moneys that are expended in this area. I think it would be quite justified, sir, that the Congress might suggest that efforts be made to find meritorious work to be supported in a given area, but I think there might be some defects if the Institute is directed to use funds.

Mr. LAIRD. Mr. Michel is going to get into that.

I had a little exchange with Dr. Ziff during his presentation and I would like to get back to that now for a moment. This has to do with the arthritis centers which you described.

We did suggest last year that the regional program be used to fund two of the centers, and I believe the authorizing language is broad enough to use the regional program for this purpose. However, the budget we have before us, as I think you are aware, Doctor provides for the creation of one of these centers under the "Chronic disease" section of this budget.

The major effort will be devoted—

And I am quoting from the justifications,

to the initiation of an arthritis center program. The first year, the operational plan of the center will be finalized, staffing will be undertaken and training programs delineated and patients' care instituted. A center will process from 3,000 to 4,000 patients per year. The expenditure of funds for these centers will return $40 for each dollar which is spent.

That is the end of the quote from the justifications.

Now, in the budget funds are provided for the start of one center. You are familiar with that?

Dr. ZIFF. Yes. I was not talking about that kind of center. That center proposes to test the effect of good treatment in rehabilitating patients. I was talking about centers which would make it possible to do clinical training and research in a variety of centers in medical schools.

Mr. LAIRD. What I am talking about here, though, is this particular Center under "Chronic disease," as set forth on page 19 of the justification volume No. 5.

Dr. ZIFF. It is not the kind of center that we have used.

Mr. LAIRD. The kind you envision are regional centers?

Dr. ZIFF. Regional centers in medical schools.

Mr. LAIRD. To serve an entire region?

Dr. ZIFF. To serve, in essence, a region, yet. They would be regional. This is a center that would be picked somewhere in one place, and almost half a million dollars would be spent to test the question of whether or not if you apply intensive care, physical rehabilitation, physical therapy, you could rehabilitate people effectively. This is not what we are interested in.

Mr. LAIRD. Why can't we tie these centers together? These justifications uses some of the same language you just used.

Dr. ZIFF. What we envision is that if we went to our medical school clinics and gave them the facilities to set up excellent clinics, we could do research and training in those clinics much better than we can do now because a chronic disease really cannot be studied very well in a

hospital. The patients are sick for years, they do not go into hospital beds, they walk around. They walk around badly, but they walk around. The place to study them is in the ambulatory type facilities. There is no provision in the NIAMD for the support of ambulatory care facilities for the research and training of people with chronic disease who walk around, who do not go to bed.

Mr. LAIRD. This does not envision, though, that the center be in a hospital?

Dr. ZIFF. No, but it envisions almost half a million dollars being used in one place which would devote itself to one question, as I understand it, whether or not if you treat patients very well they do better than if you do not treat them very well. Take an arthritic and give him all that we have in terms of physical medicine, will he actually do better than the fellow who is just left loose? We aren't even sure about that.

Mr. LAIRD. That is what they want to test here.

Dr. ZIFF. They want to test that, but we are not interested in that question. We are interested in doing research on the cause and the treatment.

Mr. LAIRD. That is here in the justification. I am just trying to get this straight in my mind. I am reading this justification and it is much the same language that you use.

Dr. ZIFF. But that is going to pick one medical school in the whole country. I am talking about 20 or 30.

Mr. LAIRD. You don't think this is a start?

Dr. ZIFF. I don't think it is equivalent to what we would like to do. It may be a worthwhile thing to do, but it attests a different problem.

Mr. LAIRD. Well, I don't know.

Dr. ZIFF. It is too big a start in the sense of being in one place.

Mr. LAIRD. My problem is that I look at this and the language is much the same as your description. I thought we were going to do this in the regional program. I found in this justification, during the hearings on the Public Health Service budget, that the Department put it back in the chronic disease budget.

Dr. ZIFF. I know something about their plan. I do not know whether it is in the budget. But their plan is to take almost half a million dollars, put it into one institution and intensively test the question I mentioned.

Mr. LAIRD. With the view in mind that perhaps other centers can be created, based on the experience and testing and research that is conducted to see whether this is feasible?

Dr. ZIFF. The thing that they will do will supply their needs but will not supply our need. Our need is to create excellent clinics in which we can do research on drugs, on the antibody relationships to inflammation, the things that cause arthritis, to test new drugs. They are interested simply in testing whether intensive physical measures, largely physical, will put patients on their feet faster.

Mr. LAIRD. Maybe this is too broad a description, but they mention training in here, research—they have all these things at the center.

Dr. ZIFF. We think that smaller amounts of money in 20 or 30 or 40 places would make possible research and training in 20 or 40 institutions.

Mr. LAIRD. And not spend that amount of money in one?

Dr. ZIFF. Well, I am not happy about discussing that program here because that is something that has been done or discussed——

Mr. LAIRD. No, it has not been done. We have not approved it. It is before us right now.

Dr. ZIFF. I think the objective is excellent, to test intensively whether by giving people a lot of treatment you get them on their feet faster.

Mr. LAIRD. How much would that 40-center program cost?

Dr. ZIFF. We think it would cost about $1 million.

Mr. LAIRD. $1 million for 40 centers?

Dr. ZIFF. Yes.

Mr. LAIRD. And you think that would be better than going ahead with one center and testing this out?

Dr. ZIFF. My own personal opinion is that that would be better, yes.

Mr. LAIRD. Thank you.

Dr. ZIFF. The strength in 40 places where there are scientists and investigators at work to attack this problem on a regional basis is better.

Could I add one more thing? I might be repetitious. The National Institutes of Health do have an extramural program to support clinical facilities, to support bed patients.

Mr. LAIRD. Yes. We are doing quite a bit of that in arthritis.

Dr. ZIFF. One other aspect of the problem: With medicare and medicaid the university medical school clinics are losing patients now. They have to be brought up to snuff because the patients that we depend on for research and teaching of students and training of physicians. they are now losing patients often to the private care sector. We have got to strengthen these clinics just to keep them to do the research and to do the training that we need to. This is a real threat to the medical schools.

Mr. LAIRD. Thank you. That is all I have, Mr. Chairman.

Mr. HULL. Mr. Casey.

Mr. CASEY. Thank you, Mr. Chairman.

Dr. Graub, you have, of course, made a pretty strong charge here that the NIH has not followed the wishes of the committee with reference to cystic fibrosis.

Now, does this really boil down to a difference of opinion of what research is related to cystic fibrosis and which is not.

Dr. HERNDON. Unquestionably, this has to be a judgment of what cystic fibrosis is and is not. We represent the National Cystic Fibrosis Research Foundation and I must say that associated with our foundation are the authorities in this field who are most competent to judge what cystic fibrosis research is and is not. Reviewing the grants that the institute claims are cystic fibrosis or cystic fibrosis-related, our experts tell us that some $500,000 of these grants are not cystic fibrosis as we requested when we testified last year and as the Congress provided as a result of that testimony. This is a genuine disagreement from our very competent scientists with the people at the Institute.

Mr. CASEY. Now, these were granted, they were all approved in the usual manner by the Advisory Committee. They have two advisory committees, do they not, where the priorities are set and they base them on that, I presume. You are on that Advisory Committee, are you not, Dr. Welt?

Dr. WELT. Yes.

Mr. CASEY. Does the Advisory Committee sort these out as to which is cystic fibrosis and which is not?

Dr. WELT. No, sir; the Advisory Committee does not do that. We have not been asked to review the particular grants, for example, that Dr. Herndon is referring to, to see whether or not we would agree or disagree with his definition of what represented cystic fibrosis research.

I gather that Dr. Whedon and his colleagues at the Institute of Arthritis and Metabolic Disease have evaluated these programs and, in his judgment and that of his staff; I gather from Dr. Graub's testimony they decided that approximately a little over $2 million of research work, in their opinion, could be considered to be in that area. I think it does come down, in a sense, to an area in which there may be value judgments in which one group might say, yes, this in a broad biological sense is something which has a very important impact on what we might learn about disease. Now, someone else might take a shorter or a longer or a different view. I would not care to put a value judgment on that because I have not examined the data myself. But I might take a different view. I think this could be an area of opinion rather than something that I was prepared to take and stand on without examining, and then it would be my opinion, which could either be right or wrong.

I think one of the things, sir; that is so important to all of us to understand is that underlying almost all disease processes there are some very fundamental biological and biomedical principles. For example, the problem of what it is that makes a cell unique, what makes a red cell a red cell, what makes a brain cell a brain cell, what makes the cell that discharges teh battery that keeps our heart beating 70 times a minute? There is something in common about all of these cells. One of them is that they have a membrane around them. What makes the cell that discharge the battery that keeps our heart beating body at a certain point, they have a particular blood supply, and so forth. One of the most elemental things that makes the cell unique is its internal composition. That internal composition is determined in great measure by the properties of that membrane which can permit things to go in and out in a passive way but can also actively transport them as if there was some kind of a ferris wheel that could lift something up from the ground to a higher level.

Mr. CASEY. Is that why you are opposed to earmarking?

Dr. WELT. No, sir; if I could just for a second make the emphasis on the point that the more that one could understand about what it is that makes a cell unique, for instance, what makes the sweat gland unique, what makes the pancreas cells unique, one might very well get some important insights into cystic fibrosis, kidney disease, and so forth, when one looks at it from this broad perspective. I am not saying that one should not suggest that we ought to look at problems and say that we ought to try to do more work in such-and-such an area but we should also realize that the work that is being done in one area has meaningful relationships to another area.

Mr. CASEY. I don't think there is any argument about that.

Dr. WELT. So that one begins to categorize and you can make little piles, depending on whether you want to pile them up in terms of size, color, or shape. Then the categories can become a little meaning-

less in terms of the long-range goals which we all share, ultimately to try to understand nature and to help live with it.

Mr. CASEY. Did we make a mistake creating a separate institute so that there would be a National Heart Institute, allocating funds for it?

Dr. WELT. No, sir; I do not think so. I would like to expand on that for a moment, if I may.

As I think I indicated in my statement, I think that there are points of departure. I think one has to make some order out of chaos. This orderliness has great advantages from an administrative standpoint, from the standpoint of having some broad premises from which one operates. I think in great measure there are values in having the several Institutes that exist among the National Institutes of Health. Then when one gets down, however, within an Institute, I would agree again that there are merits to employing disease categories and deciding or dividing up funds in some proportion that seems appropriate for these various disease categories. The thing that I would appeal for is that this not be made inflexible. That is what I am really suggesting.

Mr. CASEY. Dr. Herndon?

Dr. HERNDON. I have a great deal of respect for Dr. Welt and I have known him for years. I would like to point out for the record, however, that Dr. Welt is not an authority on cystic fibrosis nor is he working in the field of cystic fibrosis.

Now, with regard to the earmarking of this committee to support cystic fibrosis, as I see the situation, the directive has been made for this current fiscal year, but the Institute has not properly responded to it. The first problem therefore is to get the Institute to carry out the directive. The other problem, as I see it, is what is to be done for fiscal year 1969. After seeing what has happened in the current fiscal year, we urge that the money be earmarked for the next fiscal year as well. We came before this committee last year and asked for a very modest increase in cystic fibrosis research in the NIAMD. We understood, and it was in the record, that approximately $1.3 million had already been programed by the Institute. We asked for a $700,000 increase which would take care of the added interest and additional research grant requests that we knew would come about as a result of the new clues in the field. The new interest and the new applications did come about. However, the Institute did not comply with the directive and the new interest now threatens to diminish and possibly wither away.

This is the reason we cannot agree with Dr. Welt that there is no need to earmark for a special purpose. We are trying to see that a field which has new clues gets the stimulation and support it needs to help it take off and go into a new area of activity, a more increased rate of activity. In this we do not feel we are unreasonable.

Mr. CASEY. How did you interpret Dr. Whedon's statement to you that this is not classic earmarking? What is classic earmarking?

Dr. HERNDON. That is locution he must have invented because it is unfamiliar to me. I would not want to assume what he meant. I would say that when the committee wrote its directive, as it did, that it was clear that $2 million in money was to be spent by the Institute for cystic fibrosis research.

Mr. CASEY. You feel that there are five new applications and one renewal that belong on that primary list that he had there? He has one primary and one secondary list of grants. The five that you seem to be very interested in have already been approved by them, but have not been funded, and there is one renewal on which he states this was too low a priority. Do you feel they belong in the primary or the secondary list?

Dr. HERNDON. We agree entirely that the primary list is all cystic fibrosis grants and we feel that these grants should be in the primary list.

Mr. CASEY. Do you feel that those should be noted as primary and should come before any secondary grants are made?

Dr. HERNDON. Yes, sir.

Mr. CASEY. Of course, the secondary grants, I presume from the correspondence that I have had with them, indicates using the same rationale as Dr. Welt here uses, that these secondary grants would maybe have some use in cystic fibrosis as well as in other programs.

Dr. GRAUB. It has been our experience over a long period of time that the real clues that have come about in the area of cystic fibrosis have come about through the efforts of the individuals who are working in the cystic fibrosis areas. A basis scientist who may be interested in mucopolysaccharide chemistry, is very likely doing excellent research. But where we have had the best results in the area of cystic fibrosis has been where there was involvement with cystic fibrosis patients by the research scientists.

Mr. CASEY. A lot of this is too technical for me, but in view of the fact that my own observations are that since the committee did express itself, I would think that the Institute should make the first grants to the primary projects, those that the researchers are interested in and definitely working on cystic fibrosis before they ever made any secondary grants.

Mr. HULL. I would think so.

Mr. CASEY. Thank you very much.

Mr. HULL. Mr. Michel.

Mr. MICHEL. Mr. Chairman, may I first say that I regret that at the time the Department witnesses were before us on this subject matter I was holding forth in my other subcommittee. Unfortunately I just cannot be three or four different places at one time. We would have been in a little better position at that time to bear down on the people actually responsible. We appreciate you folks voluntarily coming here to testify, as you do, and grateful as we are for your testimony, we have no call upon you. You really have no real legitimate official call against us, either.

First, I want to express my sincere appreciation to you for bringing this to our attention. Obviously, you are more knowledgeable on this subject than we are as laymen, and we have to do the best we can with all the variety of subjects. The academic semantics of what is an earmark and what is a classical earmark is just so much hogwash. When the Congress earmarks, we do it for a purpose. It is a way of telling the department that this is where we want the money spent and there are no ifs, ands, or buts; it is an earmark and it is spelled out very clearly. In my years on this subcommittee. I have never heard of such a procedure.

We earmark because we want to say that within a given amount we want so much for a particular given area, a research, a product, or a program. So that, having been said for the record, I cannot argue Dr. Welt, with the points you make, either, because it is quite obvious that in this whole area there is going to be some spinoff and driftoff. Frankly, we wanted to point this thing up more and give it more impetus and emphasis because of your cystic fibrosis testimony last year. The testimony received indicated that there were some breakthroughs, that progress was being made. So we felt we should build upon that progress.

That was why the committee took the position that we did; we wanted to reward what progress was being made by a little extra incentive to get this job done and expedite it as quickly as we can.

Mr. CASEY. Will the gentleman yield?

Mr. MICHEL. Yes.

Mr. CASEY. The day they testified here in support of their request they made a very good statement about how they had even put a little more in; instead of $2 million, they put in $2,018,000. They were saying how glad they were that they did have an additional impetus, that they were making breakthroughs and whatnot. I commended them on their actions and wished them continued success. Then this pops up here and I find out that, yes, they spent $2,018,000, but not according to the gentlemen who devote their full time to this effort, not in keeping with what they requested and what we tried to do.

Mr. MICHEL. That is why I say we are most grateful for having this brought to our attention by you gentlemen who are so much more professional in the field than we are. We seem to be in between the Department people going their way and you, who want to go another.

We must get the mesage across that what we had in mind was putting more emphasis on this research. As I say again, I cannot argue at all with the good points you make. Going back to the point I was making before, if we had boundless supplies of money upon which we could draw we would have no problem whatsoever. There would be $2 million in hard cystic fibrosis research and there would be no question whatsoever about it. I should make the point, though, that we cannot be put in a position of engaging in a pressure game, either, where the amount of money we are earmarking is dependent upon the degree of pressure we get from a particular group. We would be in an uncomfortable position if we ran the show that way, and we cannot permit it to happen.

With that, I conclude.

Mr. HULL. Dr. Welt?

Dr. WELT. I would like to make several points. First of all, no one argues your privilege of writing the legislation as you see fit. That is your responsibility and we certainly recognize it is. I cannot take a position as to whether or not the Institute fulfilled within the letter how you interpreted that it should be fulfilled because I am not familiar enough with the data. What I would like to suggest for the future is that in a situation where there are fiscal constraints, where only 50 percent of approved grants can be funded, the earmarking of a given number of dollars does have some pitfalls. The questions that I think you have to ask—the question you have to ask yourself is a rather simple one: If you earmark x number of dollars for Y disease and in point of fact the grants that are submitted for Y disease are

just scientifically inferior, not trivially inferior but there is a difference in their merit as opposed to disease A, where should the money go? That is the question. Where do you get the biggest scientific return?

Mr. CASEY. That is what we are faced with in this whole budget.

Dr. WELT. I know. And your judgment is going to be exceedingly important and it has always been very good in the past.

Mr. MICHEL. I cannot be so optimistic as to believe that we will ever be able to appropriate money to fund all the applications in any given field. History has proved the opposite, and I do not expect it to change.

Dr. WELT. That is why I plead for the yardstick of excellence rather than categorization.

Mr. MICHEL. We will pursue that, too.

Mr. HULL. Thank you, gentlemen. We are delighted to have had you here this morning.

We will come back at 2 p.m.

THURSDAY, APRIL 25, 1968.

NEUROLOGY AND BLINDNESS

WITNESSES

DR. DAVID DALY (NEUROLOGY), PROFESSOR AND CHAIRMAN, DEPARTMENT OF NEUROLOGY, UNIVERSITY OF TEXAS, SOUTHWESTERN MEDICAL SCHOOL, DALLAS, TEX.

DR. JOHN STIRLING MEYER (STROKE), PROFESSOR AND CHAIRMAN, DEPARTMENT OF NEUROLOGY, WAYNE STATE UNIVERSITY, COLLEGE OF MEDICINE, DETROIT, MICH.

DR. JOHN E. BORDLEY (SPEECH AND HEARING), ANDELOT PROFESSOR AND CHAIRMAN, DEPARTMENT OF LARYNGOLOGY AND OTOLARYNGOLOGY, JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE

DR. THOMAS D. DUANE (VISION), PROFESSOR AND HEAD, OPHTHALMOLOGY, JEFFERSON MEDICAL COLLEGE, PHILADELPHIA; RESEARCH STUDY DIRECTOR, RESEARCH TO PREVENT BLINDNESS, INC.

Mr. HULL. Dr. Daly, we would be delighted to hear from you and your colleagues this afternoon.

STATEMENT OF DR. DAVID D. DALY

Dr. DALY. Mr. Chairman and members of the committee, I am David D. Daly, professor and chairman, department of neurology, University of Texas Southwestern Medical School; past president of the American Epilepsy Society; past president of the American Electroencephalographic Society; member of the board of trustees of the American Academy of Neurology; and cochairman of the National Committee for Research in Neurological Disorders.

I am pleased and honored to appear before this committee as a representative of the American Academy of Neurology and as spokesman

for the 18 voluntary health groups and 10 professional societies concerned with crippling neurological disorders which affect more than 10 million individuals in these United States.

The voluntary health groups represented are: The Deafness Research Foundation, Epilepsy Foundation of America, Muscular Dystrophy Association of America, Inc., Myasthenia Gravis Foundation, Inc., National Association for Retarded Children, National Council to Combat Blindness, Inc., National Epilepsy League, Inc., National Foundation for Eye Research, National Health Education Committee, Inc., National Multiple Sclerosis Society, National Paraplegia Foundation, National Society for Crippled Children and Adults, National Society for the Prevention of Blindness, Inc., National Tay-Sachs and Allied Diseases Association, Inc., New York Association for the Blind, Paralyzed Veterans of America, Inc., Parkinson's Disease Foundation, Inc., and United Cerebral Palsy Associations, Inc.

The professional societies in addition to the American Academy of Neurology are: American Neurological Association; Association of University Professors of Neurology; American Laryngological, Rhinological, and Otological Society; Society of University Otolaryngologists; National Committee for Research in Ophthalmology and Blindness; and four neurosurgery societies—American Association of Neurological Surgeons, American Academy of Neurological Surgery, Congress of Neurological Surgeons, and Neurosurgical Society of America.

The recommendation of the citizens' committee represent the consensus of the appointed representatives of each of these groups. The fiscal recommendations are made only after careful study in consultation with scientists and experts in the areas of both research and training. The budget is meant to be one which will not only permit the NINDB to pursue present plans, but, hopefully, one which will guarantee a strong impetus to the realization of expanded goals for the future.

Largely through the efforts of this subcommittee and its counterpart in the Senate, the annual appropriation authorized by the Congress for the Neurological Institute has increased steadily from $4,500,000 in 1954 to $128,633,000 last year. However, even this remarkable expansion is not enough to meet the urgent current needs for neurological and sensory research and training as well as to provide for future planning. Because of these important reasons, the National Committee for Research in Neurological Disorders proposes, therefore, an overall budget for fiscal year 1969 of $164,200,000 which represents a 12.3-percent increase over that recommended a year ago.

The citizens' budget proposes significant increases primarliy in the areas of training and extramural research projects.

Our committee's budget recommends an increase in training support of $5,120,000 above the 1968 appropriation, and for research fellowships an increase of $895,000. The past support by Congress of the NINDB training programs has made possible a striking increase in the number of trained neurologists and neurological scientists. They, in turn, are responsible for our accelerating progress in the conquest of neurological diseases. However, many of us in the neurological community view with concern what we interpret as decreasing momentum for support of training in neurology. If, in the years ahead, we are to staff the new medical schools—and we import from other

countries the output of about 40 medical schools in terms of the positions of people who immigrate—if we are to conquer the many diseases affecting the nervous system we must attract eager young minds in sufficient numbers. Acknowledging this, the board of trustees of the American Academy of Neurology and the Association of University Professors of Neurology have passed recommendations endorsing the concept that to maintain sound growth in the neurological sciences requires a greater percentage increase in funds for training programs compared with overall increases of budget for NINDB.

In fiscal 1968 there was only a negligible increase in funds for research fellowships, no increase for postdoctoral fellowships, and an actual decrease of $800,000 in support for graduate training grants. In fiscal 1968 the Institute had approved but unfunded training grants totaling $3.4 million. For fiscal 1969, the Institute estimates the corresponding figure will be $7.5 million. The citizens' budget recommends an increase of only $5,120,000. This compromise will still leave a $2.5 million gap in approved training programs, should your committee concur in our thoughts. Similarly, the citizens' budget recommends $4,700,000 for research fellowships, an increase of $895,000 over the 1968 appropriation. Again, the Institute has estimated that approved but unfinanced research fellowships for 1969 will total $5 million. Thus, our recommendation will still leave unfunded some research workers regarded by their peers as worthy of support.

The citizens' budget also recommends an increase of $29 million in extramural research support. Great needs exist to maintain the momentum of programs in sensory disorders involving both vision and speech and hearing, and in the crucial area of cerebrovascular disease.

Since my distinguished colleagues will speak on these areas of our concern, I should like, with your permission, to confine my further remarks to three specific topics which we feel deserve strong support. Following this, I would be pleased to try to answer any questions concerning the proposed overall citizens' budget.

One of the most promising areas of neurological research is the possible role of the so-called slow viruses in causing the progressive degenerative diseases such as multiple sclerosis. Three recent developments have greatly stimulated interest in this research approach to the disease.

First was the breakthrough in transmitting kuru, a rare human neurological disease, from man to chimpanzees and later from these chimpanzees to a second group of chimpanzees—transmission of the disease through three generations. Still another indication of the possible role of slow viruses in the etiology of these diseases was the recent transmission of Jakob-Creutzfeldt disease of humans to chimpanzees. A third important lead in slow virus research is the growing body of evidence that measles virus is involved in subacute sclerosing panencephalitis, a fatal neurological disease of children and young adults.

We support the Institute plans to exploit these leads with an expanded program in slow virus research.

The Institute has long recognized the need for special laboratories to establish an infectious etiology for the specific diseases under study. Expansion of this program requires additional facilities and an increase in the numbers of experimental animals to be inoculated. The Institute has plans for a suitable virus research facility to be constructed on the NIH animal farm at Poolesville, Md. Such a special,

highly isolated facility is required to safeguard both the scientists and the public. Extensive construction will be necessary in building holding facilities for the experimental animals, because of the long period of incubation these animals have to be held for many years to determine if they develop the disease.

Laboratories isolated from the animals and other facilities will be required so that the risk of spreading infection is held to the absolute minimum. However, our committee believes that research in this vital area should not remain restricted to the intramural program of the Institute. We hope this Congress will permit and instruct the Institute to expand this research by establishment of other high-safety virus laboratories in appropriate institutions.

Between 1 and 2 million Americans suffer from epilepsy, a condition characterized by recurrent attacks which may include such varied symptoms as loss of consciousness, confusional attacks, motor spasms, or convulsions. This chronic disorder affects between 1 and 2 million children and young adults. In the last century, one of the most dramatic advances in the treatment of neurological diseases has been the development of an effective group of anticonvulsant drugs. Yet epilepsy remains a great scourge carrying an undeserved social stigma. With medicines we can eliminate seizures in half the patients, and control them to a large extent in another 25 percent. But for many patients effective treatment still does not exist. Furthermore, for some individuals, the use of these drugs causes distressing or dangerous side effects. It is estimated that the disability resulting from epilepsy causes an annual loss to the economy of more than a billion dollars.

As you may know, the Surgeon General in 1966 appointed an Advisory Committee on the Epilepsies. The committee meets regularly to assess research and service programs and to identify and plan for unmet needs. I am privileged to be chairman of one of the two subcommittees constituting the full committee. The committee recognizes an urgent need for the development of new, safe, and effective anticonvulsants. At the present time, work in this area is at a virtual standstill. In fact, there is no organized field trial of a new anticonvulsant drug underway at the present time. We need to develop multiple centers where newly discovered drugs can be methodically, thoroughly, and precisely evaluated for efficacy and safety. Such centers could serve as sources for vitally needed information on the incidence and natural course of this disorder. Such centers could serve vital roles in training neurologists and awakening community interest and understanding. Due to public ignorance and ineffective medical treatment, epilepsy is in a sense the last stigmatic disease of our century. We believe this can be changed. We hope that you will encourage the Institute to move in this direction.

The problems of death and disability resulting from head and spinal cord injury affect all age groups, especially the young. It has been estimated that each year over 2 million Americans suffer head injury—and over half of them are children under 15. Although the exact percentage of head injuries in all accidents is not known, we do know that accidents kill more Americans of all ages than any other disorder except heart disease, cancer, and stroke. Further, it is estimated that 60,000 to 100,000 persons suffer with paraplegia resulting from accidents.

Since 1965, the NINDB's research program on head injury has had three major objectives: to prevent head injuries; to curtail the progressive brain damage which occurs after the moment of impact; and to prevent or ameliorate the neurological sequelae, such as epilepsy, which may follow a head injury.

Injuries to the spinal cord resulting in paraplegia constitute a totally different problem since almost all such injuries result in long-term survival with severe disability. During the acute and subacute stage following injury estimates of the cost of essential care for a single paraplegic patient run from $40,000 to $50,000 a year. We believe an urgent need exists for the establishment of acute spinal injury centers which can seek a better understanding of processes such as edema, or swelling of the spinal cord, which may contribute to the final disability. We believe that such centers could lead neurologists, neurosurgeons, urologists, and physiatrists to work together in applying advanced technology for the improved care of acute spinal injury. Such centers might then well become models for the development of comparable centers in many communities.

In summary, Mr. Chairman, we believe that the wisdom of the Congress in supporting the programs of the Institute has led to the dramatic progress which has revolutionized the neurological sciences in a single generation, but we believe that the best is yet to come if we can sustain the existing momentum. We earnestly hope that you will react favorably to our recommendations. I would like to express my appreciation for the opportunity to appear before you not only as a spokesman for the National Committee for Research in Neurological Disorders, but also as a spokesman for the many scientists, physicians, parents, children, and patients who look to you for help.

Thank you.

(The attachment to Dr. Daly's statement follows:)

NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL DISORDERS

PROPOSED 1969 BUDGET FOR THE NATIONAL INSTITUTE OF NEUROLOGICAL DISEASES AND BLINDNESS

[In thousands of dollars]

Program by activities	1968 appropriations	1969 President's budget	Proposed NCRND 1969 budget	Increase over 1968 appropriation
1. Grants:				
(a) Research projects	$77,346	$80,038	$106,500	$29,154
(b) Research fellowships	3,805	3,889	4,700	895
(c) Training	18,780	19,262	23,900	5,120
Total extramural	99,931	103,189	135,100	35,169
2. Direct operations:				
(a) Laboratory and clinical research	9,894	11,119	11,000	1,106
(b) Collaborative research and development	10,190	10,206	11,000	810
(c) Biometry, epidemiology, and field studies	3,371	3,388	3,500	129
(d) Review and approval	2,418	2,499	2,600	182
(e) Training activities	73	74	100	27
(f) Administration	675	720	900	225
Total direct operations	26,621	28,006	29,100	2,479
Total obligations	126,552	131,195	164,200	37,648
Unobligated balance reserve	404			−404
Transfer to Indian health activities	1,677			−1,677
Total appropriation	128,633	131,195	164,200	+35,567

Mr. HULL. Dr. Daly, I notice that you mentioned the Citizens Committee many times. What committee is that?

Dr. DALY. That is the National Committee for Research in Neurological Disorders.

Mr. HULL. I thought it was some outside committee.

Dr. DALY. No, sir. It seems simpler to abbreviate it rather than repeating that lengthy title.

This committee, as you will see from my prepared statement, is made up of voluntary health groups composed of laymen and professional medical societies concerned with neurological and sensory disorders.

Mr. HULL. Where do they come from, the voluntary health groups?

Dr. DALY. Most of them are——

Mr. HULL. Are they doctors or scientists?

Dr. DALY. The voluntary health groups are laymen who have, for one reason or another, a specific interest in certain neurological and sensory disorders.

Mr. HULL. So that is where you get the Citizens Committee?

Dr. DALY. Yes, for example.

The Epilepsy Foundation of America is made up of laymen who, either for personal reasons or perhaps more general reasons, are interested in the problems of epilepsy, trying to improve the lot of patients with seizures.

Mr. HULL. How much over the budget have you asked for?

Dr. DALY. If you will look at the appendix, you will see that in research project support we have asked for $29 million above the President's budget for 1969, and in the areas of training we have asked for approximately $7 million.

Mr. HULL. Thank you very much, sir.

Dr. DALY. Thank you.

STATEMENT OF DR. JOHN STIRLING MEYER

Mr. HULL. We will next hear from Dr. John Stirling Meyer. You may proceed in any way you like.

Dr. MEYER. Mr. Chairman, I am here as a U.S. citizen and taxpayer to speak about this country's war on stroke. The third commonest killer of U.S. citizens, after heart disease and cancer, and, in my opinion, the commonest cause of prolonged disability in this country.

There are estimated to be at least 2 million people in the United States who are paralyzed, speechless, or demented by reason of stroke. Mr. Chairman, I have testified before this committee previously and all the members of the committee know what a stroke is and what my interest in this area has been. But for the record, let me briefly review some relevant facts.

Stroke is an interruption of the blood supply to the brain due to a blockage of the arteries or a hemorrhage into the brain substance. The principal causes are hardening of the arteries or sclerosis of the brain arteries; rupture of the arteries due to high blood pressure; or weakness of the walls of the brain arteries and the blockage of the brain arteries due to clots forming in them or breaking off from the heart or blood vessels in the neck.

Mr. HULL. Does that happen at all ages or as you grow older?

Dr. MEYER. The highest peak incidence for overall stroke occurs at about 50 to 60. They occur at all ages, however. Strokes also occur in children. This is not widely appreciated. They are rare, but they do occur in children.

After the age of 20 an aneurysm is not uncommon. The peak incidence of hemorrhage in the brain occurs in the thirties and forties. The so-called thrombotic or thromboembolic incidence due to hardening of the arteries has its peak at about 50 to 60.

Mr. HULL. Off the record.

(Discussion off the record.)

Dr. MEYER. A piece of blood clot can break off from the heart or blood vessels and lodge in the brain and cause a stroke. This is the so-called brain-embolism. Stroke strikes people of all ages, but particularly in the age group around 50-plus years, the most productive time in a man's life. The economic cost to the community is enormous, let alone the inestimable tragedy to individuals and and their families. I ask you, Mr. Chairman and members of your committee, to review in your mind the number of your fellow legislators and acquaintances who have succumbed to stroke, including numerous Presidents of the United States, several of whom were in office at the time of their stroke.

I am a clinical neurologist, a physician who specializes in the treatment of diseases of the brain and, incidentally, one of the first recipients of a U.S. Public Health Service grant for research and training in stroke, about 16 years ago.

Apart from my personal research in the treatment and prevention of stroke, I have been professor and chairman of the department of neurology at Wayne State University in Detroit for the past 11 years where we have trained at least 15 neurologists in various aspects of their training, and about an equal number of research workers in the stroke field. As you will remember, Mr. Chairman, I was fortunate in 1964 in being appointed Chairman of the Stroke Subcommittee of the President's Commission on Heart Disease, Cancer, and Stroke. The recommendations of that committee led to considerable improvements in the organization and planning of this country's health resources, not the least of which was the establishment of the regional medical programs.

Since 1964 I have served my 4-year term as a member of the National Advisory Council for Neurological Diseases and Blindness, and as a member of the Joint Council's Subcommittee for Stroke, which has appointed members and representatives from the Councils concerned with stroke; namely, the National Institute of Neurological Diseases and Blindness, the National Heart Institute, and the regional medical programs.

My remarks concerning the governmental programs for stroke will therefore provide broad coverage, but will have direct and particular application concerning the appropriation for the National Institute of Neurological Diseases and Blindness, the National Heart Institute, and regional medical programs.

Let me reassure you, Mr. Chairman, that all of these and other governmental and volunteer agencies such as the American Heart Association are concerned with stroke and are all cooperating closely as a nationwide team without any waste of time, effort, or manpower.

Let me review with you the programs and progress we have made in stroke and indicate to you the areas that critically need continued and expanded support. These recommendations are made to your committee fully mindful of the growing concern of the U.S. taxpayer with increasing governmental expenditures.

Now, a word about accomplishments to date. The National Institute of Neurological Diseases and Blindness from its current budget supports 104 excellent research grants and projects concerned with cerebrovascular disease or stroke at a cost of $4.9 million per year. The National Heart Institute supports a considerable number of research programs relating to stroke, and these research programs must be continued since a tremendous amount of information has resulted from the research concerning the nature, prevention, and treatment of this dreaded condition.

It seems to me that I need say little more to your committee, Mr. Chairman, about the need for research in this area since you have already heard able testimony from all your witnesses stressing the importance of research. A word about drug trials and cooperative studies of treatment. The National Institute of Neurological Diseases and Blindness and the National Heart Institute are already supporting cooperative studies concerned with the efficacy of the surgical treatment of stroke, the treatment of cerebral hemmorhage due to ruptured aneurysms, and the control of high blood pressure as a means of preventing further strokes.

The latter study should be expanded since over 80 percent of people with stroke have high blood pressure and there is a good deal of evidence that suggests that the control of high blood pressure will prevent strokes. At the present time it is a very small study, involving few centers.

Sugar diabetes and high blood cholesterol levels are also commonly associated with stroke. We need to support carefully designed studies in the role of the treatment of these conditions, in preventing stroke. For example, a cooperative study on the use of Atromid-S, a drug that lowers cholesterol, could be mounted readily if the National Institute of Neurological Diseases and Blindness had funds available for such drug trials. Drugs that increase the brain circulation in stroke should also be investigated and tested in an objective and scientific manner.

Now I would like to speak a little bit about stroke centers. It is with great pleasure that we can report to you that there are now 18 stroke centers located strategically across the United States as treatment centers of excellence, as research centers, training centers, and manpower resources, and as demonstration units. The average cost of each of these centers is about $200,000 per year. The oldest stroke centers have been in existence for only 7 years, yet the total contributions to our knowledge of the epidemiology, prevention, diagnosis, as well as the medical and surgical treatment of stroke has been enormous. Seventeen of these stroke centers are supported by the National Institute of Neurological Diseases and Blindness and one by the National Heart Institute.

I would like to record where these centers are located.

Mr. HULL. I would appreciate that. I was going to ask you to do so.

Dr. MEYER. Each of these cities has one center: New York City; Minneapolis; Detroit; Miami; Boston; St. Louis; Kansas City, Kans., Dallas, Tex.; Chicago; Durham, N.C.; Philadelphia; Winston-Salem, N. C.; Rochester, Minn., the Mayo Clinic; Bloomington, Ind.; Berkeley, Calif.; Memphis, Tenn.; and Baltimore, which has two centers.

Now, the reason that the Southern States are so well represented is that for reasons unknown, possibly dietary factors, strokes are more common in the Southern States among whites as well as Negroes. The reason I can state this so confidently is that an epidemiological study made by one of the two stroke centers in Baltimore has proven this.

I would like to make a few comments about the activities of the Joint Council Subcommittee. The Joint Council Subcommittee, as you know, Mr. Chairman, is a committee appointed of representatives of the National Institute of Neurological Diseases and Blindness, the National Heart Institute, and regional medical programs to see that we are coordinating our activities. Apart from coordinating the activity for stroke prevention and control of both the National Institutes for Neurological Diseases and Blindness and the National Heart Institute, we are also coordinating the regional medical program as stroke activities. The Joint Council Subcommittee, as a result, has sponsored training programs and workshops in stroke control that have been well attended and have attained international recognition for their scientific contributions. These include the Princeton Conferences and the Stroke Center Conferences. Here new ideas of research, treatment, prevention, and planning have been exchanged.

Now, two important publications have been written by the Joint Council Subcommittee and have or will be printed by the U.S. Government Printing Office. These two manuals or books will be of great use to all communities across the United States in setting up regional stroke programs. The manuals have or will be distributed by the regional medical programs, the National Institutes of Neurological Diseases and Blindness, and the National Heart Institute. The first manual spells out how to set up a registry of stroke cases in the community, like a cancer registry. This will tell us the magnitude of the problem, since many cases of stroke are not even admitted to hospitals and are left in bed at home, often in shameful neglect. The second manual spells out the epidemiology, classification, causes, diagnosis, prevention, treatment, and the rehabilitation of stroke. I was fortunate to serve on the committee that prepared this manual and I think it should be helpful to those planning community programs for stroke.

Now a word about training and manpower. I have left until last, Mr. Chairman, the most important subject of all. The restriction of Government funds has already curtailed our training programs and I plead with you to increase funds for training our most precious resource—manpower. The National Institute of Neurological Diseases and Blindness, through its training programs, has provided the main source of funds for manpower for planning and manning the stroke centers, and we will need more for the stroke activities of the regional medical programs.

Now, what do we have in the way of training programs? Let's speak first of all about the cerebrovascular disease training grants, so-called

stroke grants. There are seven centers training neurologists and surgeons who specialize in stroke care and five individual stroke trainees who are directly supported by the National Institute of Neurological Diseases and Blindness in addition to the stroke training grant programs.

Mr. HULL. Where are they located?

Dr. MEYER. They are located pretty well across the United States. One is in Boston, Mass., one in Winston-Salem, N.C., one in Detroit, one in Minneapolis, Minn., one at the Mayo Clinic, one in Memphis, and one in Richmond, Va. They are geographically well represented, I think.

These National Institutes of Neurological Diseases and Blindness-supported programs train 41 stroke specialists per year. This is clearly not enough. We need more training funds in this area and for training neurologists and neurosurgeons in general.

There are a total of 495 training programs——

Mr. LAIRD. We just were having a little conference over here. We do not understand why there is not one in Wisconsin.

Dr. MEYER. I went up to LaCross, Wis., with Mike DeBakey and Irving Wright. I also went to Madison, Wis., and to Marshfield, Wis.

Mr. LAIRD. Marshfield particularly interests me.

Dr. MEYER. I think Marshfield could have a good stroke-control program along the lines of these other two places where I have been in order to help them set up programs in Wisconsin. I can tell you that the programs are very active and they are sponsored by the regional medical programs in the area that I have named. There is no reason in the world why Marshfield shouldn't be part of this. I have a feeling, sir, that it is.

Mr. LAIRD. I certainly think it should be a part of this; but I have not heard about that yet.

Dr. MEYER. I believe the regional medical programs can work out satisfactorily so that excellent stroke programs can be set up in all communities. Certainly, the opportunity is there and these manuals have been provided.

A word about manpower resources in these areas of stroke and neurological diseases in general.

There are a total of 495 training programs supported by the National Institute of Neurological Diseases and Blindness for neurologists, neurosurgeons, neuroradiologists, pediatric neurologists, neuroanatomists, neurochemists, neurophysiologists and neuropathologists. This includes training programs, special fellowships, post-doctoral fellowships, career awards, and career development awards. These are expanding and viable programs that are training for the specialists we need for stroke and other neurological diseases for the future and for our exploding population.

I hope your committee will, in its wisdom, expand the support of training programs in the National Institute of Neurological Diseases and Blindness. Finally, Mr. Chairman, I have some encouraging figures that I would like to share with you. Let us compare manpower in clinical neurology between 1962 and 1966 to show your committee what the National Institute for Neurological Diseases and Blindness has achieved with its training programs. In 1962 there were 1,159

neurologists, in 1966 there were 2,295, an increase approaching 100 percent in 4 years. In 1962 there were 574 board-certified neurologists; by 1966 there were 753, a gain of about 30 percent. In 1962 there were 910 board certified neurosurgeons; now there are 1,128, a gain of about 20 percent. In 1962 there were 386 trainees, young doctors being trained as specialists in these areas supported by the National Institute of Neurological Diseases and Blindness, and now there are 574, an increase of 40 percent.

I am deeply grateful, Mr. Chairman, for the opportunity of testifying before your committee.

Mr. HULL. Thank you.

We will now hear Dr. John E. Bordley.

STATEMENT OF DR. JOHN E. BORDLEY

Dr. BORDLEY. I am John E. Bordley, M.D., Andelot professor, chairman of the Department of Laryngology and Otology in the Johns Hopkins University School of Medicine, a member of the National Committee for Research in the Neurological Disorders, a member of the National Examining Board for Otolaryngology, past president of the Society of University Otolaryngologists, and a member of the Committees on Otolaryngic Pathology and Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology. I would like to thank you, Mr. Chairman, for the privilege of testifying before this committee.

I am here today to give my hearty endorsement to the citizens' budget for the National Institute of Neurological Diseases and Blindness for fiscal year 1969. I feel that I speak for all the members of my specialty when I say that the citizens' budget is realistic and is necessary if we are to carry out the investigation needed to advance our field of medicine and to produce a sufficient number of scientists expert in research and in teaching, to man our university programs, and to produce the hard corps of manpower in this discipline so much needed today to care for our patients.

The special area which I represent is human communication. I use the term human communication because such communication is limited to man. As a result of this unique ability, man has been able to create, store and retrieve sufficient knowledge to develop many skills. With this ability, he has become a teacher; he has learned to heal the sick; he is rapidly learning to soar through the stratosphere and to live under the ocean. Disorders of communication that interfere with this ability of man to exchange ideas, store them and recall them can be very devastating. They not only result in dreadful emotional difficulties for those afflicted, but they are also extremely costly to society. Communicative disorders cost us vast sums of money for rehabilitation where the development of special aids is necessary, where special education is required and special job training must be carried out. To alleviate the sufferers from the communication disorders is indeed a noble accomplishment, but alleviation does not compare with the development of methods to prevent such handicaps.

It is difficult to estimate the number of those handicapped by the communicative disorders in this country because of the very pervasiveness of these disorders. One can get some idea when it is realized that approximately 13 million people in this country suffer from hearing handicaps. Unfortunately, this figure is not static when one considers how rapidly our population is increasing. It is said that the problems

arising from hearing loss at the age of 70 and above, increase at a geometric rate, and it is presently estimated that 25 percent of our population, age 70 or over have hearing impairments sufficient to be real handicaps. Speech and hearing problems among children are also increasing due to the fact that so many imperfect children are now surviving the hazards of pregnancy and delivery. For instance, more than 50 percent of children suffering cerebral palsy have serious language and speech problems; 7 percent are deaf. Speech problems in our youthful population outnumber hearing problems by at least 25 percent. There are at least 5 percent of our children suffering from speech disorders. Speech disorders among our aging population are growing yearly as the result of strokes and cerebral thrombosis.

While much has been done to study the causes of these problems in our population, much more remains to be done. At present, we face these problems with inadequate manpower in the fields of research, teaching and clinical patient care. We also gravely need to develop more coordinated research to study problems from the clinical and the basic laboratory point of view, using a multidisciplinary attack. We are faced with the serious need to develop almost 100 percent more specialists in our field than we have today. Although the problems to be studied are staggering in their complexity and in their frequency, much real progress has been made in the past 5 years, and a great deal of credit for this progress is due to your committee for their past understanding, their show of confidence and their real support, which have enabled our special field of medicine to move forward in the development of research and training.

In reviewing fiscal year 1968, there are a number of accomplishments that should be cited. The successful removal and reimplantation of larynxes has been accomplished in experimental animals. With this knowledge available, work in the field of organ transplant is underway. Larynxes have now been successfully transplanted from one animal to another and have survived for periods of up to 2 weeks. This is but the first step, It shows, however, that the surgical technique of this procedure has been perfected sufficiently to make transplantation feasible. Much remains, of course, to be learned concerning the immunology of transplanted organs and until further intensive research brings us the answer to the immunological problems, we cannot hope to successfully give man a new larynx for permanent use.

Mr. HULL. Is this the same as that box that they put in the throat when they have cancer of the throat?

Dr. BORDLEY. This is the voice box that you have here behind your Adam's apple. This is the larynx. This has been removed and replaced by another one in experimental animals.

Mr. HULL. In animals?

Dr. BORDLEY. Not in man.

Mr. HULL. You have the voice box?

Dr. BORDLEY. We have an artificial arrangement that we can plug into the hole here and acts as a reed which has been helpful, and also esophageal voice has been helpful.

One can only say that the work to date is most gratifying.

The national network of temporal bone laboratories, which was supported for some time during its development by the Deafness Research Foundation, has now through the use of Federal funds been put on a firm basis and is presently performing a very important function in

studying the pathology of deafness. These "banks" as they are called process the temporal bones that have been pledged to them by deafened people and correlate the microscopic pathological changes in the ear with the records of hearing made during life. For example, such research has shown that otosclerosis, a common form of deafness resulting from bony changes within the ear capsule, not only causes deafness by interference with the movement of the bones in the middle ear, but at times may also invade the inner ear causing irreversible damage to the auditory nerve. Such new knowledge is of great importance.

Studies carried out during the current year on children born following prenatal rubella (German measles) and studies made on the rubella virus itself have revealed a mass of important information. Prenatal rubella is now thought to be the cause of much deafness, in which the pathology could not be identified previously. In the recent epidemic, it has been found that up to 50 percent of the mothers giving birth to children suffering from hearing loss, from which the virus could be identified, have shown no clinical symptoms of the disease at the time they actually suffered from active German measles.

This has been a very shocking thing. We found that mothers are walking the streets giving German measles to other people without knowing that they are carrying them. They give birth to offspring that we can culture the virus from that have bad hearts, cataracts, and deafness.

Studies to develop a German measles vaccine have shown that our early hopes for the development of such a vaccine to protect pregnant women have been overoptimistic because it has been found that people receiving the vaccine shed live virus for some time after vaccination, during which time they may pass the virus on, thus possibly starting a new epidemic. A search is now underway to find a new strain of rubella virus that hopefully will not prove so dangerous.

During the past year, two new outpatient centers for clinical basic research in the field of the communicative disorders have been inaugurated. This is a very important first step in a much-needed national network for the study of these disorders in depth.

Finally, the NINDB Information Center for Hearing, Speech, and the Communicative Disorders has developed sufficiently to now make available each month computer printouts of abstracts of the world's literature in this special field to medical libraries and to the directors of training and research programs. Such printouts made available to scientists within 20 to 40 days of initial publication is a most important step in the logical processing of the information deluge that has developed during the past 10 years. Much costly reduplication of research will now be avoided. The application of new ideas to patient care will be much speeded up.

I would like to show you this as an exhibit. This is the world's literature for 1 month in the communicative disorders. This comes off the computers once a month and is sent to all the training centers. This is an explanatory printout here. They are photo-reduced and sent out in a smaller form. Any scientist in the world can ask for these and get them, or ask for just separate chapters, separate categories, and get them.

What are some of our most pressing problems for the future? What types of new information do we need through the support of this

committee that can contribute importantly to the future well-being of our population? The work on larynx transplantation has been discussed in the previous paragraphs. Corollary to this is the possible development of an artificial larynx which can be implanted just as an artificial heart might be implanted. Design of such larynxes might permit a quick solution to the problem of tissue rejection. Certainly the plastics available today offer promise to some such development, and if a new larynx cannot be built, at least materials and techniques will become available to repair badly damaged larynxes and play a major part in the reconstruction of larynxes following surgical removal of cancers which have, in the past, resulted in severe voice problems.

New input mechanisms for hearing should be developed just as new artificial larynxes. In the case of the artificial ear, it is even more important than the artificial larynx, because the vast complexity of the neural system of the inner ear presents a nearly insurmountable challenge for replacement of damaged ears by using human ears. Some work has already been done in this field but much work needs to be done on materials, methods of implantation, and actual engineering of the input mechanism itself. As a matter of fact, two have been designed and implanted. They are not definitive enough except that the patient could tell a high tone from a low tone.

Mr. HULL. That is progress, I would think.

Dr. BORDLEY. It is progress.

More basic information concerning the development of language in man must be obtained, because it is on this information that our knowledge of speech development must be based. New forms of communication, such as computerized speech, offer new opportunities for laboratory research and must be developed further. Computerized speech gives the scientist a new type of standard to use for research in man and animals and will play a more and more important part in the development of new research instrumentation and of new sound amplifiers.

Research designed to gather more information concerning the nature of hearing disorders should be pursued, especially those disorders resulting from damage to the central nervous system. Such damage may result from the dangers of the birth canal, damage to the blood supply during and just after fetal life, arteriosclerosis in adult life, and damage to the brain or the auditory nervous system as a result of neurotoxic drugs or as a result of physical trauma. We must know a great deal more before we can hope to set up a proper "prevention program" to protect the hearing of children and adults.

I would like to speak to that part of the budget for fiscal year 1969 considered by the National Committee for Research in the Neurological Disorders to be the most critical and the most urgent. The proper and orderly development of our training programs are in grave jeopardy unless more support can be allocated for them. In the area of the communicative disorders, it is calculated that the national needs for manpower are now only half met. Presently, there are some 3,500 qualified individuals in our medical speciality, and the minimal national requirement in the next 5 years is estimated at 7,000. Such a deficit can only be overcome by expansion and improvement in our training programs. To do this, there is urgent need for more support for core faculty, because core faculty must be increased greatly to carry the

load of training for clinical and research needs of the future. In the paramedical field, which in the area of human communication is so closely allied to that of medicine, it is estimated that the Nation needs 5,000 more medical audiologists. There are about 1,500 available today. It is also estimateed that 5,000 speech pathologists should be available by 1975 if our speech programs are to be properly manned. The basic areas of otology, audiology, and speech pathology must be backed up by scientists trained in other disciplines who can apply their expertise to this special area of human communication. Such individuals should be drawn from biomedical engineering, biochemistry, ultramicroscopy, neuropathology, computer technology, and neurophysiology. These are just a few of the disciplines that must be listed.

The President's budget for fiscal year 1969 presents a serious problem even for the maintenance of our present training programs. It offers little or no hope that we can cope with the continued natural growth and expansion of training in this field where the Nation already facts such a shortage of manpower for research, training, and clinical practice.

One the other hand, the citizens' budget recognizes these national shortages in the areas of our specialty and also takes into account the increasing population and the increasing problems within this population. Unless we are to anticipate these growing programs by supporting new programs for research and training, seeking increased enrollment in our ongoing training programs and in our core faculty and preparing to take care of the increased student enrollment in the medical schools, we will indeed be in a serious plight. Eight years ago there were 83 medical schools in this country. Today, 109 have already been approved. In 8 years there has been an increase of more than 30 percent of our national medical training potential. While this was going on, our growth in training in the communicative disorders has actually been falling behind. During the past year, we were able to increase the number of trainees supported in our postdoctoral medical programs from 317 to 333, and we were able to develop two new programs for training, bringing our total to 68. During fiscal year 1968, danger signals began to appear foretelling serious future problems. Three new training programs, 12 renewal grants for training, and 13 supplementary grants for ongoing training programs were approved, but they could not be funded. This represents a deficit in our field of $1,334,000 in approved support for training in the communicative disorders. When we see the deficit of fiscal year 1968 and contemplate the natural growth of our training programs for which support is already committed, the budget for fiscal year 1969 appears very inadequate indeed. Without more realistic support, we face actual curtailment of our present ongoing training programs in the communicative disorders.

The danger in interrupting or curtailing training programs is that if you stop a training program through a lack of support you will find that it takes 5 years to get that training program on the track again.

In the area of research, the President's budget for fiscal year 1969, at best, would be able to support only 230 research projects through the National Institute of Neurological Diseases and Blindness. That will four less projects than are presently being supported. This curback is most serious when one considers that the review committees, during the past year, have approved only 45 percent of the research

grant requests presented to them. This is the highest rate of "turndown" in the history of the review committees of the National Institute of Neurological Diseases and Blindness. Approximately 25 percent of these projects are in the field of the communicative disorders. Without any expansion, our present laboratory complex with the requisite personnel could accommodate at least 25 percent more research projects in this communicative disorders.

The portion of the citizens' budget devoted to the communicative disorders proposes a modest increase over that of a year ago. This budget represents support that we feel is necessary to continue much-needed research and to support ongoing training programs and develop new programs so necessary to produce the manpower seriously lacking in the country today. The serious threat to the continuation of even our inadequate number of training programs is of deep concern to those individuals working in our field.

The citizens' budget provides $27,130,000 for the support of the communicative disorders. The principal sums in our proposed budget are as follows: $19,250,000 for the support of research grants, research centers, program projects, and the much-needed clinical research centers; $7,300,000 for the support of training—the principal expenditure from this will go to the support of training grants; the smaller sums will be devoted to special fellowships and postdoctoral fellowships. Career development awards are also listed under the training category. These very important awards make feasible the recruitment of promising young teachers and researchers. Five hundred and eighty thousand dollars is requested to support the activities of the Information Center for Hearing, Speech, and Communicative Disorders and for the development of a neuro-otolaryngology intramural center within the Institute.

We feel that this budget is realistic, is necessary to support our endeavors in the field of human communication, and it represents the thought and the approval of our entire specialty.

What I really mean is this should be supported in an ideal manner.

I speak for my specialty when I say that we all hope that this committee will see fit to appropriate these funds, so that our present programs can be preserved and necessary new programs can be started to keep abreast of our national needs.

(The attachment to Dr. Bordley's statement follows:)

Proposed citizens' budget for communicative disorders for the fiscal year 1969

	Millions
1. Research:	
Research grants	$14.2
Research centers	2.0
Clinical research centers and program projects	2.8
Total	19.0
2. Training:	
Training grants	6.0
Special fellowships	.4
Postdoctoral fellowships	.2
Career development awards	.5
Total	7.1
3. Center:	
Information center for hearing, speech and communicative disorders; Neuro-otolaryngology intramural center	.58
Total	.58
Grand total	26.68

Mr. HULL. Thank you, Doctor. How much over the budget are you requesting?

Dr. BORDLEY. For speech and hearing research, we are requesting about 17 percent of the proposed National Committee for Research proposed budget. We run about 17 percent of the expenditures of the national budget approved for the National Institute of Neurological Diseases and Blindness. So it will be about $6 million over the President's budget for the National Institute of Neurological Diseases and Blindness.

Mr. DALY. We are proposing an increase of $29 million, plus $7 million in training.

Mr. HULL. I think all of us would like to be able to do all of these things that you request, but you realize that we have a terrific money situation.

Dr. BORDLEY. Yes, sir. We are here to point out to you the best national interest as far as the health in these areas is concerned.

Mr. HULL. I understand.

Dr. BORDLEY. It is not our job to do anything about the finances except to pay our taxes.

Mr. HULL. Are there any questions?

Mr. LAIRD. No questions, Mr. Chairman.

Mr. HULL. Thank you very much.

STATEMENT OF DR. THOMAS D. DUANE

Our next witness is Dr. Thomas D. Duane. Dr. Duane, you may proceed.

Dr. DUANE. Mr. Chairman and members of the committee, I am Dr. Thomas D. Duane. It has been my privilege to engage in the private practice of medicine, to pursue basic and clinical research, and to administer similar activities in my present capacity as professor and head of ophthalmology of the Jefferson Medical College of Philadelphia. In addition, I have had the rare opportunity of viewing at first hand

the entire scope of ophthalmic research as it is pursued in the various laboratories throughout our Nation.

This latter opportunity was provided by Research to Prevent Blindness, Inc., a national voluntary health foundation whose mission, as its name implies, is to attack the problem of blindness by sponsorship of research directed at its causes. Under their auspices I have traveled to every major eye research laboratory and to almost all the medical schools in the land. Hundreds of individuals, including deans, trustees, department heads, and active researchers were interviewed. As a result of this survey, in 1964 a scientific symposium was held in Chicago, attended by over 300 scientists, practicing ophthalmologists, and others interested in blindness. The survey findings were subsequently printed in a volume entitled "Ophthalmic Research: U.S.A.," and 40,000 copies of this report were widely distributed to every Member of Congress, and to all those individuals and organizations who are deeply concerned with, and influential in, those matters related to public health and the welfare of our citizens.

Thus, it has been my privilege and opportunity, provided by both private philanthropy and the Federal Government, to experience the broad relationship which exists between visual research and those areas where research results are put into action; namely, in the practicing physician's office, in the classroom, and in medical centers at large.

The facts regarding blindness are not pleasant, and I would be remiss not to present them to you today:

> Ten years ago the number of blind people in the world was estimated by the World Health Organization as well over 10 million. Even this fantastic number is considered to seriouly underestimate the magnitude of today's blind population. Whatever the exact number, it is obvious that loss of vision is without doubt a catastrophic health problem throughout the world. While there are 400 million people who suffer from trachoma—the greatest cause of blindness in the world today—I will not dwell upon world-wide statistics. Rather, let us now confine our remarks to the situation here in the United States, where trachoma blindness is a numerically unimportant problem.
>
> One million Americans are functionally blind.
>
> Three and a half million have only partial vision—and their defects * * * with present methods of treatment * * * are non-correctable.
>
> Ninety million Americans—almost one-half our population—have some ocular malfunction.
>
> One and one-half million among us are blind in one eye.
>
> More than 10 percent of all patients seen at the Nations' medical hospitals are eye patients.
>
> More than 127,000 eye surgical procedures are performed each year in the United States.
>
> Blindness is on the increase. In the 20-year span from 1940 to 1960 the blind population increased by 67 percent while the general population increased by 36 percent. More than 42,000 U.S. citizens now become blind every year.

What are some of the causes of blindness in our country? I think you should know that 80 percent of all blindness is the result of diseases whose causes are unknown to science. Less than 5 percent is caused by

injuries and 3 percent by posioning. When we speak of causes, therefore, we are in most cases identifying a condition which we do not fully understand.

Cataract is the leading cause of blindness in the United States, representing about 25 percent of all cases. Sixty percent of all people over age 60 have some cataract formation, and almost 100 percent of all who reach age 80 have some cataract formation.

Glaucoma is the second leading cause of blindness in the United States, representing 15 percent of all cases. Almost 2 million Americans over 40 years of age (or about 2 percent of this age group) have glaucoma, and more than half don't know it.

Mr. HULL. If they do not know that they have it and they do not go to the doctor, they are the ones that would go blind eventually without being taken care of. They would automatically go blind?

Dr. DUANE. Yes. Every now and then there is a miraculous case that stops.

Mr. HULL. Yes. But I mean, nine times out of 10 they go blind before they can catch it.

Dr. DUANE. Or more; yes, sir. About 10 percent of the population has glaucoma by age 65.

Diabetic retinopathy, a major ocular complication of diabetes, is the most rapidly growing cause of blindness in the United States. In 1930, it was a causative factor in less than 1 percent of all new cases of blindness. Today, it is responsible for almost 15 percent of all newly reported cases. Four million Americans have diabetes, and at least 1.8 million of these are undetected at present. I will come back to this problem.

Twelve million children—one out of four—require some form of eye care. Nearly 2 percent of all children in the United States have crossed eyes, and 3 to 4 percent of the total population has poor vision as a result of crossed eyes.

Admittedly, some of these figures are educated estimates. Accurate national figures on the blind population, annual incidence, and causes of blindness are not provided by the U.S. Public Health Service. The need is acute for authoritative data that will accurately reflect the scope, seriousness, and nature of visual disabilities. These facts tend to be submerged by narrow emphasis on blindness which is the ultimate condition of visual deprivation. Between this and normal visual function, there is a world of suffering, despair, and social and economic loss which defies description.

The diseases I have mentioned represent merely a portion of those which are responsible for serious visual disability among millions of our people. There are many others, also of unknown cause, such as uveitis—inflammation of the colored part of the eye—retinal detachment, corneal disease, senile macular degeneration, ocular infections, and tumors of the eye. Although we can treat most of these entities in an empirical manner, we cannot provide definitive therapy because the causes and mechanisms of the diseases are unknown.

Consider diabetic retinopathy. The problems here are alarming, and may be considered an offshoot of medicine's previous successes. Since the advent of insulin, the life span of diabetics has been greatly increased. Not only do they live longer, but they are able to produce many more offspring with the inherited inborn defect. Unfortunately,

greater longevity also brings greater risk of visual difficulty among the Nation's 4 million diabetics. Among those who have had diabetes for 11 years or more, the complication of retinopathy is present in 64 percent. Among those with diabetes 15 to 20 years, diabetic retinopathy is present in as high as 93 percent. Our laboratory and medical center is typical of those attacking this disease from a research standpoint. We are studying the natural evolution of the complication in man and animals. We have under surveillance one of the few colonies of animals in the world in which inborn diabetes is transmitted from generation to generation. We are following over 125 patients who have had their pituitary glands removed in treatment of this condition. The problem is being attacked by microscopic studies, investigations of circulatory phenomena in the retina, medical and surgical approaches to treatment, and correlations, all of which are computer oriented. Although we are greatly encouraged by our approach, there is no real clue as to why this complication arises.

Therefore, our treatment remains empirical. We are representative of not more than five or six centers in the land. There should be at least 20 full-time teams devoting all their skills and energies to this devastating problem. In other words, people are working in this research area, and all are supported by the Government through the splendid efforts of this committee. But as long as so few are engaged in the battle, we must recognize that the Nation's capacity for research in this area, as in other areas of eye research, has hardly been tapped.

The taxpayers should, nevertheless, appreciate what their research dollar has bought for them in the field of visual research sponsored by the National Institutes of Health.

There has been established a national information center for visual services, at Harvard University; glaucoma continues to receive attention from NIH-supported grantees; cataracts, particularly those occurring infants, are being studied by clinical researchers; corneal diseases are being attacked; and new methods of retinal examination and reattachment are being vigorously explored.

The most important element in ocular research, however, is the sponsorship of men and women who work in the research laboratories. It has been stated that "money does not do research, men do." The National Institute of Neurological Diseases and Blindness has made only a bare beginning into the problem of providing clinical and basic researchers in ophthalmology. There are training programs in only 34 university centers today. This means that approximately 50 additional medical schools are without this type of support. Last year, there were 379 trainees in these programs. In addition, there were 18 special fellows, one research career awardee, 13 research career development awardees, and seven postdoctoral fellows. These figures represent an advance, but they are only a "thumb in the dike" when one considers the magnitude of the blindness problem.

Eye research stands in grave danger today from another quarter. I know it is important to you gentlemen that this Government exercise economy in appropriating funds, whether for health research or any other purpose. In considering the appropriation for eye reseach and training, I implore you to recognize that the Government has only begun to meet the essential needs of this neglected science.

At stake is all the good that has been accomplished in the past few years in terms of exciting the interest and devotion of the most

promising people. You must appreciate what effect your judgments must have on current and potential researchers. Your encouragement of the continued, necessary growth of eye research support will have a deep and permanent influence upon our research manpower. For the quest for answers to the blindness problem depends upon our ability to attract, train, and hold these gifted people.

We cannot attract the necessary manpower until we give all aspects of the visual problem the kind of attention, interest, and financial support that we give other areas in which widespread and extremely serious health problems are being acted upon with intelligence and vigor.

It is, therefore, my urgent request that this committee give full support to the citizens recommendation that $36,600,000 be allocated to vision research and research training within the total request for appropriations to the NINDB for fiscal 1969. The following is a financial breakdown of the funds requested for vision and research training:

Intramural	$3,000,000
Extramural	18,782,000
Total research grants	21,782,000
Training grants, traineeships, and fellowships	9,000,000
Clinical centers	3,000,000
Institutional grants	2,818,000
Grand total	36,600,000

This sum does not seem large if one thinks of it in a human context. Suppose that suddenly vision were removed from 42,000 people—during this summer. The Nation would be in a state of chaos. You are reminded that not very long ago an epidemic of 42,000 cases of polio caused near panic in this Nation. Yet only a small fraction of these infected were seriously disabled. Gentlemen, when we say that 42,000 persons will become blind in 1968 we are speaking of a permanent, irreversible, and tragic disability. In addition to these, the welfare of not thousands, but millions of Americans is involved in the decisions of this committee in relation to visual research. I am confident you will act upon this request with the same laudable degree of wisdom which you have shown in promoting the health and welfare of our people in the past.

Thank you.

Mr. HULL. Thank you, Dr. Duane.

Mr. Laird?

Mr. LAIRD. Dr. Duane, if you were to pick the area of highest priority among these increases, would it be the area of training or the area of research grants?

Dr. DUANE. The two are intimately intertwined. It is a little like asking you which of your children you would give the best education to. But all things considered, if I had to choose one or the other I would choose training because I think ultimately this will result in humans who will do research.

Mr. LAIRD. I would, too. I am glad that I was on the right track. I feel that the training area should have the highest priority in 1969, realizing we cannot do everything. It would seem to me that the training program should receive a higher priority than we have seen it given in the budget document before us.

It is going to be impossible to go along with increases in all areas this year. For that reason I think we are going to have to single out one or two areas which we concentrate on as far as our budget markup is concerned.

What do the others here think in the areas of their concern?

Dr. MEYER. Mr. Laird, I think you are on the right track. I think you got the message that I personally wanted to bring. I think we have hurt most in the training programs because of the restriction of Government funds. I would agree with you completely that in the upcoming fiscal year anything you can do to increase the training grant money would be most helpful. We are actually having to cut back on well-established, well-known programs of very, very excellent quality. You have already heard all across the board all of us say the same thing, that this is hurting. We have had to cut back the number of men we want to train from what we have done in the past, and this is a tragedy when we have an expanding population to take care of.

Mr. LAIRD. I don't want to pin any of you down. I know you represent different areas here, speech, vision, stroke. But it seems to me as I travel around the country that the greatest shortage is of ophthalmologists, and then hearing would come about second.

Dr. DUANE. I would like——

Dr. BORDLEY. Excuse me. We have just 50 percent of what we think we ought to have. I think the greatest danger in even a temporary cutback in our training programs is that it takes so long to get them started. We were in serious trouble when this committee began to support us. We had only turned out 55 otolaryngologists in the previous year.

Mr. LAIRD. We are not making as rapid progress as we thought we would make.

Dr. BORDLEY. We are not making as quick progress as we had hoped to make, but we have turned out last year about 200 as compared to 50 in 1954. So we have come quite a way.

Mr. LAIRD. I do not mean to downgrade your field, but hearing and vision, it seems to me, are areas where we have a greater shortage than in your field.

Dr. DALY. We all feel our own fields are important. While there has been a very significant rise in the number of people trained in neurology, what impresses us is the even greater rise that we can see facing us in just a short time. In my medical school, the board of regents just approved $135 million, a 10-year expansion program that is going to double our school by 1972. I don't know where we are going to get the people to do the teaching in a school of this size. By 1988 we are going to have 4,000 people in our school. But I would agree with everybody, training is of the greatest urgency.

Mr. LAIRD. Back when I first came on this committee our most urgent need was facilities. We had a very short supply of space for training people. Before we could train people we had to have some place to train them. We haven't made as good progress there as we would like to, but we have made some progress. But the new question is one of financing the people that you have to train. We have made enough advances in facilities so that there are places to train people now; isn't that correct?

Dr. DALY. This is true. It is a leapfrogging operation, also. As you train more people and you develop more people in any of the re-

search areas; for example, you generate then the needs for more facilities.

Mr. LAIRD. We appropriated quite a little money for facilities last year but, of course, that has been frozen.

Dr. DALY. I realize that.

Mr. LAIRD. Our committee has evidently overappropriated in that area, in the minds of some people, because the money has not been released.

Dr. DALY. The other problem that is inescapable in all of our areas is that the technology of research is becoming so complicated. We are moving out of the age of the village blacksmith type of research in which a microscope and a few simple tools were sufficient. Now we need very complex equipment, which becomes very expensive. So that there is an ever-increasing capital investment involved in the productive research.

Dr. MEYER. I would like to say, sir, that all of us here are really neuroscientists, and the Neurological Institute trains men in the neuroscience, neurosensory field, ophthalmology, ear, nose, throat, neurosurgery, and the sensory sciences are all in the same area.

Mr. LAIRD. Yes. All these training programs would be funded out of one appropriation item.

Dr. MEYER. Yes.

Mr. LAIRD. I was merely using those two as examples.

Dr. MEYER. I think there is an across-the-board need that none of us would deny. Everything I have heard in fields which are not mine, I certainly know to be factual. I think they would also agree that there is a tremendous shortage of nerve specialists, brain specialists, neuroscientists but, you see, we work together.

I think we all work together, Mr. Laird. I would not like to say that there is a greater shortage of one than another. There is a shortage across the board. I think the way that the awards are set up, if you finance the Institute they will pick out the peoeple who need it. I think it is pretty fair because we all sit on the Council, representatives from all these specialties. Where the need is, the money goes, and there is a very fine competition, I might say. I want to reiterate, you have put your finger on the spot; we are very short of funds in the training area and it is hurting badly. If you cut out the training programs the future is ruined. Once you stop our training program you cannot start it again for maybe 5 or 10 years.

Mr. LAIRD. Thank you very much. Thank you, Mr. Chairman.

Mr. HULL. Thank you.

THURSDAY, APRIL 25, 1968.

GENERAL MEDICAL SCIENCES

WITNESSES

DR. RICHARD EGDAHL, CHAIRMAN, SURGERY DEPARTMENT, BOSTON UNIVERSITY MEDICAL CENTER

DR. SHELDON COHEN, PROFESSOR, BIOLOGICAL RESEARCH, WILKES COLLEGE, WILKES-BARRE, PA.

Mr. HULL. We will next hear from Dr. Egdahl who is accompanied by Dr. Sheldon G. Cohen. We would be glad to hear from you gentlemen at this time.

Statement of Dr. Richard Egdahl

Dr. Egdahl, you may proceed.
(Dr. Egdahl's biography follows:)

Curriculum Vitae, Richard H. Egdahl, M.D.

Date of birth: December 13, 1926, Eau Claire, Wis.
Education: High school—Eau Claire High School, Eau Claire, Wis., 1940–44.
Undergraduate—Dartmouth College, 1944–46 (no degree).
Medical school—Harvard, 1946–50 (M.D., 1950).
Graduate—University of Minnesota, 1951–52; 1955–57 (Ph. D. 1957).
Military service:
July 1944 to November 1945, U.S. Navy V–12 program (apprentice seaman).
October 1952 to June 1955, U.S. Navy (lieutenant).
October 1952 to September 1953, naval medical officer on USS *Lacrtes* (AR–20) (Japan-Korea).
September 1953 to June 1955, Naval Medical Research Institute, Bethesda, Md.
Internship: University hospitals, Minneapolis, Minn., July 1950–51 (straight surgery).
Residencies: University hospitals, Minneapolis, Minn., July 1951 to October 1952; June 1955 to March 1958.
Certification: American Board of Surgery (May 1959).

Societies:

1. A.A.A.S.
2. American College of Surgeons.
3. American Federation for Clinical Research.
4. American Medical Association.
5. American Physiological Society.
6. American Society for Clinical Investigation.
7. American Society for Experimental Pathology.
8. American Surgical Association.
9. Endocrine Society.
10. Halsted Society.
11. Society of Surgical Chairmen.
12. New York Academy of Science.
13. Society for Experimental Biology and Medicine.
14. Society of University Surgeons.
15. Surgical Biology Club.
16. Transplantation Society.
17. N. E. Surgical Society.
18. Norfolk District Medical Society.
19. Benjamin Waterhouse Medical Historical Society.

Honors and awards:

1. Phi Beta Kappa (Dartmouth College, 1946).
2. Boylston Medical Society (Harvard Medical School, 1947).
3. USPHS, Special Research Fellow, July 1957 to March 1958.
4. John and Mary Markle Scholar in Medical Sciences, 1958–63.
5. Ciba Award of Endocrine Society, 1962.

Committees, editorial boards, et cetera:

1. Editorial board—"Transplantation," American Journal of Surgery.
2. Committees on Exhibits, American Society for Clinical Investigation.
3. Chairman, Committee on Education, Society of University Surgeons.
4. National Academy of Engineering Committee on Interplay of Engineering with Biology and Medicine.
5. Surgical Training Committee, National Institute of General Medical Sciences (July 1968).

Consultant to:

1. Central office, VA, on research in surgery.
2. NIH General Medicine Study Section.
3. Surgical Forum Committee of American College of Surgeons.
4. ACS Committee on Pre- and Post-Operative Care of American College of Surgeons.

Address: University Hospital, Department of Surgery, 750 Harrison Avenue, Boston, Mass.
Married; 4 children; home address: 84 Upland Road, Brookline, Mass.
Clinical:
Surgeon-in-chief, University Hospital.
Consultant, III (B.U.) Surgical Service, Boston City Hospital.
Consultant, Providence Veterans' Hospital.
Consultant, Boston Veterans' Hospital.
Consultant, U.S. Public Health Service hospital (Boston).
Consultant, Chelsea Naval Hospital.
Special interests: Chronic pancreatitis, carcinoma of the pancreas, splenectomy for hypersplenism in hemolytic anemias, hyperparathyroidism, Cushings syndrome, primary aldosteronism, pheochromocytoma.
Research interests: Neuroendocrinology and hemotransplantation of tissues (especially pancreas).
Previous faculty positions:
Instructor in surgery, University of Minnesota, 1957–58.
Associate in surgery, Medical College of Virginia, 1959–61.
Assistant professor of surgery, Medical College of Virginia, 1962–63.
Professor of surgery, director of surgical research laboratories, Medical College of Virginia, 1963–64.
Current academic title: Professor and chairman, Department of Surgery, Boston University School of Medicine.
Publications: 117.

Dr. EGDAHL. Mr. Chairman, I am chairman of the department of surgery at Boston University and I appreciate the chance to talk with you about the budget for the National Institute of General Medical Sciences. I am vitally involved in biomedical engineering and the training of both practicing and research-oriented surgeons. If it would be all right with you I would put my formal statement in the record and talk in supplement thereof, if I may.

Mr. HULL. That would be fine. Without objection, it is so ordered.

(Dr. Egdahl's prepared statement follows:)

Mr. Chairman and members of the committee, I very much appreciate the chance to discuss with you the request for appropriations of the National Institute of General Medical Sciences of the National Institutes of Health.

I am Richard Egdahl, professor and chairman of the department of surgery at Boston University Medical Center. In this role I have the responsibility for the training of both clinically oriented and academically directed surgeons, the postgraduate education of practicing surgeons and the education of medical students. I am a member of the General Medicine Study Section of the National Institutes of Health and a member of the Committee on the Interplay of Engineering with Biology and Medicine of the National Academy of Engineering. I am a consultant to the Veteran's Administration for research in surgery, am on the editorial boards of two scientific journals and am the author of over 100 papers on clinical and experimental medical subjects. During the past several years my interest has become particularly intense in two areas which might generally be defined as surgical training and biomedical engineering, and it is to these subjects that I would like to address myself. Because of the importance of the two areas for the future delivery of health services to the people and because of the long time required for investment in these latter two areas to bear useful fruit, a decision to provide solid support at this time assures particular importance.

There is general acceptance that a considerably increased number of doctors will be necessary in the next decade if we are to deliver the quality and quantity of health care which is both ethically desirable and practically realizeable. Though the exact dimensions of this expansion of medical personnel will depend upon the rapidity with which acceptable advances in technology and paramedical personnel can be integrated into the delivery of health services, but it has become quite apparent that large increases in M.D.'s that can assume responsibilities in both clinical and academic areas. Having already passed legislation that accents the principal of medical care as a right and appropriate funds toward this end, it would indeed be unfortunate if appropriate numbers of doctors were not made adequately available to deliver the care these programs propose.

My first point has to do with the training of the teachers of doctors—and since my special area of activity is surgery, I will use departments of surgery in medical schools as an example. Recent experiences in recruiting of staff for medical schools in departments of surgery have made it apparent that our supply of "academic surgeons" is, and threatens to continue to be, entirely inadequate. A recent visit by me to a major medical school teaching hospital revealed that there were eight unfilled, high-level faculty positions in surgery in spite of the fact that there was cash on hand to pay for salaries, research, space available, and a favorable academic climate. Despite intensive recruiting by the chairman of the department of surgery, he had only been able to fill a few of his billets and the few people that he was currently in contact with for the remaining several positions were being highly sought after by other departmental chairmen about the country.

In the face of this, it does not take much imagination to forsee the situation which will exist when the 17 new medical schools now in construction or in planning phases come into existence within the next few years. I am already aware of some of the recruiting problems which departmental chairmen in the new medical schools are having and it needs to be emphasized that these problems will become greatly intensified as the public's demand for adequate care catches up with the ever-increasingly accepted concept of top quality care as a right. In this light, there would appear to be little room for disagreement on two fundamental points. The first is that a greatly increased number of surgeons who teach in medical schools will be needed in the next decade and the second is that the supply is grossly inadequate at the present time and that this deficiency will become further exaggerated unless steps are taken to correct it now.

One might reasonably ask why special training is needed for the academic surgeon and why it is not possible to simply coax clinical surgeons from their practices into an environment where they will continue to do some practice but also concentrate on teaching and research. The answer to this is that although a very important proportion of the clinical teaching in a major university medical center can be carried out by completely clinical-practice-oriented surgeons, these individuals seldom have backgrounds which will allow them to interact with investigators in other disciplines such as medicine, physiology, and bioengineering and they only infrequently play a major role in the medical school power structure. It is obvious that if surgery is to maximally utilize advances in the physical sciences and engineering this will depend on the group of knowledgeable and trained individuals who combine clinical talents in surgery with scientific investigative backgrounds and secure positions in the academic hierarchy at their own school. Only in this fashion will departments of surgery effectively compete with other specialty areas for talented young men in terms of the development of future surgeons.

It is particularly important that clinicians of all types be trained properly and in appropriate numbers because they represent the end of the funnel, so to speak, with respect to the delivery of health services. Whatever the future patterns of health care, and regardless of how concepts of group practice, better utilization of hospitals, and advances in the administrative aspects of health care evolve, the actual delivery of the service will in the end depend upon the actual surgeons, internists, pediatricians, anesthesiologists, radiologists, and other clinical specialists. In other words, no matter how strong the basic science departments of the medical school become, or how large and prestigious the undergraduate campus is, if the clinical departments are not strong, academically oriented, and able to expand the interface between the basic sciences and clinical practice, the delivery of health care will be seriously impaired.

In the instance of the academic surgeon, an unfortunate aspect of his training is that it takes so many years. He must complete the entire clinical training program, which the person who is oriented exclusively toward practice does. In addition, he must become armed with the necessary scientific background so as to be able to seriously collaborate with workers in other disciplines and thereby bring their discoveries and technical advances to the bedside. Although very serious attempts are benig made at the present time to shorten the current minimum of 5 years necessary to train a surgeon following graduation from medical school, it probably will be several years before this is carried out on a large enough scale to have great practical importance. In addition to these basic clinical years, the young academic surgeon must spend a minimum of 2 years in investigative activities learning at least to talk the language of the basic scientists and develop meaningful relationships with them. The training grant

mechanism of the National Institute of General Medical Sciences has emerged as the best device to provide stable support for trainees during this long period of education in clinical and investigative pursuits. Though the needs of different medical centers vary as do their physical plants, orientations, and budgets, the further development of training programs for academic surgeons must be encouraged in every medical school environment in which the leadership and facilities are adequate to the task and the climate is conducive to success. As has been so strongly pointed out during the past several years, a major proportion of research grant and training moneys has gone to a relatively small number of institutions. It is now possible both because of leadership and developing physical facilities for other medical centers to undertake training programs to develop academic surgeons and it would be indeed unfortunate if lack of funds were to hamtstring this evolutionary broadening of the base of support.

Those of us in academic surgery therefore feel that the establishment of training programs for academic surgeons represents a fundamental and farsighted decision on the part of the NIH and the Congress and it is my purpose today to reemphasize the importance of these programs and the long leadtime which exists before their products—academic surgeons—become available. The decisions now being made which are resulting in the failure to fund highly qualified training grant programs that have been assigned high priorities by appropriate scientific reviewing sections will necessarily result in a curtailment of the training of the teachers that will be required to staff the new medical schools which are being constructed. Considerable moneys could be put into construction and funds could be appropriated for salaries in medical schools and it would all be to no avail if there do not exist enough academic surgeons to train both medical students and clinical surgeons in the type of clinical practice that will utilize the most up-to-date methodologies and techniques. It therefore becomes imperative that those of us responsible for the training of these individuals, with the clear-cut prospect of immense future needs in terms of numbers, make this point as strongly as we can to you at the present time, so that the country will not be caught short several years hence wih a markedly deficient pool of appropriately qualified individuals. I speak to the manpower needs of academic surgery as it is my primary area of competence and responsibility. However, surgery's needs serve by example to characterize the overall general need for academic manpower—especially in the areas of anesthesiology and diagnostic radiology.

My second point has to do with the mission of the National Institute of General Medical Sciences in the biomedical engineering area. Generally speaking, it has become almost impossible for a person to function responsibly in a major medical center without some appreciation of biomedical engineering developments. As a clinical and experimental surgeon, I have found both my research and clinical activities in the past several years becoming more and more bound up with developments in such biomedical engineering areas as materials science, computers, electronics, and instrumentation of all sorts.

During the last two decades, physiology and chemistry have become an integral part of clinical medicine and there is little difficulty in communication between the chemists and physiologists and their clinical counterparts. In fact, it is not uncommon for internists or surgeons to spend extended periods of time in departments of chemistry and physiology and indeed the academic internist and surgeon must have as a part of his working armamentarium in the care of patients, a large knowledge of clinical physiology and chemistry. However, it has now become apparent that biomedical engineering is an area of science that is becoming of increasing importance to clinical medicine. Unfortunately, the communication lines between engineering and clinical departments, for example, are almost nonexistent when compared to the same channels which exist between physiology and chemistry departments and the clinical departments. For one thing, the engineering campuses are usually separate from the medical schools and for another, the terminology and orientation of engineers is quite different from that of medicine. Nevertheless, developments in the past several years have served to throw scientists from these two groups into close proximity often with rather exicting and productive results. For example, the advances in the artificial heart and artificial kidney areas could not have been possible without the close collaboration between engineers and clinicians. The rather extensive computer-oriented patient monitoring procedures, so essential to the modern management of patients after major surgical procedures and following severe trauma, which are currently being carried on in intensive care units in major

medical centers are again a tribute to the fact that this interface between engineering and clinicians has begun to flower. However, at this time, biomedical engineering which has so much to give, by releasing new knowledge through its application to basic and applied research in the world of physical biology, by the development of new instruments, devices, and systems for the prevention, diagnosis, and treatment of disease, and as an important aid in the development of more adequate systems for the delivery of health services, is in an extremely incipient phase and the opportunity exists now, as never before, to bring its full impact to bear for the relief of sick peoples' distress. What is apparent is that a more concerted effort to bring individuals from the two disciplines closer together must be undertaken. It is for this reason that I express the utmost enthusiasm for the biomedical engineering activities of the National Institute of General Medical Sciences.

Of prime importance are the Institute's biomedical engineering training programs which are extremely significant because of the invigorating effect that the hybrid type of individual they train can have on both the schools of engineering and the medical school faculties with whom they come in contact. At our own institution we have found such individuals invaluable in opening lines of communication and making it possible to bring engineering science to the service of the patient in the clinic. Their appearance on the scene has made it apparent that it will be impossible for the well-trained surgeon in the future to carry out his clinical activities in a thoroughly competent fashion without considerably more understanding of technology than has been possessed by most surgeons in the past. The investigator in surgery will certainly have to put in a much greater fraction of his background time than before in mathematics, the physical sciences, and engineering. In this sense developments in biomedical engineering are radically altering the course of training of the surgeon; many of the ongoing training programs for academic surgeons have already struck up working liaisons with ongoing biomedical engineering programs.

The interaction of biomedical engineers with surgeons to date makes it seem very likely that in the future decisions as to whether a portacavalshunt or arterial reconstructive procedure should be carried out and if so, which type should be performed will be determined by sophisticated blood flow measurements; threatening cardiac arrests in patients undergoing complex surgical procedures will be predicted by computer analysis of a complex and physiologic parameters which are constantly being monitored in an on-line fashion during surgery; intensive application of fundamental knowledge in material science will lead to the development of nonclotting surfaces and polymers which will be used in the development of artificial organs; and understanding of the most modern and ultraminiaturized electronic principles will permit the application of a variety of electrical pacing techniques in the treatment of disorders such as hypertension, heart block, gall bladder, angina pectoris, and central nervous system disturbances of various sorts.

Accordingly, much as for surgery, engineering also has considerable to offer to the rest of clinical medicine. If its potential for patient care and the delivery of health services is to be realized in the near future, the importance at this time of increased support for biomedical engineering training is difficult to overstate, particularly in the light of the leadtime involved in such training.

In addition, there are special problems which are posed by the need to integrate engineering into clinical practice which can only be met by farsighted commitments at the present time in the area of federally initiated research and development. Special problems in the development of instruments and devices which are based on engineering skills but which have particular pertinence to clinical practice must be actively fostered, nurtured, and pushed on to completion. The problem is how to get this developmental work done. Most engineering schools traditionally are concerned with engineering as such and have little medical expertise. On the other hand, the medical centers, although interested in instrumentation are both wary and unsure as to how to work out closer relationships with the engineering schools and with the industrial engineering community. Also, the development of prototype instrumentation is a risky and expensive process and certainly will not be taken on in the natural course of events by our national laboratories or by profitmaking industrial engineering firms unless stimulated by contracts or other mechanisms. It is notable that the National Institute of General Medical Sciences has taken initiative in this area, particularly as regards the development of the instruments, devices, and systems that will be necessary for the realization of automated clinical laboratories.

My own conviction about the funds needed by the National Institute of General Medical Sciences is shown in the attached table and exceeds the President's budget by $28 million. The increase of $7 million in the category of "Direct operations" largely reflects a proposed increase of $5 million for collaborative research and development in biomedical engineering. If this needed increase in funds for collaborative research and development is not realizable in the light of current budgetary stringencies, I suggest strongly, for the purpose of providing flexibility and insuring efficiency and speed in program operation, that $3 million of the funds requested in the President's 1969 budget for research grant projects be made available interchangeably for contracts under the collaborative research and development program of the National Institute of General Medical Sciences as follows: $2 million for the development of instrumentation, devices, and systems to meet important needs in the prevention, diagnosis, and treatment of heart disease, cancer, stroke, and other important causes of disease and disability; and $1 million specifically for the development at the Oak Ridge National Laboratory of prototype instrumentation now needed for the successful advancement of the Institute's ongoing program for automated clinical laboratories. There is no question but that it is of utmost importance at this time that such developmental work in the field of biomedical engineering be moved ahead as rapidly as possible so hat more extensive health benefits can be amde available to the people.

I know that I speak for many physicians when I say that we appreciate the opportunity to appear before you and present our views based on our experience and our evaluation of future needs.

NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES—CITIZEN'S BUDGET FOR FISCAL YEAR 1969

	1968 fiscal year	President's budget	Recommended
Research grants	$84,054,000	$88,886,000	$100,000,000
Fellowships	20,910,000	21,373,000	23,000,000
Training	45,729,000	46,901,000	55,000,000
Direct operations	8,353,000	8,617,000	15,000,000
Total	159,046,000	165,777,000	193,000,000

Dr. EGDAHL. The points that I would like to make basically have to do with the training of specialized health manpower. As the director of a training program in an academic surgery department and as a person deeply concerned with the matter of the training of specialists in biomedical engineering, I am quite aware of the constraints that must be faced as a result of present budgetary stringencies. Most of us involved in these two areas feel that, although support for facilities and research are extremely important, if training programs of such a scope to insure an adequate delivery of health services——

Mr. FLOOD. Are you a surgeon?

Dr. EGDAHL. I am a clinical surgeon involved in research activities.

First, I would like to emphasize the difference between training programs for academic surgery and training programs for surgeons in general. This is an important distinction, because while it takes 4 years after medical school and the internship to train surgeons in general, it takes additional years beyond that to train the type of surgeons we are going to have to have in the future—surgeons who can teach medical students, interact adequately with scientists and engineers and produce the needed advances in clinical research and patient care. It is certainly a credit to the foresight of the National Institute of General Medical Sciences and the Congress that appropriated the funds that these academic programs in surgery and also those in anesthesiology and radiology as well have been established. Because of the tremendous investment of time necessary to get these physicians trained in an intrdisciplinary fashion——

Mr. FLOOD. Off the record.

(Discussion off the record.)

Dr. EGDAHL. In academic surgery there is a tremendous manpower deficiency at the present time. With the training programs presently supported we will be able to supply only a fraction of the academic surgeons necessary in the future. As a matter of fact, if funds were appropriated to support the approved training programs that have not been funded, we still would produce only about a fifth of the academic surgeons necessary to man the staffs of the new medical schools planned. My point is that these are unique people and the amounts of money you are being asked to appropriate are most essential if we are going to have these young surgeons spend an additional 2, 3, or 4 years working with engineers, chemists, and physiologists so that when new technology and basic science insights do come into clinical medicine, the men will be available who can effectively use them.

My second point has to do with biomedical engineering. As to what it is I would say that for practical purposes, biomedical engineering is the application of engineering techniques to biomedical research and patient care. Its significance is evident in the following examples. About 1 billion laboratory tests are done per year in hospitals throughout the country. As this number doubles approximately every 5 years, it is clearly going to be physically impossible to generate the number of technicians that will be required to run the billions of tests necessary in the future.

Mr. FLOOD. It is going to be what?

Dr. EGDAHL. Physically impossible to generate the number of technicians that will be required to run the billions of tests which will be necessary in the future. We simply are going to have to develop the automated techniques and computer technology required to meet these needs. The problem is that—if the funds are not made available at this time to develop the prototype instrumentation, devices, and systems necessary to bring automation to the clinical laboratories—it will, in the near future, seriously compromise our capability to adequately deliver health services in the country.

Biomedical engineering development is costly but it is absolutely necessary if we are going to get the machinery necessary to carry out these large numbers of laboratory tests.

I might note that a similar situation exists with respect to the development of the new instruments, devices, and systems that will be necessary for the prevention, diagnosis, and treatment of heart disease, cancer, and stroke.

Mr. FLOOD. What about the laser?

Dr. EGDAHL. The laser has been a fascinating development in engineering science. It is useful in eye surgery, and its effect is being explored with respect to superficial tumors. Its ultimate use in surgical practice, however, is yet to be defined.

While on the topic of engineering instrumentation, I might note that new devices for the early detection of arteriosclerosis are being worked on by a group at Washington University. It is exciting to see what can be done by close collaboration of doctors and engineers.

STATEMENT OF DR. SHELDON G. COHEN

Mr. FLOOD. May we now hear from Dr. Cohen.
(Dr. Cohen's biography follows:)

CURRICULUM VITAE, SHELDON G. COHEN, M.D.

Date of Birth: September 21, 1918.
Address: 309 South Franklin Street, Wilkes-Barre, Pa.
College: Syracuse University, 1936–37; Ohio State University, 1937–40. Degree: Bachelor of arts.
Medical school: New York University, College of Medicine. Degree: Doctor of medicine, 1943.
Internship: Bellevue Hospital, New York, N.Y. 3d (NYU) division, 1944.
Military service: U.S. Army Air Force, 1944–46. European Theater, Flight Surgeon. Rank: Captain.
Residencies:
(1) Resident in internal medicine, Veterans' Administration Hospital, Fort Howard, Baltimore, Md. (in affiliation with Johns Hopkins and University of Maryland Medical Schools) January 1947–July 1948.
(2) Resident in allergy, Veterans' Administration Hospital, Aspinwall, Pa., and the University of Pittsburgh Medical Center, July 1948–June 1949.
Fellowship: Research fellow, physiology, Addison H. Gibson Laboratory, University of Pittsburgh School of Medicine, 1949–50.
Teaching and research appointments:
University of Pittsburgh School of Medicine, Pittsburgh, Pa.
(1) Research associate, Addison H. Gibson Laboratory, July 1950–July 1951.
(2) Attending physician allergy clinic, Falk Clinics, 1950–51.
Wilkes College, Wilkes-Barre, Pa.
(1) Research associate in immunology, department of biology, 1951–56.
(2) Associate professor of biological research, 1957–1962.
(3) Professor of biological research, 1962 to present.
Hospital appointments:
Mercy Hospital, Wilkes-Barre, Pa., chief of allergy, January 1951 to present.
Veterans' Administration Hospital, Wilkes-Barre, Pa.
(1) Attending physician in allergy January 1951–June 1960.
(2) Consultant in internal medicine (allergy), July 1960 to present.
(3) Consultant in research, 1961 to present.
Societies:
1. Society for Experimental Biology and Medicine.
2. American Association of Immunologists.
3. Fellow, American Academy of Allergy.
4. Society of the Sigma Xi.
5. American Society for Microbiology.
6. College of Physicians of Philadelphia.
7. Fellow, American College of Allergists.
Committee appointment: Member, National Institute of Allergy and Infectious Diseases Committee on the Standardization of Allergens (Dr. Dan H. Campbell, Chairman) 1959–62.
American Academy of Allergy Appointments:
Committee on Education:
Subcommittee on Undergraduate and Graduate Education, 1960–63.
Chairman, Subcommittee on Undergraduate and Graduate Education, 1962–63.
Historian, 1963 to present.
Research Council:
Chairman, Committee on Food Allergy 1959–62.
Advisory Board to Research Council, 1962–63, 1966 to present.
Chairman, Research Council, 1963–66.
Publications: 51.

Dr. COHEN. I appreciate the privilege and the honor of the opportunity of appearing before you to discuss the statement I have prepared in behalf of the National Institute of General Medical Sciences. I

should like to respectfully submit this for your review and if I may have it incorporated in the record.

Mr. FLOOD. Without objection, it is so ordered.

(Dr. Cohen's statement follows:)

STATEMENT FOR THE NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES, NATIONAL INSTITUTES OF HEALTH BY SHELDON G. COHEN, M.D.

I am indeed honored and privileged to have the opportunity to appear before this committee to offer remarks in support of the programs and activities of the National Institute of General Medical Sciences.

My keen interest in the mission and objectives of this Institute can perhaps best be understood in the light of my particular background and experience in biomedical research. I come to you as a member of a small college faculty, involved simultaneously in the practice of medicine and in biomedical research at Wilkes College. I also serve as a consultant to the medical service and research section of the Wilkes-Barre Veterans' Administration Hospital. I had been on the clinical and research staff of the University of Pittsburgh School of Medicine prior to my return home to enter the practice of medicine in Wilkes-Barre. In order to retain contact with biomedical research, I sought affiliation with the biology department of Wilkes College, where I am currently professor of biological reearch.

A few words relating to the manner in which my own program at Wilkes College evolved through the years may perhaps be in order. In retrospect only a combination of motivating factors and fortuitous circumstances could have made this development possible. Prerequisite were a real desire to continue the basic research to which I had previously been oriented at the University of Pittsburgh; a sympathetic, helpful, and visionary college president; a corresponding willingness to start with very little in the way of facilities and equipment; and our foresight to plan for and energetically seek larger goals. Thus the gradual progression from my own bench work during off hours in a small laboratory in a refurbished livery stable and coachman's house, to a converted dormitory kitchen aided by student volunteers, and finally to a well-designed laboratory in a newly constructed science building at Wilkes. Throughout all of this was the realization that drive, intellectual curiosity, and a small allotment of funds are not in themselves totally adequate. Without grants-in-aid from private foundations and sizable support from governmental agencies—NSF and NIH—temporary roadblocks might have proven to be insurmountable obstacles. In addition the rapid pace and almost explosive development in our expanding knowledge of biomedical science have further emphasized that productive research will increasingly depend upon sophisticated experimental research equipment. I would therefore hate to think that the talents, ambitions, and enterprise of young investigators in colleges and small universities might be defeated by the frustrating inability to obtain necessary financial support.

Because of my familiarity with biomedical research in a university medical center on the one hand, and with the problems of physician-investigator-teacher in a liberal arts college within a more medically isolated community on the other, I should like to describe some urgent problems that I see. Solutions to these problems offer challenges and benefits that serve not only the best interests of biomedical research, but also of the college and community as well. Some of the experiences upon which this discussion is based have previously been presented in a document entitled "The Undergraduate Student and Scientific Research at a Liberal Arts College," which I prepared in 1958 for publication in the Bulletin of the American Institute of Biological Sciences (AIBS Bull. 8 (2): pp. 16–18, 1958).

The problems of the liberal arts colleges in preparing young men for careers in the biomedical sciences or in medicine, as described in this report of nearly a decade ago, are even more acute today, and will become increasingly difficult to resolve if measures are not taken to achieve a solution. Although in the past colleges have been major contributors of bright young men to the fields of science and medicine, they face increasing difficulty in obtaining young faculty, equipment, and facilities. This is putting them farther and farther behind in competition with big universities having large faculties, ample equipment, and extensive facilities in each department. There is reason for serious concern for the future of the liberal arts college if science should disappear as a meaningful intellectual challenge within the college curriculum. I have therefore come today with the

thought that your committee might help to call attention to the growing problems of liberal arts colleges and assist in developing a solution to some of these problems insofar as they relate to the biomedical area.

I would like to speak from the viewpoint of one who has been on the faculty of a small college in a region which has been considered economically depressed for a number of years. In such an area many of our citizens have only recently realized the importance of higher education for their children, and with this realization now willingly make great sacrifices for their children to give them the advantages of a college education. However, encouragement and sacrifice are usually not enough, so that many of these highly motivated students are able to achieve this goal only because of financial aid made available to them through Wilkes College. This year, for example, the attendance of 1,238 students of 2,202 enrolled has been possible through help received in the form of scholarships and campus work opportunities. I have been working with these young people for 16 years and can speak to you firsthand of their native talents and capabilities for achievement.

Many of the students who come to Wilkes live at home. If a college did not exist within the community, many of these students would be unable to go beyond high school levels. Despite the difficult circumstances of some students, Wilkes has developed a relationship that operates to the mutual advantage of both college and student. The college has the opportunity to develop the able scholar whose full potential is yet unknown. At the same time the close faculty-student contact provided by the college is available to the young student just emerging from a restrictive home environment, especially at a time he is most in need of guidance and assistance in formulating his own future goals. It is therefore important that this student be exposed to stimulating and creative faculy who can help him recognize and develop his own talents and interests to full potential.

In fact, our research activities within the community have reached even further down to the high school level to attract outstanding students seeking to identify potential career goals in preparation for the next stage of their education. I would mention one example, John Shaskis, who while a high school student came to work with us and developed his own research project in botany. His efforts reached higher and higher recognition in competition at city, county, and State levels, and finally culminated in national recognition by the award of second place at the National Science Fair at Dallas, Tex., in 1966. He is now a student at Wilkes.

Because of our success in preparing these young men for the sciences, Wilkes College has steadily expanded its program and enlarged its staff. Recently, graduate programs in biology, chemistry, and physics have been introduced to meet the needs of local institutions for the continuing education of their scientific personnel. Twenty-seven Ph. D.'s in the sciences now combine research and teaching at both the undergraduate and graduate levels. Fortunately, a number of gifts have permitted the college to provide modern laboratories for instruction and research. Within the past decade more than $2,500,000 has been spent to develop a modern plant and obtain equipment. To assure continual growth of such services, Wilkes has recently entered into a cooperative program of graduate studies with Lehigh University.

It is in just such an environment that stimulating new areas of sciences, such as modern biology and medicine, can offer challenges to capture the imagination of the young student. Biology and medicine, at the same time, are provided an untapped reservoir of talent that might otherwise be lost. By providing new perspectives in science and medicine, the college's program and activities can become increasingly relevant to the needs of modern society.

It should be emphasized that in most liberal arts colleges the biomedical sciences and the area of human biology as a whole have been neglected subjects in the past. As a result, many college undergraduates deprived of the opportunity to learn about the structure and function of the human body may fail to appreciate the challenges of modern medicine, which has a great need for their talents. College undergraduates need an opportunity to explore their potential interests within biomedical areas and, where present, to let these interests develop and take form. If this is to come about, faculty members actively engaged in the biomedical sciences are urgently needed by the colleges.

Now let me turn for a moment to the problems of the physician in smaller communities. In my own region, the majority of practicing physicians were educated prior to World War II and are now well advanced and established in the pursuit of their professional careers. There are relatively fewer young physicians entering the community. As this trend continues, the staffing of hospitals and

the provision of adequate medical care to the population is becoming increasingly difficult. One understandable reason for the failure to attract bright young physicians is the lack of a stimulating medical and educational environment within the community. Without an influx of able young physicians trained in the newer methods and techniques of medicine, the senior physicians and the community are deprived of the benefits of this newer knowledge developed through medical research. It must be emphasized that the relationship between science and medicine is and should be very close, and that if we in the community are to practice modern medicine, our needs cannot differ greatly from those of physicians in large university medical centers who have the assistance and consultation of informed scientists in the biomedical disciplines readily available. It seems quite probable that if many of the recent advances in medicine which have been developed through biomedical research are to be incorporated into the clinical practice of medicine at the community level, biomedical scientists as well as physicians will be required. The availability of such biomedical scientists within the community in turn would do much to attract younger physicians. In my own area of medical specialization, that is, allergy, I have need for contact and communication with scientists in a number of basic areas, such as immunobiology, genetics, biochemistry, and cell biology, regardless of my location. If I am to keep abreast of my field and to utilize the advances of modern medicine in my practice, this must continue.

A long-range goal for the future therefore must be the creation of foci of biomedical research within academic and medical institutions in the community which will, at the same time, create an environment favorable for the contnued development and evolution of medical practice.

If we are to attract biomedical scientists to the community, our first requirement is to provide a suitable environment as well as facilities where they can lodge. It is my experience that liberal arts colleges, if given proper support, can furnish an appropriate environment that will attract biomedical scientists who can provide a stimulating scientific environment in the college. At the same time, through working with physicians in the community, the quality of medical care can be enhanced. As a result the college benefits, the communty benefits, and so does biomedical research.

The cost of such efforts in relation to their anticipated impact and contribution need not be great. I find it extremely important that the means be provided not only for encouragement and recruitment of excellent young faculty, but equally important for the college's ability to retain them in the capacity for which they have been hired. We at Wilkes feel this very acutely. Even at the moment we have on our faculty a young cell biologist trained at Yale whom we may lose to a more affluent institution bidding for his services with the lure of the more sophisticated equipment and facilities required for his specific field of research.

For this reason, I would like to make a special plea for a program of small grants especially designed and aimed at investigators in liberal arts colleges and small universities—a program of research grants which can be handled with some flexibility and without the lengthy delay of 6 to 12 months that is required to gain support through the regular research grant mechanism. A program of this nature was established by the NIH in the late forties and early fifties, but when large amounts of money became available during the period 1957–62, the small grants program assumed lesser importance. The need for such a program was also diminished by the general research support grants, which provided bloc support to medical schools and large universities to be used for a wide variety of purposes. This included the support of younger investigators and the meeting of sudden requests for research and training funds in smaller amounts for which application to the NIH provided an unnecessary and lengthy delay.

Now, at a time when grant funds are short, it is important to recreate a small grants program for colleges and smaller universities that do not have the base of $1000,000 in NIH research grants required to qualify for the General Research support grant program. The availability of a small-grants program would help the National Institute of General Medical Sciences meet the urgent needs of investigators in liberal arts colleges and smaller universities in a flexible way. It would further permit the investigators in these institutions to compete against each other for a limited amount of funds, rather than being forced to compete against the highly sophisticated programs of the larger universities. I would recommend that $1 million be provided for this specific purpose during fiscal year 1969.

I would also like to make a plea for expansion of the experimental college program in the biomedical sciences, the main goal of which is to assist the liberal arts colleges in the identification and training of potential young scientists seeking to enter careers in the biomedical sciences. I have been intrigued by the imaginative programs at Haverford, Providence, and Pomona Colleges. These excellent programs have shown that, if given appropriate financial assistance, liberal arts colleges can provide an excellent multidisciplinary program of undergraduate training in mathematics, physics, chemistry, and biology needed for a career in the biomedical sciences. At the same time the student has been helped to identify his interests in a future research carrer. By providing an extremely high quality of undergraduate training to students interested in biomedical research, these experimental programs have eliminated many of the deficiencies of current undergraduate curriculums. A direct result is a shortening of the graduate training period. These programs thus make a direct contribution to the NIGMS training effort. Although the overall responsibilities for undergraduate science education lie with the Office of Education and the National Science Foundation, experience has shown that the obligations and demands placed on these organizations to meet other social and scientific problems are so great that they have little time or money to devote to the training of biomedical scientists. It is my considered opinion that if significant experiments are to be conducted on the improvement of undergraduate training in biomedical areas, NIH will have to take the initiative. I would therefore like to recommend that the present programs be expanded by five programs each year over a 5-year period, at an average cost of $100,000 per program. Initial funds would amount to $500,000 in the first year, with increments of $500,000 per year to a maximum of $2,500,000 in the fifth year. These experimental programs should do much to develop and elucidate the concepts that I have just discussed and provide a base from which further expansion can be developed following cessation of the Vietnam conflict and the anticipated redirection of the Nation's resources.

It should be emphasized that these challenges as described reflect only one aspect of the critical need for research-trained physicians, scientists, and educators to:

a. staff our medical schools for the training of greater numbers of physicians urgently needed to improve the quality of health care throughout the Nation;

b. staff our universities and colleges, which are rapidly expanding to meet society's demands for adequate education for all of our young people;

c. staff the medical facilities of our Armed Forces and Veterans' Administration hospitals;

d. staff the hospitals of large urban areas; and

e. assist in the improvement of the quality of medical practice within each community, regardless of size and location.

The need for physicians, scientists, and educators is great and it is indeed unfortunate that because of the length of time required for their training we cannot rapidly meet the Nation's requirements. If we are to fulfill the needs of which I speak we are going to have to plan ahead for the next 10 to 20 years to fill this gap. It must be remembered that the men we train today are to be the scientists, research physicians, and practictioners of medicine for the rest of the century.

The problem, therefore, concerns itself with getting the brightest and most able young people we can into the biomedical areas. It is here that the use of all available resources, including the untapped reservoirs of talent that we have in colleges such as Wilkes, is so important. We must therefore begin to learn how to capture and utilize this talent most effectively. I would therefore make a special plea for the training efforts of the National Institute of General Medical Sciences, which have a central role in the development of biomedical scientists and faculty for the Nation's medical schools and universities. Because of the critical shortage of physicians, the needs of the medical schools must be met before we can hope to attract biomedical sicentists back into smaller universities and colleges.

In the development of a program related to the needs of the liberal arts colleges, it would be very valuable for the Institute to bring in appropriate people from the colleges to assist the NIGMS staff in the planning and development of this program. It would also be valuable for members of the staff to spend sufficient periods of time at liberal arts colleges and universities to work with them and help strengthen their programs. Colaborative efforts between the institutions

requiring and utilizing such assistance and NIGMS staff would be invaluable in nearly every program area. Thus my recommendation for inclusion of 20 additional professional positions in the Institute's budget, with appropriate increments for travel, at a total cost of $500,000. I can think of few expenditures of money that would do so much to improve the Institute's program and objectives.

As a practitioner of medicine and investigator, I have witnessed the important application of automated clinical laboratory techniques at clinical medicine in our local hospital and State laboratories. At a time when hospital costs are rapidly rising and the science of medicine is providing more and more valuable diagnostic procedures, the utilization of more accurate and less expensive clinical laboratory techniques is vital. Recent efforts have shown that automation of clinical laboratory tests can do much to increase accuracy while reducing the cost of diagnostic study. I cannot speak too highly of this NIGMS endeavor.

As an aside, I cannot refrain from personal and professional observation and comment on studies in trauma. Accidents take the lives of more than 100,000 Americans each year and are the leading cause of death during the age of 1 to 35. For every person killed by trauma, 10 to 15 require hospitalization—a total of 22 million patient-days each year, or 12 percent of hospital beds. Accidents cost many billions of dollars annually as the result of death, disability, and loss of income. Yet because of the difficulties and complexity of research in this area only one-half of 1 percent of medical research funds is being applied to trauma research. This is indeed an urgent problem which has a potential impact on people in every city, village, and hamlet, and merits support for the NIGMS mission.

Finally, as an investigator dependent on development in immunology, genetics, biochemistry, and cell biology for the progress of my own research and the attendant improvement of medical care resulting therefrom, I would like to state my general support for the institute's overall budgetary requirements. Of the many creditable investments made by this country for improving the well-being of its people, there are few that have greater and more long-range impact than the support of the basic medical sciences. These are of critical importance to man's understanding of his own self and the development of underlying scientific knowledge upon which the continuing and future progress of medicine must be based. I should like, therefore, to support an appropriation for the National Institute of General Medical Sciences at a level of $198.5 million to meet the many important obligations that I have reviewed and firmly agree are its mission to fulfill.

CITIZENS' BUDGET FOR FISCAL YEAR 1969—NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES

	Fiscal year 1968	1969 President's budget	Recommended
Research grants:			
Regular program	$79,545,000	$84,386,000	$98,000,000
Automated clinical laboratories	[1] (4,200,000)	[1] (3,500,000)	[1] (4,500,000)
Trauma research centers	[1] (2,800,000)	[1] (3,500,000)	[1] (3,900,000)
Small research grants program			1,000,000
Subtotal regular programs	79,554,000	84,386,000	99,000,000
Special programs:			
Pharmacology-toxicology research centers	3,500,000	3,500,000	4,700,000
Anesthesiology and diagnostic radiology centers	1,000,000	1,000,000	2,500,000
Total research grants	84,054,000	88,886,000	106,200,000
Fellowships	20,910,000	21,373,000	22,800,000
Training	45,729,000	46,901,000	53,500,000
Direct operations	8,353,000	8,617,000	16,000,000
Total	159,046,000	165,777,000	198,500,000

[1] Amounts included in regular research grants.

Dr. COHEN. I have been extremely interested and intrigued by two pursuits that the National Institute of General Medical Sciences has become involved with. One is their awareness of what the small college has to offer. Secondly, their awareness of what the community will

have to benefit by that program and how this can in turn reflect itself to improved medical care in the community in which we live.

Now, if I may just give you a little background of my own particular interest and station. I come here wearing two hats: I am a practitioner of clinical medicine and I am at the same time involved in basic research in the basic sciences and in teaching.

Now, I have been at the University of Pittsburgh Medical School and it seemed necessary and feasible that I return home to enter private practice. When I arrived home in Wilkes-Barre, I felt the need to reorient myself to research that I had been motivated with at the University of Pittsburgh, and therefore sought an application of this. There was a young college growing in the community. At the time it was the only academic institution in Wilkes-Barre. We arrived at a way in which, with a small National Institutes of Health grant, I could establish a small research section in the basic science of immunology. In retrospect, it seems that drive and motivation and encouragement are what has been responsible for evolving this particular program that we are engaged in. But this alone does not seem to be enough to evolve a program of the type that requires sophisticated instrumentation.

I am much interested in the program in the small college and how it relates to biomedical sciences and at the same time I am much concerned as to how this will benefit the community.

Mr. Flood. Your subject is "General Medical Sciences." What does that mean?

Dr. Cohen. That is the National Institute of General Medical Sciences. The National Institute of General Medical Sciences is the Institute that supports the basic biomedical sciences, such as genetics, biophysics, biochemistry, microbiology, physiology, and pharmacology, and the general areas of medicine, such as surgery, pathology, radiology, and anesthesiology, that are not within the province of any of the categorical Institutes. Its mission is, therefore, broad and general. In order to increase the flow of excellent young students into the biomedical sciences, this Institute is concerned with developing a small-college program in biomedical research. We have had experience with this at Wilkes-Barre. We have seen it develop, we have seen it evolve, and we feel that this program deserves a viewing of its merits. We feel this can be duplicated in other institutions. We feel that the mission of getting the undergraduate student and exposing him to biomedical areas, human biology, will in turn motivate him to go on to a medical career.

A small-college program has been generally neglected by the National Institutes of Health. The large universities have developed their training programs and research grants. We have many able and talented students. The idea is to capture the imagination of these young people and direct them and motivate them to biomedical careers. At the same time, we have very able young faculty members who have been trained in affluent institutions and who come back to the small colleges, but because of a lack of research facilities it is difficult to keep them there. So if we can evolve a program to capture and hold the bright young students in our community, motivate them into the biomedical sciences and at the same time with our talented faculty help them engage in research careers, it would be a great benefit.

Mr. FLOOD. What are the financial dimensions of your proposal? This is an appropriations committee.

Dr. COHEN. There are three programs that are prototype programs now. One at Pomona College in California, one at Providence College in Rhode Island, and one at Haverford in Pennsylvania. And we have our program at Wilkes.

It would appear that if five programs could be established per year at a cost of $100,000, bringing in five new programs each year at $100,000 per program, or $500,000 per year so that we will have reached a goal of 25 programs in operation.

Second, what we find in these small colleges is the fact that we have the talent, we feel we have the facilities to offer these men, but we must compete with the larger institutions. To have general operating research grants, one must have a broad base of $100,000 of Federal-sponsored grants which we in the small colleges just do not have. Yet we must compete on paper with the larger institutions. In this regard, it is more difficult to achieve our training programs and achieve our research grants, yet we feel that if we can supply, on the one hand, the medical schools, if we can develop the students to orient them to biomedical careers and, on the other hand, if we can attract the young men in the community, the high school students of outstanding ability, we can in both directions benefit the ultimate goal which is the upgrading of the medical care, the training of more physicians.

It is a pleasure to discuss these things because they are exciting ideas to me. We have been able to accomplish them at Wilkes—that is, to motivate people to enter the biomedical sciences and to go on to graduate school and medical school. At the same time, I do not feel I could exist in the practice of medicine if I did not have the association of men doing biomedical research, physiology, pathology.

Mr. FLOOD. Doctor, you were talking about hardware. We call it hardware. Engineers, mechanics, hardware.

Mr. EGDAHL. Yes, sir.

Mr. HULL. And talking about the computers.

Dr. EGDAHL. A surgeon cannot be an effective clinical surgeon without being able to use some of this hardware, without knowing something about materials, computers, systems analysis, and control systems. Surgical practice is becoming extremely complicated because it involves so much hardware and instrumentation.

Might I say a word about the Citizens Budget?

Mr. FLOOD. Please do.

Dr. EGDAHL. The point has previously been made that money is very short. The Citizens Budget that I am suggesting is $193 million which is more than the President's Budget of $165 million, but less than the Institute requested. This largely represents the bioengineering developments that I have spoken of, both in direct operations and also in training. I would like to make one final plea, and that is that if budgetary restrictions are such that it is impossible to realize the increases that are needed, then because of the extreme importance of the automated laboratories and development of these new instruments, could we free up——

Mr. FLOOD. Is this a realinement of priorities?

Dr. EGDAHL. Realinement; yes, sir. And make interchangeable to the Institute of General Medical Sciences $3 million from the research grants category of the President's budget to the contract category, $1

million to be used for the development of the automated laboratory equipment at Oakridge National Laboratories and $2 million to be made available for the development of instruments, devices, and systems along the lines that I have mentioned. If we don't get this hardware developed now, we are not going to be able to give the quantity and quality of medical care that we want.

Mr. FLOOD. Are you through, doctor?

Dr. COHEN. I think I have made my point. I am most interested in that particular aspect of the Institute's program for small colleges, for the development and training of young men in the biomedical sciences so that we can spread it and dilute it a little bit more effectively. I am interested in the young investigator who is lodged in small college and who is on the periphery of medicine through physiology and microbiology. I am extremely interested in the small grants research program that would help to foster and encourage and develop these people in its applications to medicine, per se, and how it will improve the hospitals where there are small communities. I feel that, regardless of location, we who live in areas geographically apart from medical centers have something to offer. I think the experience of the small four colleges has been presented to you. I realize a vast amount of money cannot and possibly should not be expended to do this all at once, but rather on a small, evolving program. It is exciting, and I would hope it would be ultimately beneficial to us who have this common denominator, interested in medicine.

Thank you.

Mr. FLOOD. Dr. Egdahl and Dr. Cohen, we are delighted to have had you here with us this afternoon. I am sorry we kept you so late.

Dr. EGDAHL. Thank you very much.

Dr. COHEN. Thank you very much.

Mr. FLOOD. We will recess until 2 o'clock Monday afternoon.

THURSDAY, APRIL 25, 1968.

CHILD WELFARE SERVICES

WITNESSES

HON. JAMES A. BURKE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

RT. REV. JOSEPH T. ALVES, D.S.W., DIRECTOR, FAMILY COUNSELING AND GUIDANCE CENTERS, INC., BOSTON, MASS.

JOHN R. McGAUGHEY, DIRECTOR, MASSACHUSETTS DIVISION OF CHILD GUARDIANSHIP

Mr. HULL. The committee will come to order. We are pleased to have at this time our colleague, Mr. James A. Burke, of Massachusetts.

Mr. BURKE. I have a statement which I think will cover the subject matter that we are discussing here today.

Mr. Chairman, I appreciate the opportunity to testify before you today and to make a plea on behalf of the most disadvantaged children in our Nation. This appropriation comes under title 4, part B, child welfare services. For the fiscal year of 1968 the authorization

was $100 million and it was cut to $46 million. For the year 1969 $100 million was again authorized and the recommended cut is $54 million.

Going back over the history of child welfare and the contribution by the Federal Government indicates a rather harsh, cold, and cruel attitude toward these most unfortunate children who are without parents. For the fiscal year 1965 the percentage distribution for the country of funds for public child welfare was as follows: Federal funds 9.7 percent, State funds 50 percent, and local funds 40.3 percent. It is noteworthy to mention that total expenditure for child welfare services for the year 1955 was $134,900,000. This figure increased to $352 million by 1965, an increase of 160.9 percent. Of this amount $34,200,000 were Federal funds and $317,800,000 State and local funds. This means that the State and local governments have assumed approximately 90.3 percent of the total responsibility for expenditures for child welfare in recent years while the Federal Government has assumed only 9.7 percent of this responsibility.

The cost for foster care alone rose from $95,500,000 in 1955 to $228,900,000 in 1965, a 139.7 percent increase; cost for personnel increased from $33,600,000 in 1955 to $96,700,000 in 1965—up 187.8 percent.

The philosophy of financing child welfare services by the Federal Government has not changed since the genesis of the Social Security Act of 1935. Under title 5, part 3 of the Social Security Act, Federal money is available to stimulate the development of Child Welfare Services in the States. The philosophy should be changed to allow the Federal Government to participate fully in the total costs of Child Welfare Services as it does in other public welfare programs such as public assistance. I might point out that under AFDC, the Federal Government contributes from 75 percent up to 83 percent in matching funds for the care of the children of this program. Contrast this to the minute amount that the Federal Government contributes toward those children under Child Welfare Services. It is shocking when one contemplates what is going on around the country and while I realize that we are faced with many financial problems in this Nation, I do not believe the people of this Nation expect the Federal Government to hold back funds in this very distressed area.

Therefore, Mr. Chairman, I am appealing to you and the members of this committee to raise the appropriation for Title 4, Part B, Child Welfare Services to the recommended amount of $100 million, which is the authorized amount in lieu of the proposed $54 million.

Now this will barely scratch the surface and it will by no means solve the problem. It will be a step in the right direction, however, and it will bring the Federal Government's contribution toward the care of these most disadvantaged children up to a point where the Federal Government will be assuming approximately 20 or 21 percent of the costs.

I have with me today, Msgr. Joseph Alves, who is in the Boston Diocese and who is well versed on the problems that confront the administration of child welfare, and with him I also have Mr. John R. McGaughey, director of the Division of Child Guardianship for the Commonwealth of Massachusetts. I know that both of these gentlemen concur with me in my statement and will be happy to answer any questions.

I might point out in conclusion that this matter was brought to my attention several years ago by the former chairman of this subcommittee, the late beloved John E. Fogarty, Congressman from Rhode Island, and I don't believe there was a more dedicated person, at least during my service in Congress, than John E. Fogarty in matters of this kind.

In fact, I spoke to John E. Fogarty the day before he died and he asked me to pledge my complete support for this program and to see to it that the authorizations were granted, and of course he told me that when it came before this committee he would carry the fight on. Unfortunately, he passed away the next day. I know the respect the Members here had for John E. Fogarty and I want to assure you that this was a program that was very close to his heart and I trust that you will look into this appropriation and bring it up to a more realistic figure.

I know there are those who are asking that expenditures be cut this year but let's not make the cuts to the expense of the poor. Those, who in my mind, are the most disadvantaged in this Nation. These children have no one to speak for them, they have no political strength, there are no special interests who are fighting for them and they stand neglected, and I believe I can say without exaggeration it is one of the black marks on America today that you and I have failed them.

I might point out that there is a great deal of misunderstanding in Congress about the participation that the Federal Government makes in the case of these children. You have one group of children under AFDC. These children usually have at least one parent, usually the mother. The Federal Government contributes to their upkeep 75 to 83 percent. Now, the children we are talking about here—and there are approximately 400,000 or more throughout the Nation today—these children, the Federal Government contributes only 9 percent toward their upkeep. Who are they? They are children who are completely abandoned, thrown upon the street, placed in foster homes and cared for with whatever funds the Federal, State, and local governments can raise.

Now, I would not want an investigation conducted in this country to find out what the true conditions are throughout the country in many areas on how these children are being treated. I do not see how we in the Federal Government can discriminate against one child in favor of another. I do not see how we can say: "Well, this child here with one parent is entitled to a contribution by the Federal Government of from 75 to 83 percent, but this child here, who has no parent, the Federal Government will only assume a responsibility of up to 9 percent." This is what we are trying to point out. It is unfortunate that the Congress and the Federal Government have not realized that there is a separate group of children today who are being discriminated against. I believe they are the most disadvantaged children in the Nation. A child with a mother has someone to love and watch out for him. The child on child welfare has the State looking out for him and some of them get into fairly good foster homes but this is not true throughout the Nation.

Mr. HULL. What is the age group of the children you are talking about?

Mr. MCGAUGHEY. It varies.

Mr. HULL. I am talking about in your area.

Mr. McGAUGHEY. It is up through age 21. In many States it runs to about 18.

Mr. LAIRD. Some of these children, though, are taken care of, I think, very well. John Fogarty and I visited a lot of these places from California to New York. We went into many of the foster homes. I do not want to give the impression that they are not taken care of well, because the vast majority of them are taken care of well. It is a question of cost sharing, I think, that we have here. Local communities, church groups, and others, and the States in most cases, take these. I think the basic problem that we have to live up to here is the question of cost sharing.

Mr. BURKE. Cost sharing is a great problem, but the information I have would indicate that there are many real problems in some of the States. I do not know of any State in the country that does not favor this increase.

Mr. McGAUGHEY. Could I respond to that because I have been associated with this program for some 20 years.

In Massachusets we have had it for 100 years. We spend—next year we will spend about $17 million. The program is fully inadequate. It does not have the resources to meet the needs of the children that we are serving. We do not reach all of the children who need this service. The Federal Government's share next year, if this appropriation is sustained, will be about 6 percent of what Massachusetts will spend. It is not a question of reducing the State's investment. As a matter of fact, I believe that any Federal increased funds should require that there be no reduction in the State investment, but I think you will find, if you talk with the executives around the country, that Massachusetts is no different than most and is probably better off than many. It is simply a fact that these children do not have the services they require. The children are taken out of their families unnecessarily because there are not services to help them stay there. The children are neglected and nobody gets to them because there are not enough social workers and no funds to provide the social workers to get there.

Mr. LAIRD. I think this question is the important one. The ADC program is being a far larger proportion of the cost and that is not right.

Mr. HULL. What is the population of these youngsters in Massachusetts, for instance?

Mr. McGAUGHEY. At the moment we are serving about 13,000 children in various circumstances. I think the national total, which I looked up a day or two ago, was on the order of 700,000, probably, this year.

Mr. HULL. That is in the overall United States?

Mr. McGAUGHEY. That is right. Now, if Massachusetts is any indication, that is below the number that ought to have this service.

Reverend ALVES. And the services that are being provided in Massachusetts are pretty good, I do not mean to criticize you, Bob, but from where we sit they are extremely inadequate even for those children that you are assuming responsibility for caring for. I am alarmed at the lack of investment by the Federal Government in this area because I see these children who are cared for inadequately growing up to be the dropouts of the next generation and they are fostering families

that are very insecure. They are parenting families that are costing hundreds of thousands of dollars in public funds to support.

For example, I have a very close friend—I worked in the social welfare field before I became a priest. I worked in a parish at one time where I fingered a number of responsible people in this industrial city of Everett and asked them if they would take foster children into their homes. They had never considered this possibility before. Well, I have kept very close touch for 15 years with some of these families that did accept the children. I must say this was my introduction first hand to the services provided by the State. They are very inadequate. We have children who have been in 24 foster homes before the age of 7. These children are so emotionally wrecked and disturbed that 15 years later they are still unable to relate to other human beings. They are causing all kinds of difficulties in their neighborhoods and everything else. You do not have enough therapeutic services available to them. These foster families that take them in need professional help if they are going to benefit these children.

Mr. McGAUGHEY. Really, it is a matter of having the personnel with the right equipment. It is a matter of having the other kinds of resources also. We do a periodic analysis of the children in our caseloads. Within a month we identified nearly 400 children—and this has been a recurring fact—who need specific residential types of placements which do not exist in Massachusetts. Massachusetts has a higher proportion of those facilities than almost any other State, but we still have 400 kids who lack this facility.

Mr. LAIRD. What did they raise your appropriation to this year?

Mr. McGAUGHEY. It has not been enacted yet. We are still trying to get more.

Mr. LAIRD. What did you ask for?

Mr. McGAUGHEY. On the order of $18.5 million, I would say.

Mr. LAIRD. Is that an increase? If so, how much is it over last year?

Mr. McGAUGHEY. At least $3.5 million, I would say.

Mr. LAIRD. I have heard from the people in my State about this. They are very concerned about it because they feel that the administration ought to have given this a higher priority within the HEW budget this year. It is really a question of priorities.

Mr. McGAUGHEY. I understand that, Congressman, as it is in the States, where we are trying to convince the State legislature, too. My own impression is that the priority established by the Federal department does not represent the views of the States.

Mr. LAIRD. I have to, in all fairness to the Department, indicate that the Department did request more.

Mr. McGAUGHEY. I thought they asked for $46 million. I am sorry.

Mr. LAIRD. I have not checked, to be certain, but I was told that this was cut at a higher level, not at the Department level.

Mr. McGAUGHEY. Then in terms of priorities, the Department did identify this as a high priority?

Mr. LAIRD. Yes, I think it strengthens your case to have the fact that the Department did make the request.

Mr. McGAUGHEY. What I was about to say is that I am sure from my discussion with other State executives and from meetings we have had at HEW, that this represents a high order of priority for most States.

Mr. LAIRD. For the whole area of maternal and child health and welfare, the Department requested $365 million, and this was cut at the White House level to $297 million.

Mr. BURKE. The Department has failed to relate the real problem. The Department, while they might have requested it, I do not believe has been aggressive enough in it. It is almost like some of your general revenue codes which are set up, they are so unfair. They realize it but they are concerned with the money end of it, not with the equity that is involved. You can't tell me that the Federal Government can take a moral stand and recommend only 9-percent contribution in matching funds toward these children who have no parents and then contribute 75 to 83 percent toward these other children who have a parent.

Mr. HULL. It does not seem quite correct, does it?

Mr. LAIRD. This is a real problem, one we have had before this committee right along. We tried to get the social security amendments changed.

Mr. BURKE. I was able to prevail upon the Ways and Means—this is off the record.

(Discussion off the record.)

Mr. BURKE. All these funds here will do is help finance the personnel problems that every State has today to conduct this work on. The State and local governments will still have to carry the lion's share which will be over 80 percent of the cost of this program. All we are asking the Federal Government is to come in with their $100 million that will bring up the Federal contribution to around 19, 20, or 21 percent. It seems to me that that is very little to ask.

Mr. MCGAUGHEY. Congressman Burke did sponsor a bill last year, and several people did, to do what you refer to.

Mr. LAIRD. That is the best way to do it.

Mr. MCGAUGHEY. I think we all agree.

Mr. LAIRD. The bill that Mr. Burke had in was the best bill, and that is the bill my State favored.

Mr. BURKE. Let me tell you what we have done. We not only failed here, but then they put the restrictive amendments in AFDC. I realize there is a growing problem of costs and everything else, but what have you succeeded in doing? In these large cities where all these people are coming in, and these problems are being created, we have penalized the innocent child who has nothing to say about their plight in this world. We are saying to those children, "We are going to cut off any Federal aid to you children because of this problem that exists." It is not the way the Federal Government, in my opinion, should proceed. I was the only one in the House who voted against the social security bill because of the restrictive amendments in AFDC. I say if you are going to penalize a parent, all right, but for God's sake do not turn around and penalize innocent little children that cannot fight back and have nothing to say about their plight. This was the whole mistake in this AFDC. We are going to hear an awful lot about it. We are going to hear about it all over the country. What the Congress has done, it has given some of these people in these ghetto areas who do not understand some of the problems they are confronted with, it has given

them a cause. This group sitting out here on the Capitol steps the other night, that is one of the reasons.

In Boston we have had marches on the city hall, we had a riot break out in Roxbury caused by these mothers on AFDC who were objecting to the problems they are confronted with. Here the Federal Government steps in at a time of trouble in this Nation and says, "Well, this is getting to be a way of life. We have to stop this. So the way we are going to stop it, we are going to set a ceiling on how much money we will appropriate for AFDC and the children that come in over and above this ceiling will not get any assistance." It seems to me that we have not used too good a judgment. I have not made any speeches on the floor. I have not done any speaking out on this in public, but I have talked to members of the House Ways and Means Committee privately, as I am talking in the closure of this room here. I think we have a very serious situation on our hands in this country. Things like child welfare and the restrictive amendments on AFDC are the causes of some of the riots, burnings, and things going on in this country today because these people find out they have been shut off and they do not know where they were shut off. They know that they have been shut off of their money and they are turning to this type of action.

I think that if we are going to deal with anyone in this country we have to deal with the children. I know that you men realize that because the child is growing up he is a future citizen. If we neglect him, if he suffers from malnutrition, from a lack of education, lack of training, he is going to be on the public rolls. He is going to be a problem.

Mr. HULL. From then on.

Mr. BURKE. That is right. So this is the time to do the work, in the formative years. We can start on this child welfare, on the restrictive amendments, those are the things that Congress should take a real good look at. You gentlemen have an opportunity here to correct part of the problem. You will be able to give your home State and all the States throughout the country the amount of personnel they need to see that these children are being placed in foster homes, getting the proper care, and they will be able to assist them in many other ways. I do not want to take any more time.

Mr. HULL. Very good, Jimmy.

Mr. LAIRD. You have been most helpful. Thank you.

Mr. BURKE. Just remember the spirit that John Fogarty had.

Mr. LAIRD. We have to remember that, and we also have to remember, too, that the Senate has already cut this budget.

Mr. BURKE. We are separate from them. Let's do our part over here.

Mr. LAIRD. Yes. As you know, the Senate passed that expenditure reduction, on all these items, a total of $6 billion, 10 percent.

Mr. BURKE. I know.

MONDAY, APRIL 29, 1968.

NATIONAL HEART INSTITUTE AND HEART DISEASE CONTROL BRANCH BUDGETS

WITNESSES

WALTER B. FROMMEYER, JR., M.D., PRESIDENT-ELECT, AMERICAN HEART ASSOCIATION

DR. CLAYTON B. ETHRIDGE, ASSOCIATE DEAN OF THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE FOR POST-GRADUATE EDUCATION AND MEDICAL DIRECTOR OF THE UNIVERSITY HOSPITAL, WASHINGTON, D.C.

DR. CAMPBELL MOSES, JR., MEDICAL DIRECTOR OF THE AMERICAN HEART ASSOCIATION

Mr. FLOOD. The committee will come to order.

We now have witnesses representing the American Heart Association. Dr. Walter B. Frommeyer, you are president-elect of the American Heart Association?

Dr. FROMMEYER. Yes, sir; I am.

Mr. FLOOD. We will insert your biographical sketch in the record at this point.

(Biographical sketch follows:)

BIOGRAPHICAL DATA ON WALTER B. FROMMEYER, JR., M.D., PRESIDENT-ELECT OF THE AMERICAN HEART ASSOCIATION

Dr. Walter Benedict Frommeyer, Jr., of Birmingham, president-elect of the American Heart Association, is professor of medicine and chairman of the Department of Medicine at the Medical College of Alabama, University of Alabama Medical Center. He is also physician-in-chief at the University Hospital.

Dr. Frommeyer will succeed to the presidency of the Heart Association at its annual meeting in Bal Harbour, Fla., November 1968. He was born in Cincinnati, received his A.B. from the University of Cincinnati in 1939 and his M.D. from its College of Medicine in 1942.

After serving his internship at Cincinnati General Hospital, Dr. Frommeyer joined the U.S. Army Medical Corps in 1943. He served until 1946, achieving the rank of major, and was awarded the Bronze Star Medal with Oak Leaf Cluster and the Purple Heart.

Leaving the Army, he became assistant resident in medicine at Cincinnati General Hospital until 1948, when he accepted a research fellowship at Boston's Thorndike Memorial Laboratory while also serving as assistant in medicine at Harvard Medical School.

In 1949, Dr. Frommeyer went to the University of Alabama College of Medicine as clinical instructor in medicine. In 1951 he was made assistant professor of medicine through 1953, when he was named associate professor of medicine. In 1954 he was also named associate dean of the Medical College of Alabama. He attained full professorship in 1957 when he became chairman of the department of medicine.

In addition, Dr. Frommeyer served as director of the university's tumor clinic and blood bank in Jefferson-Hillman Hospital, and as chief of medical service at Veterans' Administration hospital in Birmingham. From 1963 until 1967 he was chief of staff at University Hospital.

Long active in the work of both the American and Alabama Heart Associations, Dr. Frommeyer has served on the national organization's board and executive committee since 1960. He was a vice president of the association from 1963 through 1966 and served with distinction on various key committees, including the committee on medical education of which he was chairman from 1966 through 1967. He has served the Alabama Heart Association since 1954, as president in 1958–59, as chairman of the board in 1959–60, and on its board and executive committee from 1957 through 1967.

Dr. Frommeyer is a diplomate of the American Board of Internal Medicine and is vice chairman of its board of examiners. He was governor for Alabama of the American College of Physicians from 1960–66, and served as chairman of its committee on postgraduate courses for the 1964–67 term. He has been named chairman of the committee on scientific program for 1967 and is on the board of regents of the American College of Physicians.

He is presently councilor for the Medical Association of the State of Alabama and has been secretary of the Southern Medical Association's Section on Internal Medicine.

He holds membership in many scientific societies, including the Association of American Physicians, Alpha Omega Alpha, and Sigma XI.

A recipient of the Alabama Heart Association's Distinguished Service Award and the Peter T. Kilgour Award of the University of Cincinnati College of Medicine, Dr. Frommeyer is the author and coauthor of numerous papers on subjects in internal medicine.

Mr. FLOOD. You may proceed.

Dr. FROMMEYER. Mr. Chairman and gentlemen, I am Dr. Walter B. Frommeyer, Jr., president-elect of the American Heart Association and professor of medicine and chairman of the Department of Medicine at the Medical College of Alabama of the University of Alabama. With me are my colleagues, Dr. Clayton B. Ethridge, who is the associate dean of the School of medicine for postgraduate education and the medical director of the University Hospital of George Washington University School of Medicine, and Dr. Campbell Moses, Jr., medical director of the American Heart Association. As you know, the American Heart Association is a national voluntary health agency whose members number some 35,000 physicians and 40,000 laymen.

With considerable reluctance, and only after extensive debate, the American Heart Association has concluded that it should support a "hold-the-line" policy with respect to that portion of the administration's 1969 fiscal-year planning for those activities of the Department of Health, Education, and Welfare which are concerned with problems of the heart and blood vessels. In so doing the association knows full well that it risks the charge that it is abandoning the goals and principles of the National Heart Institute and of the Heart Disease Control Branch, which the association has wholeheartedly supported throughout the years of the association's existence. Such a charge could not be farther from truth and fact. I know full well that these units need a minimum increase of approximately 15 percent per year to cover project increments and new costs of anticipated growth. As president-elect of the American Heart Association, I am taking my stand today in support of the administration's stringency because the association believes that sacrifice and temporary slowdown, even in so vital an area as the health sciences, are dictated by financial exigencies—by the need this year to divert a larger portion of our national income to the solution of major problems involving civil rights, minorities, defense, and the Nation's international economic security.

In assuming this posture I am, in principle, giving support to the administration's budget items amounting to $176.8 million dollars for use in the battle against cardiovascular disease.

This includes $169.7 million for the National Heart Institute. It is imperative to point out at this time, that if appropriated, these funds would permit the support of only 1,668 research grants after July 1, 1968, as compared with 1,900 in the year ending June 30, 1968, a decline of 232 projects. In this connection, I must recall to you the fact

that in the fiscal year ending June 30, $9 million in grants which the National Heart Institute considered worthy, and which it approved, went unfunded. Also, I want to point out that, under the proposed 1969 budget, $11 million in approved projects will go unfunded. Implicit here is a stern commentary on our real needs in behalf of the attack on cardiovascular disease.

The balance of the total budget under discussion here is accounted for by requests for the Heart Disease Control Branch—an item of $7.1 million. The costs of supporting the researchers carrying on the practical and highly productive studies of this branch, which are directly concerned with delivering medical advances to the public, will increase a minimum of 5 percent in fiscal year 1969 and in some instances, it is estimated that such increases will be as much as 10 percent. There is, however, no increase in the budget of this branch to cover these rising costs.

Also, beyond this, there is no budgetary increase either to update the mechanical and electronic systems, without which many elements of the heart disease control branch overall program could well be stymied. Specifically, this means that some projects must be dropped from the heart disease control branch program, others must be slowed down with a loss of the value of earlier investment, while some must be passed by altogether. Again, the heart disease control branch budget in effect applies a braking on progress.

Obviously, support of a "hold-the-line" budget involves for all of us a serious calculated risk.

We in the American Heart Association recognize the budget-planning difficulties that arise in so critical a year, and, believe me, we are most sympathetic toward these difficulties.

In agreeing with the administration's attempt to hold the line for a year, we are knowingly creating very real hardships, not only for the programs of the National Heart Institute and the heart disease control branch, but also for our own research program and for all of those in the scientific community who have been struggling to provide more well-trained medical and allied health personnel to meet the growing health needs of our peoples.

The decrease in the number of grants funded or expected to be funded by the National Heart Institute has an immediate and direct effect upon the research activities of the American Heart Association. The demand for support by the association is thereby greatly increased. Confronted by the same type of cost increases afflicting the National Heart Institute, the association's capabilities to support new projects, while continuing its ongoing programs, are also severely strained.

The American Heart Association, aside from its affiliates, has approved research applications requiring approximately $3 million for the period beginning July 1968 and ending June 1969. This is approximately the same amount as appropriated in the current period of 1967–68. In our forthcoming budget, however, because of increased costs, we have been able to add only 42 new projects—100 fewer than in the current 1967–68 budget. And, whereas only 33 approved projects went unfunded this year—that is 19 percent of the total projects accepted—117, or 74 percent of the total approved projects, will go unfunded in the coming year.

The overall decrease in research grants has several other serious effects, particularly in the area of personnel training. Gentlemen, research is the life-source of teaching in our medical schools. By decreasing the supply of researchers, we are automatically decreasing the supply of available qualified teachers at the precise time when we are attempting to reverse a treacherous undersupply of trained physicians, technicians, and allied health workers.

Let me cite here an actual example of this situation. In the past 5 or 6 years, and with great difficulty, this country has succeeded in establishing 14 sorely-needed new medical schools. These schools have been gradually tooling up and the larger majority now are about ready for full-scale operations. I have serious doubts, however, whether they can achieve full operation on schedule in the face of a cutback in the number of research investigators from whose ranks must come the bulk of the teachers on their faculties.

There were at least 1,300 full-time teaching vacancies at the end of 1967 on the faculties of U.S. medical schools—23 percent more than in 1966 and more than ever before in the history of our country. Most medical educators will agree that the problem is going to be still greater by the end of 1968.

Now, let us be entirely realistic about the full impact of economies that are being proposed here and which we agree, in view of circumstances, must be considered. The sacrifices involved could have long-range effects.

We are not only briefly postponing the discovery of new knowledge through unfunding of worthwhile research projects—we are not only tolerating disappointments from slowdown of a carefully planned program; we are not only failing to shift our medical school program into high gear; the fact is that the cost is much greater than these sacrifices. The impact of cut backs in fiscal year 1969 will show their effects in 1971, 1972, and 1973 in terms of reduced health care for a Nation that will have outstripped our ability to deliver to it traditionally high caliber medical care.

Confronted by the need for stringent expenditures and awareness of the risks herein enumerated, the American Heart Association feels a great responsibility in assuming its hold-the-line posture. We ask ourselves, and I respectfully ask of you, whether some of the stringency contained in this budget does not threaten us with irreparable harm. I ask whether some of the cutbacks necessitated by this budget do not, in effect, go beyond a hold-the-line position—whether they do not in fact represent a retreat from the forward position we have been able to achieve through diligent and costly efforts against diseases of the heart and the blood vessels over the past several years.

The American Heart Association asks you, therefore, to carefully evaluate the inherent dangers of such stringency and to reexamine our national resources for 1969 to determine whether a more liberal apportionment can be made in this area; somehow, some way.

Should this be possible, then it is suggested that the threat to our medical services of tomorrow could be lessened through making pos-

sible some of the following, relatively low-cost projects, which are not now included in the budget requests before you.

These additions are within the Heart Disease Control Branch area, where considerable time has been spent investigating how to save some of the approximately 200,000 Americans who die of heart attacks each year before even reaching a hospital for treatment.

Three study projects which we consider of distinct value have emerged and are ready for implementation, although they have not been included in the budget requests of this Branch and which are before you. These are as follows:

(1) One project would investigate the kind of equipment, the number of persons and the technological requirements for effective mobile emergency care unts. These could rush life saving service to patients who cannot otherwise be brought to the distant hospital in time for effective treatment. There are no such mobile emergency care units in the United States, although they have been successfully demonstrated and used in Belfast, Ireland, as well as on the Continent. An appropriation of $1 million would make it possible to set up six such units for evaluation and further development.

(2) A second approach to the reduction of this large heart attack death toll is to identify and treat heart attack symptoms at the earliest possible moment. It is known that many victims of fatal coronary attacks report symptoms to members of their family, hours and sometimes even days, before being acutely stricken. This proposal, by creating pilot projects, would provide well-equipped facilities for monitoring the action of the heart and temporary holding areas in hospitals, large hotels, stadiums, and even in areas where the symphony orchestras perform and the operas are staged. Patients with suspected heart attacks could be followed in these facilities for 12 hours or longer, or until a definitive diagnosis could be established.

(3) A third livesaving effort is the introduction of a technique that would automate certain critical heart signals of patients being monitored in coronary care units, thus providing a delicate, technical reaction which even carefully trained specialist nurses frequently cannot discern. Automatic detection would provide an alarm in time to save many lives that are now lost in the slim 1- to 2-minute period available to these nurses to use their skills and their modern equipment.

As president-elect of the American Heart Association, and I recall to you that this is a voluntary health agency dedicated to eradication of the No. 1 killer of our people, I submit to the judgment of the President of the United States and I beseech you, as the representatives of the people of this country, to weigh in your heart what is the best way to protect the health and welfare of the people of this Nation.

I thank you, sirs, for this audience and for your consideration of these suggestions. I hope that we can be helpful in responding to your questions.

Mr. FLOOD. Thank you very much, Doctor. I am glad you came.

MONDAY, APRIL 29, 1968.

DENTAL PROGRAMS

WITNESSES

DR. MAYNARD K. HINE, DEAN, INDIANA UNIVERSITY SCHOOL OF DENTISTRY
REGINALD H. SULLENS, ASSISTANT SECRETARY FOR EDUCATION, AMERICAN DENTAL ASSOCIATION
B. J. CONWAY, CHIEF LEGAL OFFICER, AMERICAN DENTAL ASSOCIATION

Mr. FLOOD. We will now hear, speaking for the American Dental Association and the American Association of Dental Schools, Dr. Maynard K. Hine.

Dr. HINE. Mr. Chairman and members of the committee, my name is Dr. Maynard K. Hine. I am dean of the Indiana University of Dentistry. I am, as well, a past president of both the American Dental Association and the American Association of Dental Schools, the two organizations on behalf of whom I appear here today. With me are two executive staff members of the American Dental Association, Mr. Reginald H. Sullens, assistant secretary for eduction, and Mr. Bernard J. Conway, chief legal officer of the American Dental Association.

We are here to comment on the President's fiscal 1969 appropriations for the National Institute of Dental Research, the Division of Dental Health, and other selected Federal activities of interest to dentistry. We have a full statement which we would like to submit for publication in the record and which we will summarize in this our oral statement.

Mr. FLOOD. It will be made a part of the record following your oral statement.

Dr. HINE. The fiscal 1969 budget provides $30.4 million for the National Institute of Dental Research and $11.2 million for the Division of Dental Health. There is, in addition, a $1 million budget item for a program of dental care pilot projects for needy children. Dentistry also shares in Federal funds directed toward Federal assistance supporting health, education, and manpower supply.

It is, we think, fair to say that these dollar amounts are more reflective of the current strain on Federal resources than they are of the urgent national needs in the areas of dental health, dental research, and dental education.

As citizens as well as dentists, however, we recognize that we must share, at least in part, the heavy burden of this committee to differentiate between what is desirable and what is essential, and thus accommodate a vast array of demands within the framework of a prudent budget. We have kept this obligation in mind. Our paramount purpose, in the course of these remarks, will be to take note of those programs where a temporary interruption of forward progress can best be borne and those areas where, in our opinion, future difficulties may well be such that the short-range saving will prove to be illusory even from a fiscal point of view.

With this preliminary comment, we should like to discuss, in turn, each of the enumerated programs.

The fiscal 1969 budget of NIDR is $30.4 million. This is an increase of one-half of 1 percent over fiscal 1968. In real terms, of course, it is a cutback.

Mr. FLOOD. You did not get together with the medical people before you came in here, did you?

Dr. HINE. No, sir, but we have problems that I think are unique to our particular situation. I was interested in hearing their testimony. They note that they have problems in carrying on the program the way they want to, and we have the same kind of a problem. We think that unless we can continue to move forward, we are having in effect a cutback. An increase of one-half of 1 percent is, in any sense a reduction.

The reduction is reflected in all of NIDR's activities. The budget language itself points out that 288 research grant projects will be funded in fiscal 1969 as compared with 297 in fiscal 1968; 138 fellowships will be awarded as compared with 143 this year, and 96 training grants will be supported as opposed to 97 this year and 108 in fiscal 1967.

We understand the reasons leading to this reduction, reasons deriving from the present fiscal strain on the total Federal budget. We assume the administration understands that when these basic, supportive programs in dentistry are reduced, it affects unfavorably the national effort to increase the amount and quality of dental care available to the public. We cannot, for example, graduate greater numbers of highly qualified dentists unless we can simultaneously expand our facilities. Since NIDR's fellowship and training programs are a prime source of future faculty members, reductions here will be felt all down the line.

The same is true with respect to some of NIDR's direct operations, especially collaborative studies, which are, in large part, highly practical, applied efforts to translate laboratory findings into preventive or curative practices. Just 3 months ago, public announcement was made of the discovery of an enzyme, dextranase, that holds great promise for control of tooth decay.

Mr. FLOOD. Enzymes seem to be getting a great deal of attention this year.

Dr. HINE. There has been a lot of work in this field. This is an enzyme, as I understand it, that is produced in the laboratory that interferes with the formation of this adhesive constituent of plaque, Dextran. This does hold promise.

Mr. FLOOD. Isn't an enzyme also a medication?

Dr. HINE. Enzymes, sir, may be used sometimes as a mediation, I understand. It is an organic compound that acts as a catalytic agent. The theory here is that this enzyme will interfere with the formation of the plaque that holds the acid being formed against the tooth. Many, many years ago there were studies made as to why this acid formed and is not immediately neutralized by saliva. It is now apparent that Dextran does it. If we can get rid of that, we might have a method of controlling dental decay that is quite dramatic.

Laboratory tests have been completed and an FDA application to begin clinical tests on humans is pending. Through the collaborative budget, as well, development of a better filling material is being pursued. A filling material that would adhere inseparably to the sur-

face of the tooth would reduce patient expense—since fillings would not have to be replaced—and greatly conserve the dentist's time, thus permitting him to care for more patients. Some such studies are being cooperatively pursued by NIDR and the National Bureau of Standards. The collaborative studies budget is listed for an increase of one-half of 1 percent or, in practical terms, a reduction. This item needs to be increased.

In agreeing with the necessity for particular economy at this time in the Federal budget, we believe that great care should be taken to assure that the results of the necessary economizing are shared proportionately by every agency. There is some indication that NIDR will suffer, in comparison with its seven companion institutes at NIH, rather heavily. Based on new obligational authority, the seven other institutes are receiving increases ranging from 1.7 to 9.5 percent. The average increase, excluding NIDR, is 3.85 percent. NIDR's increase, as we have noted, is less than 0.5 percent.

In addition, of course, NIDR is, by fiscal measurement, much the smallest of the institutes, with a base of $30 million. The next smallest has a base more than twice as large and the average base for the other seven institutes is $139 million. If this indication of disproportion is borne out, we would hope that a readjustment could be made without increasing the total appropriation, to the effect that NIDR could continue its program at least at the current level.

Finally, we should like to say a word about regional dental research institutes. A concept long urged by the entire scientific community, it was this committee that initiated appropriations for it 2 years ago. Five such institutes are now in being at the Universities of Alabama, Michigan, North Carolina, Pennsylvania, and Washington. The fiscal 1969 budget contemplates no increase in their level of support. We understand that NIH and NIDR officials feel that, because of certain nonrecurring expenses, it will be possible both to nourish adequately the existing institutes and to establish two more. We do not think this would be possible and believe strongly that an increase should be made in this budget item, which is so basic to progress in dental research.

This Division, in addition to administering the dental share of Federal health manpower funds, has under its direct authority a number of programs important to dental health. With an operating budget of only $11.2 million, its efforts are spread paper-thin.

The Division is additionally handicapped by the fact that it doesn't have final control over even this small amount of money. Funds intended for the Division are included in the Bureau of Health Manpower and the Division itself no longer appears in the Federal budget as a line item, though it was so included for many years.

Our associations believe this is unwise not only because we consider the Division entitled to greater autonomy but also because the present arrangement prevents Congress from hearing directly from the Director and questioning him on the Division's activities.

Of the wide range of programs the Division operates, which are dealth with more fully in the statement submitted for the record, we should like to call your attention to the dental auxiliary utilization program. Like every health profession, dentistry not only needs to increase its total numbers, but also needs to increase the productivity

of the individual practitioner. One of the swiftest and most certain ways of doing this is to teach the dentist, while in dental school, to work effectively with the auxiliaries, especially the dental assistant. The Division's dental auxiliary utilization program is the one Federal source of support for such an effort in the dental schools. We are, consequently, most pleased to see that this budget item has been increased for fiscal 1969. The sympathetic attention of this committee over the years is, we feel sure, substantially responsible and we should like to express our appreciation. There are other programs in the Division's budget, such as continuing education, that should be supported at a higher level.

The Division, as noted, also administers—with exceptional efficiency—the funds available to dentistry under the Health Professions Educational Assistance Act. At this moment, there is no more critical health program being operated by the Federal Government. Since the initiation of this activity in 1963, substantial progress has been made and is discussed in detail in our record statement. If all goes well, we can today project a 1973 freshman dental school enrollment of some 5,300 as compared with the present figure, 4,198. The improvement grants section of the law has provided some $12 million in Federal funds to the dental schools. Moreovre, these grants have acted as a stimulus to non-Federal sources to the point that, since 1964, their contribution has risen by $14 million, more even than the amount of direct Federal money.

Unhappily, these positive accomplishments do not constitute the entire picture. Severe problems still face us. Some result from the continued pressure exerted by rising demand for dental services; others stem from the great expense involved in operating a professional health school of high quality, a particular difficulty in the case of private universities.

Our associations believe it essential that appropriations for construction continue to be pressed. In connection with this, it should be noted that of the $480 million authorized in the legislation, $135 million was appropriated in fiscal 1967 and $175 million in fiscal 1968. Of this $310 million total, $220 million has been spent and, thus, $90 million could be carried over. The administration apparently intends to carry over only $60 million, however, in addition to requesting $75 million for fiscal 1969. Over the life of the act, under these circumstances, about 20 percent of the authorized funds—or $95 million—will never be made available for use. This lends special urgency, in our opinion, to the necessity for approving at least the full fiscal 1969 request.

We should also like to note that, over the life of the law, Congress has provided that a fixed percentage of the available construction money be allocated to dental educational institutions. This procedure has unquestionably worked well and is accepted as being equitable. We believe the same provision should continue to be made. On this basis, the dental share of the fiscal 1969 request would be $15 million.

The section of the law concerning improvement grants relates directly to the second difficulty facing us, that of the enormous expense involved in operating a professional health school at a modern-day level of quality.

The financial pressures continue to mount, especially on private schools. The fiscal crisis that many have long foreseen is now upon us in a very concrete fashion. In recent years, a number of private dental schools have had to switch to a public basis in order to continue. One private school in Louisiana was phased out of existence and taken over by a public university. Late last year, an additional private school—this one in Missouri—announced that it will close its doors. Our associations can identify another four to six private dental schools that are actively considering discontinuance.

This would be a disastrous blow to the national effort to keep pace with the accelerating demand for dental care. The retention of an existing school, its faculty and student body, is at least as important to the future as is the funding of a completely new school that will require 8 to 10 years before graduating its first practitioner.

In connection with this crisis, it should be noted that the basic and special improvement grants section of the existing law has also never been funded to the level authorized. For fiscal 1966, $20 million was authorized, while $10.5 million was expended. For fiscal 1967, $40 million was authorized and $30 million spent. In 1968, it is estimated that $49 million will be spent rather than the $60 million authorized. There is, then, a cumulative gap between authorization and appropriation of $30 million. Had some of that $30 million been available, it is quite possible that the dental schools that have closed or announced discontinuance might have been able to continue.

Under these circumstances, we are distressed to see that in fiscal 1969, the requested appropriation, $71 million, is once again below the authorized amount, $80 million.

Even with recognition of the current fiscal situation, we cannot consider this cutback feasible. We would strongly urge this committee to appropriate money to the full level of authorization in order to prevent an even more drastic worsening of the present crisis.

The final section of the existing legislation—that relating to loans and scholarships to health school students—has more than proved its value and should be supported to the level of the administration request.

In the same way, the programs just beginning under authority of the Allied Health Professions Personnel Training Act are going to be of immense importance in meeting the demand for health care. The fiscal 1969 request of less than $2 million is modest, indeed, and should be appropriated.

In no part of our population are the ravages of dental disease more tragically revealed than with children. By age 5, the typical American child already has three carious teeth; by age 15, he has 11 permanent teeth damaged or destroyed. It is in childhood that the disease process begins that results in such a great percentage of American adults suffering the loss of many or all their teeth. And it is in childhood, as well, that the effort must begin to reverse this.

The public sector, our associations have long believed, has an important role to play in this effort, especially on behalf of needy children since the frequency with which a child sees a dentist is closely related to family income. Nearly 70 percent of the children belonging to families earning less than $4,000 annually do not receive regular dental services. For children from families whose incomes exceed $10,000,

the statistics are more than reversed, with 80 percent seeing a dentist on a reasonably regular basis.

In the fall of 1966, as the culmination of a long series of efforts, the American Dental Association established a national dental health program for children as official policy. The initial step of that program contemplates establishing some 40 pilot projects throughout the Nation that would give care to needy children and would also explore various methods for establishing a more comprehensive approach.

Subsequently, the administration submitted to Congress a program resembling this initial step of the American Dental Association proposal. This administration proposal became law early this year. During the legislative process, John W. Gardner, then HEW Secretary, said that the administration was thinking in terms of 10 pilot projects, costing $5 million, in the first year of the 4-year program.

When the fiscal 1969 budget was submitted, the request for the program was $1 million.

This is not, in our view, sufficient even to be considered a token sum. It means that 1 whole year—25 percent of the total life of the program—will be, in large measure, lost. It means that the Nation will continue to postpone, unintelligently and uneconomically, the effort to bring our dental disease epidemic into control by means of a thoughtfully planned dental health program for children that can be supported by the combined efforts of the private and public sectors.

In fiscal 1968, official Government sources estimate that $1.383 billion in Federal funds was being spent to benefit the health of children and youth. A percentage of that, of course, goes for dental care. It is a necessary expenditure. Too much of it, however, goes to repair the ravages of dental disease that went undetected and untreated too long. It simply makes no sense, then, to refuse to allow an additional $4 million for the one Federal program that has as its paramount purpose the development of a thoughtfully planned attack on the dental disease problem of children. It is an investment that will pay vast dividends.

This pilot dental health program is part of a number of similar demonstration programs related to the health of children that are authorized under title V of the Social Security Act. The total sum allocated for them in fiscal 1969 is $67 million. In addition, there is $100 million in the proposed budget for related programs of maternal and child health care and crippled children's services. Surely, there can be located $4 million for the pilot dental health project without increasing the overall appropriation. We are hopeful that this committee will find that $4 million and allocate it to the dental health pilot projects.

Mr. Chairman, this concludes our summary statement. On behalf of the American Dental Association and the American Association of Dental Schools, I wish to thank you for this opportunity to appear before the committee. Mr. Sullens, Mr. Conway, and I would be glad now to try and answer any questions.

(The supplemental statement follows:)

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION AND THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS

Mr. Chairman and members of the committee, my name is Dr. Maynard K. Hine. I am dean of the Indiana University School of Dentistry. In addition, I am a past president of both the American Dental association and the American

Association of Dental Schools, the two organizations on whose behalf I appear here today. With me are two executive staff members of the American Dental Association, Mr. Bernard J. Conway, chief legal officer and Mr. Reginald H. Sullens, who has charge of education. We are here to comment on the President's fiscal 1969 appropriations for the programs of the National Institute of Dental Research, the Division of Dental Health and other selected Federal activities related to dental health.

The fiscal 1969 budget provides $30.4 million for the National Institute of Dental Research (NIDR) and $11.2 millon for the Division of Dental Health. There is, in addition, a $1 million budget item for inauguration of a new program of dental care pilot projects for needy children. Dentistry also shares in those programs directed toward Federal assistance for education and manpower supply in the health field.

It is, we think, fair to say that these dollar amounts are more reflective of the current strain on Federal resources than they are of the urgent national needs in the areas of dental health, dental research, and dental education. Observers are unanimous in agreeing that in each of these areas there are many more worthwhile activities that could and should be carried out than can be accomplished within these budget limitations.

As we all recognize, dental disease is perhaps the most pervasive ailment in society; almost no one is immune from its effects. This basic fact has a twofold consequence. First of all, the widespread nature of dental disease dilutes its dramatic impact on the public consciousness and the result is that dentistry has unique difficulties in attracting private support for its research and public health activities. However, this same fact also means that any breakthrough in understanding the causes of dental disease or in perfecting techniques for preventing or controlling its manifestations brings benefits not to a segment of the population, but to virtually everyone. Since the private sector spending for dental care activities now exceeds $3 billion annually, the savings that could result from research breakthroughs in prevention of dental disease or expanded public health activities in controlling it would not be insignificant.

The extent to which dental disease is a national problem was, for many years, underestimated by everyone except dentists themselves. This has begun to change rapidly and emphatically and greater attention is now being paid by both the private and the public sectors of society.

In the private sector, these has been an immense growth in dental prepayment plans initiated by the profession itself and by the commercial insurance industry. Such plans, by encouraging early and regular dental care, will enable families to prevent much dental disease that now occurs and exists untended until it becomes so serious that it can't be ignored.

The public sector's new level of attention can be seen in the programs being enacted by Congress. The Office of Economic Opportunity's project Headstart has a significant dental component. Most of the title XIX programs now being enacted by the States include dental benefits and, by 1975, this will be mandatory.

Such activities, both in the private and public sector, are supported by the dental profession. It must be recognized, however, that the scope and cost of these care programs will be determined in large measure by the activities being carried on in dental research laboratories, schools, and public health agencies.

A program of dental care for needy children, for example, will have a very different form if we know how to prevent tooth decay than if we do not. But such a discovery will come only through those research activities supported by the budget of the National Institute of Dental Research.

A program of dental care, as a further example, will have a different form if the dentists involved have been trained, during their dental school years, to work effectively with dental auxiliaries. By thus restricting his attention to those procedures requiring his level of proficiency, the dentist is able to care for more patients. But the training now given dental students in working with auxiliaries is supported by the Division of Dental Health. To the degree that such support is adequate, young dentists leave school with a less than optimum understanding of the value of the auxiliaries and the ways in which to use them.

The more sympathetic attention that is paid, then, to the budgets of the National Institute of Dental Research and the Division of Dental Health, where are carried out the fundamental investigations that support and shape all other efforts, the greater hope we have of evolving care programs that are as efficient and economical as we could desire. Saving pennies on the budgets under scrutiny here today, it may be argued, can well result in wasting more than pennies elsewhere.

As citizens as well as dentists, however, we recognize that we must share, at least in part, the heavy burden of this committee in differentiating between what is desirable and what is essential and thus accommodating a vast array of demands within the framework of a prudent budget. We assure you that we have kept this obligation firmly in mind as we prepared our testimony. Our paramount purpose, in the course of these remarks, will be to take note of those programs where a temporary interruption of forward progress can best be borne and those areas where, in our opinion, future difficulties may well be such that the short-range saving will prove to be illusory from even a fiscal point of view.

With this preliminary comment, we should like to discuss in turn each of the programs of appropriate interest to dentistry.

NATIONAL INSTITUTE OF DENTAL RESEARCH (NIDR)

The fiscal 1969 allowance for NIDR is, as noted, $30.4 million. This is an increase of $126,000 over fiscal 1968 in terms of new obligational authority. Such an increase—amounting to less than one-half of 1 percent—is, of course, an actual reduction. Overall programing at NIDR, then, will be cut back.

While understanding the imperatives that lie behind this decision by the administration, our associations do regret that NIDR seems to have suffered, in terms of percentage increase, more heavily than any of its seven sister institutes at NIH. Based on new obligational authority for fiscal year 1969, as compared with fiscal year 1968, the seven sister institutes are receiving increases ranging from 1.7 percent to 9.5 percent. The average increase for the seven institutes, is 3.85 percent as compared with NIDR's 0.5 percent.

In addition, of course, NIDR is, by fiscal measurement, much the smallest of the eight institutes. The fiscal base of the next smallest institute is more than twice the size of NIDR's and the average base for the other seven institutes is $139.2 million as compared with NIDR's $30.4 million.

By all odds, the greatest share of NIDR's funds is distributed in the form of extramural research grants. The budget estimates that $15.626 million will be allocated to this effort in fiscal year 1969, an increase of $9,000 or six one-hundredths of 1 percent. As a result, in the words of the budget submission, "approximately 288 project grants will be supported in 1969 as compared with 297 grants in 1968 and 295 in 1967."

Contained within this $15 million research grant budget item is an allocation for further development of regional dental research institutes. It was this committee that initiated this activity in fiscal year 1967. For some years prior to that time, it had become increasingly clear that establishment of a number of large scale, multidisciplinary centers throughout the Nation offered greater hope for dental research progress than did any alternative. The conviction is shared, not merely by observers within dentistry but by the scientific community at large, than through their location in university environments, these institutes can bring to bear a variety of skills and approaches on those oral health problems not yet wholly understood. Five such institutes have now been established and are in the process of being developed. They are located at the Universities of Alabama, Michigan, North Carolina, Pennsylvania, and Washington.

The American Dental Association recently had cause to ask some two dozen experts in dental research what their opinion of this regional institute concept was. Without exception, these observers subscribed to the viewpoint of the one who called it "the single most exciting development to take place in the field of dental research in the last decade." They were also unanimous in noting that special attention must be paid to what one educator called "the genius of the concept—adequate and stellar staffing."

In both the present and the preceding fiscal year, $3 million has been allocated to this effort. Fiscal year 1969 allows another $3 million. It is our understanding that officials of NIH and NIDR believe that, because of a number of nonrecurring expenses in fiscal years 1967 and 1968, this $3 million will be sufficient both to adequately nourish the existing institutes and establish three additional ones. While we must confess considerable skepticism, our associations hope that this will indeed prove to be true because the institute concept is basic to progress in dental research. If it is allowed to falter now, much of the Federal money and effort already expended will have been wasted.

The funds available to NIDR, according to the budget, for fellowship awards and training grants will dictate a level of activity somewhat below what is being

done now. The language in the budget submission shows this clearly: "*Fellowships*—approximately 138 * * * will be supported in 1969 as compared with 143 in 1968 * * * *Training*—it is estimated that 96 grants will be awarded in 1969 to schools for training individuals for academic teaching and research careers in the various fields of dental sciences. This compares to 97 grants in 1968 and 108 in 1967."

These fellowship and training activities have a very direct relationship to the present national effort to increase substantially the health manpower supply and thus make possible the provision of more adequate, continuing care for our fellow citizens. There have been repeated calls by leaders of both the public and private sector for expanded enrollment in existing dental schools and establishment of new schools. There have been repeated calls for increasing to an even higher level the quality of the education given dental students. To do these things, of course, requires an expanding supply of qualified instructors and researchers to teach the students. If NIDR's Fellowship and Training programs are to be cut back instead of expanded, then we must be willing to face the fact that this cutback will be reflected as well in the parallel effort to increase the amount of high quality dental care available to the public.

Within its direct operations budget, NIDR has funds for what are called collaborative students. This activity results from the fact that investigations initiated in NIDR's own laboratories cannot always be carried to completion and certain types of investigations cannot be undertaken there because special facilities and/or personnel are required to pursue them. In such instances, outside facilities are used, generally under contract arrangements.

Since their establishment, collaborative studies have been, in large part, highly practical, applied efforts to translate laboratory findings into preventive or curative practices that can be employed by the practitioner and in public health programs.

One very recent example, publicly announced less than 3 months ago, relates to the identification of a specific enzyme that might be used for control of tooth decay. Collaborative investigators have found that adding the enzyme, dextranase, to drinking water reduces dental plaque and, thus, caries in laboratory animals. Dextranase attacks a metabolic product—dextran—that can be described as that element within dental plaque—a film of acid and bacteri products that adheres to the teeth—that gives plaque its adherent qualities. Beneath the plaque, protected by it, decay in the smooth surfaces of the teeth develops. Dextranase, by attacking dextran, has the effect of preventing the adherence of plaque. Since decay on the smooth surfaces of teeth—that which develops under the plaque—accounts for more than 50 percent of caries in children from ages 6 to 18, the implications of this finding are obvious and immense.

Another example of the value of collaborative studies is seen in efforts being undertaken to develop better dental filling material, especially one that would adhere inseparably to the surface of the tooth. The potential consequences for patient care are considerable since development of such a material would make it virtually unnecessary ever to have fillings replaced, thus not only saving expense on the part of patients but also conserving much of the dentist's time and thus freeing him to care for more patients. Work of this type is being presently pursued under arrangements between NIDR and the National Bureau of Standards.

In addition to the value of work itself, the relationship between these two Federal agencies is worthy of note. It brings together the two major arms of Government concerned with basic and applied sciences and makes possible mutual progress in such areas as biomaterials, biophysics, and bioengineering. To our knowledge, there are officials both at NIH and at NBS who look upon this present arrangement as a possible prototype for more extensive cooperation between the two agencies. Our associations agree wholeheartedly with this feeling, believe that an exciting number of practical results can be obtained, and are most anxious to see the present NIDR–NBS relationship not only maintained but strengthened within the context of the collaborative studies budget item of NIDR.

For fiscal 1969, the collaborative studies budget is being increased to $844,000 which is $3,000—or slightly less than one-half of 1 percent—over 1968. The associations regret to see such inadequate treatment for activities productive of results with positive potential effects on patient care. This budget item should be increased by at least $500,000.

In summary, then, NIDR will be unable in fiscal 1969 to do more than hold to approximately its present level in some areas while suffering a setback in others. To a degree, this is due to the overall fiscal situation of the Government, as we have already noted and about which we, too, are concerned. It does, nonetheless, seem possible to us that there could be some readjustment within the total amount of Federal money available for health research in order that NIDR be asked to bear no more than its proportionate share of the necessity for economizing in the coming fiscal year.

At a minimum, we believe that funds must be found of an order that will permit NIDR's extramural research grants, fellowships, and training grants to be continued at no less than their present level. Additionally, we believe that the allocation for regional research institutes should be increased to $4 million.

PROFESSIONAL MANPOWER SUPPLY IN THE HEALTH FIELD

Federal involvement in health education and health manpower supply began in 1963 with passage of the Health Professions Educational Assistance Act. The original law has since been extended and expanded. The American Dental Association and the American Association of Dental Schools have strongly supported this activity and, indeed, were suggesting it for some years prior to 1963. Dental education, and thus dental care of our fellow citizens, has greatly benefited from its enactment.

Since 1963, a total of 33 applications involving construction, renovation, or rehabilitation have been received from 29 dental schools.

These applications include plans for new dental schools as well as additions to or replacements of existing facilities.

As a result only of those construction grants that have already been funded, it is our understanding that places for 681 additional first-year students will be created. An additional 100 places will come into being as a result of applications that have been approved but are not yet funded. There are four applications awaiting approval that, if it is received, represent 200 more such places. Finally, 10 schools have given notice of intention to apply for grants by submitting plans that, in total, would provide 272 new first-year places.

If all goes well, we can project a 1973 freshman enrollment of some 5,300 as compared with the current figure—4,198.

This effort has been a cooperative one between the Federal Government and the States and private educational institutions involved. The 33 applications that have been received involve a total estimated cost of $216 million, of which some $98 million would be non-Federal. Thus far, $71 million in Federal funds has been paid out.

This has been an immense effort with gratifying results and our associations would like to say that much of the success achieved can be credited to the intelligent and vigorous administration of these funds that have been provided by the Division of Dental Health.

Unhappily, these positive accomplishments do not constitute the entire picture. There are severe problems still facing us. Some arise from the continued pressure exerted by rising demand for dental services; others stem from intrinsic difficulties in the operation of a modern-day professional health school, particularly one that is part of a private university.

This national effort to increase manpower supply in the health field began long after the problem became acute and a considerable backlog of need had developed. We must, consequently, consider the present pace to be a minimum one. Even with appropriation of all authorized construction funds, there will not be sufficient money available to achieve fully the results discussed above. For this reason, our associations are gratified to note that the legislative process is already underway to extend and improve this legislation, which expires at the end of fiscal 1969. Hearings have already been held by the Senate, at which we testified, and House hearings will be coming soon. For fiscal 1969, however, we urge this committee to approve the full administration request for construction funds.

It should be noted that a total of $480 million was authorized for this purpose by the existing legislation. The appropriations have been $135 million for fiscal 1967 and $175 million for fiscal 1968. Adding this year's request of $75 million gives a total of $385 million. Thus, $95 million of the authorized amount will never have been appropriated.

We should also like to note that, over the life of the law, Congress has provided that a fixed percentage of the available construction money be allocated to dental educational institutions. This procedure has unquestionably worked well and is accepted as being equitable. We believe this committee should make the same provisions for fiscal 1969. Under such circumstances, the dental share of the new obligational authority requested would be $15 million. Added to this would be $12 million as the dental share of the funds being carried over.

A second section of the law, that providing basic and special improvement grants, relates directly to the second problem we have noted: that of the intrinsic difficulties involved in operating a professional health education school. To operate such a school at a high level of quality is an expensive and demanding task. Viewed as incentive programs for the maintenance and improvement of dental education, these grants have been most helpful.

In 1964–65, for example, the operating dental schools spent approximately $51 million on their teaching programs. In 1967–68, that total had mounted to $77 million. Of this $26 million increase, $12 million is accounted for by Federal funds and $14 million by non-Federal funds, showing clearly how strong an incentive the Federal assistance has been.

Gratifying as this cooperative progress is, however, more must be done. The financial pressures continue to mount, especially on private schools. The fiscal crisis many have long foreseen is now upon us in a very concrete fashion. In recent years, a number of private dental schools have had to switch to a public basis in order to continue. One private school, in Louisiana, was phased out of existence and taken over by a public university. Late last year, an additional private dental school, in Missouri, announced that it will close its doors this fall. Our associations can identify four to six more private dental schools that are likewise seriously considering discontinuance.

This would be a disastrous blow to the national effort to keep pace with the accelerating demand for dental care. The retention of an existing school, its faculty and student body, is at least as important to the future as is the funding of a completely new school that will require 8 to 10 years before graduating its first practitioner.

In connection with this crisis, it should be noted that the basic and special improvement grants section of the existing law has never been funded to the level authorized. For fiscal 1966, $20 million was authorized, while $10.5 was expended. For fiscal 1967, $40 million was authorized and $30 million spent. In 1968, it is estimated that $49 million will be spent rather than the $60 million authorized. There is, then, a cumulative gap between authorization and expenditure of $30 million. Had some of that $30 million been available, it is quite possible that the dental schools that have closed or announced discontinuance might have been able to continue.

Under these circumstances, we are distressed to see that, in fiscal 1969, the requested appropriation, $71 million, is once again substantially below the authorized amount, $80 million.

Even with recognition of the current fiscal situation, we cannot accept this cutback as being reasonable. We would strongly urge this committee to appropriate money to the full level of authorization in order to prevent an even more drastic worsening of the present crisis.

In appropriating the additional sum, the committee may wish to take note of a provision in the proposals now before Congress to extend these laws. This provision would grant explicit authority to make use of these funds to rescue schools that are in "serious financial straits." It is an excellent, desperately needed provision and our associations strongly supported it in testimony before the Senate Committee on Labor and Public Welfare and will do so when House hearings are held.

In addition to the construction and improvement grants, the laws under discussion provide scholarships and loans to health school students. We know this committee shares with us the conviction that the apportunity for professional health education should be available to any young person with the talent and initiative to pursue it. A lack of personal financial resources should not be a determining factor. The loan and scholarship provisions have moved us closer to that goal. The need for them is, if anything, even greater today. The cost of dental education to the student continues to increase. The average tuition cost per year for private schools was $1,100 in 1963 and is $1,476 today. The average total expense for the 4-year dental education program, exclusive of living costs, was $7,000 in 1963 and is $9,300 today.

The schools have no difficulty in identifying students who are in need of scholarships and loan funds and the available sums have always been distributed.

The activities authorized under the Health Research Facilities Act are directly and essentially related to the continued expansion of our supply of health practitioners and continued improvement in the education of health students. The final goal, in all instances, is to make the finest possible care readily available to our fellow citizens. If properly funded, the health research facilities program will make an essential contribution.

ALLIED HEALTH PROFESSIONS

Our associations supported the passage of the Allied Health Professions Personnel Training Act of 1966, which was intended to permit the expansion of training activities in 2- and 4-year schools and colleges for a number of allied health personnel categories, including dental hygienists. A rapid expansion in the number of dental auxiliaries, and in their usefulness is an essential component of our effort to increase the availability of care.

In 1967, there were 57 dental hygiene programs accredited by the American Dental Association's Council on Dental Education and 18 new programs at some stage of development. Based on current rate of growth, the profession anticipates that there will be about 90 dental hygiene programs in operation by 1970. Dental assisting programs are expected to increase to a total of 140 and programs for dental laboratory technicians to about 30 in 1970. If current predictions prove accurate, the profession anticipates a 100-percent increase in the number of dental assisting, hygiene, and laboratory technicians training programs between 1965 and 1970.

While the effort to expand training opportunities for dental auxiliary personnel continues to be productive, a joint report of the councils on dental education, dental health and legislation of the American Dental Association recommends that 5,300 dental hygienists, 5,300 dental assistants, and 2,200 dental laboratory technicians should be graduated annually from accredited programs by 1975 in order to maintain existing ratios of auxiliaries to practicing dentists. On the basis of both current and projected training capacity, an annual deficit of auxiliaries of about 2,500 hygienists, 9,600 assistants, and 1,800 laboratory technicians can be anticipated in 1975.

This legislation represents a modest but welcome addition to cooperative efforts by both Government and the professions to increase the supply of vitally needed dental manpower and to expand the educational capacity of the profession to prepare educationally qualified auxiliaries for service in the dental offices and clinics. The funding has not begun to approach the level of need to continue the expansion of new training programs for dental assistants, hygienists, and technicians. The fiscal 1969 request, together with carryover funds, would permit the distribution of $2.8 million. Clearly, this is the barest of beginnings.

The two associations are in full accord that dental auxiliaries can be prepared educationally in a variety of settings which include both 2- and 4-year educational institutions. As an illustration of this point, among 60 dental hygiene programs now accredited by the American Dental Association's Council on Dental Education, 30 are conducted in dental schools, 16 in community colleges, 11 in 4-year colleges or universities, and three in vocational technical schools. Further, among the new and developing programs which are expected to meet educational standards for accreditation, four will be developed in dental schools, 10 in junior colleges, eight in 4-year colleges, and three in vocational technical schools.

The same variety of educational settings described for training of dental hygienists exists, to an even greater degree for the other two recognized auxiliaries of the dental profession.

PILOT DENTAL CARE PROJECTS FOR NEEDY CHILDREN

The extent of dental disease in this Nation is enormous. There is almost literally no Amrican who is not suffering from one or both of its most common manifestations, tooth decay and gum disease. Yet, these manifestations are reasonably controllable with regular professional care, intelligent home hygiene practices and proper diet. The gap between what can be done and what is being done is wide indeed.

In no subgroup of our population are these problems more glaringly and tragically revealed than with children. By age 5, the average American child already has three carious teeth; by age 15, he has 11 permanent teeth damaged

or destroyed. It is in childhood that the disease process begins that results in a great percentage of American adults suffering the loss of many or all of their natural teeth. And it is in childhood, as well, where the steps must be taken to reverse this dismal state of affairs. If we can once manage to bring a generation of children to a state of sound oral health, it will then be a relatively simple matter to maintain that condition as the child grows up and lives out his span of years.

The dental profession, through the American Dental Association, has long held this belief and publicly urged wider recognition of its truth. The association consistently called for increased Federal activity long before the Federal Government was willing to play more than a minimal role. This is particularly true in the case of children of poor families. Such children are frequently victimized by improper diets and ignorance of home hygiene practices. In addition, the frequency with which a child sees a dentist is closely related to the income of his family. Nearly 70 percent of children from families earning less than $4,000 annually do not receive dental services. For children from families whose incomes exceed $10,000, the statistics are more than reversed, with 80 percent seeing a dentist on a reasonably regular basis.

In recent years, as the climate of public and governmental opinion seemed to grow more favorable, the dental profession has intensified its efforts. In the fall of 1966, the American Dental Association's house of delegates adopted, as official policy, a national dental health program for children. As one of the initial steps in this program, the association suggested that some 40 pilot projects be established in sections of the United States. These projects would have a dual purpose: care would be extended to a number of needy children with the support of public funds; and secondly, various methods by which a more comprehensive dental health program for all American children could be established would be systematically explored.

In January of 1967, the administration presented a proposal to Congress based on this initial step in the association program. In tetsimony on the measure, John W. Gardner, then HEW Secretary, said that the administration was thinking in terms of $5 million. In its testimony, the association accepted 10 projects and $5 million as a minimal level of beginning activity, assuming that in the remaining 3 years of the program there would be a substantially increased effort. No administration spokesman, during the long course of House or Senate hearings or during the conference period, ever amended Mr. Gardner's public statements. The program was passed in the fall of 1967 and signed into law.

When the fiscal 1969 budget was issued, the line item for the program was $1 million.

This $1 million budget is not, in the American Dental Association's view, even sufficient to be considered a token amount. What it means is that 1 whole year—25 percent of the total life of the program—will be wasted as the Nation continues to postpone, unintelligently and uneconomically, its efforts to bring our dental disease epidemic into control by means of a thoughtfully planned, vigrously implemented, preventive program for all children.

This pilot dental health program is part of a number of similar demonstration programs related to the health of children that are authorized under title V of the Social Security Act. The total sum allocated to all such programs for fiscal 1969 is in excess of $67 million. In addition, there is $100 million in the proposed budget for related programs for maternal and child health and for crippled children's services.

These sums do not, of course, reflect the totality of the across-the-board Federal effort related to health programs for children and youth. A recent publication of the Children's Bureau[1] contains the following information on page 48: "Among the programs specially identified as benefiting children and youth, there have been a rapid improvement since 1960. In that year, only $377 million of Federal health funds were spent for such programs. For 1968, expenditures of $1,383 million are estimated, a three-fold increase. Public Health Service funds have increased over six-fold, welfare administration health programs for children over twelve-fold."

A percentage of that $1.383 billion in Federal health funds for children and youth does go, of course, for dental care and other dental purposes. It is neces-

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[1] Federal Programs Assisting Children and Youth, Interdepartmental Committee on Children and Youth, Children's Bureau, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, December 1967.

sary to spend such funds and it will continue to be necessary to do so. It is unquestionably true, however, that a portion of this money goes to repair the ravages of dental disease that went undetected and untreated for too long. It is the price we pay for our continued refusal to take action on a comprehensive, preventive basis. This is what we mean, in part, when we refer above to the unintelligent and uneconomical course of present Federal action.

An additional $4 million for the one Federal program that has as its paramount purpose the development of a thoughtfully planned attack on the basic causes of dental disease is an investment that will pay vast dividends on just a fiscal basis. Surely, that $4 million can be located for this purpose, and located in such a way as to not increase the present appropriation level.

The American Dental Association is most hopeful that this committee will find that $4 million and allocate it to the dental health pilot projects. Though this is a new program, it is obvious to all of us that it is not concerned with a new need. We would respectfully suggest that too much time has been wasted already, too many youngsters have been victimized by oral disease. We must begin now on a more rational plan of control and prevention. The association should also like to confirm its previus public statements that administration of this program should be provided by the Division of Dental Health. This Division is the only HEW agency with demonstrated competence and interest in this aspect of dentistry.

THE DIVISION OF DENTAL HEALTH

In addition to administering the dental share of those Federal programs assisting health schools and health school students, the Division of Dental Health has under its direct authority a number of activities directed toward alleviating current dental problems. It studies and suggests solutions to the problems attendant upon dental health care of the indigent, the handicapped, and those living in remote areas. It conducts and supervises investigations leading to the increased efficiency of our current manpower pool. It supports investigations designed to make it easier for practitioners to stay abreast of developments in dentistry and incorporate them without unnecessary delay into their practices.

The Division is the sole HEW agency devoted primarily to dental public health affairs. With an operating budget of only $11.2 million, its efforts are obviously spread paper thin.

An additional handicap arises from the fact that the Division does not have final control over even this small amount of money. As as result of a partial reorganization within HEW 2 years ago, the Division became part of the Bureau of Health Manpower. Funds intended for the Division are included within the total available to that Bureau and the Dental Division, as such, has disappeared from the Federal budget.

Our associations believe this trend to be unwise for two reasons. First of all, these applied public health efforts in dentistry have a substantial importance far beyond what the severely limited funds would indicate and a greater degree of autonomy for those who are expert in dental matters is indicated. Second, the present arrangement prevents Congress from hearing direct testimony from the Dental Division Director and questioning him on his agency's activities. We believe it important that Congress, during the appropriations process, have that opportunity.

We recognize that the HEW reorganization process is by no means complete and that further changes are being planned, some of which may relieve this situation. The American Dental Association has consulted with HEW officials on this point. In the meantime, however, we believe there should be a return to the long tradition whereby Congress hears testimony on dental health matters from the Director of the Division of Dental Health.

The Nation's sharply focused attention on increasing dental care for the population has, if anything, intensified during this past year. The dental profession welcomes this trend and welcomes, as well, the public statements that have been made by many congressional and administration officials on the subject.

There is unanimous agreement that dentistry, like the other health professions, must take every possible step to increase not only the available number of practitioners and auxiliaries but also to increase the productivity of the existing force. One of the swiftest and most certain ways of doing this, it has long been recognized, is to make greater use of the dental auxiliaries especially the dental assistant, who works at the dentist's side as he cares for patients.

The best way to teach a dentist how to work most effectively with dental assistants is, obviously, to do so during his student years, in the dental school where he prepares himself for all other phases of his future practice. The dental auxiliary utilization program of the Division is the one Federal program helping to support such an effort. In recent years, this budget item has been inadequately funded. Under prevailing circumstances, all of the senior students in the dental schools received some experience in working with auxiliaries and about half of the junior students. There is unanimity among dental educators that the senior students do not receive enough experience under the current program and that all of the junior students, not just half of them, should be included.

Our associations, consequently, are most gratified that the fiscal 1969 budget includes a significant increase for this activity and that $4 million will be available in the coming year. This is important not only because it will enable the dental schools to expand the program to a level closer to what is necessary but also because it indicates a fuller recognition on the part of Federal planners of the importance of this effort and the necessary relationship of it to any future increase in availability of dental services to the Nation. This committee has been most sympathetic over the years to our testimony on this matter and we feel sure its attitude has had some bearing on the change in administration thinking that has led to this increase. We hope that future budgets will continue to reflect enhanced understanding of the unique value of this program.

The Division has, since 1964, been operating a research grants program. This activity has underwritten investigations into a wide variety of clinical dental research problems. These have included investigations into the relationship of oral hygiene and periodontal disease, the single largest cause of tooth loss in adults. Evaluations have been undertaken of various methods of applications in the use of fluoride for the reduction of dental caries. Intensive studies have been made to evaluate the methods of prevention and treatment of cleft palate and other disfiguring oral disease.

Much more needs to be done along this line. We need to know more than we presently do about such questions as patterns of dental service procurement, distribution of dental care, methods of practitioner and public education. We need to deepen our knowledge in those areas related to biodental and human engineering and research in the sociological and psychological aspects of dental care.

The fiscal 1969 budget contemplates the same level of funding as fiscal 1968. Though more, in our view, is needed, we would urge this committee to consider the sum included in the fiscal 1969 budget as a rock-bottom minimum.

At its Dental Health Center in San Francisco, established in 1961, the Division carries out a number of notable activities. One of special note is directed toward developing new methods and approaches to providing continuing education for the Nation's nearly 100,000 dental practitioners. This is of heightened practical value today because of the increasing discussion being held in some States to require continuing education in connection with renewal of licenses. The funding for this program should be increased significantly at the first available opportunity.

Mr. FLOOD. I think you did this very well.
Thank you very much.
Dr. HINE. Thank you.

MONDAY, APRIL 29, 1968.

SOCIETY FOR EXCELLENCE IN EDUCATION

WITNESS

FREDERICK S. KLINE, DIRECTOR, SOCIETY FOR EXCELLENCE IN EDUCATION

Mr. FLOOD. Mr. Kline, I see you are representing the Society for Excellence in Education. How do you wish to proceed?

Mr. KLINE. I have a brief testimony I would like in the record, to save you time, which also has a short biographical sketch. This is not before your subcommittee, but a related document.

(The statement referred to follows:)

Senator BAYH. The next witness is Mr. Frederick S. Kline, member of the Society for Excellence in Education. Mr. Kline has a master's degree in education from the University of Michigan, and has worked in both the Detroit and Boston school systems.

I note that Mr. Kline has some presidential scholars with him. The record will make note of this fact.

If you will tell us their names, we would like to have them for the record.

STATEMENT OF FREDERICK S. KLINE, DETROIT, MICH.; ACCOMPANIED BY ANNE BITTNER, ANN PASQUALE, AND GEORGE A. TROSPER, PRESIDENTIAL SCHOLARS, THE CATHOLIC UNIVERSITY OF AMERICA, WASHINGTON, D.C.

Mr. KLINE. Senator Bayh, members of the subcommittee, I am Frederick Kline, founder of the Society for Excellence in Education. I am pleased to have this opportunity to suggest necessary civil rights legislation.

After my testimony, the presidential scholars with me from Catholic University of America will be happy to answer any of your questions.

Senator BAYH. Would you give us their names, please, so we will know one from the other?

Mr. KLINE. Yes. Miss Anne Bittner of Brattleboro, Vt.; Miss Ann Pasquale of Short Hills, N.J.; and Mr. George A. Trosper of Salt Lake City, Utah.

There is immediate need to enact a law to forbid a State and/or the Federal Government from assigning students or teachers to schools on the basis of race. The educational establishment must be made accountable to parents and local communities to provide equalized excellent educational opportunities for all students instead of complying with arbitrary racial guidelines.

At this time, I would like my previous testimony, sent on July 27, 1967, to be written into the record and the additional testimony I have now will accompany this.

Senator BAYH. We will have that included in the record as requested.

Mr. KLINE. The reports, "Equality of Educational Opportunity," by the U.S. Office of Education, and "Racial Isolation in the Public Schools," by the U.S. Civil Rights Commission, statistically confirmed that lower verbal achievement standards are generally required for promotion for schools where most of the students' parents have less than a high school education than for schools where most of the students' parents have at least a high school education. These studies also confirm Negro students and other minority groups, such as American Indians, Puerto Ricans, and Mexican Americans, are generally promoted after achieving considerably below verbal grade level achievement standards regardless of the racial compositions of their schools, with the scores for Negroes being lowest in racially imbalanced schools. This is fairly common knowledge to graduates of racially imbalanced schools and their teachers.

The "Equality of Educational Opportunity" report stated that the teacher quality was more important for the achievement of Negro students than for white students. The report, "Racial Isolation in the Public Schools," did not contradict this statement, but did state advantages of having more qualified teachers seemed to be outweighed by the advantages of attending majority white schools. This is an implicit racist assumption and it is also an insult to those dedicated and highly competent teachers in racially imbalanced schools that we have today.

Senator BAYH. I do not believe you submitted a copy of that report for us. Let me then ask you to repeat to make certain that I understand. Does this report say that you should have one and not the other, or does it try just to say that the most important ingredient in the classroom is the teacher?

Mr. KLINE. The report, "Racial Isolation in the Public Schools," states clearly, on page 100:

"Thus the advantages of having more highly qualified teachers seem to be outweighed by the advantage of attending majority white schools."

Further down on page 100 it states:

"The analysis thus suggests that changes in the social class or racial composition of schools would have a greater effect upon student achievement and attitudes than changes in school quality."

Changes in school quality would include the teacher.

Senator BAYH. Well, I do not mean to take issue with you, but it would seem to me that the language of the report makes a relative judgment as to which of the two is the more important. It does not say that both are not imporant ingrediens of better education.

Mr. KLINE. But it said the social class or racial composition is more important.

Senator BAYH. What made me ask the question is that you said the report was an insult to the highly qualified Negro schoolteachers in the minority school areas. I hope that is not the case, because I think what they need is probably better schools and relatively better balance racially, plus good teachers.

Mr. KLINE. I made that statement because it implies that the social class or racial composition of a school is more important than the teacher. This is what I feel is an insult to highly competent teachers.

Volume 2, page 45, of the Civil Rights Commission report, this is an appendix, described the four variables combined to form an index of teacher quality, and "emphasized that other variables could have been included as well." The teacher variables measured by the Civil Rights Commission were average educational level of the school faculty: the percent majoring in an academic subject; the percent wanting to continue teaching in the current school; and the average years of teaching experience.

These variables are of importance. However, they are heavily outweighed, especially in a racially imbalanced school, by the following characteristics: The ability to gain firm, fair discipline; ability to establish rapport with students and guide them to respect themselves; abilty to motvate students difficult to motivate; and insistence that each student achieve to the best of his ability. Variables such as these, while subjective and difficult to measure, must be measured before submitting an completely factual report to Congress that recommends nationwide standards to eliminate racial isolation and would force millions of students to go to different schools if this law were enacted by Congress on the basis of this recommendation.

The reports of the Civil Rights Commission and the Office of Education do present factual evidence to recommend the need for minimum basic achievement standards for all students for promotion as a first step to provide equal educational opportunities. Regardless of the racial composition of the school, most Negro students are denied equal education opportunity if they have a mediocre teacher trying to help them reach these standards. It is discriminatory to Negro students when highly competent Negro teachers are assigned away from their school to go to a majority white school just because these teachers are Negro and they want some Negro teachers in a majority white school. This also deprives these students of teachers that might be the only people who will help them reach equal achievement levels. This also will help them reach equal achievement levels. This is the major problem all students have to achieve basic equal achievement levels to merit promotion.

It is also discriminatory, regardless of the student's race or color, to assign him to the track system. Judge Wright brought this out in his decision on the District of Columbia schools. He brought it out because it led to segregation, but regardless of the segregation factor, it is disciminatory because it downgrades the slower students in a school, whether it is racially imbalanced or where all the students are white.

Another presidential scholar who is helping us mentioned that he was in the top grouping track. Naturally, he would not be in a bottom group. But many other students in the school regarded his group as freaks. This is a very bad situation.

Senator BAYH. Is it your judgment that the track system per se is the culprit here? Is there a means by which we can emphasize the individual different abilities of a student? For example, if you have an exceptionally bright youngster and this youngster is slowed down, it seems to me you discriminate against that individual just as much as if you do not do what you can to pull up the slower learner.

Mr. KLINE. Senator Bayh, in regard to this, we should have a draft of our report, "Searching for Excellence in Education," written into the record at this time. Beginning on page 4 of the report, we have means of motivating the students; this section is described here in the fourth paragraph.

We refer to having students progress at their own rate of speed. This is called the nongraded school system and it is being used in many school systems in our country now. This allows the more advanced students to progress at their own rate. They are not held back. It allows the average students to proceed at their rate and the slower students to proceed at their rate. Each student is treated as an individual under this method. Again, this allows the slower students to avoid being downgraded socially.

Does this answer your objection to this, Senator?

Senator BAYH. Well, I do not impose an objection. I just want to get your thinking. I think what we need, as far as I am personally concerned, is an all-out effort to develop to the maximum those students at all levels, that it is absolutely indispensable to our society to train some of those who are now not trained and thus unemployable. It is also imperative for the safety and welfare and the continued growth of our country to stimulate and develop to the maximum extent of their capabilities some of the real genius that we have in our schools today.

Please proceed.

Mr. KLINE. Thank you.

It must be thoroughly emphasized that equal educational opportunity for Negro students or for any students is not synonomous with attending a majority white school. The Office of Education—Health, Education, and Welfare, of course, handle their compliance now—and the Civil Rights Commission seem to imply this to be true. They also implied that the problem is not only a racial problem, but a social class problem as well. But it is neither. It is strictly a problem to be corrected by a purely educational means, as we have suggested in our report in further sections.

To get equal educational opportunity for all students, it will be necessary to revise some State teacher certification requirements to attract some of America's best students into education and revise teacher tenure laws to protect American schoolchildren from incompetence. But again, this does not require assignment to schools by basis of race.

A high school graduate, who is handed a diploma after reading at a seventh-grade level, is not qualified for equal employment opportunity regardless of where he has gone to school. The point is this educational opportunity must be made equal by equalizing. So most Negro students—and this will definitely apply to many poor white students as well—will have to be brought up in achievement levels so they are qualified for equal employment opportunities.

Recently, the Massachusetts State Advisory Committee to the U.S. Commission on Civil Rights published a booklet called "The Voice of the Ghetto." Quoting from page 23, from a Negro mother, "It is not that I want my child sitting next to a white child. All I want is an equal education for her."

Or, as a college student expressed this sentiment using a play on words, "It is more important to be enlightened than whitened." In short, the racial composition of a school regarding equal educational opportunity is irrelevant. The only value of attempting to assign students by race is to conduct a social experiment that may or may not be practical depending on attitudes existing in the local community. If it can be done voluntarily in a local community, this is desirable, because in our American society, people should learn to live together. However, at this point, especially after the results of this summer, it could be disastrous to force a racial imbalance on students and their parents where the majority of the local community does not desire it. Just a minor unpleasant incident in school can explode into the street and lead to a racial disturbance that could make this summer's happenings seem like a picnic. It might only happen once. But are we to gamble the lives of children and their parents for a social experience in this case, strictly because the Department of Health, Education, and Welfare and the Civil Rights Commission seem to be more interested in a laboratory experiment in our schools than actual equal educational opportunities? Students are treated as black and white statistics rather than emphasizing the statistics of their academic achievement, which is the relevant concern.

A civil rights law is needed to protect students and their parents from groups like the Civil Rights Commission and Department of Health, Education, and Welfare, and some of our State departments of education and State boards of education that insist on assigning students by race.

In this country, we are trying to teach our children the concepts of liberty and freedom and then, we set an undemocratic means of assigning them to school, which is based on an untrue premise. Children and their parents need protection from this unjust and unfair practice. Assigning students to a school to relieve overcrowding is justified, but this is a local school problem.

The Society for Excellence in Education proposes the following law:

"The right of all persons in the United States to choose an educational institution which they will attend or be employed in or from which they will receive benefits of programs or activities qualified to receive Federal and/or State financial assistance shall not be denied or abridged by the United States or by any State imposing assignment standards on the basis of race, color, or national origin."

It is unthinkable that the parents and children should be deprived Federal or State financial aid because they and their parents want to make a choice of their own. Withholding Federal aid or State aid does not punish the school district, it punishes the child and parents. Our proposed legislation will not solve all of the complex problems of discrimination, but can, by its passage, make a significant contribution, and then Federal, State, and local educational legislation and voter action at the ballot box is needed to provide equal educational opportunities for all and equal justice for all citizens in this Nation.

At this time, I and the presidential scholars will be happy to answer any of your questions.

(The prepared statement follows:)

STATEMENT OF FREDERICK S. KLINE BEFORE THE SENATE SUBCOMMITTEE ON CONSTITUTIONAL RIGHTS

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The Commission's report "Racial Isolation in the Public Schools" also contained elements of bias and omission of fact in an attempt to prove their viewpoint that racially imbalanced schools are inherently inferior.

Volume I, page 98 of the report contains a table (table 4) which attempts to measure the average achievement in grade levels of 12th grade Negro students in majority-white schools with comparisons for teacher quality, social class of the Negro student, and social class level of the school. Camparison (E) gives an achievement level of 9.1 for a student of high social class attending a school of low social class level with low teacher quality and 10.7 with high teacher quality. This is a variation of 1.6 grade levels according to teacher quality. Comparison (F) relating achievement of students of high social class attending a school of high social class gives a variation of .5 grade levels according to teacher quality. Comparisons (A, B, C, and D) show less if any variation according to teacher quality. Yet, in discussing these comparisons the third sentence of the last paragraph on page 97 merely states: "Reading down column 1 reveals that the student achievement differences associated with variations in teacher quality are virtually nonexistent in four of the six comparisons (A, B, C, D)."

In further commenting on these and related statistics, page 100 of the report states: "Thus the advantages of having more highly qualified teachers seem to be outweighed by the advantages of attending majority white schools."

"It must be noted again that this analysis deals only with existing variations in teacher quality. It cannot assess the potential effects upon Negro students of improved teacher quality and teaching techniques."

The Commission's analysis is based on the U.S. Office of Education report Equality of Educational Opportunity. The summary of this report states on page 22: "It should be noted that many characteristics of teachers were not measured in this survey; therefore, the results are not at all conclusive regarding the specific characteristics of teachers that are most important." The Commission omits this qualification thereby seriously questioning the validity of their measurements and related conclusions.

As the founder of the Society for Excellence in Education, I would like a draft copy of our first report to accompany this statement. This report proposes a plan of action to correct any inferiorities that may exist in racially imbalanced schools. The Society for Excellence in Education firmly rejects the Commission's suggestion that "changes in the social class or racial composition of schools would have a greater effect upon student achievement and attitudes than changes in school quality." The right to attend the school of one's choice must be respected. The passage of a civil rights law to protect this right is needed to prevent needless discrimination.

Searching for Excellence in Education

First Report of the Society for Excellence in Education

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Introduction

The Society for Excellence in Education is dedicated to improving education and to helping solve related social problems troubling America today. This can be achieved by implementing the recommendations proposed by the Society for Excellence in Education (SEE).

The most urgent social problem facing this country is the conditions in the urban ghettos. This problem begins with inadequate education. Considering that the overall quality of American public education is insufficient, arbitrary racial balance is not the solution.

The improvement of education today is too important a responsibility for educators alone. Because this responsibility concerns all Americans, SEE informs the public about educational issues related to the national interest. Elected local, State and Federal government representatives can then be notified through the power of public opinion so that action can be taken.

The recommendations summarized in this report are the result of research analysis and the experience and observations of teachers, as well as opinions expressed in interviews by the overwhelming majority of thousands of students and former students, ranging from dropouts to university honor graduates, teachers, educators, parents, clergymen, and civic leaders.

SEE membership is open to all adults, students of high school through university level, and former students. Membership is free.

Directing Misspent Tax Dollars Toward Bettering Education

Federal funds are taxpayer's money and millions of taxpayers' dollars are being abused on a nationwide basis. In some cases, they are wasted on repetitions of previous research projects or on projects of questionable merit. In other cases, there is far too much money allocated where results obviously do not justify the expenditures, and in all instances of these misspent moneys there is far too little return for the taxpayers' dollars, especially in education. Before more studies are made those that already have been evaluated as useful must be put into the classroom.

This Nation has spent more money on education per capita than any other nation in the world. But, ironically, it has received some of the lowest educational returns for this investment. For example, the results of the *International Study of Achievement in Mathematics: A Comparison of Twelve Countries* conducted by the International Project for the Evaluation of Educational Achievement, and published in 1967, show that the United States ranked near the bottom for 13-year-olds and at the very bottom for high school seniors. Our low achievement on this test reflects the low standards of education to which our students are subjected.

It is true that our low scores at the high school senior level reflect the large percentage of students who are retained in school. However, many students are not truly being educated, but merely filling classroom space and receiving meaningless diplomas.

Better results can be achieved from the tremendous investment this country has in education by making the following basic changes:

1. *Update outmoded schools to create a reserve of money to be used for better education.*—There is too much emphasis on building more new schools and not enough on the qualities and the needs of education itself, i.e., higher teachers' salaries, library facilities, and additional counseling services. Better planning for school construction could save great costs in maintenance and create the most economical use of space. When new construction is undertaken, teachers should be consulted as to the exact needs for a new school building. In this way the greatest long-run economies can be gained.

2. *Increase the efficiency of teacher training programs and introduce a more flexible curriculum.*

3. *Form a joint committee composed of representatives of the U.S. Office of Education and the recently organized Education Commission of the States.*—This committee would control disbursements of Federal funds to education and thereby eliminate complete Federal control of such funds. It would work in cooperation with tax-exempt foundations and philanthropic organizations. The committee will also approve and coordinate the studies to be done, and distribute the findings of these studies in conjunction with the Educational Research Information Center (ERIC). This organizational change would avoid needless and repetitious investments, as well as reproduction of energy, time, and effort. Tax dollars will thus be spent more efficiently and with better direction.

The money saved through these proposed changes could then be redirected to raising teacher salaries, to supporting teacher aides, volunteers, and home visiting aides, and to expanding headstart and similar education programs. As a result, the quality of teaching will be improved and taxpayers will begin to receive a satisfactory return on educational investments.

STRENGTHENING SCHOOL-COMMUNITY RELATIONS

It is increasingly obvious that in many communities there is a lack of understanding and cooperation between school and community. This problem demands that a common and shared understanding be developed between the community and its schools in terms of their respective needs. Part of improving education is improving public relations.

One of the public-relations functions of a school system is to educate the public about its operations, activities, and special events, in the hopes of stimulating participation. Unless the community is involved, education cannot fulfill its potential.

The school system, as a public service organization, is accountable to the community and must be sensitive to the needs of students. Parents must be informed about the school's program if they are to cooperate with the school's efforts to teach and to guide the students. Through an open-door policy parents can be encouraged to be active in school affairs. Mothers trained to act as teachers' aides can be utilized in supervising study halls and general monitoring of the building.

Schools must not necessarily be used only for education of children. All schools can be kept open for more hours on a year-round basis. The redirected savings can help support adult education programs, youth and adult recreation programs both in winter and summer, amateur community theater productions, etc.

The local communication media—newspapers, radio and television also can work to strengthen school-commodity relations by publicizing the achievements of students, faculty and administration. Criticism should be fair, dispassionate, and editorially constructive.

DEVELOPING EACH STUDENT'S MOTIVATION FOR LEARNING

Lack of motivation is a major problem in our public schools. Stagnant school systems have not concentrated on stimulating the students' dormant motivations. Presently, many students come to class with negative attitudes and feelings of frustration, regarding school as a prison which they must attend because the law says so, or as a place to fool around and waste time. The role of firm, fair discipline should be to make the student aware that he is in school for the purpose of gaining an education and that this can be a satisfying experience. The student must always know why he is in school, what he is to accomplish and what is expected from him. The school, in turn, must provide a direction for his development.

Many methods for stimulating and increasing motivation may be used. One of the most effective is the teacher's appeal to the student's sense of self-worth and respect, in combination with his ego ideal and interests. Reaching the student in terms of himself makes the whole educational process more interesting and exciting. The heroes of the youth culture, such as entertainers and athletes can aid this process by making films stressing motivational themes that will encourage the student to do his best work. Use of peer group incentives also can be used to further stimulate motivation and gain cooperation.

Athletic coaches can also fill the role of guidance counselors, for the coach represents the ideal of manliness toward which the boy strives. Identification is obvious, and can be very beneficial for troubling cases.

The method of programed instruction where feasible for use with basic skills, combined with emphasis on use of problem solving, is one of the best ways to motivate and insure educational success. This technique allows the student to progress at his own speed; he cannot advance to the next section until he has mastered the prior material. This will reduce lectures to a minimum, thus freeing the teacher and his aides to act more as tutors and counselors offering more individual attention to the student. Programed instruction will help to motivate the slow student by letting him work in the same classroom with the high achievers. He will not be downgraded socially by being placed in a class with all slow learners, and may be spurred on to do better. If used on a national basis, programed instruction would insure at least minimum standards and consistency in educational levels. Furthermore, students who are currently enrolled, those who are out of school, or those unemployed could be trained to work with students using well-prepared programed instruction.

By not restraining the more capable student and offering him more personal attention, student motivation at every level will improve, while increasing the return on our investment in education. Standardized programed instruction, if made available to rural schools as well as big city schools, often could eliminate the need for costly school consolidations. Advanced high school courses or advanced standing college courses could then be offered to select students in all school districts.

Institution of the nongraded school system with promotion by individual subject will best serve the needs of all students. A marking system of complete and incomplete would be used, coupled with a written evaluation. Automatic social promotion and undeserved high marks stifle initative and lead students to believe they can receive something for nothing. In a sense then, the school deceives the student and the parents and performs a disservice to them. Promotion by individual subject is achieved after the student completes the course work at his own rate. Those taking similar courses should be expected to achieve the same basic level of work. The student must learn to earn promotion.

More opportunities for independent study should be allowed because it helps the student to become more self-reliant. He must be free to work by himself in order to achieve more fully success in learning and be a responsible person in a competitive world.

Class size also is related to motivation. Classes at early learning stages of the child's development should remain small because these youngsters need more individual attention. With the additional use of programed learning in the upper elementary and secondary school classes, personal attention from teachers, assisted by tutors and aides, would continue to stimulate the student in larger classes.

Healthy student motivation can be maintained if the student is made to feel that he is a vital part of the school. Social experience and the opportunity to express himself verbally, to understand others' viewpoints as well as his own, to learn to dissent in a socially acceptable manner, can be provided for by the school through discussion groups, clubs and organizations, and by allowing the student to help those who need assistance. Such provisions will help to develop intellectual curiosity, leadership, self-esteem and responsibility.

A curriculum which is meaningful and relevant to today's problems is essential to maximum motivation. Interested students could evaluate each of their subjects and join with teachers and research specialists on committees devising new curriculums. These new curriculums can then be tested and evaluated directly in selected classrooms. Literature, social studies and cultural enrichment courses can be designed so that students can identify with their regional, racial and ethnic group interests and become aware of the contribution of cultures that are different from their own. Lack of objectivity, clarity, and accuracy has obscured the achievements and cultural heritage of American minority groups and is a factor in the low motivation of some minority group students.

UPGRADING INADEQUATE TEACHER EDUCATION PROGRAMS

James B. Conant, former president of Harvard University, and other prominent American scholars have leveled valid criticisms at our teachers' colleges and schools of education. Teacher education and training programs must be

greatly revised if America is to produce high quality teachers and high quality education.

There has been too much use of the terms "culturally deprived" or "disadvantaged" students in reference to their background. The fact is that any student is disadvantaged who has a poor teacher. It can also be said that our teachers are disadvantaged. They are the victims of a poor teacher education system. In order to insure better coordination between the theory of teaching and its practice, measures must be immediately instituted to bridge the gap.

Education courses at the college level are often far too abstract and too removed from the realities of everyday classroom situations. A sensible program would require more courses in a trainee's academic major area coupled with condensed education courses taught by an active or former classroom teacher to give reality to the training. The trainees, in small groups, would also observe selected teachers in their classrooms. Teacher trainees then would undergo a practical, in-class teacher-aide program including tutoring, which would increase their student teaching experience while eliminating the need for so many education courses.

At this time, the majority of our most educated people enter fields other than education. The main reasons are that teaching lacks prestige and adequate financial compensation, and its professional schools are burdened with trivial, time-wasting courses. To give teaching the status it is due, certain changes and reorganizations in existing structures must be made.

One factor in improving prestige is success. In order to experience success teachers must work in improved schools and with colleagues they respect. A second source of prestige is creating an image of importance in the eyes of the students and the community. The teacher prestige can also be improved by giving the teachers more freedom from controls. Teachers, not the administrators, are the key to educational success. Perhaps the most important way is to provide the teachers with faster advancement combined with commensurate salaries.

An innovation to counter these problems is the creation of the master teacher. He is one who can serve as a classroom teacher, instructor of teacher-trainees, and a contributor to policymaking. His selection would involve a combination of factors, such as evaluations of directors of student teachers, peer group judgment and teaching experience. Certification as a master teacher would come from a teacher's college, subject to periodic review by the above, plus the evaluation of teacher-trainees whom he instructs. The master teacher's salary would be adjusted upward towards administrative levels and would act as an incentive to keep the better teachers in the classroom. Master teachers could teach larger classes, assisted by tutor and/or aides. It is better for many students to have one fine teacher than to have smaller groups being taught by a mediocre instructor. This is especially necessary to attract and retain experienced superior teachers for classes difficult to motivate. Higher salaries for teachers are not enough to make a mediocre teacher a good one. Higher standards and certification requirements combined with higher prestige and morale are necessary.

To further improve the programs of teacher education, a committee established by the education commission of the States could prepare the details of certifying teacher training institutions and the teachers. Some amount of standardization of quality is necessary because the levels of education from one system to another and from one State to another vary so greatly. However, flexible certification requirements are needed with credit given for equivalent preparation. These suggestions are, of course, subject to approval of the individual State. The teacher and/or the student who is forced to change areas will usually see little or no consistency. This would imply at least minimum basic national standard curriculums should be established subject to approval of the individual school district.

EQUALIZING EDUCATION OPPORTUNITIES FOR ALL

The present lack of equality in educational opportunities for all is just as serious a problem as the lack of truly excellent quality of education. According to the report, "Equality of Educational Opportunity" by the U.S. Office of Education:

"One implication stands out above all: That schools bring little influence to bear on a child's achievement that is independent of his background and general social context; and that this very lack of an independent effect means that the inequalities imposed on children by their home, neighborhood, and peer environment are carried along to become the inequalities with which they

confront adult life at the end of school. For equality of educational opportunity through the schools must imply a strong effect of schools that is independent of the child's immediate social environment, and that strong independent effect is not present in American schools."

A related report by the U.S. Civil Rights Commission, "Racial Isolation in the Public Schools," suggests that "changes in the social class or racial composition of schools would have a greater effect upon student achievement and attitudes than changes in school quality." (This suggestion is based on an incomplete analysis of existing variations in teacher quality which failed to include the teacher's rapport with students and the ability to motivate them.) They recommend standards to eliminate racial isolation as a remedy. To accept this as a solution to equalizing educational opportunities relegates certain schools to an inferior status.

Focus must be placed instead on acquiring excellent teachers who can motivate students, and on the elimination of racism and social class distinctions existing in education. This would be a constructive start to eliminate the present educational inequalities.

It should be remembered that each student is an individual and should be treated like one. A way to respect differences among people, particularly white and nonwhite, is to leave each free to choose which schools to attend within their school district.

Congress should enact a law to forbid a State and/or the Federal Government from assigning children to schools on the basis of race. It will make the Massachusetts racial imbalance law illegal as well as HEW guidelines. The law must cover both students and teachers in situations regarding racial imbalance. The law might read:

"The rights of all persons in the United States to choose an educational institution which they will attend, or be employed in, or from which they will receive benefits of programs or activities qualified to receive Federal and/or State financial assistance—shall not be denied or abridged by the United States or by any State imposing assignment standards on the basis of race, color or national origin."

The Society for Excellence in Education (SEE) has presented, in summary, its program for alleviating the most serious problems in American education today. SEE, a nonprofit organization, serves as an information agency to make the public aware of educational problems and issues. It also serves as liaison agent between the community and the school system, acting as a forum to promote understanding and cooperation between them, and as a body through which the community can demand and develop excellence in education.

SEE intends to conduct a survey by distributing this report to those most interested in education—students, teachers, parents, administrators, educators and public officials in order to receive critical comments or suggestions to improve it. It is expected that excellence in education will be a key political issue at local, State, and national levels for the 1968 campaigns. In this way, the SEE program will develop, either through modifications or expansions, according to suggestions offered in the evaluations. Thus, with flexibility, SEE will serve the best educational interests of students, teachers, communities, and the Nation.

After school opens in September 1967, SEE will publicize its program on a nationwide basis. This will allow sufficient time for planning and organizing a conference to be held during the summer of 1968. Representatives should be invited from the U.S. Office of Education, the education commission of the States and from among administrators, teachers and students. The conference will be designed to develop a pilot program to be used in school systems which volunteer to try it. Implementation of the SEE program will result in equalizing educational opportunities for all and the excellence in education for which we all strive.

Senator BAYH. I think I have impolitely interrupted your statement. I have no further questions.

Do all of the scholars share your thoughts on this matter?

Mr. KLINE. I'll let them make their own comments, Senator Bayh.

Mr. TROSPER. We have talked this over, last night, back at the university. We talked particularly about the track system, the constitutionality, the equal opportunity of that. I was the only one of us who had the track system.

I believe I see Mr. Kline's point. Unconstitutionality is a harsh-sounding word, but I think he is right. The idea of programed instruction, et cetera, does sound, to me, at least, like a better way of allowing social contact between students

of different intellectual achievement. The idea of the track system—it works. It worked at our high school. But I can easily see—as Mr. Kline points out now—I had not been thinking about this particularly much until Mr. Kline met with us and I have been thinking a good deal since—that it would easily be harsh on the fellow who is put in the high track and looks, as the other scholars said, like a freak, to the one in the low track, who looks like an equal freak.

Senator BAYH. You were in a track system?

Mr. TROSPER. Judge Memorial Catholic High School. We had a track system there.

Senator BAYH. How many tracks?

Mr. TROSPER. We had one college preparatory with emphasis on science. There was one with more languages, one that was more or less commercial. The school could not quite cater to a commercial background, of course. But it being the only Catholic high school in the city or for some distance around it, had to have some kind of program. It had mechanical drawing, that sort of thing, there was that track.

Senator BAYH. Which one were you in?

Mr. TROSPER. The top track.

Senator BAYH. Did you feel like a freak?

Mr. TROSPER. On occasion, sir. I do not know for sure about the rest of the people in my division. I, for one, did not participate in extracurricular activities to any great extent, was highly unathletic.

Senator BAYH. Maybe I ought to rephrase my question. Was your membership or was your assignment to this track responsible for your feeling that way?

Mr. TROSPER. I would say "No." I am agreeing with Mr. Kline's suggestions. I am saying also, since you asked, that I cannot offer any personal experience of my own to substantiate it.

Senator BAYH. I do not think we are here to try to determine whether the track system is good or bad. I think all of your thoughts are helpful to us on this.

Mr. TROSPER. If you will excuse me, sir, just one thing, also. I think what we are trying to find out—from what you said—it sounded like whether or not we presidential scholars here at the moment were in agreement with Mr. Kline. I think generally we are. We have not been listening particularly to other versions. We have met them before, of course. We agree with Mr. Kline at the moment, the last fellow we have had arguments from, and very good arguments, too.

Senator BAYH. Perhaps you can come back and let us have the benefit of your thoughts after you have listened to someone else. I say that facetiously.

Are the three of you in school now?

Mr. TROSPER. Catholic University, Washington, D.C.; yes, sir.

Senator BAYH. All three of you?

Mr. TROSPER. The girls are sophomores. I am a junior.

Senator BAYH. We appreciate your coming.

Mr. Kline, thank you for letting us have the benefit of your thoughts.

Mr. KLINE. Mr. Chairman and members of the subcommittee, I am Frederick S. Kline, founder and director of the Society for Excellence in Education.

Mr. FLOOD. Is there anybody against excellence in education?

Mr. KLINE. I don't know but there are conflicting views on how to achieve it.

I am pleased to have this opportunity to suggest essential legislation to prevent any future HEW appropriations intended for the benefit of needy American schoolchildren being withheld because of misinterpretation of the concept of equal educational opportunity.

Legislation designed to achieve this objective is as follows: The right of all persons in the United States to choose an educational institution which they will attend or be employed in——

Mr. FLOOD. "Employed," what does that mean?

Mr. KLINE. Employed in teaching—or from which they will receive benefits of programs or activities qualified to receive Federal and/or State financial assistance shall not be denied or abridged by the United

States or by any State or school district which receives Federal financial assistance imposing assignment standards on the basis of race, color, or national origin or assigning students outside of their residential attendance zone except for physical, academic, or emotional differences.

To conserve your time and yet present a necessary explanation, I would like part of my statement of September 27, 1967, before the Senate Subcommittee on Constitutional Rights of the Committee on the Judiciary to be inserted following this statement.

The complete war on ignorance program of the Society for Excellence in Education is now being drafted and will be presented after completion to all members of this subcommittee and other concerned Members of Congress.

For the schools to provide equal educational opportunity, to the extent they are capable of, each student must be given the opportunity to achieve to the full extent of his potential. By this criterion only a small percentage of American students, regardless of their hereditary or environmental background, are offered equal educational opportunity by their schools.

The May 1968 issue of the Ladies Home Journal has an article briefly describing America's 10 top high schools as selected by a panel of experts. While some educators may disagree with the selections, brief comments on two of the schools chosen will help to clarify the concept of equal educational opportunity. Melbourne High School in Melbourne, Fla., and Nova High School in Fort Lauderdale, Fla., allow students to progress at their own rate of comprehension. This is one essential of equal educational opportunity. To attempt and teach individual students with unequal potentials as one equal mass is automatically unequal. Both schools, however, do group students by ability which is unnecessary and also discriminatory, as explained in my testimony of last September.

Both schools spend less per student than the national average, although Nova has a 200-day school year. Money alone is not the answer to quality education, but more will be needed to provide equal educational opportunity to students eligible for title I assistance, combined with an educational approach that is sound for all students.

When children enter kindergarten or prekindergarten, emphasis must be given to developing good work habits along with verbal skills and reading readiness. A careful diagnosis of each child must be made and those children who are considered mentally retarded placed in an appropriate class. Mentally retarded pupils must be given special attention, and to place them in a clasroom where they cannot hope to do the academic work prevents them from receiving equal educational opportunity. These children may eventually be able to benefit if placed in a normal classroom and should be if and when it is to their benefit.

The children capable of functioning in a normal classroom should be placed in the first grade as they are ready to read and not before. These children should be expected to achieve at basic minimum standards or higher for each academic subject before being promoted to the next grade or level, which should be determined by the learning rate of the child and not by an arbitrary date for group promotion or failure.

This will prevent students being failed and having to repeat material they may already know, and also prevent the opposite extreme of promoting students who have not learned required material that will be needed as a foundation for the next grade. Many students are promoted without doing their work because of the teacher's low expectational level of the child combined with an inflexible educational organization. Children in the fourth grade should all be able to read at a fourth-grade level or higher. The current emphasis on comparing average achievement scores between schools fails to cover the concept of equal educational opportunity for the individual child.

Along with standards for achievement, emphasis on developing good work habits and self-discipline combined with good motivational techniques are needed to help each student make the most of his time in school.

In addition, many other educational problems must be corrected for students to have equal educational opportunity. Unfortunately, the Equal Educational Opportunities Division of HEW appears to be neglecting them while expending their efforts and the taxpayers' money on the issue of a school's racial composition. This often deprives students of an equal educational opportunity by taking educators' time away from compliance with needed educational improvement to compliance with arbitrary racial assignment of students and teachers. This is a disservice to American schoolchildren, to their parents who are responsible for educating them, and to all Americans who believe in true freedom and equal educational opportunity.

In the past when schools were legally segregated, some children were denied the freedom to attend the school of their choice because of their race. This deprived them of equal educational opportunity by degrading them and lowering their self-respect.

Now that schools are legally desegregated, some children are still denied the freedom to attend the school of their choice because of their race. Reverse discrimination also deprives them of equal educational opportunity by lowering their self-respect due to inability to control their own destiny.

If appropriations are to be continued for the Equal Educational Opportunities Division of HEW, this discrimination must be prevented by the legislation suggested.

Thank you.

Do you have any questions, Mr. Chairman?

Mr. FLOOD. Are you an educator?

Mr. KLINE. I was a former teacher.

Mr. FLOOD. Where were you born?

Mr. KLINE. Detroit, Mich.

Mr. FLOOD. How old are you?

Mr. KLINE. Thirty-eight.

Mr. FLOOD. How long have you been with this organization?

Mr. KLINE. About 2 years.

Mr. FLOOD. Thank you.

Mr. KLINE. Thank you.

(The following statement was submitted for the record.)

MOTIVATIONAL TALK ON POSITIVE THINKING

(Prepared for the Society for Excellence in Education)

POSITIVE THINKING

I. Introduction—James Brown awarded for dropout record.

II. Education is important because without it most employers won't even consider hiring you for a good job. Getting a college diploma is necessary if you want to be a doctor, lawyer, teacher, social worker, engineer, or at least a high school diploma is needed to be a secretary, tool and diemaker, airline hostess, and most other jobs. But waving a diploma in someone's face is not always enough to make you successful. Some things that successful people have in common are often learned on your own, outside of school.

III. James Brown although a dropout himself, has learned these things better than many college graduates so he can make use of the talent he has to reach the top. Other people with more talent and ability fail to accomplish what they are capable of because they have not learned how to control their thinking and actions and use common sense. They often use the excuse that their luck is bad but this is not the answer.

James Brown, The Supremes, Thomas Edison the inventor, and George Washington, our first President, all learned how to control their thinking and actions and became successful even though they lived during different periods of time and had to overcome hardships.

IV. Let's try an experiment now and find out how well you can control your thinking and actions by concentrating on two simple sentences. First, tell yourself I canot lift my left foot—now tell yourself I can lift my right foot. Please lift your right foot. Try and lift your left foot.

V. If you concentrated your thinking you can tell it is easier to lift your right foot. If you can't tell any difference, you need to concentrate more or you may not have gotten enough sleep. How many were able to lift their right foot easier than their left foot?

VI. This experiment demonstrates to you it is easier to do things when you think that you can do something. We call this positive thinking. Than when you think you can't do something, we call this negative thinking.

It is just commonsense to use positive thinking and make things easier for yourself. Isn't it?

VII. There are three different times to use positive thinking.

A. First think positive about yourself. This means having self-confidence and self-respect. Everyone can do some things well and other things not as well. The Supremes are wonderful singers but they are not skilled medical doctors. It's a waste of time to think and complain about things you can't do well. Negative thinking only makes everything harder to do and can often make a person sick. Many headaches are caused by worrying about things. So think positive about what you can do well and that you will improve in other things. Remember the last four letters of American spell I can.

VIII. This leads into the second way of using positive thinking. Thinking positive about whatever you are doing. If you make a mistake you can't change what you did, but you can learn from the mistake and correct what you are doing. It may even be good luck that you make mistakes at certain times so you can learn the right way to do it later on when it is more important. Everyone should have a goal and it is best to have more than one goal in case things change. Set your own goals. Winners never quit and quitters never win. We have to keep on trying. Then action is needed just thinking positive without doing anything about it is only wishful thinking, you must plan your work and work your plan. If you think classes are boring and teacher makes you sick, you make yourself tired. Think of a reason for each class. Even if you can't think of a reason for the class, try and become interested in it; everyone has to do things they can't think of a good reason for. Being quiet in school has a reason, in fact, two good reasons—get work done and get less tired. So even when a substitute comes instead of wasting time making noise, think of something useful to help you reach your goal.

Do these things with enthusiasm and look at school work you don't know as a challenge of somethting you want to learn. Make time work for you, not against you. Don't waste it. It took James Brown, the Supremes, Edison, Ford, years to accomplish their goals and they kept enthusiastic regardless of how long it takes.

Take one step at a time once you reach your goal keep on trying to stay there. Joe Louis example.

IX. The third way of using positive thinking is think positive about other people. Don't have to agree with everything a person is doing. You can always ask another person with commonsense about changing instead of calling them names, and often they may see your point of view and agree with you. Two people, one with intelligence thinks negative about other people, thinks he knows it all. 1,000 facts. Take another person with less intelligence who has many friends and asks them. Others will help but you can't depend on them to do it for you. Treat others the way you want to be treated. Someday that person or the other will help you, law of averages. It's not just who you know, it's why you know them. Good to meet many people. If you respect yourself you will respect other people. It's nice to be important, but it's more important, to be nice.

X. You must think positive about yourself, practice long enough and get along with other people. List your goals, look at them every day and revise them if necessary. You must do this every day because it will take several days or several months before you can tell the difference. By thinking positive every day, success becomes your habit and like a ball keeps rolling along once it gets started. If you have bad luck and think negative now, you must change and get used to doing positive thinking. Do it now.

MONDAY, APRIL 29, 1968.

PROGRAMS FOR CHILDREN WITH LEARNING DISABILITIES

WITNESSES

ROBERT RUSSELL, DIRECTOR OF SPECIAL SERVICES, NORTHERN VALLEY REGIONAL HIGH SCHOOL DISTRICT OF CLOSTER, N.J.
WILLETTA W. SILVA, EDUCATOR, BUCKS COUNTY, PA.
SHELDON R. RAPPAPORT, PRESIDENT, PATHWAY SCHOOL, NORRISTOWN, PA.

Mr. FLOOD. Now we have the Association of Children With Learning Disabilities.

Proceed, Mr. Russell.

Mr. RUSSELL. Mr. Chairman, the Honorable Daniel J. Flood, and members of the Appropriations Subcommittee for the Departments of Labor and Health, Education, and Welfare, I want to thank you for this opportunity of presenting to you, on behalf of the Association of Children With Learning Disabilities, the problems our association faces in serving children with special learning disabilities. I am Mr. Robert Russell, director of special services of the northern valley regional high school district of Closter, N.J., president of the ACLD, and a parent of a child with learning disabilities. Assisting in presenting the testimony is Mrs. Willetta Silva, an educator from Bucks County, Pa., the second vice president of ACLD, and also the mother of two children with special learning disabilities. The third member of our panel is Dr. Sheldon R. Rappaport, a clinical psychologist and the president of the Pathway School in Norristown, Pa.,

Mr. FLOOD. This seems to be a regional operation.

Mr. RUSSELL. No, sir. We are a national organization. We are affiliated in several States. Some of them are: Pennsylvania, New Jersey, New York, Vermont, Massachusetts, Connecticut, Illinois, Oklahoma, Texas, Colorado.

We are growing very rapidly. We are a very new organization,

grown to a complex unit of over 200 local and State groups, currently representing more than 6,000 families. Our newsletter, Items of Interests, reaches 23,000 persons across the country. This rapid growth is a reflection of the increasing public interest and concern regarding children with special learning needs.

Seven State legislatures have already enacted legislation to establish programs for such children. Several Federal and private agencies have appointed study committees or sponsored conferences to discuss this area of handicap.

The first public report of the National Advisory Committee on Handicapped Children, which was created under the provision of title VI of Public Law 89–750, the Elementary and Secondary Education Amendment of 1966, reports that of the many areas of special education needing development, particular consideration should be given to the area of special learning disabilities. The function of the national advisory committee is to review the structure and function of the new Bureau of the Education of the Handicapped, to delineate crucial issues, discuss them, and make recommendations toward developing a solution of these issues. This report, made public in January of 1968, selected special learning disabilities as one of the four current issues crucial at this time.

To enable you to appreciate the kind of children we are concerned with, I would like Mrs. Silva to define and describe the population we are serving.

Mrs. SILVA. Mr. Chairman and members of the committee, as an educator, I want to inform you about one of the more perplexing problems facing school people today—that of the increasing numbers of children in our midst who have good or superior intellectual potential, but who have difficulty acquiring academic skills. Behind the facade of our modern school buildings whose architectural grandeur conceals the tragedies within, there exist children with unique learning and behavior problems. Despite the excellence of progress in curriculum development in the past years, there exists the paradoxical situation of children who cannot learn, even though considered to be of adequate intelligence. These children are not primarily emotionally disturbed, although emotional problems may exist. They are not mentally retarded, but they are often found in classes for the retarded or in one of the school's slower sections. They are not blind or deaf, but they usually have visual and auditory perceptual problems that as yet cannot be easily defined. These children are often known as learning-disability children. Since case studies tend to indicate that their learning and sometimes accompanying behavioral deviations are related to central nervous system dysfunction, they are sometimes referred to as brain-injured or perceptually handicapped.

Mr. FLOOD. Your brochure indicates there is a minimal brain condition or problem.

Mrs. SILVA. Yes, there is.

Mr. RUSSELL. This is not our brochure. It was prepared by the National Institutes of Health.

Mrs. SILVA. We mentioned the brochure.

In a statement from "Progress in Learning Disabilities—Phychoneurological Studies in Childhood," Dr. Helmer Myklebust, an ACLD professional advisor from Northwestern University, indicates that

"it is assumed that some children do not learn normally, though they have no impairment of hearing and vision, are not emotionally disturbed or cerebral palsied, and are of average intelligence. Moreover, it is recognized that when children have these integrities, with adequate opportunity for learning, their deficiency may be explained by a dysfunction in the brain. A child might not learn adequately for his age and ability for a number of reasons. When underachievement persists, it is the role of the diagnostician to determine the reasons for the inferior performance. To have a learning disability is to have one of the conditions which lead to underachievement, there is a discrepancy between potential and actual success in learning. A learning disability, however, differs from other types of involvement in that the deficiency can be attributed to neurogenicity, to a dysfunction in the brain."

An expansion of this description is the definition which has been formulated by the National Advisory Committee on Handicaped Children. This definition states: "Children with special learning disabilities exhibit a disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written languages. These may be manifested in disorders of listening, thinking, talking, reading, writing, spelling, or arithmetic. They include conditions which have been referred to as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, developmental phasia, etc. They do not include learning problems which are due primarily to visual, hearing or motor handicaps, to mental retardation, emotional disturbance or to environmental disadvantage."

From an educational standpoint, special learning disabilities must be identified primarily through psychological and educational diagnosis. The total number of children involved has been difficult to estimate since adequate diagnostic criteria have only recently evolved and comprehensive studies of incidence are yet to be completed. To assist the committee with the magnitude of the problem facing public schools today, I would like to have Dr. Rappaport present some significant figures regarding incidence.

Dr. RAPPAPORT. Mr. Chairman and members of the committee, although comprehensive research on the incidence of children with learning disabilities remains a product of the future, we do have some idea of the magnitude of this national problem.

Mr. FLOOD. Ph. D. in social studies?

Dr. RAPPAPORT. Clinical psychology.

Mr. FLOOD. A doctor of medicine as well?

Dr. RAPPAPORT. No, I am not.

At the 1967 International Convocation on Children and Young Adults With the Learning Disabilities, Commissioner Howe, of the U.S. Office of Education, cited 7 percent of this country's schoolchildren as unable to succeed in regular classes because of this handicap. At a meeting in Colorado Springs called by the National Institute of Health in April of 1967, Dr. Janet Hardy of Johns Hopkins reported that, based on their 8-year perintal study, 18.4 percent of our Nation's children can be expected to show sufficient indication of brain dysfunction to warrant careful, continuous clinical followup or intervention. The prevalence of all forms of reading disabilities is established at 15 percent of the school-age population.

Recognizing that those figures represent overlapping groups of children, it is safe to assume that the handicap of learning disabilities disrupts the lives of at least 3 million of our Nation's children and their families, and more likely it disrupts the lives of close to 8 million of our Nation's children and families.

Because we do not have, as yet, established preschool programs that could prevent the main symptoms of learning disabilities from occurring, and because research has not as yet shown us how to prevent this handicap completely, our burgeoning population can only result in even a greater number of children being affected by learning disabilities.

Mr. FLOOD. Have you been identified with any part of the Office of Economic Opportunity, like the Headstart program?

Dr. RAPPAPORT. I am sorry?

Mr. FLOOD. Have you been identified with the Headstart program?

Dr. RAPPAPORT. I am familiar with the work in the area; yes.

Mr. FLOOD. You have not been identified with it?

Dr. RAPPAPORT. I have not been identified with it; no.

Mr. FLOOD. I mean by "you," your organization.

Mr. RUSSELL. No, we have not been specifically identified with it. We are interested, very interested in it, though.

Mr. FLOOD. I am sure of that.

Mrs. SILVA. In view of these incidence figures, it is important that we consider the services available to these children, in terms of public school facilities in the United States and existing teacher-training programs.

In a recent analysis of the title VI–A, ESEA State Plans, submitted in 1965, the 45 States who developed State plans indicated that within their States there were a total of 19,532 learning-disability children being serviced within State and public educational facilities. Employed to teach these children were 1,596 teachers and clinicians. These same 45 States indicated that their census listed 685,779 children who were without services in 1965. The analysis indicated a need for 56,122 trained teachers and requested funds of $58,581,894 to develop and improve special education within those States.

A survey developed by the State representatives of the Division for Children With Learning Disabilities, a new branch of the Council for Exceptional Children, illustrated the extreme shortage of services in the States. In 22 States reporting, representatives listed 38 private facilities and 705 public school classes. It is interesting to note that of the 705 facilities, Texas provides 431 classes. The lack of public school facilities can be traced to inadequate teacher training programs.

Mr. FLOOD. Are they all over the State of Texas?

Mr. RUSSELL. We don't know of the precise location of these classes. This was just the total that we have gotten from this particular source.

Mrs. SILVA. In April 1966 Dr. Sam Kirk, chairman of the ACLD professional advisory board and director of the Institute for Research on Exceptional Children at the University of Illinois, testified before the Ad Hoc Subcommittee on the Handicapped of the Committee on Education and Labor, House of Representatives. Dr. Kirk stated:

> Only four colleges in 1964 had proposed college programs to train teachers in the area of learning disabilities. Two years later, in 1966, approximately 10 such programs were partially supported by Federal legislation—Public Law 88–164.

In 1968, figures from the U.S. Office of Education indicate that there are only 20 colleges with programs to train teachers in this area.

When an examination is made of the funds awarded for teacher training programs in other areas of handicapped children, the facts indicate that in award year 1968–69, funds to train teachers of the mentally retarded amounted to $6.6 million, funds for the speech and hearing disabilities received $3.1 million, and the category of the emotionally disturbed received $2.6 million. In contrast, funds to train teachers under the heading of "Other health impaired" amounted to less than $1 million. This area includes learning disability children. Of the total moneys allotted for all areas of the handicapped in award year 1968–69, $19.2 million, only approximately 5 percent went into teacher training programs for the learning disabled. That percentage is not commensurate with the incidence figures.

One of the factors relating to inadequate fiscal expenditures is the failure to give the learning disability child an identity in legislation. At present, this term does not appear within the guidelines of Federal legislation. The identification of learning disability children as a legal entity is one of the major goals of ACLD.

Perhaps Dr. Rappaport can provide further information on the national impact of inadequate teacher training facilities.

Dr. RAPPAPORT. The problems attendant to training teachers for the exceptionality of learning disabilities can perhaps best be understood in the broader context of funds allocated to solve the problems of that exceptionality in general. In turn, the funds needed for that exceptionality must be viewed in terms of funds needed by special education as a whole. In this vein, it is highly significant that the national average of per annum cost per person served is as follows:

Special education	[1] $217.50
Regular education	562.00
Mental hospitals	2,544.05
TB hospitals	5,737.80
Chronic illness in general hospitals	6,901.15

[1] Taken from "Education in the Seventies: Report of Program Planning and Evaluation," U.S. Office of Education, as yet unpublished.

Obviously, the funds expended to alleviate the suffering in the exceptionalities encompassed by special education are both disproportionately small and pitifully inadequate for what needs to be accomplished for millions of American families. Considering the fact that learing disability children comprise by far the largest group receiving service under the aegis of special education, the comparative pittance spent for them must doom them to lifelong ineptitude. If that is allowed to happen, this Nation's greatest resource, mentality, will be wasted. That surely would be the great American tragedy.

To deprive the millions of learning disability children of their right to overcome their handicap, so that they can utilize their inborn potential to become self-respecting and productive citizens, would also add immensely to the economic burden of our society. When deprived of the benefit of an appropriate habilitative program, these children cannot earn the income needed to contribute to society, which they would earn otherwise. Moreover, when deprived of the benefit of an appropriate habilitative program, these children often are unwittingly and inappropriately consigned to the ranks of the mentally subnormal who require lifelong subsidy. Even more unfortunate and costly, both

in terms of dollars and pain to the families, when these children are deprived of the benefit of an appropriate habilitative program, they often vent their frustrations and hurt pride in antisocial acts. Thus they become wards of the court.

Today, 35.9 percent of those arrested in our country are referred to juvenile court, and 3 percent of those incarcerated in correctional and training institutions are under 15 years of age—20,500,000 children. Although there are no figures on how many of those children got there via the route of learning disabilities, or brain dysfunction, experience indicates that there are many. Thus added to the costs of institutionalization and welfare subsidy is some portion of the $30,990,000 spent annually on penal institutions, most of which could be saved if children with learning disabilities were given the opportunity for adequate habilitative programs.

In the book entitled "The Teacher of Brain-Injured Children," edited by William M. Cruickshank and published in 1966, I wrote:

> Such a conceptual framework also enables the clinician, including the school psychologist, to transcend the immediacy of his measuring instruments, so that he does not accept intelligence as being nothing more than an IQ, or personality as nothing more than a Rorschach profile, or neurological integrity as nothing more than an EEG pattern. Instead, it insists on investigating which factors are responsible for a child not functioning at his grade level and for his not achieving one academic grade per year. It also insists on the clinician determining if those factors can be overcome, and if so, how. It means that all situations in which the child is involved, including the classroom, will be opportunities for diagnostic observation which continuously supply data to the treatment team; data they need in order to identify the ego insufficiencies resulting from brain damage and to facilitate the transition of those insufficiencies into skills. To accomplish that, at one time the neurosurgeon might lead the team, at another the psychotherapist or the educator. Regardless of who leads, the goal always is to built intact and functioning ego skills. All members of the team—which includes, among others, the educator, the pediatric neurologist, the psychotherapist, the parent counselor, the parents, and the visual-motor specialist—are intent upon the goal of aiding the child to develop those skills which he lacks because of neurological impairment to the development of his ego.
>
> For the those who beileve that it is unrealistic to instrument such a team approach in public education, one should at least be cognizant of the possibility that the team approach would substantially reduce the total amount of time required for these children to spend in special education classes and, of equal importance, to sustain the gains made in such classes after returning to regular class. Then undoubtedly it would be less expensive to use the multidisciplinary team in public education and thereby to enhance the opportunity for these children to go on to regular class and to become self-sustaining citizens than not to use it and bear the expense of special classes which do not habilitate the youngsters and prepare them only for being lifelong expenses to society.
>
> In our work thus far we have encountered a mean stay of 3 years per child. We estimate the cost of the team approach in public education to be $1,372.50 per child per year in addition to expenses regularly encountered in special education classes. When one considers that in 1962 the average cost per institutionalized patient in this country was $1,998.24 a year, and that if not properly helped many of these children are institutionalized for decades or for life, the expenditure of an additional $4,117.50 to save a child and his family is a good investment.

Although my estimate of the cost of an interdisciplinary program was in error by approximately $1,000 per pupil per annum, today an interdisciplinary habilitative program for learning-disability children does exist in public schools. It is in Bucks County, Pa. The annual cost per pupil is $2,800, which is not appreciably more than is currently being spent on patients in mental hospitals. However, the problem is that our Nation has extremely few programs such as that in Bucks County.

To foster the thousands of such programs needed in communities across our Nation requires, first of all, the funds to make them possible. It requires, second, that part of those funds be allocated to establish conjoint efforts between the public schools and the professional resources of the community. It requires, third, that part of those funds be spent on teacher-training programs in which the universities and the service-oriented schools work together to bridge the gap between theory and practice, so that a new, innovative curriculum for teacher training can be devised—one that will merge theory and practicum harmoniously, so that the new teacher can indeed be effective. It requires, fourth, courageous and foresighted State legislators, such as those in Connecticut, to mandate the education of preschool children, so that most of the florid symptoms attached to learning disabilities can be prevented. To do so would not only ameliorate the tragedy inflicted on millions of families, but would also be economically sensible. For example, we have written a prospectus whereby a comprehensive preschool preventative program could be initiated at a cost per pupil of only $335 per year. That could save society, over a child's lifetime, tens of thousands of dollars for millions of children. Those possibly billions of dollars thus saved would, in turn, be inconsequential compared to the blessing afforded to the well-being of our Nation's families.

Mrs. SILVA. In summary, the ACLD respectfully requests that—

1. All the recommendations of the National Advisory Committee on Handicapped Children be recognized and provisions be made for their implementation.
2. This committee approve the appropriations recommended in the budget and, over and above this budget, authorize—
   (*a*) $2.5 million to be appropriated for teacher training specifically in the area of learning disabilities; and
   (*b*) $3 million to be appropriated for research in all aspects of learning disabilities, including preschool prevention.
3. Congress consider giving this type of child an identity in legislation for handicapped children by inserting the term "and/or special learning problems" wherever the phrase "other health impaired" now appears.

Mr. RUSSELL. Gentlemen, we know that the time for deliberation and decision is upon you. Within the next few days, you will be charged with the responsibility of deciding the destiny of millions of handicapped children who at present face a bleak and impossible future because of lack of facilities. We know, too, that you will be faced with the age-old dilemma of choosing between the role of statesman and politician. We only hope that we have presented the case for our children in such a way that the truth is self-evident and directions are clearly perceived.

We, the members of ACLD, hope that we can have faith in a telegram from the White House, addressed to me, from S. Douglas Carter, Jr., Special Assistant to the President. It reads:

The President has asked me to thank you for your telegram of February 3. As you know, the President has throughout his years in office accorded highest priority to the improvement of education in this country, and has strongly supported programs providing special assistance to children with learning disabilities. This year, in the face of very serious fiscal problems, he has recommended that the Congress increase appropriations for title VI of the Elementary and Secondary Education Act from $15 million in fiscal 1968 to $36 million in

fiscal 1969. We appreciate your concern and hope that the Congress will act promptly on the President's recommendation.

May we ask that you on this committee also "accord the highest priority to the improvement of education in this country"? Thank you, gentlemen, for your attention. The future of our children rests in your hands.

Mr. FLOOD. You have some problems with the Legislative Committee, do you not?

Mrs. SILVA. Yes.

Mr. FLOOD. Thank you very much.

Mr. RUSSELL. Thank you, sir.

MONDAY, APRIL 29, 1968.

NUTRITION PROGRAM OF THE NATIONAL CENTER FOR CHRONIC DISEASE CONTROL

WITNESS

DR. WILLIAM J. McGANITY, CHAIRMAN, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, UNIVERSITY OF TEXAS MEDICAL BRANCH, GALVESTON, TEX.

Mr. FLOOD. Dr. William McGanity.

Doctor, I believe that you are chairman of the Department of Obstetrics and Gynecology, University of Texas Medical Branch, Galvaston, Tex.

Dr. MCGANITY. Thank you, Mr. Chairman, for giving us this opportunity to present a request before your subcommittee. This has to do with matters pertaining to the nutrition program budget of the National Center of Chronic Disease Control.

If I might take a minute or two to identify my own interests, and background, as an obstetrician and nutritionist. I have had bilateral training and certification in both. I have worked for over 21 years in both areas. I have had as an area of investigative interest—nutrition in relation to the female with particular reference to the reproductive female.

My initial training was in Toronto. I am a Canadian-born American citizen now. I have served on the faculty at Vanderbilt University for 8 years and since 1960 at the University of Texas Medical Branch in Galveston. I am currently chairman of obstetrics and gynecology, I have served as a nutrition consultant to the original Interdepartmental Committee on Nutrition for National Defense (ICNND), now know as the Nutrition Program of the National Center for Chronic Disease Control.

I have served as a nutrition consultant to three other Government agencies and on the AMA Council on Nutrition. My background includes epidemiological nutritional studies, 16 in number, which include two in the obstetrical field, involving about 3,000 people, and 14 in the general population involving over 50,000 people.

I have been privileged to serve on 12 of the 33 ICNND nutrition surveys that have been performed. Two of these were actually con-

ducted in the continental United States; three in the Southeast Asia area and four each in the Middle East and in Central America regions.

On 11 of these 12 I served either as the director or codirector of the project.

From the overseas experience, we have available to us hard data on the nutritional health status of the population of these 33 countries that have been surveyed. We have dietary, biochhemical, and clinical evidence to support the existence of health problems in these areas with particular reference to nutrition.

In almost all of these groups there are several general categories of health difficulties which involve nutrition: goiter related to iodine; anemia related to iron folic acid and protein; protein malnutrition and growth retardation problems; vitamin A insufficiency and riboflavin insufficiency.

Mr. FLOOD. Isn't goiter rather restricted to certain regions?

Dr. MCGANITY. In all 33 countries that we have surveyed, there has been a goiter problem to some extent or another. The areas that we have surveyed have been in many instances mountainous highland regions. We looked just not in our Central American data. As an example, data for Guatemala reveals about 10 percent incidence, which is below the level of a Public Health problem.

There was 48 percent goiter in El Salvador, while Costa Rica, Panama, and Honduras had about a 25-percent prevalence.

Mr. FLOOD. I am not clear how the subcommittee is concerned with these 33 countries. Give us an example.

Dr. MCGANITY. This is in former existence, sir. The Interdepartmental Committee on Nutrition for National Defense was formed 12 years ago in response to a need. It had representatives from nine departments of Government of the United States which responded to requests from foreign governments, processed through State and appropriate health agencies for the conducting of nutritional surveys of the populations of these countries. These have been done between the years 1956 to the present.

The Central American activities were completed in 1967, approximately 9 months ago.

This is the program which has now been moved into the national center for chronic disease within the Public Health Service. We have all this data that is based on overseas experience. At the present time in our country, with two exceptions from Montana Indian reservations, we do not have comparable comprehensive hard data concerning the prevalence or severity of nutritional problems in the United States at the present time. Data limited to only dietary aspects, has been reported by the Department of Agriculture. The most recent report has been submitted by the Citizens Crusade for Hunger.

Both of these lack supporting evidence of either clinical or biochemical evidence to support them. It is not quite as bad as I make out. We certainly recognize problems of excess calories and obesity in the American population; and the inadequate iron status leading to the high prevalence of "anemia." We are aware of the public health significance of fluoride as a means of controlling at least in part the problem of dental caries.

In some areas, we have dietary intake data that suggests that vitamins A and C and calcium status are less than desirable. Anemia, as a

public health problem in this country, has hard-core documentation, particularly in children and in women during the reproductive years from 12 through 50 years of age, with particular emphasis on the pregnant women.

Limited current data, providing specific information on the nutritional health status of women, can also be illustrated from that we have accumulated from our own institution over the past 2 years. This involved 800 teen age pregnancies as they entered prenatal care. All fell into the lowest socioeconomic groups. Sixty percent were white, 40 percent nonwhite, and primarily in the age group 16 to 19 years of age. If we compare their dietary intakes to the National Research Council recommended allowances, we find that their average intake of calcium was about 60 percent of the recommended: iron, 65 percent, vitamin A and niacin, 84 percent. All of the rest were 95 percent or above. Let us look at the biochemistry aspect.

Anemia—of this population 22 percent had hemoglobins less than 10 grams as they entered. There were 46 percent who had hemoglobins less than 11 grams as they entered. Low hemoglobins were twice as common in the nonwhite as in the white. Vitamin A–12 to 33 percent of the values fell in the low and deficient range.

I need to clarify that the ICNNI established standards 5 and 12 years ago of deficient and low values. When I refer to these I use those standards. Niacin—only 8 percent fell in the low range. Vitamin C—between 15 to 27 percent were low, increasing from second to third pregnancy. Riboflavin—30 percent were low on entry into prenatal care.

Our dietary evidence would not have suggested this. These were teenagers. Their dietary pattern of food intake, at least in our community of Latin American, Caucasian, and Negro young women was not different. It is all the same at this time in mid-sixties.

Unfortunately, one cannot extrapolate those data to similar populations in Chicago, Pittsburgh, Philadelphia, Boston, or wherever it may be.

As obstetricians, we recognize that low birth weight is the major obstetric and pediatric problem relating to infant mortality in the United States. We have well-documented evidence that low-birth-weight infants are increased two to three times their expected rate when they are delivered of mothers who enter pregnancy underweight.

We have nutritional leads which are worth pursuing. When the maternal vitamin C level and folic acid level are decreased, there is a twofold to threefold increase in the incidence of low-birth-weight infants. The evidence for folic acid is not as firm at the present time but both may contribute.

Mr. Flood. The high mortality rate in such children born alive?

Dr. McGanity. Of live births, that is correct.

In this same population, 800 teenagers, the incidence of low birth weight of infants was 13.4 percent of all living births. To me these are major health problems for our patients. I believe that there are major nutritional manifestations. To give you a perspective of the order of magnitude, in this same population of teenagers the incidence of positive serology was 2 percent; positive gonorrhea smear was 4 percent; abnormal pap smear was 1.2 percent; and urinary tract infection was 12 percent. When compared to nutritional components.

anemia was present in 22 percent; low vitamin A in 33 percent; vitamin C, 27 percent; and riboflavin in 30 percent.

We need similar comprehensive data for all segments of our population, particularly in the lower socioeconomic sector. It is to me only on this basis, after we have identified the problems, their severity, and extent, that we can come to grips with the basic question as to whether nutritional problems do exist in the poverty portion of our population. Of equal importance is the training of personnel which goes along with this type of survey effort. On the basis of findings, educational programs beginning at kindergarten and extending through life could be developed and introduced. From such data would come recommendations with suggestions for programs to correct and prevent nutritional health problems in the American population.

Having just completed a cross-sectional nutritional evaluation of Central America in cooperation with U.S. agencies, Institute of Central America and Panama and the host governments, we now have hard data on 25,000 individuals in Central America obtained at 190 different locations through the six countries. These countries have a total population of a little over 10 million. This represents a 0.25 percent sampling. I believe that a similar level of sampling is needed for the phase I portion of the National Nutrition Survey as requested by Congress last fall in the Partnership for Health Act.

We need a sample of approximately 70,000 people and at least 10 major locations, either in States and/or regions. Each survey should be composed of about 7,000 persons. At the present time, only Texas and Louisiana have been authorized. The Texas survey provides a 0.25 percent sampling of the poverty group. It is a random sample which includes 26 counties, 103 ED's within those counties, with approximately 1,700 families.

If only Texas and Louisiana surveys are to be performed as the current appropriation permit, then one cannot form a national planning in agriculture or in health extrapolate from these data to other regions of the country as to what is the extent of their problem. Solutions that may be appropriate for Texas, may not necessarily be appropriate for all parts of our States let alone for the Puerto Ricans in New York city.

If the current cost figures as published in Hunger USA are correct, Federal agriculture payments, plus the food assistance moneys to Texas would provide sufficient funds to do 999 Texas surveys from the former and 30 Texas nutrition surveys from the latter fund sources.

The total cost of this survey will average 1 cent for every poverty-rated person in the State of Texas. If we look at current expenditures being made by the surplus food, food stamp, school lunch, and the milk program, they total almost $575 million. The cost of 10 nutritional health surveys, which I think are necessary to provide factual information, will require an appropriation of $2.5 million instead of the $250,000 currently earmarked for the next year. Even so, this would represent only 0.4 percent of the total expenditures that are now going into some form of feeding program directed at the poverty groups.

What are the other costs in the implementation of nutrition survey programs? I can only give the background of 33 countries. There has not been any recommendation as transmitted to the host country through our Government or the agencies, that has had a significant

costs to develop or implement programing. To give you a specific illustration of how economically some can do it is the major goiter problem in Lebanon. At that time the population was about 1.5 million people. Salt iodization, complete for the total population, cost their government $15,000. This corrected a nutritional health problem.

Mr. FLOOD. Did you find that problem in Beirut as well as upcountry?

Dr. MCGANITY. It was in Beirut, but primarily upcountry.

Mr. FLOOD. What elements?

Dr. MCGANITY. In all elements of the population.

Before you is some additional documentation of the biochemical data mentioned above.

With these few remarks I request that your committee consider very thoroughly an enlarged expenditure for the nutrition program of $2.5 million. It is a modest request in the current appropriation; the recommendation of $250,000 for this activity over the next period of time will not permit sufficient baseline data on which plans for agriculture, education, and health can intelligently be based. Thank you.

Mr. FLOOD. Thank you.

NUTRITION

WITNESS

DR. DAVID BAIRD COURSIN, DIRECTOR OF RESEARCH, ST. JOSEPH HOSPITAL, LANCASTER, PA.

Mr. FLOOD. Now we have Dr. David Baird Coursin, director of research, St. Joseph Hospital, Lancaster, Pa.

How in the world did anybody by the name of Coursin get to Lancaster? It sounds French.

Dr. COURSIN. It is, sir.

Mr. FLOOD. Do you have a statement you wish to make?

Dr. COURSIN. I have a few observations I wish to make.

First of all, I deeply appreciate the opportunity of meeting with the subcommittee this afternoon and expressing a few thoughts from the pediatric point of view. As indicated, my name is Dr. David Baird Coursin. I am director of research at the St. Joseph Hospital. I am certified in both specialties of pediatrics and nutrition. I have three appointments at various universities, including the University of Pennsylvania, Massachusetts Institute of Technology, and an adjunct professorship at Pennsylvania State University.

Mr. FLOOD. What would you be doing at Penn State?

Dr. COURSIN. They developed a new College of Human Growth and Development. It is part of the university and will be tied in with the establishment at State College as well as the Hershey Medical School. They asked me to be head of it. Since I declined, they asked if I would serve as one of the adjunct professors. This is how I became involved with it.

My concern relating to this particular problem arises out of being a member of the Committee on Nutrition for the American Academy for Pediatrics, a member of the Maternal Health Subcommittee and Vietnam B–6 Subcommittee of the National Research Council, a con-

sultant to the Agency for International Development and consultant——

Mr. FLOOD. That is how you and Dr. McGanity got together this afternoon?

Dr. COURSIN. We have known each other for years. Incidentally, I support entirely what my colleague has said. As he stated, we have expended enormous efforts to look at the problems internationally with little being done in this country.

Further, I have been involved with three separate agencies of the National Institutes of Health, as a consultant. I am a member of the United States-Japan Committee for Cooperative Research.

Mr. FLOOD. You yourself are a fine example of what good nutrition can do.

Dr. COURSIN. Splendid, sir. We regard Lancaster County as one to sustain its citizens adequately.

My concern is with the total broad picture of responsibility for nutrition in our Government. At the present time we are factored into various structures without any real consideration for a total program that involves the relationship of nutrition to the health and well-being of our population. We have splendid establishments such as the U.S. Department of Agriculture that has very recently published its report on a survey, documenting commodity distribution in terms of diets available to our population. The well-recognized National Institutes of Health, especially the Arthritis and Metabolic Disease Institute and the Child Health Institute as well as the Children's Bureau who have directed tremendous research programs toward specific aspects of scientific advancement that relate to nutrition. However, none of these organizations have comprehensive health-oriented programs that are designed specifically for the population at large.

As Dr. McGanity pointed out, when one attempts to evaluate the population; groups must be sampled randomly throughout the country. The necessary factors not only of clinical examination but physiological measurements and biochemical measurements, must be coordinated on an individual basis to provide definitive data on the groups under study. This approach not only applies to the poverty groups that has been in focus recently, but it concerns itself with the entire nutritional well-being of our Nation. In essence, nutrition is an integral part of the makeup of everyone's health. It is important not only during pregnancy, as Dr. McGanity mentioned, but is directly related to the general physical and mental growth and development of the child from infancy onward.

This goes further than just the child and adolescent because we see nutrition being important in the problems of susceptibility to disease, and to patterns of cancer and heart disease that arise later in life.

Mr. FLOOD. Nutrition and cancer?

Dr. COURSIN. Yes, sir. The entire spectrum of the basic molecular phenomena underlying all of these situations may be influenced by nutrition. One must move from the thesis that nutrition simply relates to the satiated, full stomach that you feel comfortable with when you have had dinner. The scientist's viewpoint looks at the nutrients as specific substances that enter the body's cells and affect their molecular makeup. In the long run this influences growth and development

as well as the aging and deterioration of the individual. My concern is with this total gamut of the relationship of nutrition to health within which Dr. McGanity has focused specifically on several very important elements. As we look at the Nutrition Center of the New Bureau of Chronic Disease, we find it interested not only in the poverty program that necessarily includes undernutrition but also in the total nutritional well-being of our entire population.

Mr. FLOOD. You are suggesting that you have the basic cure of all evil?

Dr. COURSIN. I do not present this as a panacea. I think if one views nutrition from a molecular basis you recognize that the nutrient makeup of the diet as it is directly assimilated and utilized by the body affects all structures and, therefore, is a significant factor. In other words, you can take things like the physical growth and development of the individual, either in animals or man and project them on a 1-to-1 basis with regard to nutrition. In our own research on the relationship of nutrition to brain function, we have determined that a single deficiency such as vitamin B–6 has a direct effect on the metabolism of the brain.

Mr. FLOOD. What do you think about the food faddists who have broken out in a rash throughout the country?

Dr. COURSIN. These people come in various sizes and shapes. Depending on the specific food faddist, some are downright dangerous. In some instances, there has been utilization of their products as milk substitutes. We have seen infants being metabolically damaged by poor nutritional intake, when changed from a recognized infant formula to a preparation that is not adequate for this purpose.

To get back to the point I was going to make on the central nervous system, we have direct definite information on undernutrition having a specific effect on this facet of growth and development as well as the physical one. With respect to infection or cancer, or heart disease, as you raised the point, Mr. Chairman, we are confronted here again with the fact that you can influence the incidence of these problems by specific dietary manipulation in the experimental animal or it may be seen in populations that have been exposed to various specific diets. In these situations we can document increased susceptibility to infection and altered patterns of heart disease, as well as cancer.

I would certainly not present nutrition as a panacea. However, it is intimately involved in man's well-being besides keeping his stomach full.

Mr. FLOOD. Do you think most people know that?

Dr. COURSIN. I think in terms of most people being aware of the significance of undernutrition. However, its scope and order of magnitude and the directions we should move in treating it—these have only be given lipservice. We do not have any real documentation other than in the Blackfeet Indian survey that Dr. McGanity pointed out; in the work that Drs. Hodges and Krehl have done in Iowa; and in a few scattered studies that have been done in places such as New York and Columbus, Ohio.

There has really been no major force mounted in this country to attempt to identify this problem, its scope or consideration of the specific difficulties we have in its treatment or prevention. Furthermore, we have no mechanism for following up to see if we are successful or

not successful in pursuing any given program. We have a major vacuum which is surrounded by a number of organizations that are, piecemeal, handling certain parts of this problem. But these in no way provide the type of information that is necessary to even meet the needs for properly applying the standards of the National Research Council.

The National Research Council in its preamble to the "Dietary Allowances" very carefully points out:

> The allowances are intended to serve as goals toward which to aim in planning food suplies and is a guide for the interpretation of the food consuming records of groups of people. Actual nutritional status of groups of people or individuals must be judged on the basis of physical, biochemical and clinical observations combined with observations on food or nutrient intake.

When you take that definition, which I think is the best accepted we have in the world, and the lack of such documentation that exists in the literature in this country—except for the few you have at hand—one can readily see why we feel that adequate support of a nutrition center is so important.

Mr. FLOOD. We need these reports.

Dr. COURSIN. I think that you will agree that it would be impossible to extrapolate from this very limited data to our population at large. We are in no position to make judgments. One can do studies such as the USDA has. You can determine what commodities may be available and what the market basket availability of food may be in the household. In terms of specifically what this has done to the individuals in that household—clinically, physiologically, biochemically—we have virtually nothing.

Mr. FLOOD. Race is not an element?

Dr. MCGANITY. The only data I have that has any racial differences is in regard to hemoglobin. All the rest of it is a common denominator, indistinguishable from all the other components.

Dr. COURSIN. I think that I can sum that up further. If we compare the Japanese studies since World War II with improvement in diet, there has been a marked increase in weight of as much as 10 to 20 pounds and in height upward of 6 inches in a race that previously had been viewed as of very small stature. Incidentally, this is the kind of information that one learns from studies abroad. I would view the structure of the nutrition center as being responsible for the nutrition component of our national health and also having an international program. This component could address itself to research projects overseas where we can very often study more severe types of deficiencies that relate specifically to our country's needs. The types of information that Dr. McGanity mentioned in the 33 surveys overseas have a direct applicability. They provide a far greater degree of certainty in terms of identifying the items; determining how much of a problem may exist in a country; permit development of the most propitious program to answer it; and provide for monitoring how successful a specifically selected program might be.

We sit here unable to tackle this in the United States.

Mr. FLOOD. We have a problem of overeating in this country, do we not?

Dr. COURSIN. There is no doubt that we do have a problem of obesity. On the other hand, I think this in no way relates to the large

percentage with whom we are far more deeply concerned and who may have borderline needs but don't have obvious deficiencies such as lip or tongue changes or severe clinical symptoms that are seen in underdeveloped countries. This requires the whole battery of test procedures to evaluate the problem. We are persuaded that until we have this kind of information at hand, one should not expend large sums of money to put out nutritional brush fires here and there as they appear. Unfortunately, in terms of having a realistic basis to move from, we are better off in 33 developing countries where we have data than in our own.

It is for these reasons that I would urge that adequate funds be made available for the nutrition program of the Bureau of Chronic Disease. These should be of the order of $2 million for the first year rather than the very inadequate sum of $250,000 to which it has been cut. This would permit it to operate constructively in its designated roles and to facilitate the rapid application of new research findings to meet practical needs. Furthermore, this organization should have ongoing support for its total program with adequate provision for the national nutrition survey that has been proposed for eight States. This would provide a realistic basis for: (1) Proper identification of the problem of undernutrition in the United States; (2) determination of the scope and adequate sampling that would permit extrapolation to a national level; (3) facilitate development of action programs to meet these needs; (4) monitor the results of these programs so that their progress could be measured and appropriate improvements made where necessary.

Mr. FLOOD. Thank you, gentlemen.

Dr. COURSIN. Thank you, sir.

MONDAY, APRIL 29, 1968.

GROUP HEALTH

WITNESS

DR. ROBERT L. BERG, CHAIRMAN, DEPARTMENT OF PREVENTIVE MEDICINE AND COMMUNITY HEALTH, UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE AND DENTISTRY

Mr. FLOOD. Dr. Robert Berg will be our next witness.

Dr. Berg, I understand you are chairman of the Department of Preventive Medicine and Community Health, University of Rochester School of Medicine and Dentistry.

Dr. BERG. Thank you, Mr. Chairman. I will read this statement and would be pleased to answer any comments that you may have.

I should like to urge that the Congress make substantial appropriations to promote experiments and studies in group health plans. Group health program may well decrease costs and increase the quality of medical care, but my chief concern is to provide care through this mechanism for persons who do not now receive adequate health care.

Mr. FLOOD. You are not in the insurance business?

Dr. BERG. No; I teach in a medical school.

There are two large groups of our citizens who do not receive adequate general medical care; that is, comprehensive health services, with the opportunity of seeing a personal physician in continuity. These two groups are the urban poor and persons living in rural areas in many parts of the country. The need of these two groups does not need documentation. There is good reason to expect that group practice will go far toward solving these problems.

Medical care for the urban poor has not been provided to any large extent by physicians in their offices, either at reduced fees or gratuitiously. As a result, these patients have gone to hospital clinics and emergency departments, usually seeing many different physicians, and the care has not been comprehensive. It has not usually included home calls when necessary nor adequate concern for social, pychological, and environmental factors in health care. The alternative open to correct the situation is to assign such persons, hopefully at their own choice, either to a single physician or to a group of physicians.

Mr. FLOOD. Would the physicians like that?

Dr. BERG. There are problems in terms of the physician's responsibility, but in general there is no reason to believe it would not be satisfactory.

There are great disadvantages to a single physician panel arrangement. Physicians do not live in adequate numbers in areas where these services are needed. There is a reluctance by most physicians to include these patients in their practice even if a patient can get to their office. Organized medicine has not evolved a method for accepting aliquots of these patients into each of the practices of its members. And perhaps most important from the long-term point of view, the office of the single physician cannot offer that breadth of services which are necessary for comprehensive modern practice.

Mr. FLOOD. Do you know about the proposals under what we are now calling the regional medical program?

Dr. BERG. Yes, sir. I will comment on that in a moment.

The range of services needed in modern comprehensive health care, even in private solo practice, includes social case work, public health nursing, health education, as well as technical and clerical services. They are needed not only because special skills are needed, but because the physician must pass on to ancillary personnel many of the tasks he has done in the past which do not require the extent and breadth of training he has had. It is only by sharing his activities that on the average more patients can be cared for by each physician. Even if the solution in the long run is to consider increasing the absolute and relative number of physicians, there is going to be a long period in which there will be inadequate numbers to practice in the way we have practiced up to the present.

And I suppose many who prefer solo practice would take objection to these proposals.

Mr. FLOOD. Isn't your trouble rather with specialization and the lack of general practitioners?

Dr. BERG. It is an interesting problem. When you mention general practitioners, the problem is the lack of personal physicians which would include general practioners.

Mr. FLOOD. What we call G.P.'s. That is what you need, isn't it?

Dr. BERG. There are other kinds of physicians in addition to G.P.'s who can fill these positions.

While solo practice appeals to many physicians, it is unlikely that it will remain as a major component of our American health system. It is not feasible to engage that variety of skilled persons in a solo practice office that are needed for modern medical care. It is only when a group of physicians work together that it can be managed.

Mr. FLOOD. Isn't this developing rapidly?

Dr. BERG. No; it is hardly developing at all. Only 3 percent of office visits in this country are from prepared groups and only 7 percent are from other group plans.

Mr. FLOOD. I thought the Internal Revenue Department policies helped their growth.

Dr. BERG. They did for a time. As I understand it, now the solo practitioner gets most of the tax advantages of the group.

These reasons for the evolution of group practice as a major form of care are equally true in special ways for rural practice. As there are fewer and fewer people living in rural areas, more and more living in cities, it becomes increasingly difficult to staff the rural areas of this country with physicians if solo practice is the only form of medical care. A group practice in the form of a rural health center with public health nurses, social case workers, sanitarians, health aides, and health educators is a model which we may need to evolve increasingly. It has evolved in developing countries of the world in their response to a very inadequate supply of physicians. It is now evident that we face the same problems to a lesser extent and can learn much from these examples. It is likely that health centers in rural areas can provide adequate ambulatory care either by patients getting themselves to the health center, or from doctors' surrogates, such as public health nurses, having stations in remote, thinly scattered areas. Such nurses can provide the primary contact with patients and report to and consult with physicians as to whether a doctor is needed.

Mr. FLOOD. Of course you have no neurosurgical care at all.

Dr. BERG. In that case you would not, but the health center notion involves the sense of sorting and getting people to the place where you do have this type of care, but it would not exist in this type of center; that is correct.

This pattern does not exist to any extent in this country as yet, but if it were to be established, the main residual problem would be the care of emergencies. Much thought needs to be given to the care of emergencies, particularly in rural and outlying areas, and support needs to be provided for imaginative experiments in competent and effective case finding and transport of acutely ill and injured patients. This involves better training for the ambulance drivers or helicopter pilots involved in moving the patients, studies on the quality of care, on the means of communication, and on the integration of services. But particularly, subsidies are needed to get such experiments under way. They are costly and are not likely to develop in the near future otherwise. In particular, a number of demonstration projects should be financed in remote areas, utilizing a combination of ambulances and helicopters to assure the most rapid access of injured or ill patients to high quality hospital services.

To return to the general opportunities provided by group practice, similar demonstration projects need to be supported in a wide variety of communities and with a wide variety of populations to determine under what circumstances given patterns of group practice are most effective. Is it better to provide a local clinic for a poverty group in an urban area, or would it be wiser to provide transport to get such patients to a group practice clinic that involves all social and economic groups?

What are the appropriate roles for the nurse, the aide, and the medical assistant? How can they be most effectively trained and utilized? What measures of the need and effectiveness of each of these team members can be evolved? What is the most efficient size and form of group practice? How can medical records and other communications be made available and pertinent? What are the factors involved in the failure of patients to follow their medical regimens as outlined by physicians, and why do they fail to return for therapy? How can such group practices with a portion of all population groups relate to comprehensive health care planning and regional medical programs? How can these groups best relate to hospitals; should they be located adjacent to or in hospitals or part of hospital administrative structures? What is the effect of such group practice on the use of facilities, including hospitals and chronic care facilities? What arrangements should be made for evening and weekend clinics? What flexibility can be allowed physicians in such practices? What is the role of the trustee groups or advisory councils of citizens in setting policy and managing such groups? What are the ties to university medical centers; how can they best be exploited for teaching and for clinical experience? Should work with group practices in poverty areas or rural regions be regarded as the equivalent of military experience or should a period of 1 to 3 years of work in deprived areas be a requirement on some other basis? How are the costs of such groups identified and allocated? These and many other questions need to be answered, and unless specific programs to support such studies are initiated under a program of Federal grants, there is little likelihood that these questions can be studied in sufficient depth to have valid answers.

In summary, group practice appears to hold the only practical answer to the provision of care for persons not now receiving it either in urban or rural areas. In order to encourage the more rapid experimentation with and development of such groups, demonstration projects need to be supported by Federal funds. Such demonstration projects in addition must be thoroughly studied to answer important unanswered questions to achieve the highest quality of care at the lowest cost.

Mr. FLOOD. Do you people tie in with the Civil Defense organization, Federal, State, and local, at all?

Dr. BERG. The ararngement for health care through the Civil Defense organization is tied to the hospitals primarily.

Mr. FLOOD. Thank you.

MONDAY, APRIL 29, 1968.

EMERGENCY HEALTH SERVICE BUDGET

WITNESS

RODDY A. BRANDES, PRESIDENT, AMBULANCE ASSOCIATION OF AMERICA

Mr. FLOOD. Mr. Roddy A. Brandes, president of the Ambulance Association of America.

Mr. BRANDES. I am Roddy Brandes of Charlotte, N.C., president of the Ambulance Association of America, and operator of ambulance services in Charlotte, Greensboro, High Point, and Hickory, N.C., in Columbia, S.C., and Knoxville, Tenn.

I am here as a voluntary witness respectfully asking Congress to support improvement of the quality of emergency health services to more than 2 million victims of accidential injuries or sudden illnesses who are transported by ambulance every year to the hospital. In this regard I fully endorse the appropriations request of the Emergency Health Service Branch of the Division of Direct Health Services of the Public Health Service.

Since my interest is in ambulance service, I will confine my discussion to this phase of emergency care. It should be recognized that this is one of the most sensitive public or quasipublic services in the country. Millions of Americans sooner or later will be transported in an ambulance. Their very lives sometimes will depend on the care they receive in that short period of time.

Unfortunately, and despite the efforts of the Ambulance Association of America and its members as well as some excellent volunteer rescue services, particularly along the East and West Coast, the chances of obtaining good care on the way to a hospital are often poor. Many of the ambulance crews in this country are untrained or poorly trained; many of the ambulances are unequipped or inadequately equipped.

President Johnson in his health message to Congress on March 4, 1968, called attention to the compelling need for modern, effective rescue systems to give immediate attention to accident victims, on the spot and while they are being speeded to the hospital. The question that bothers me every day is this: How many of the nearly 50,000 fatalities from automobile accidents every year—and more than 50,000 deaths from other accidents—could have been prevented by having an adequately trained ambulance crew? An injured soldier in Vietnam on the average has a better chance of surviving—or having his injuries properly tended—than a person hurt in an automobile accident in this country.

The story is repeated daily where another person expires due to an untrained ambulance attendant not knowing how to treat an accident victim for shock or to stop profuse bleeding. The repition of this situation is becoming more prevalent with the increase of our population.

A major problem is that the general public is unaware of the need for adequate ambulance services. That probably is why most local

governments have failed to establish uniform standards of service. The shocking fact is that in most communities you can buy a dilapidated station wagon and use it as an ambulance without equipping it with as much as a band aid or having attendants who know what a band aid is. This situation is compounded by the fact that many local governmental officials accept this and are thus relieved from the responsibility of seeing that adequate service is provided. Be mindful, however, that in these same communities, bargers, beauticians, and embalmers—but not ambulance attendants who are concerned with people's lives—must meet certain standards of perfection to obtain a license to operate.

Perhaps the most basic element of emergency medical services is trained personnel. We would not tolerate a hospital emergency room with no trained personnel, yet it has been recognized by knowledgeable persons that the care given an accident victim in the first minutes after his accident is perhaps the most important. At a minimum, an ambulance crew's training should be comparable to the advanced first aid course of the American National Red Cross.

My home city of Charlotte is one of the few communities in the country that insists by ordinance, on a high standard of training. Charlotte requires that no person shall be employed as an ambulance driver or attendant unless he has completed the Red Cross advanced first aid course. He also must complete 25 trips as an observer before being allowed to operate an ambulance or touch a patient. He must complete a course on administering oxygen, one on handling persons whose larynx has been removed, one on handling expectant mothers, and one on handling heart patients. Every American city should have similar standards.

Good equipment is another serious deficiency in many ambulances. Often these vehicles lack such common sense first aid items as splints or even bandages. I had occasion recently to talk with one of our local doctors who would not let an out-of-town ambulance continue on to a veteran's hospital without oxygen for a patient requiring oxygen. For the sake of the patient we furnished the necessary equipment for this out-of-town ambulance. The ambulance vehicle itself might be a $26,000 limousine; again, it might be a 20-year-old battered panel truck. Often ambulances lack room for the attendants to move about in or sufficient space to treat patients. Please bear in mind, these vehicles are supposed to be life saving instruments, but in most communities in this country, the local funeral parlor provides transportation to the hospital in a hearse with no first aid equipment but with a red light and siren. Granted and with grateful acknowledgement to the funeral parlors for handling our injured and infirmed for so many years, can you imagine, in this age of revolutionary developments, that an organiaztion whose reputation is built on how well they can bury you, transporting the injured and infirm to a medical facility in a hearse.

Ambulances often have inadequate radio and telephone communications, especially in communities and on interstate highways remote from cities. Without a good communications system, many valuable minutes are wasted by ambulance crews hunting for addresses.

Good communications between the ambulance and the hospital emergency room also is essential. To let the emergency room personnel know

about the patient's condition in advance so that proper preparations can be made is another dimension to be added in the process of saving lives.

I have purposely left out other weaknesses in ambulance services in this country. To say more would sound like a shotgun indictment of our emergency services spectrum. We must, however, acknowledge the fact that thousands of our fellow citizens are every day given shoddy ambulance service and that some of them are needlessly dying—or suffering increased injury or illness—because of this type of service.

We, the concerned members of this industry, respectfully recommend that Congress support the appropriation under discussion to better enable this agency to gather information, establish guidelines, and assist local governments in setting up adequate services across this Nation.

The Emergency Health Services Branch of the U.S. Public Health Service has the experience and the know-how to accomplish these things. If members of Congress wish to insure that the lives of all American citizens are protected from death and permanent disability as a result of injuries, they will see that staff and funds are made available this year to broaden the efforts of the Department of Health, Education, and Welfare. Only if adequate funds are provided can the Public Health Service participate with and properly support the highway safety programs of the Department of Transportation.

I doubt that there is a single area open to Federal investment where dollars will produce as much in terms of protection and welfare of this country's population.

Mr. FLOOD. Thank you, sir.

Mr. BRANDES. Thank you.

Mr. FLOOD. We will adjourn until 2 p.m. tomorrow.

TUESDAY, APRIL 30, 1968.

LABOR–HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS, 1969

WITNESSES

RAY DENISON, FOR ANDREW J. BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION, AFL–CIO
GEORGE TAYLOR, DEPARTMENT OF RESEARCH, AFL–CIO

Mr. FLOOD. The committee will please come to order.

Now we have Mr. Ray Denison, who will speak for the Department of Legislation of the AFL–CIO.

Mr. Denison, I see that you have a most imposing statement. How do you wish to proceed?

Mr. DENISON. I would like to read into the record the covering statement of about six pages here and then have the supplemental statement included in the record, with your permission.

Mr. FLOOD. Yes, we can do that. Proceed.

Mr. DENISON. Mr. Chairman, my name is Ray Denison. I am legislative representative for the AFL–CIO. I am appearing here today in behalf of Andrew J. Biemiller, the AFL–CIO director of legislation.

On behalf of the AFL–CIO, I want to express our appreciation for this opportunity to present to your subcommittee our views and comments on appropriations for the Department of Labor, for the Department of Health, Education, and Welfare, and for related agencies for fiscal 1969.

We in the AFL–CIO have viewed with grave concern for the past several months the proposals put forth for cutting the Federal budget, virtually all of which would make their deepest slashes in the programs we consider of most urgent need to the well-being of America.

This deep concern led the AFL–CIO executive council to voice its fears at its most recent executive council meeting, when it stated:

> A determined campaign is now underway to force across-the-board cuts in Federal expenditures without regard to merit or need. Leading this fight is the same coalition of conservatives who traditionally oppose social progress. This effort must be defeated.
>
> Today, those who would slash domestic programs piously declare that America's first priority must be Vietnam and that all other goals must be postponed or ignored until the Nation's Asian expenditures can be reduced.
>
> America's urban crisis, its growing population, its educational needs, its housing shortage, its povertystricken citizens and its other pressing problems demand immediate attention, not avoidance.
>
> The AFL–CIO has stated before—and we reiterate—our conviction that America can afford both the defense of freedom in Vietnam and a meaningful program at home.

Mr. FLOOD. Did you bring this to the attention of the other distinguished body before they took their dramatic action a few weeks ago?

Mr. DENISON. The surtax?

Mr. FLOOD. No, no—on the $6 billion cut.

Mr. DENISON. The Williams-Smathers amendment?

Mr. FLOOD. Yes.

Mr. DENISON. We have not testified before the Senate at this time on Labor-HEW appropriations. While this subcommittee hearing is not the forum to declaim on taxation, the AFL–CIO further declared in its statement that "we are prepared to pay our fair share of the costs of such effort." The council statement concluded by saying:

> The AFL–CIO executive council calls upon Congress to reject the reactionary appeals of those who would block economic and social progress at home. We seek, instead, the continued funding of ongoing programs and full appropriations to meet already approved authorizations for vitally needed legislation. We urge Congress to help head the Nation forward by expanding and strengthening programs designed to solve the programs of a rapidly growing urban population.

We are submitting to this subcommittee a supplemental statement with our specific position on several aspects of agency budgets being considered here today.

I would appreciate the opportunity to draw the committee's attention to a selection of these budget areas where we feel that extraordinary study and concern is due.

There runs throughout the budgets of these several agencies a common thread, wherein a sufficient sum of Federal funds expended now can bring about great savings in lives, education, injuries, personal incomes, individual well-being, and national welfare.

As a specific example, there is the continued need for additional wage-hour investigators to carry out the mandate of Congress under the Fair Labor Standards Act. This is a need we have stressed many times in the past. We do so again and with increased emphasis. There are also other areas where increased Federal efforts can bring about returns that are many, many times the budget expenditure. For example, there is a need for additional safety inspectors to fufill the provisions of the Walsh-Healey Public Contracts Act. A third area, of great importance, and similar great return in investment, is the funding of an adequate national occupational health program. In these three areas alone, the achievement in wages recovered, injuries avoided, and the prevention of occupational diseases and hazards in behalf of American workers would result in a monumental conservation of our human resources.

First, consider wage-hour investigators. We are pleased that the budget provides for an additional 50 investigators, which would bring to 1,225 the number of personnel responsible for investigating FLSA compliance by the 2 million covered establishments.

Mr. FLOOD. You know, I am receiving letters from all over the country objecting to Congress interfering with safety matters?

Mr. DENISON. I would not imagine these letters would be from the workers or people affected.

Mr. FLOOD. I am sure of that.

Mr. DENISON. We are concerned in this area. We do not think there are enough Federal safety inspectors around for people even to notice, unfortunately, much less to write about.

We note, however, that the failure again to provide an adequate number of investigators will keep the level of investigation at only 3 percent of the number of covered establishments, instead of at the 5-percent level maintained prior to 1968. Not only will the number of establishments inspected continue to be less in fiscal 1969, but there will be an increase of 100,000 establishments never before covered. Furthermore, the recent increase in the minimum wage rate, will tempt more unscrupulous employers to underpay thir workers if they feel the odds favor them getting away with it. Preliminary data for 1968 already indicates that violations and the dollar volume continue to rise.

In 1967, 59,000 workers were underpaid $76 million in wages, an increase of 73 percent in the last 5 years.

To adequately protect the 42 million working Americans who are covered by FLSA provisions, fully 325 more investigators are needed. There is also a critical need for greater emphasis on the recovery of the funds once violations have been uncovered. In fiscal 1967, $50 million in underpayments were never received by defrauded workers, fully $1 of every $3 in underpayments disclosed by investigations.

A similar story of underprotection—this time safety protection—will be the consequence of the budget provisions for safety under the Walsh-Healey Public Contracts Act. At the present time, there are 10 safety inspectors charged with Federal responsibility for 75,000 work locations and 27 million workers in the United States. The fact that 13

additional positions are sought in the budget is encouraging, but, realistically, it is totally inadequate to meet the need. The delegation of some inspection responsibility to the States with their inadequate staffs, has not diminished the problem. We declare that fully 100 additional inspectors are necessary to bring about an effective safety program.

At the present time, Mission Safety–70, the President's own program, has reached its midpoint in time with strong doubt that its goal of a 30-percent reduction in Federal injuries by 1970 will be attained. The achieved figure of 13-percent reduction in Federal work injuries thus far represents a saving of $8 million to the Government and an immeasurable saving in human misery. Greater emphasis on safety—in the face of a rising incidence of accidents—could bring about far greater savings than is represented in the budget for the program itself. Going a step further, if research were provided into the areas of occupational health, quality of medical care and income maintenance, we could not only realize a lessening of accidents but also undertake a long-needed reevaluation of antiquated practices and attitudes toward this problem.

Directly related to this area of concern, is the provision in the HEW budget for funds to carry out the occupational health programs. Unfortunately, we note, there is no change in funds from the previous year except for an additional $800,000 to provide for uranium miners.

We strongly urge that this budget figure be increased by an additional $4.5 million for present program activities. The existing programs that would benefit would: establish criteria and standards on asbestos and beryllium; allow for further work on programs dealing with the problems of uranium miners; increase activities on occupational respiratory diseases at the Occupational Health Division's Laboratory; make possible a special project on noise, and expand programs of technical assistance in occupational disease control.

Mr. FLOOD. Do you know if the problem of beryllium is associated with the acquisition of the ore or with the manufacture of the raw material?

Mr. TAYLOR. This is in the manufacturing process mainly.

Mr. FLOOD. There are not many companies manufacturing beryllium. I know of only two.

Mr. TAYLOR. There is one in your State.

Mr. FLOOD. One in my district and one in Ohio.

Mr. TAYLOR. That was my point of information. There was a case of a lady who lived downwind from a beryllium plant somewhere in Pennsylvania—it might have been in your district—who recovered in a court suit from the manufacturing company some $120,000 as a result of getting berylliosis from the fallout of the plant. One of the major difficulties now is not only in the plant but——

Mr. FLOOD. It is not the same as asbestosis, from the fiber, is it?

Mr. TAYLOR. No. One of the problems is that there are some 20 other conditions which resemble berylliosis and unless you have a qualified industrial physician who knows the symptoms it can be confused with other symptoms. It is like seeing the top of the iceberg.

Mr. DENISON. If Americans are to be safeguarded from illness and death caused by occupational health hazards, we must move ahead with a concerted program to find out more about their cause and effect and how to reduce them.

I would like to turn now from those Americans who are employed (though they face the problems of below-minimum-wage employers, unsafe working conditions and health hazards) to preemployment Americans—those in schools of all levels and quality.

Recent years have seen an important series of educational programs enacted into federal law. These programs are bringing significant benefits to millions of children and young people in the cities, in the suburbs, and in the rural areas of America. They have opened up new educational opportunities extending from prekindergarten programs to graduate schools and adult education. Above all, these laws are providing opportunity to those who need it the most, those children and young people from low income families who must have excellence in education if they are to break out of the poverty cycle which has entrapped their families, in many cases for several generations.

We of the AFL–CIO are proud to have played a major part in bringing about the enactment of these laws. We have repeatedly expressed our view that existing legislation falls short of the kind of Federal support that is needed to provide quality education for every child wherever he may live, whatever his family income, and whatever his race or nationality background. The present laws are not enough, but they are an impressive beginning.

It is because we are so convinced that the present legislative authorizations are unrealistically low that we are particularly concerned that educational programs at least be fully funded to the limit of existing authorizations.

On this basis the most tragic of all the proposed reductions is in the suggested appropriation for title I of the Elementary and Secondary Education Act. The congressional authorization for this title for 1969 is $2.5 billion. This minimal figure was reached by Congress after schoolmen from all parts of the Nation testified that previous levels of funding under title I left them with the alternatives of spreading the funds too thin for them to be helpful of concentrating the funds on so few pupils that only a fraction of the need could be met. Yet the budget request for title I funding for fiscal 1969 is only $1.2 billion, less than half of the $2.5 billion which Congress has authorized.

Other educational programs seem to be accelerated under the proposed budget, where actually they are being underfunded. The Teacher Corps is providing highly motivated, well-trained teachers in many of America's largest cities. The National Advisory Commission on Civil Disorder said: "The Teacher Corps should be expanded into a major national effort." The proposed appropriation of $31.1 million does in fact represent considerable increase over the $13.5 million appropriated in 1968. The level of increase, however, becomes considerably less impressive when one notices that the suggested $31.1 million is nearly $15 million below the $46 million which Congress authorized for fiscal 1969. It is in fact even below the $33 million which was authorized for fiscal 1968.

Along with our grave concern over the erosion of educational funds there is another matter that grieves us considerably, and that is the meager funds for the Bilingual Education Act, which was passed on the final day of the first session of the 90th Congress. Here is a program for aiding a long-neglected area of educational need, involving 1¾ million American children, who have been handicapped in their education because they come from Spanish-speaking homes and are enrolled in English-speaking schools. The admirable purpose of this act is to provide methods and special programs to help Mexican-American, Puerto Rican, and other children overcome the language barrier which has kept them from good education. We were most pleased that the legislation was enacted with an authorization of $30 million for fiscal 1969. We were completely deflated to learn that the budget request is for only $5 million. We urge most strongly and emphatically that this program be fully funded in this its inaugural year to enable its implementation in all affected areas of the United States and to guarantee that no child—because of his Spanish heritage—shall be deprived of the opportunity to a meaningful education. Every year, at ages 4, 5, and 6 we lose forever the golden education opportunity among tens of thousands of children. We must not perpetuate this neglect by failing to appropriate the funds necessary to make this program successful.

The many programs of Federal support for education adopted under the last three administrations have made it possible for American education to move rapidly in new and hopeful directions. Now that we are underway, the Nation can ill afford to lose the momentum which we have now achieved. We urge therefore that the education programs adopted by Congress be fully funded to the limit of existing authorizations.

Mr. Chairman, I appreciate the opportunity to present the views of the AFL–CIO in this statement and in the attached supplemental statement, which I am submitting.

Let me state that although the volume of our supplemental statement did not allow for oral comment on each individual item, we feel no less strong in our views and in the urgency of the budget needs set forth therein. Therefore, I hope you and the members of the subcommittee will give careful and sympathetic attention to our presentation and proposals for achieving the greatest betterment to all who are served by these agencies.

America is the globe's wealthiest nation. But if we fail to meet our obligations, as reflected in the agencies of Government before this subcommittee, millions of our citizens will be no better off than if they were nationals of a poor, backward undeveloped country. If that were the case, their plight could be understood, but in rich, affluent America it is unpardonable.

We in the AFL-CIO sincerely believe that America's domestic crisis will not be met by across-the-board budget cuts or wholesale jettisoning of programs that we all know are necessary to improve the quality of American life.

(The supplementary statement follows:)

SUPPLEMENTARY STATEMENT OF
ANDREW J. BIEMILLER, LEGISLATIVE DIRECTOR
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

April 30, 1968

This supplementary statement details the specific recommendations of the AFL-CIO for the fiscal 1969 budgets of the Department of Labor, the Department of Health, Education and Welfare and various related agencies.

The AFL-CIO is deeply concerned by a determined campaign now under way to force across-the-board cuts in federal expenditures without regard to merit or need.

We, in organized labor, have noted with considerable distress that those who would slash domestic programs piously declare that America's first priority must be Viet Nam and that all other goals must be postponed or ignored until the nation's Asian expenditures can be reduced. The AFL-CIO Executive Council, in its most recent meeting, declared that "America's urban crisis, its growing population, its educational needs, its housing shortgage, its poverty-stricken citizens and its other pressing problems demand immediate attention, not avoidance." It is to this end that we direct our attention here and urge with all possible emphasis that America undertake both the defense of freedom in Viet Nam and meaningful programs at home. We have earlier declared that we are prepared to pay our fair share of the costs of such effort.

In support of our position relative to the funds we feel are necessary for these agencies to carry out their duties, we offer here two recent statements by the AFL-CIO Executive Council on the national economy and on minimum wage.

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The National Economy

February 23, 1968

The national economy's advance, which got underway in 1961, continues to add to employment and incomes. The economic performance of the past seven years has been a most welcome improvement after the trend of rising unemployment and recurring recessions during most of the 1950's. Between 1966 and 1967, for example, employment rose 1½ million.

Despite this record of achievement; the American economy remains some distance from full employment. Unemployment persists at much too high a level and in 1967 there was no improvement in this important indicator of the American people's economic well-being -- 3.8 percent of the labor force remained unemployed.

The economic advance, thus far, has failed to provide enough job opportunities for a rapidly growing labor force in a period of radical technological change -- particularly for the most disadvantaged job seekers among teenagers, Negroes and unskilled workers.

Moreover, the benefits of the national economy's much-improved performance in the 1960's have not been shared equitably among the various groups in the population. A disproportionately great share has gone to business and upper-income families, even after accounting for last year's small decline in profits.

Although some business and government spokesmen attempt to blame rising unit labor costs for much of the increase in the price level, the record clearly shows that the price level has been rising in recent years, regardless of what happened to labor costs per unit of production. Between 1960 and 1965, for example, when unit labor costs of manufactured goods fell 1½ percent or more, wholesale prices of manufactured products rose 1.7 percent -- boosting profit margins and increasing the business share of the fruits of the economy's progress. And when workers sought to catch up with rising living costs and the gains of the economic advance in the past two years, business raised prices at a faster pace, to maintain enlarged profit margins.

After a brief and slight decline from great heights, corporate profits are now booming again. As the Wall Street Journal of February 13, 1968 reports: "Business appears to be back on the comfortable track it wandered off for a year beginning in late 1966 -- the track that leads straight from one quarterly profit record to another."

Between 1960 and 1967:

. Corporate profits, after payment of taxes, skyrocketed 77 percent.

. Dividend payments to stockholders soared 70 percent.

. Weekly after-tax take-home pay of non-supervisory employees in private industry with three dependents, increased only 25 percent -- and in terms of buying power, less than 11 percent. Moreover, in the two years between December 1965 and December 1967, the buying power of these workers' weekly take-home pay actually fell 1½ percent.

. Real compensation per hour of non-supervisory employees in private, non-farm industries increased only about 2½ percent a year in the 7 years 1960-1967. But the real volume of production per manhour in the entire private economy rose at a yearly rate of 3.3 percent.

The vast majority of wage and salary earners have not received a fair share of the fruits of the national economy's advance. A disproportionately large share has gone to business, to executive and mangerial personnel, to the self-employed such as doctors and similar groups, to capital gains from the sale of property.

This unfair distribution of the benefits of the economy's progress is clearly unjust to wage and salary earners, who are the vast majority of the population and the backbone of American society. It undermines the strength of consumer markets, the base of our economic system. And it helps to explain the slower-than-expected expansion of consumer sales in the past year, which seems to mystify so many business and government commentators on economic trends. In addition, it widens the economic and social distance between various groups in the nation.

Moreover, the complex domestic problems that festered from neglect during most of the 1950s remain unsolved despite the beginnings of numerous federal government programs to achieve solutions. Radical changes in technology, accompanied by rapid urban growth and changes in race relations, pull and tug at the fabric of our society.

However, there are those who claim that the economic advance has gone too far and clamor for unemployment-breeding restrictive policies. In 1966, the Federal Reserve pursued a very restrictive monetary policy, which pushed interest rates to their highest levels in 40 years, through much-needed residential construction into a deep recession along with such related industries as lumber and furniture, and contributed to the economic slow-down of the first half of 1967. There is danger that similar policies may be pursued in 1968, despite the fact that unemployment persists and industry is operating only about 85 percent of its productive capacity.

There are also those who clamor for a slashing of federal expenditures for such essential measures as federal aid for education, housing, urban affairs, healthcare, air and water pollution measures, anti-poverty and welfare -- those who claim that America's $800 billion economy cannot afford public facilities and services in the midst of the Viet Nam war.

1. We reiterate our conviction that the American economy has the resources to extend and expand social advances at home, while meeting military requirements in Viet Nam. The cost of the war should not be absorbed by cutting back or freezing essential federal programs for domestic progress. The great productive ability of the American economy can provide the foundation for both continued social progress at home and an honorable settlement of the war in Viet Nam.

The expected sharp rise in the government's administrative budget deficit in fiscal years 1968 and 1969, due to military expenditures, can be reduced, without mounting pressures on interest rates and the availability of money and credit. A temporary war surtax is needed to reduce the amount of money the government will have to borrow in the money market and to eliminate the threat to home-building and related industries from tight money and higher interest rates.

The needed temporary surtax should be based on ability to pay, including taxation of personal and corporate income that escapes taxation through major loopholes in the tax structure. The surcharge on corporations should be at least twice

as great as on personal income. The surcharge on personal income should be clearly set on the basis of ability to pay. Corporate and personal income, excluded from taxation by tax loopholes, should be subjected to at least the same tax rate as the surcharge.

2. We insist that the top-priority objective of national economic policy should be to achieve and sustain full employment -- jobs at decent wages, for all people who are able to work and desire employment. The demand for goods and services from consumers, government and business must expand sufficiently to provide enough new job opportunities for the unemployed, for the great numbers of entrants into the labor force and for those displaced by spreading automation. The federal government's tax, expenditure and monetary policies, in combination, should encourage the necessary expansion of demand to achieve and maintain full employment.

3. Adoption of a program to create one million public service jobs for the unemployed and seriously under-employed is essential -- along the lines of the bill introduced by Congressman O'Hara of Michigan. Such a decisive measure to create jobs in socially useful work -- to perform much needed services that would not otherwise be done in parks, playgrounds, hospitals and other public facilities -- is urgently needed.

4. Manpower training programs -- including basic literacy education, personal guidance and health rehabilitation -- are essential to aid the unemployed and under-employed to compete more effectively for available employment. Although such programs do not create jobs, they can be of great benefit to the national economy, as well as the workers themselves, by upgrading the skills of the unemployed and unskilled. The recent emphasis on government-financed business programs to train workers should not include wage subsidies or other payments to the employer, beyond the extra cost of providing special training and supportive services for the hard-core unemployed, that are in addition to his normal training costs. Even the best-planned training programs, however, can be of little avail, if they are not accompanied by government programs to create jobs and achieve full employment.

5. The lag of real wages and salaries must be ended. A substantial rise in the buying power of wages, salaries and fringe benefits is needed to provide wage and salary earners with a fair share of economic progress and to strengthen consumer markets that are the foundation of the American economy. Only through an improved balance in the economy -- between wages, profits, dividends and other forms of income -- can there be assurance of sustained economic growth to reach full employment and maintain it.

Rising business profits should be based on an expanding sales volume -- rather than on swollen profit margins at the expense of workers and consumers.

We will continue to press for wage and salary increases to offset rising living costs and to advance buying power. We firmly believe that wage and salary earners deserve to share equitably in the gains of the economy's progress. The nation's rapidly rising productivity and great profitability of business make possible such improvements in wages, salaries and fringe benefits, within the context of a relatively stable price level.

We repeat again, as we have in the past two years: If the President determines that there is a national emergency that warrants extraordinary stabilization measures -- with even-handed restraints on all costs, prices, profits, dividends, rents, corporate executive compensation (salaries, bonuses and stock options), as well as employees' wage and salaries -- he will have the support of the AFL-CIO. But rigid application of a single "magic number" based on one economic factor alone, cannot be a workable or fair means of wage determination in a country of continental size, with thousands of different markets, industries and occupations. We are prepared to sacrifice -- as much as anyone else, for as long as anyone else -- so long as there is equality of sacrifice.

Minimum Wage
February 23, 1968

Major improvements in the Fair Labor Standards Act adopted by the 89th Congress in 1966 are still in the process of taking effect. They demonstrate the lasting rewards of effective political action; for these improvements, successfully pressed to enactment by the AFL-CIO, were made possible by an election victory in 1964, in which the AFL-CIO membership played a major part.

Though we can be proud of these gains we cannot be satisfied with them. The FLSA remains far short of its stated objective of assuring a "minimum standard of living necessary for health, efficiency and general well-being of workers."

The basic minimum wage of $1.60 an hour, which became effective February 1, still falls far short of providing adequate support for a family. Moreover, workers newly covered by the 1966 amendments will not reach the $1.60 floor until 1971; and for those farm workers now protected, the upward progression will stop next year at $1.30. Still worse, some 11 million wage-earners are completely excluded from the law's protection.

At the very least, the law's coverage must be extended to all who work for wages and salaries, and farm workers placed on the same schedule, rising to $1.60, as other newly-covered workers. The AFL-CIO's objective of a $2 minimum wage can no longer be regarded as a long-range goal; it must be reached as soon as possible.

The recent report to Congress by the Secretary of Labor proves again that wage-hour improvements are beneficial, not only to those who are directly affected by them, but to the economy as a whole.

Contrary to the predictions of some business spokesmen, the first wage increase ($1.40) and the extended coverage that took effect in 1967 were accompanied by a rise in employment, especially in low-wage occupations. Although consumer prices went up, they rose more slowly than in the same period a year earlier, when no wage-hour changes were made. Despite a concerted effort by the Department of Labor to encourage reports on adverse effects, out of 700,000 newly-covered establishments only three plant closings, involving 33 workers, could be found.

It is obvious that the further improvements so desperately needed by the lowest-paid workers are in the best interests of all. But those improvements will be realized only in the same way as the current ones were won -- through effective political action.

Meanwhile, each wage-hour change intensifies the importance of effective enforcement. Many more establishments and many more workers are covered; the higher minimums increase the temptation for chiselers. Even under the old law an estimated 850,000 workers were underpaid in 1966; only half the violations were discovered, and within that half, restitution was a mere one-third of the underpayments.

The AFL-CIO will continue to press for more effective enforcement of the FLSA by the Department of Labor. In addition, we call upon state and local central bodies to intensify the use of their own procedures, established a year ago under President Meany's direction, to assist all low-wage workers to receive their full due under the terms of the law.

Litigation instituted by Maryland and joined in by other states has unfortunately delayed effective coverage for school and hospital employees of state and local governments. The AFL-CIO and the State, County and Municipal Workers have participated in this litigation and have supported the constitutionality of this coverage, and will seek to file briefs in the Supreme Court. We are hopeful that the court will shortly clear the way for effectuation of this much-needed coverage.

DEPARTMENT OF LABOR

WAGE -- HOUR DIVISION

During Fiscal 1969, an additional 100,00 establishments and 1 million more workers will be brought under coverage of the Fair Labor Standards Act as provided in the 1966 legislation. However, for the act to have full benefit to those newly covered workers -- as well as for the 41 million workers previously covered -- it must be enforced. We are pleased that the President's budget provides for an additional ~~75~~ 50 Wage and Hour Investigators which would bring to ~~1,250~~ 1225 the number of investigators responsible for the 2 million covered establishments.

We whole-heartedly support the budget request for additional investigators and point out once more that the level of investigation, including those personnel provided for in the budget, will again be at an annual rate of investigation of only 3% as contrasted to the previous level of 5% maintained before Fiscal 1968. It is our feeling that this decline in enforcement ability is a travesty on those whom the act is intended to protect.

The AFL-CIO Executive Council on February 23, 1968 said:

". . . each wage-hour change intensifies the importance of effective enforcement. Many more establishments and many more workers are covered; the higher minimums increase the temptation for chiselers. Even under the old law an estimated 850,000 workers were underpaid in 1966; only half the violations were discovered, and within that half, restitution was a mere one-third of the underpayments.

"The AFL-CIO will continue to press for more effective enforcement of the FLSA by the Department of Labor. In addition, we call upon state and local central bodies to intensify the use of their own procedures, established a year ago under President Meany's direction, to assist all low-wage workers to receive their full due under the terms of the law."

Investigation by the Wage and Hour Division disclosed that 59,000 employees were underpaid in Fiscal 1967 indicating an increase of 73% in the last five years. These workers were underpaid a total of $76 million. Preliminary data for the first half of 1968 indicates that there is a further rise in the number of workers found to have been underpaid and in the total amount of underpayments.

It is our continued goal that 325 additional investigators are warrented in order to provide a minimum of protection for these 42 million working Americans who are at the bottom of the economic ladder and must be protected from unscrupulous employers.

We realize that these additional investigators will not be forthcoming under current budgetary restraints. We therefore ask the Appropriations Subcommittee to direct the Wage and Hour and Public Contracts Division to investigate the feasibility of alternate enforcement methods.

For example, in addition to the current investigation program, some type of reporting procedure might be adopted or some other methods used to enhance the enforcement activities of the Division. We are encouraged by the Division's new flexible investigation procedure, and would like to see more experimentation in enforcement techniques.

We would also desire to see greater emphasis placed on the recovery of funds actually due workers. Currently only one out of every three dollars found due is being paid to the workers wrongfully underpaid. Even after investigation disclosed underpayments, chiselling employers, failed to pay $50 million owed workers in fiscal 1967. According to the 1965 compliance survey of the Wage and Hour Division, total underpayments due workers may actually be as high as $350 million.

Such violations not only under cut the operations of honest employers, but hold many workers in abject poverty contrary to the Act's purpose. The only way to insure that the Act achieves its goal of improved economic standards for all covered workers, is to provide adequate resources for its enforcement.

Bureau of Employment Security

The budget request for an increase in personnel and funds, which we endorse, will permit the Bureau of Employment Security to expand its manpower and development training activities and to coordinate a comprehensive management improvement program throughout the employment security system. The requested appropriation would permit the establishment of an automated reporting system, the installation of plans of service geared to the needs of local communities, the implementation of a cost accounting system in a number of states, and the further development of the application of automatic data processing technology to employment security operations.

All of these efforts will result in a more efficient and effective employment security system to better serve the nation's workers and employers. The plans of service to be developed at the local and state level will contain evaluations of manpower needs, proposals of actions to be taken, and a program for the greatest level of accomplishment to be achieved with available resources. An automated management information system will provide the information necessary for decision making at all levels of the employment security system on a more timely and consistent basis. It will enable program managers to assess all aspects of administration and management, program achievement, and resource utilization and to take timely action to assure that resources are used most effectively. Compatible systems of financial management and reporting of planned utilization and actual expenditure of funds will insure proper accountability and management. The system being developed will incorporate the ability to accumulate the cost data necessary to identify elements of cost with specific program objectives and evaluate the cost-benefit relationship of employment security programs.

In general, the system will provide the basis for both effective planning and control by providing the means to project anticipated activities by appropriation, organizational unit, activity, and program, coupled with quantitive and qualitative controls to compare actual results to planned objectives. These measures are designed to improve the management of the employment security system.

Improved management of state operations is also given emphasis in the budget request related to the unemployment insurance program.

The budget for the unemployment insurance program is based on the assumption that insured unemployment, which averaged 1.1 million persons a week during the last two months of 1967, will remain at this level during Fiscal 1969. It would be more realistic to assume insured unemployment in Fiscal 1969 will be approximately the same as Fiscal 1968 -- 1.2 million weekly. The anticipated growth in the insured labor force, unless accompanied by a decline in the unemployment rate, could result in an even higher weekly volume of insured unemployment. It is also doubtful that the number of federal employee and ex-servicemen claims will remain at the 1968 level. Insured unemployment and initial claims under both programs have been higher each week in January and February of this year than they were during the same period in 1967. The appropriation should be increased substantially by approximately $7 million to provide the bureau with adequate funds to administer an average weekly workload of at least 1.2 million persons.

It is disappointing that no request has been made in the budget to undertake long delayed basic research related to unemployment insurance problems. No fundamental studies of unemployment insurance have been made since those authorized by the Congress in connection with the Temporary Emergency Unemployment Compensation Program of 1961-1962.

Authorization to provide funds for unemployment insurance research on a continuing basis was contained in legislation introduced in the 89th Congress. The failure of Congress to enact this legislation has not eliminated the need for research in this area. The Bureau of Employment Security should be given at least the initial amount ($5 million) proposed in the last administration bill to carry out studies on such important issues as the adequacy of benefit amounts, required duration of benefits, the role of unemployment insurance in meeting the problems of the long term unemployed and appropriate criteria of attachment to the labor force.

Bureau Of Labor Statistics

The appropriation request of the Bureau of Labor Statistics -- in addition to increases for mandatory items -- includes new program proposals in the field of prices and in the field of wages and industrial relations. The cost of these new programs is placed at $823,800. It is a request which we endorse, since it would help to fill existing gaps in the bureau's overall program.

In the area of prices, the bureau proposes (1) to develop indexes for sectors not presently covered and to improve existing indexes, and (2) to develop measures of price competitiveness of U. S. products in the world market.

The data which would be provided through these programs in the price field would significantly enhance our ability to analyze economic developments and trends, and formulate appropriate policies -- both for purposes of collective bargaining and the development of sound national economic policy. As is well known, price data have long had a role at the bargaining table and, in recent years, the problem of international competitiveness has become a subject of increasing interest -- as well as dispute -- in labor-management negotiations. It is our view that the proposed program would provide information which would facilitate the ability of the parties to arrive at fair and equitable settlements.

Furthermore, the need for improved data on international price competitiveness -- given the current concern over balance of payments problems -- requires no lengthy elaboration. Such data can be exceedingly helpful as an analytical tool in the formulation of sound policies by both private parties and government.

In the second major area -- wages and industrial relations -- in which the BLS is requesting funds for new programs, it is proposed to (1) obtain and analyze wage changes in non-manufacturing industries, and (2) develop a continuing program of analytical studies of labor-management relations in federal, state and local government.

At the present time, the bureau collects data on wage changes for non-supervisory workers in manufacturing industries and in certain non-manufacturing industries which are unionized. There are significant gaps in this body of information insofar as the non-manufacturing sector is concerned. In our view, steps to remedy this situation are long overdue. The data would be helpful in analyzing and understanding wage trends and manpower problems, as well as price changes. We would, therefore, urge the subcommittee to look with favor on this proposed program.

The program that is proposed with respect to public employment is one in which we are particularly interested. The growth of public employment and the growth of public-employee unions, and the growth of collective bargaining between governments and their employees, are matters of major importance. The problems which have accompanied these developments make it imperative that much more attention be given to the need for information and analysis in this field.

We have no doubt that, under the best of circumstances, it will take time to find viable solutions to many of the knotty problems inherent in union-management relationships with government as the employer. However, the proposed BLS program can make a significant contribution in the search for those solutions.

We would urge, therefore, that the subcommittee give its approval to this proposed program, as well as to the other program proposals of the BLS for Fiscal 1969.

Manpower Development and Training Activities

The budget for Fiscal 1969 provides a total of $2.1 billion for manpower programs. This represents an increase of more than $440 million over the estimate for the current year's activities. However, the Manpower Development and Training Act is involved with only a small portion of this increase. The actual amount is less than $30 million.

We would urge very strongly that the committee give its approval to this request. It is, in our view, absolutely minimal, and there is every justification for a considerably greater amount to be expended for MDTA purposes.

Reliable estimates suggest that current federal programs for training, work experience, and employment are reaching fewer than 10% of the unemployed and underemployed who need the type of assistance which these programs provide. Even allowing for the full increase requested for all manpower programs in the budget for Fiscal 1969 -- $440 million -- there will be no significant change in the portion of the work force who will receive assistance.

Moreover, among those who are being reached, the evidence is that they are not being reached very well, in terms of the quality of the programs. The source of this difficulty is the level of appropriations.

This shortcoming in our manpower training programs is something which the AFL-CIO has pointed to in the past. And we are encouraged to note that it has also been recognized by the Committee on the Administration of Training Programs, which completed its report earlier this month. In one of its recommendations that committee said:

> The level of funding for the training programs must be raised substantially if these activities are to make visible inroads into the problems they seek to remedy.. The present level of funding is inadequate to provide meaningful training for many of those currently enrolled in programs, let alone the vast numbers whom the programs should be serving.

We believe that the problems of poverty and deprivation and racial unrest which confront this nation have many roots, and no single activity or program can provide the answer. But we are firmly convinced that manpower programs are an important element in the equation. In our view, therefore, the request of the Department of Labor for this increase in funds for manpower development and training activities, modest though it may be, warrants the support of this subcommittee, and we would strongly urge that you give your approval.

Bureau of Labor Standards

The AFL-CIO is particularly disappointed by the requested increase for only 13 additional positions and $214,000 to improve safety under the Walsh-Healey Public Contracts Act.

The need for more effective safety personnel to help protect workers whose employers are covered by the Walsh-Healey Act is no better illustrated than by the fact that there are only 10 safety engineers whose capability is limited to performing about 1500 inspections per year. Against this insignificant staff there are 27 million workers in 75,000 work locations covered by the Public Contracts Act.

We realize that the argument is sometimes made that some of the federal responsibility has been delegates to the states, but for the federal government to transfer its responsibility because of staff insufficiencies to states, which themselves are badly understaffed, does not lessen nor solve the problem.

The AFL-CIO has consistently pointed out that if the current ratio of inspectors to establishments continues, it is entirely possible for 18 or 20 years to have elapsed before a federal safety inspector returns to the plants he inspected during the past year.

Delegation of responsibility to the states, as has been done in several instances, has not improved worker safety to any degree because state labor laws and their enforcement are in most jurisdictions weak, archaic, poorly financed, undermanned and broken up among many jurisdictions.

The 13 additional positions being sought are completely inadequate to meet the need, except in the high hazard areas as defined under the Act. Unfortunately, the department has never possessed the manpower and budget to begin carrying out its clear responsibilities.

While the Bureau of Labor Standards has been able to improve safety conditions in the shipbuilding, repairing and longshoring industries, as reflected by a significant reduction of injury rates in those areas during 1967, the overall safety picture under Walsh-Healey remains bleak.

It is our firm belief that there will be no real safety improvement unless the Congress takes a hand this year to increase the number of federal safety engineers and inspectors far beyond the meager request that has been set before you by the Department of Labor. We specifically urge that one hundred additional inspectors be added. We are aware that the additional cost would be approximately $1.7 million, but the reduction in work injuries that would accrue from a more effective safety program would provide savings to the federal government several times this amount, not to mention the saving in human suffering.

The AFL-CIO strongly urges that this subcommittee recommend appropriation of the necessary funds to acquire 100 additional safety engineers and inspectors for Fiscal 1969 to begin to carry out a responsible program to protect the health and safety of the 27 million workers employed by contractors under the Walsh-Healey Public Contracts Act.

Previously, we pointed to the need for the federal government to demonstrate its interest in safety by investing adequate funds to provide safe working conditions for workers employed by the federal government. The need for these funds is reflected in the record of Mission Safety-70 -- the President's own program. At midpoint, the goal of a 30 percent reduction in federal injuries by 1970 is not certain. It is true that a 13 percent reduction in federal injuries reflects improvement, but adequate funds would improve on this record. The 13 percent reduction in federal work injuries has saved the government $8 million; this saving represents approximately 66 2/3 percent of the proposed budget for the Wage and Labor Standards Administration. We do not feel it is unreasonable to ask Congress to reinvest at least part of this saving in the Wage and Labor Standards Administration.

It is a shocking fact that on a nationwide basis industrial injuries are increasing instead of decreasing. The preliminary rate of 13.2, disabling injuries per 1 million manhours worked, based on the first half of 1966, points to the possibility that injury rates in 1966 were higher than for any year since 1953. This points to an unmet need for research that the bureau can perform in the areas of occupational health, quality of medical care, and income maintenance for those injured on the job, all of which would contribute to the elimination of industrial injustices that have too long been ignored.

Unfortunately, there is no provision made in this budget for funds to stimulate this kind of research. We respectfully urge this committee to encourage the Department of Labor toward imaginative research for the purpose of improving workmen's compensation. Income maintenance, adequate medical care, and rehabilitation are essential if the victims of industrial injuries are to escape the despair of poverty and hopefully, be returned to productive employment.

Through its cooperation with the individual states in their efforts to enact and administer protective labor laws, the Bureau of Labor Standards has constructed a bridge between the Department of Labor and the State labor agencies. State labor legislation to protect children, to insure fair treatment of unemployed workers by private employment agencies, to collect wages, to establish minimum wages, and to provide workmen's compensation protection for wage earners killed or injured on the job has significantly advanced the welfare of workers. The following are just a few of the state laws enacted in 1966-67 which directly or indirectly reflect Bureau of Labor Standards assistance and guidance.

Significantly improved control of radiation hazards: Colorado, Idaho, Illinois, Maryland, Montana, Puerto Rico, South Carolina, South Dakota, Utah, and Vermont.

Workmen's compensation provisions making radiation exposure a compensible disease: Alabama, North Dakota, and Wyoming.

Liberalization of time limits for filing for radiation diseases: Idaho, Maryland, Nevada and West Virginia.

The increasing demand for its services in these many areas taxes to the limit the capabilities of the bureau's staff. The request for 10 positions and $263,000 to provide executive direction, planning and evaluation is a modest one. The increase in personnel and funds would benefit each of the bureaus within the Wage and Labor Standards Administration to more effectively meet its responsibilities. We hope the Committee will act favorably on this request and thus enable the Administration to increase its efficiency and meet the ever-increasing demands for technical assistance by the states.

Women's Bureau

For the coming fiscal year, funds for the Women's Bureau are consolidated into the budget for the new Wage and Labor Standards Administration, set up by the Secretary of Labor in July 1967. Its activities are carried forward under the general function "advancing opportunities and status of women," for which an appropriation of $967,000 is requested. This compares with an expenditure of $920,000 estimated for fiscal 1968.

As has been true for several years, the current request simply maintains Women's Bureau staff at pre-existing levels, with money increases reflecting general employee pay increases only.

The Women's Bureau is the primary federal agency concerned with working conditions and the special employment, training and service needs among the continually growing number of women in the labor force. Women's Bureau services are now in special demand in connection with efforts to upgrade the opportunities for working women in the very lowest earning groups and in the promotion of counseling services and day-care facilities for working mothers. The Women's Bureau carries an unabated responsibility for meeting informational demands throughout the United States, stimulated by the state commissions on the status of women.

We urge that appropriations be approved for at least the amount requested and increased if possible.

The International Labor Programs

The functions of the U.S. Department of Labor in the field of international trade, as it affects labor and negotiations both in this and in other countries, unfortunately have a minimal budget allocation. The amounts seem entirely inadequate for the growing problems affecting the United States.

It is interesting to note that there is not any specific budget allocation for the Department of Labor to examine the impact of international trade on employment. Yet, this issue, repeatedly before the Congress in this and other years, has become increasingly important. Such a study, based on problems facing American business and labor in the 1960s , is long overdue.

The Bureau of International Labor Affairs is responsible for drawing together the foreign economic policy activities of the Department of Labor and to provide information to other government and international agencies. Trade negotiations do not begin or end on any specific date: Each time any country has a specific problem with the U. S. or each time the U. S. raises problems abroad, these negotiations involve American labor. To handicap the gathering of information and the availability of analysis to the Congress and to other government departments is a short-sighted and self-defeating policy. If anything, therefore, the budget should be expanded.

If the Congress passes a workable trade adjustment assistance program, activities for this purpose will increase in the Department of Labor, and funds should be available not only for payment of allowances but also for specific retraining projects.

Employment in textile, steel, chemical and other major U. S. industries affected more and more by imports, and more and more subject to legislative consideration by the Congress, require much more extensive investigation than has been possible to date.

BUREAU OF EMPLOYEES' COMPENSATION

The AFL-CIO has a strong interest in the programs administered by the Bureau of Employees' Compensation. The programs of the bureau are vital to the economic well-being of workers covered by the federal workmen's compensation laws. These laws provide workmen's compensation protection to approximately five million workers in both government service and private employment. In tens of thousands of cases each year, this protection represents the bulwark against poverty and despair for injured workers and their families. During fiscal 1967, the bureau was responsible for providing prompt workmen's compensation service to over one-quarter of a million injured workers (121,322 federal workers and 130,389 workers covered by the Longshoremen Act.)

We feel federal laws should be models for the states to follow, both in terms of benefits and administration. All laws, regardless of how well devised or how adequate in terms of benefit structure, are only as good as their administration. Over the past 50 years, we have been pleased with the administration of the federal workmen's compensation laws. The accomplishments of the bureau over the years is a tribute to the ability and ingenuity of its administrators.

Increasing employment levels in both the federal service and private industry have added to the workload of the Bureau of Employees' Compensation. Failure to provide adequate funds would deny to many injured workers the remedy the law intends they should receive.

Moreover, the appropriation of the additional funds requested would result in overall savings by enabling the bureau to improve reporting, engage in closer case management, return injured workers to their jobs at an earlier date, and provide workmen's compensation benefits and service in the manner contemplated by the laws.

NATIONAL LABOR RELATIONS BOARD

The National Labor Relations board is requesting for fiscal 1969 an appropriation of $35,074,000, which is $2,921,340 more than the board expects to have available for expeditures this year.

As this subcommittee knows, the National Labor Relations Board occupies a distinct place in the structure of government, not only from the standpoint of labor and management but from the standpoint of public interest as well. To a very considerable extent, the preservation of peaceful and useful labor management relations depends upon the ability of the NLRB to carry out its functions under the National Labor Relations Act expeditiously and efficiently. As has been pointed out many, many times, justice delayed is all too often justice denied.

The need for the increase in the amount requested by the National Labor Relations Board, including the offices of the general counsel and the board's office of the regional offices arises primarily because of the continuing increase in the board's work-load. In addition, as this subcommitee knows, there is a backlog factor to be taken into account.

These developments also need to be considered against the background of an increasing volume of labor disputes in recent months, many leading to strikes, and often accompanied by rejection of strike settlements and negotiated agreements. The Board has further pointed out that there has been a substantial increase in the filing of charges by individuals against both unions and employers.

At a time when there has been an increase in board activities and workload, the board has reduced expeditures, cutback on various activities and carried out the freeze imposed on hiring new personnel. The board we submit has more than met its obligations to the nation in this period of budget strain and difficulties.

We believe that the NLRB has fully demonstrated its responsibilities and vital purpose in providing means for orderly selection of employee representatives, for purposes of collective bargaining and for peaceful settlement of labor-management disputes. We believe the board has made an outstanding record of useful public services in the field of labor-management relations.

We urge that the full amount requested for the work of the board and the general counsel be approved by this subcommittee and the Congress.

Federal Mediation and Conciliation Service

If any part of government can be singled out as a "bare bones" operation that is doing an excellent job despite great handicaps and discomforts, it is the Federal Mediation and Conciliation Service.

For many years now this service has labored without adequate secretarial assistance for the mediators in the field and has seen its case load grow and its volume of paperwork multiply. In the face of recent budgetary cutbacks, there is absolutely no area whatsoever for this small and already austere organization to make further cuts or to absorb mandatory increases in expenditures.

The additional funds of $653,000 being sought are primarily for the purpose of handling an anticipated higher volume of disputes and to carry out its laudable and successful preventive mediation activity.

Each year 50,000 union contracts are negotiated and agreed to. Actively participating in the talks that bring successful conclusion to 8,000 of these activities has been the FMCS. No one can estimate the saving in GNP, man hours, tax revenues and personal anguish that these mediators have achieved, but it is beyond a doubt many times that of the budget cost each year.

The strike headlines of the past year -- in copper, auto and elsewhere -- have dramatized the important role that this service plays in our society; the many thousands of non-strike collective

bargaining situations in which they have played a vital -- if not determinent -- role number in the thousands.

An adequate staff, properly trained and effectively buttressed by competent office assistance is necessary for the continuation of this excellent service. Any attempt to cut back will be at a very high cost in industrial peace and achieving those desired areas of agreement between labor and management in our democratic society.

NATIONAL MEDIATION BOARD

The AFL-CIO fully supports the $2,242,000 appropriation request for the National Mediation Board. The additional funds being sought are clearly necessary to handle the increased workload that has accumulated during the past year and will undoubtedly continue in the future.

Creation of public law boards was for the purpose of cutting down on the load of work but has failed to do so; in fact, the increase in work has caused such additional expenditures in behalf of referees on adjustment boards that in many instances it was necessary to close down boards until a new quarter was reached and new funds were available. Consequently, the backlog of work remains heavy and delays swift handling of cases. It is clear that the disputes before the referees and the adjustment boards and within the functions of the National Mediation Board reflect the increasingly complex problems involving operating workers, shopcraft employees, clerks, maintenance, yardmasters and shopworkers. If these issues are to be resolved properly, without agonizing delay, -- and within the channels provided for peaceful resolution -- there cannot be any miserliness over the funds to achieve these goals.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

The programs of the Department of Health, Education, and Welfare are so far-reaching as to affect the lives of almost every American. They range from child health to old age insurance; they are important to young and old, rich and poor, black and white. The aid and services are provided through and in cooperation with hundreds of state agencies and thousands more school districts, nursing homes, hospitals, colleges and universities and other public and private institutions and vendors.

Consequently, it is vital that the department assure that no funds it administers are used in programs which discriminate or segregate on the basis of race, color or national origin.

The Office for Civil Rights, the departmental agency responsible for assuring compliance with the nondiscrimination requirements of Title VI of the Civil Rights Act of 1964, is seeking 66 additional positions in the next fiscal year to improve its ability to see that funds are not used to support state or local programs which discriminate.

The most widely known activity of the Office for Civil Rights is the desegregation program it has conducted with respect to elementary and secondary education. Efforts to eliminate dual school systems are being continued. Under guidelines, the major thrust in the 1,179 school districts still in the process of converting to desegregated systems is the negotiation of comprehensive plans ending dual structures by the start of the 1969-70 school year.

The Office for Civil Rights is also carrying out major compliance programs with respect to hospitals, state agencies involved in the administration of programs under the department's jurisdiction and institutions of higher education.

The office has the added responsibility of coordinating enforcement of the provisions of the Executive Order on Equal Employment Opportunity among contractors dealing with the department and with contracts affecting schools and hospitals entered into by any Federal agency.

The AFL-CIO is aware of the growing significance of guaranteeing equal employment in Federal contracts. Minority under-employment and unemployment in urban areas has been a major factor in civil unrest. By stepping up efforts to see that equality of opportunity in employment is a fact in contracts with the department, HEW will be working constructively, in cooperation with the private sector, to provide new and improved job opportunities to many who may have been denied such employment in the past.

We in the AFL-CIO are proud of the fact that our organization has consistently been in the vanguard of those pushing for equal rights and equal opportunities for minority Americans. We strongly supported the adoption of Title VI of the Civil Rights Act, believing then as we do today that no Federal funds should be spent in any activity which is not open to all without regard to race, color or national origin. We feel even more strongly in this year of 1968 that the Federal government has a solemn obligation to assure equal rights and opportunities for all of our fellow citizens. We urge that the full request of the department for 66 new positions in the area of civil rights compliance be approved by the subcommittee.

Social Security Administration

The 1969 budget of the Social Security Administration reflects the continuing growth and expansion of the social security program. In fiscal 1969 under the Old Age, Survivors, and Disability Insurance Program, an estimated $26.2 billion in benefits are expected to be paid to some 25 million people. The hospital insurance program will provide protection against the hospital and related costs of major illnesses for over 19½ million persons and will pay $3.9 billion for services to an estimated 4.6 million. The medical insurance program will protect 18.3 million persons and actually pay $1.7 billion for medical expenses incurred by 7.6 million persons. In total, benefits under the social security program are estimated at $31.8 billion for 1969 and represent an increase of approximately $4.0 billion over 1968. Approximately $2.6 billion of this increase is due to the 1967 amendments. Fiscal year 1969 will be the first fiscal year to reflect a full year's cost of the amended program because the 1967 amendments generally became effective in the second half of Fiscal year 1968.

The amendments provided for an across-the-board increase of 13% for persons now receiving retirement, survivors, or disability benefits, with an increase in the minimum monthly benefit from $44 to $55, effective February 1968. A number of other changes contribute to increased workload. Beneficiaries may now earn $1680 a year without a reduction in benefit payments. Certain new beneficiary groups were added, the principal ones being disabled widows and widowers at age 50 who are unable to do any gainful work, dependents of women (who will now be eligible for benefits under the same conditions as dependents of men), and disabled workers under age 31 who previously could not meet the insured status requirements. The amendments also provided for some additional services to be covered by the Medicare program.

For salaries and expenses, the Social Security Administration has requested $778.1 million, which includes a $25.0 million contingency fund. Excluding the contingency fund, this is an increase of about $36.7 million, of which $19.3 million is for built-in Federal salary and postal rate increases and increases in wage and price levels of public and private agencies under contract with the Administration, and $17.4 million is for handling a larger volume of work in 1969 than in 1968 due primarily to the growth of the population served. This growth will result in a 4.2% increase over the 1968 level in the volume of work to be handled by the staff of the Social Security Administration and by public and private agencies under contract to perform certain administrative functions of the health insurance and disability insurance programs. For fiscal year 1969, the administrative expenses of the Old-Age, Survivors and Disability Insurance Program will represent about 2% of benefit payments and administrative costs of the Health Insurance Program about 5% for the same period. These are extremely low administrative costs and compare most favorably with any similar public or private program.

Included is a request to appropriate $1.4 billion of the general funds of the Treasury to the social security trust funds for hospital insurance benefits for persons not insured under the social security and railroad retirement programs and to pay the government matching premiums for the supplementary medical insurance program. Other requests for general fund moneys

include: $105 million as a recurring payment to the trust funds to reimburse them for benefit payments and related costs resulting from the non-contributory coverage extended to certain veterans; and $225.5 million to reimburse the trust funds for the benefit payments and related costs incurred in 1967 for certain noninsured persons aged 72 and over.

We urge approval of these budget requests in order that social security beneficiaries shall continue to receive benefits promptly and efficiently and without the hardship that might occur were inadequate funds appropriated to properly administer the program.

Social and Rehabilitation Service

In the partial reorganization of some of the functions of the Department of Health, Education and Welfare which took place last year, no section of the Department was given a more important assignment than the newly created Social and Rehabilitation Service. This agency is charged with the responsibility for public assistance, medical assistance to the needy and medically needy, child health and welfare, programs for the aging and rehabilitation of the physically and mentally handicapped. In one way or another, these programs affect the lives of tens of millions of Americans of all ages, races and regions of the country. It is therefore of the utmost importance that the programs entrusted to the administration of the SRS, as well as the SRS itself, be adequately funded. With respect to most phases of these programs, we recommend that the amounts requested by the President be made available. In some cases, however, as we shall indicate, we believe these amounts are or could be inadequate.

Public Assistance

The estimates on which the budget requests are founded reveal how unrealistic are the assumptions behind the regressive restrictions on public welfare programs adopted last year. The apparent assumption was that those dependent on welfare would not suffer because of the freeze on the Federal contribution to Aid to Families With Dependent Children because the rolls would be proportionately reduced by work and training programs for employable adults and day care for children of such adults now on the rolls. It is clear, however, that this assumption bears no relationship whatsoever to the reality.

Unless the freeze is removed, it is estimated that Federal participation will be denied for payments to over 475,000 children in fiscal 1969. Yet, during the same period, it is estimated that the new work and training program administered by the Labor Department will reduce the welfare rolls by an average of only 41,500. During the same year, day care will be available for only 17,500 mothers with an average of two children each requiring care. Thus, it is clear that the possibilities for training and employment, as well as available day care facilities, will be so limited that most of those affected by the freeze can anticipate no alternative source of subsistence. To prevent cruel hardship to hundreds of thousands of families, therefore, it is essential that the freeze be repealed. If that is done, it is estimated that even at the existing subpoverty level of payments, an additional Federal appropriation of $126.2 million would be needed.

Child Welfare

In the Social Security Amendments of 1967, Congress raised the authorization for Child Welfare Services to $100 million in 1969 and $110 million per year thereafter, from the previous level of authorization of $55 million. This represented a considerable potential for improvement of Child Welfare Services. Unfortunately, the budget request for child welfare appropriations for fiscal 1969 is only $46 million, the same as the appropriation for 1968. Thus, the Congressional concern for expansion of Child Welfare Services has not been reflected in the amount which has been requested. Because of increased costs, the services will actually have to be reduced or states will have to provide a greater proportion of funds than previously in order to maintain even the same inadequate level of services. In order to expand needed Child Welfare Services, we urge that the full amount of $100 million for 1969 which has been authorized be appropriated.

Medical Assistance (Medicaid)

The Department has requested an increase of $366.9 million for the Federal share of the costs of medical assistance under Title XIX of the Social Security Act. Approximately $85 million, or one-fourth of the increase, is due to the

rise in cost of medical services. In the Social Security amendments of 1967, Congress cut back eligibility standards for Medicaid, thereby depriving large numbers of low income families from obtaining medical care they cannot afford to pay for out of their meager resources. If this cutback in the number of families eligible for Medicaid had not been made, the total additional amount over the requested funds would have been $125 million, of which the Federal share would have been $100. Thus, two-thirds of the total cost of medical care for those now to be deprived could be met if proper controls are placed on fees and charges within the program. If the rise in costs which has already taken place had been forestalled, it would have been possible to provide medical assistance at or below the estimated cost in fiscal 1969 for all those who are to be cut from medical aid.

We urge, therefore, that instead of depriving poor families of needed medical care, effective measures should be taken to control the rapid escalation of medical costs.

Maternal and Child Health

We are pleased that the budget provides for a new, and badly needed, dental health program for children. However, in view of the fact that approximately one-half of all children under 15, and two-thirds of all children in families with income under $4,000, have never been to a dentist, the budget provision of only $1 million to meet the dental requirements of only 30,000 children is grossly inadequate, even if this is regarded as a pilot program. It is our understanding that the American Dental Association, to which most dentists are affiliated, would participate in a much larger program. Therefore, we urge that this program be greatly enlarged and that at least $5 million be provided for a first-year pilot program and substantially larger amounts in subsequent years.

Although the budget calls for an increase of $57 million for maternal and child health programs, this is $13 million under the authorized amount. We urge that the total amount be appropriated. These funds are needed for such important activities as early identification and treatment of children with handicapping conditions, health care for school and preschool children and other measures to improve the health of mothers and children. In view of the inadequacy of maternal and child health, as revealed by our infant mortality statistics, everything possible should be done to fully fund these programs.

The President has announced a new program of prenatal and postnatal care up to one year of age to take effect in Fiscal 1970, but no amount is specified in the budget for Fiscal 1969 for this program which we understand, if enacted, will be covered in in an appropriation request for Fiscal 1970. We strongly support this program and believe that it should be extended beyond the first year to cover all preschool children and that the necessary additional funds should be provided for that purpose.

Public Health Service

The goal of public policy should be to provide comprehensive health services to all of the American people. It is also the responsibility of government, Federal, state and local, to provide the healthiest possible enviornment in order to reduce the incidence of disease. The main barriers to accomplishing these goals include (1) a lack of needed health facilities; (2) the need for more health manpower; and, most important, (3) the need for rationalization of health resources and services based on some priority of need.

The Public Health Service plays a very important role in the national effort to improve the health of the American people. Therefore, we strongly support the budget request to finance its program. We would particularly stress the need for adequate funds, if necessary even increasing the appropriations for those programs where the need is greatest.

Planning is being increasingly recognized as essential in order to allocate our health care resources most effectively. Health planners have indicated that our greatest need is no longer in the area of acquiring new medical knowledge. The most urgent task now is applying what we already know. Therefore, our greatest need is to promote and expand those programs which hold promise of improving upon the organization and delivery of health services.

The last decade has seen a phenomenal advance in medical science and technology. Within the last few years, spectacular advances have been made in the application of automation and electronics to medicine. We now have, for example, automated laboratories and auto-analyzers capable of reading electro-cardiograms. These developments not only have the potential of reducing errors and improving the quality of medical care but also of reducing the cost of detecting and treating disease.

However, the pace of scientific advance has far outstripped our capacity to apply what we now know for the benefit of the people. This gap is widening. The current budget contains $1.5 billion for biomedical research but a relative paucity for research into methods and systems of health service delivery. What use is new medical knowledge if it isn't applied, or, at least, if it isn't applied efficiently? We would like to cite just two examples to illustrate our point. The heart lung machine, which made open-heart surgery possible, was a most dramatic scientific break-through. What happened? We now have an expensive proliferation of such equipment most of which sits idle most of the time in many hospitals and the surgical team, including highly trained technicians, have little opportunity of developing their skills. At another extreme, a technique for early detection of cervical cancer, the Papanicolaou or "Pap" smear test could all but eliminate this form of cancer, yet the test is all too rarely utilized.

This is why the AFL-CIO believes the number one priority for the 1969 budget should be the PHS programs which hold promise of improving the delivery of health services. These programs are:

(1) The Regional Medical Program (Heart, Cancer and Stroke).

(2) Comprehensive Health Planning and Services (Partnership for Health Program).

(3) The National Center for Health Services Research and Development.

The Regional Medical Programs show great promise of coordinating, on a voluntary basis, our efforts to increase the availability and utilization of advanced diagnosis and care for victims of heart disease, cancer, stroke and related diseases. Approximately $100 million is being made available in fiscal 1969 for this program of which $68,922,000 is new obligational authority. We recommend the amounts requested be appropriated.

The Comprehensive Health Planning and Public Health Service Act of 1966 (P.L. 89-749) as amended by the Partnership for Health Amendments (P.L. 90-174) calls for grant support to the states and other public and nonprofit agencies for health planning and for health services. The budget calls for an appropriation of $195,383,000 for fiscal 1969. Of this sum, $89,100,000 is allocated for project grants of which $20 million, we understand, is earmarked for rat control. Also,

this money replaces sums earmarked in prior years for the so-called "categorical" grant programs for chronic disease, tuberculosis, venereal disease, etc. Thus, very little actual funds will be used to stimulate innovations in the provision of health services.

Also included in this budget item are funds for projects to increase the capabilities of people and agencies toward the goal of helping them to become more effective in health planning. Congress, in passing P.L. 89-749, rightly stipulated that the majority of persons on the advisory councils to the state planning bodies should be consumers. If such consumer representation is to be effective, it is most important that consumers receive training in the concepts and principles of planning. We feel very strongly, therefore, that the appropriations for project grants should be very substantially increased, particularly such appropriations that would apply to sections 314(c) and 314(e) of the Public Health Service Act.

Section 314(c) provides grants for training, studies and demonstrations in health planning including training to increase the capabilities of people in health planning skills. If planning is to be effective, the members of the advisory councils established under the Partnership for Health Program will require such training to be able to serve constructively on these advisory bodies. This is particularly true for consumer representatives on the councils.

Section 314(e) provides for grants to stimulate innovations in the provision of health services for the purpose of developing new methods or of improving existing methods of providing health services. Of the total amounts of Federal support for medical research, the amount we spend for research to improve the delivery of health services represents only 5 percent of what we spend on cells, organs and organisms. We know more and more about disease and apply this knowledge less and less. We therefore request a very substantial increase in the budget for section 314(e) of the Public Health Service Act.

P.L. 90-174 established a National Center for Health Services Research and Development (Section 304) for which $27,720,000 is requested. We believe this appropriation should also be increased.

Two out of three doctors today are specialists and less than 10 percent of our medical students plan to go into general practice. With the increase in specialization comes a need for a greater degree of association and organization of health specialties. Therefore, one of the most important things that can be done to improve the quality of medical care and to render that care more efficiently is to stimulate the growth of the group practice of medicine. The current administrative budget contains a new item of $400,000 for a Group Practices Section in the Division of Medical Care Administration. The AFL-CIO strongly feels the appropriation for this section should be greatly increased.

For migratory health services, $8,100,000 is requested. The neighborhood health centers program of the Office of Economic Opportunity is bringing health services to the urban poor. The migratory workers in agriculture have a need for health services no less than the urban poor and we strongly recommend the appropriation for this program be substantially increased.

Other programs for which we feel the full amount requested should be granted are those programs related to increasing health manpower, to air pollution, to radiological health and to urban and industrial health.

Food and Drug Administration

For the fiscal year 1969, the appropriation requested for the Food and Drug Administration is $69,801,000, an increase of only $3,868,000 over the $65,933,000 estimated for the 1968 fiscal year.

We firmly believe that a vigorous operation of the Food and Drug Administration is essential. Certainly we have every right to expect that all drugs marketed for human use should meet standards of purity and effectiveness. The Food and Drug Administration, under contract with the National Academy of Sciences, has been evaluating the effectiveness of drugs now on the market. However, the issue has been raised by the drug manufacturers that drugs of identical chemical composition may not be therapeutically equivalent because of differing manufacturing procedures or because of the combination of such drugs with different inert substances. While the problem of "therapeutic equivalency" affects very few drugs, it is important that physicians have objective information regarding the equivalence of certain drugs. The FDA should be allowed sufficient funds to make a determination regarding the therapeutic equivalency

of, essentially, the same drug manufactured by different manufacturers.

The functions of the Food and Drug Administration in protecting the health and safety of the public are too vital and too basic to be sacrificed to economy. Some 7 percent of the drugs that are being marketed today do not meet FDA standards of potency and purity. We submit that this is scandalous. Physicians and consumers alike should have maximum assurance that the drugs that are prescribed and consumed accomplish what they are purported to accomplish. With present limitations on its funds the FDA cannot discharge this responsibility. We therefore strongly recommend an appropriation of at least $100 million for the Food and Drug Administration.

Occupational Health

This is the third year that AFL-CIO has appeared before this subcommittee and called attention to the inadequate budget request for funds to carry forward an adequate national occupational health program.

The budgeted item for fiscal year 1969 occupational health programs represents no change from the previous year except for an additional $800,000 for the problem of uranium miners.

While we heartily endorse this provision in the budget, we state once again that another year will be lost in carrying forward the program recommendations in the 1965 special report to the United States Surgeon General (the Frye Report) which continues to receive general support from organized labor, the organized medical profession, and other public health and medical groups.

The AFL-CIO therefore urges this subcommittee to make substantial increases in recommended appropriations for the occupational health program of the Center for Urban and Industrial Health. This should be done to place into effect the key recommendations of the Frye Report.

We recommend that the approximate $8.4 million approved by the Bureau of the Budget be increased by another $4.5 million for present program activities.

The existing program items that would be strengthened by the recommended increase of $4.5 million would be these: Establishing criteria and standards on asbestos and beryllium, additional work on going programs dealing with the uranium miners; increased activities on occupational respiratory diseases at the Occupational Health Division's laboratory in West Virginia; expansion

of laboratory and other study and research into occupational diseases; a special project on noise; and expanded programs of technical assistance in occupational disease control, exchange of technical information and in-plant health services.

All of these activities need to be adequately funded if the federal government is to begin any kind of a concerted program geared to safeguard this nation's workers from illness and death from occupational health hazards by finding out more about their cause and effect and how to reduce them.

President Meany recently declared, "....workers should never be called upon to pay for their jobs with their health or their lives. The producers of our goods and the providers of our services merit the best and most effectively coordinated effort of the federal government and those of the states to see that safety (and health) standards in their places of work are constantly and steadily improved."

The AFL-CIO believes, for the first time in our history, the eyes of Congress are focused on the national tragedy of thousands of deaths and hundreds and thousands of illnesses from harmful job conditions. We reiterate our hope that this subcommittee will consider our recommendations for a sharp increase in appropriations for occupational health as reflecting the need for action now, toward the long awaited goal of a safe place of employment for the American worker.

The related problems of disability and dependency are major national problems. Over 22 million persons in the United States have some type of physical, mental or health handicap and about 13 million are within a working age and potentially eligible for employment. Each year an additional 500,000 persons become handicapped.

Unfortunately, since most of our existing programs are still far from adequate, we must, as soon as possible, expand rehabilitation services to the point where the opportunity to benefit is available to every person who needs them at the time needed, or millions of persons will live out their lives in unnecessary misery and economic dependence. Though universal availability of rehabilitation is justified for humanitarian reasons alone, it is imperative from the viewpoint of economic self-interest. For the rehabilitated person will return in taxes, on an average, five times the cost of his rehabilitation.

In addition to some necessary increases to maintain existing programs at present levels, the President's budget for the Rehabilitation Services Administration includes additional funds for some growth and expansion in the mental retardation and vocational rehabilitation programs. The 1969 budget also includes a new program of grants to states for projects to provide rehabilitation services to handicapped migratory agricultural workers and their families. This program was authorized by the Vocational Rehabilitation Amendments of 1967. The budget includes a request for $3,500,000 for this new program which will provide assistance to an estimated 3,500 disabled migratory workers and members of their families.

The budget also includes a total request of $11 million for expansion grants, an increase of $3,650,000 over the 1968 level. Of the total request, $6,650,000 will be used to fund approximately 59 new grants. Included in this amount is $4,500,000 to fund approximately 16 projects to expand rehabilitation services to handicapped persons who face the added problems resulting from social and economic deprivation. These projects will be directed to the handicapped living in the poverty area in large urban centers. This is part of the national effort to emphasize and to direct our resources toward solving the problems in cities. In addition to the special program effort, a total of $2,150,000 will be available in 1969 to fund approximately 43 additional new expansion projects in other priority areas of concern.

In addition, a supplemental estimate of $1,900,000 was sent to Congress to complete the programs of state-wide planning now under way in nearly all the states. Unfortunately, Congress in approving the need for additional funds stated that they should be obtained by transfer from other vocational rehabilitation programs rather than by new appropriation. This will be done but will come at the expense of other important programs. We urge that Congress make available in the new appropriations the additional funds necessary to complete the state-wide planning programs now in progress.

In general, we feel there is a need for higher appropriations for the Rehabilitation Services Administration than those proposed. Congress, in appropriating money for this program, is in the fortunate position for a long time to come of helping society both monetarily and productively as it appropriates money to rehabilitate the disabled. At the very least, the AFL-CIO urges

the Congress to consider our recommendations stated above to provide the Rehabilitation Services Administration the funds necessary to restore greater numbers of the handicapped to happy and useful lives.

The President's Committee on Employment of the Handicapped

One of the most effective means of developing more jobs for physically and mentally handicapped citizens, a disproportionate share of whom are in the ranks of the disadvantaged, is through aggressive local action.

The guiding force in this area is the President's Committee on Employment of the Handicapped. Governor's Committees in all the states of the Union and local committees in more than 1,000 cities and towns look to the President's Committee for guidance and ammunition in their efforts to expand job opportunities for the handicapped.

Yet the President's Committee finds itself hampered by an artificial appropriations ceiling of $500,000 which prevents it from even considering any expansion in order to meet urgent needs at every level -- national, state and local.

We are confident that based on its past record elimination of the ceiling would certainly not result in excessive spending by the President's Committee; the committee has a long history of economy combined with effectiveness. But at least it would give the chairman the option of considering modest increases to enhance activities in urgently needed areas. Among such areas are these: strengthening state and local committees; special efforts in behalf of more seriously handicapped groups; educational campaigns among the physically and mentally handicapped to create awareness of training opportunities; and expanded programs to eliminate architectural barriers.

Actually, additional funds for the President's Committee are more in the nature of investments than expenditures. The Department of Health, Education and Welfare has estimated that a handicapped person will earn $35,000 in his lifetime for each $1,000 spent on his rehabilitation. The handicapped represent a great national asset to America, rather than a national liability. The President's Committee, properly funded, can assure the utilization of this asset to a much greater extent.

Appropriations for Education

Recent years have seen an important series of educational programs enacted into federal law. These programs are bringing significant benefits to millions of children and young people in the cities, in the suburbs, and in the rural areas of America. They have opened up new educational opportunities extending from pre-kindergarten programs to graduate schools and adult education. Above all, these laws are providing opportunity to those who need it the most, those children and young people from low income families who must have excellence in education if they are to break out of the poverty cycle which has entrapped their families, in many cases for several generations.

We of the AFL-CIO are proud to have played a major part in bringing about the enactment of these laws. We have repeatedly expressed our view that existing legislation falls short of the kind of federal support that is needed to provide quality education for every child wherever he may live, whatever his family income, and whatever his race or nationality background. The present laws are not enough, but they are an impressive beginning.

It is because we are so convinced that the present legislative authorizations are unrealistically low that we are particularly concerned that educational programs at least be fully funded to the limit of existing authorizations.

The largest reduction in the previous level of spending which the budget of the United States proposes in educational appropriations would come in college construction.

The present authorizations for higher education construction were set by Congress after careful study of the needs. Both in the Senate and in the House, the committees which handled this legislation expressed the view that the authorizations were adequate only to meet the country's minimal needs for additional facilities in higher education. The drastic slashes which are being proposed could only have the effect of limiting the number of young people who can continue their education beyond high school.

The growth of junior colleges would be particularly hit by the suggested authorization of only $34 million for construction in this category. Junior colleges have proved to be the most promising means of making higher education available to a wide range of young people with varying needs, and especially those who come from low and moderate income families.

Similarly the suggested appropriations of $33 million for four year college undergraduate construction and $8 million for graduate school construction could only mean that there will continue to be too little room to accommodate those who want and need higher education.

Although college construction funds, under the budget suggestions, would suffer the greatest reductions from previous levels of spending, other programs would in fact be reduced even more drastically from the levels which Congress has authorized for this year.

On this basis the most tragic of all the proposed reductions is in the suggested appropriation for Title I of the Elementary and Secondary Education Act. The Congressional authorization for this title for 1969 is $2.5 billion. This minimal figure was reached by Congress after schoolmen from all parts of the nation testified that previous levels of funding under Title I left them with the alternatives of spreading the funds too thin for them to be helpful or of concentrating the funds on so few pupils that only a fraction of the need could be met. Yet the budget request for Title I funding for fiscal 1969 is only $1.2 billion, less than half of the $2.5 billion which Congress has authorized.

Title III of the Elementary and Secondary Education Act has done much to stimulate innovative new programs in school systems across the nation. Many of these have been among the most promising educational developments of our time. We would hope, on the basis of experience, that additional funds might be put into this program. Instead the suggested appropriation for 1969 is actually $20 million less than was appropriated in 1968.

The Elementary and Secondary Education Act has done much to stimulate the long overdue development of new teaching materials and more realistic textbooks. The proposed reduction of $123 million in the appropriation for equipment and library resources could only mean further delays in getting these new materials into the hands of the student.

Other educational programs seem to be accelerated under the proposed budget whereas actually they are being under-funded. The Teacher Corps is providing highly motivated, well-trained teachers in many of America's largest cities. The National Advisory Commission on Civil Disorders said: "The Teacher Corps should be expanded into a major national effort." The proposed appropriation of

$31.1 million does in fact represent considerable increase over the $13.5 million appropriated in 1968. The level of increase, however, becomes considerably less impressive when one notices that the suggested $31.1 million is nearly $15 million below the $46 million which Congress authorized for Fiscal 1969. It is in fact even below the $33 million which was authorized for Fiscal 1968.

Along with our grave concern over the erosion of educational funds there is another matter that grieves us considerably, and that is the meager funds for the Bilingual Education Act, which was passed on the final day of the first session of the 90th Congress. Here is a program for aiding a long-neglected area of educational need, involving 1 3/4 million American children, who have been handicapped in their education because they come from Spanish-speaking homes and are enrolled in English-speaking schools. The admirable purpose of this Act is to provide methods and special programs to help Mexican-American, Puerto-Rican and other children overcome the language barrier which has kept them from good education. We were most pleased that the legislation was enacted with an authorization of $30 million for Fiscal 1969. We were completely deflated to learn that the budget is for only $5 million. We urge most strongly and emphatically that this program be fully funded in this its inaugural year to enable its implementation in all affected areas of the United States and to guarantee that no child -- because of his Spanish heritage -- shall be deprived of the opportunity to a meaningful education. Every year, at ages 4, 5 and 6 we lose forever the golden education opportunity among tens of thousands of children. We must not perpetuate this neglect by failing to appropriate the funds necessary to make this program successful.

The many programs of federal support for education adopted under the last three administrations have made it possible for American education to move rapidly in new and hopeful directions. Now that we are under way, the nation can ill afford to lose the momentum which we have now achieved. We urge therefore that the educational programs adopted by Congress be fully funded to the limit of existing authorizations.

Vocational Education

The funds for vocational education for fiscal 1969 are $10 million below the legal authorization for these programs. In addition, the 1969 budget contains an additional amount of $15 million for a new "Exemplary Program."

The following table shows the total 1969 budget for current vocational education programs:

Legislation	Legal Authorization	Suggested Appropriation
	In Millions	
Smith-Hughes & George-Barden Acts	$ 57.2	$ 57.2
Vocational Education Act of 1963		
Sec. 4(a)	202.5	199.3
Sec. 4(c) - Research	22.5	15.7
Total - Present Legislation	282.2	272.2

As far as these programs are concerned we would like to point out that in 1962 the panel of consultants on vocational education suggested $400 million annually as necessary to carry out an effective vocational education program in the United States. The sum of $272 million for all vocational education acts, including research, is far below the figure suggested in 1962. The National Advisory Council on Vocational Education in 1968 recommends $500 million for the regular programs -- not including work-study, residential, exemplary and disadvantaged youth programs.

We strongly urge this subcommittee to appropriate the whole amount as authorized by the present vocational education legislation and to restore the amount of $10 million ($3.2 million for programs under Sec. 4(a) and $6.8 million for research under Sec. 4(c) to its full legal authorization.

Only with adequate funds can our schools build the vocational education system which is necessary for our young men and women to profit from occupational programs that relate directly to meaningful employment.

Mr. FLOOD. Thank you, Mr. Denison.

TUESDAY, APRIL 30, 1968.

BUREAU OF EMPLOYMENT SECURITY BUDGET

WITNESSES

HON. LAURENCE J. BURTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH
CURTIS HARDING, EMPLOYMENT SECURITY ADMINISTRATOR, UTAH

Mr. FLOOD. I notice our distinguished colleague, Congressman Burton of Utah is here. I think he wishes to present a witness. Is that correct Mr. Burton?

Mr. BURTON. Yes, sir. May I be allowed to introduce to the committee Mr. Curtis Harding. Mr. Chairman, before giving a brief introduction about Mr. Harding's qualifications, I would like to comment on your beryllium statement and add a third producer to the list. There is one in the State of Utah. That is just getting underway now and hopefully within a year or so we will be employing 300 people.

Members of the committee, Mr. Harding has had wide experience in the field of employment labor. During the summer of 1963, he was one of the team of seven State administrators who at the request of the U.S. Labor Department made studies of labor exchanges, industry and management attitudes, as well as economic cooperation between Government, management and labor in the nations of France, England, Holland, Denmark, and Sweden.

Mr. Harding was appointed in his present position as administrator of the Utah department in 1949. In 1946, the American Legion presented the 1956 National Employment Citation to Curt Harding for his outstanding record in the employment of the physically handicapped veterans. In 1957, the Utah Chapter of the American Society for Public Administration presented him with an award as administrator of the year. He is here today to speak for all of the State departments of employment planning and security. He is competent in this respect because he chairs the committee concerned with program planning, budget and evaluation. He is also a member of the committee working on an interrelated cost accounting activity reporting program and is also chairman of the State committees concerned with the data processing system for the whole employment program. I think you will be interested in what he has to say.

Mr. FLOOD. That, Mr. Harding, is a rather impressive introduction. Did you write it?

Mr. HARDING. I just helped him a little bit.

Mr. FLOOD. Go ahead.

Mr. LAIRD. I hope the statement lives up to the introduction.

Mr. HARDING. I hope so, too.

Incidentally, I will just cover the first part of the statement. There are two attachements. It is not going to take as long as it appears to be.

Mr. FLOOD. The rest we will insert in the record.
Mr. HARDING. Thank you.
(The attachments follow:)

INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES

APRIL 2, 1968.

MEMORANDUM

To: All State employment security agency administrators.
From: G. A. Foster, executive secretary.
Subject: Poll on points to be covered in proposed testimony on the 1969 appropriation request.

The National Executive Committee has authorized Mr. Brown to arrange for testimony to be presented on behalf of the conference before the House and Senate Labor-HEW Appropriations Subcommittees on the fiscal year 1969 request for grants to States. If you approve, the following points will be covered in the testimony:

1. The testimony will support the full amount of the request for grants to States of $616,573,000. This is an increase of $59,346,000 over funds available in 1968; $50,764,000 is to cover increased costs of a mandatory nature, the largest single item of which is $35,529,000 for additional State salary costs; $8,582,000 of the total increase is for program items.

2. The testimony will emphasize the need for $35,529,000 to provide funds needed to finance the increase in personal service costs resulting from statewide compensation plan changes effective in fiscal year 1968 (financed from contingency funds in 1968) and increments to be paid in 1969. It will also emphasize the need for the $8,582,000 for program increases. $8,484,000 is to provide State agencies with additional resources for management improvement through the establishment of an automated reporting system, a State-based evaluation system, the installation of a planning system at the State and local level which would provide a means of allocating resources to meet State and local needs, the implimentation of an accrual cost accounting system and the further development of automatic data processing techniques; $98,000 of the program increase will be to annualize the cost of operating an expanded veterans' program in fiscal year 1969. A supplemental in the amount of $295,000 for the balance of fiscal year 1968 has already been sent to the Congress.

Please advise me by returning the attached ballot whether or not you favor the testimony covering the points enumerated. Since we will have to make our appearance before the House subcommittee very soon, please send me your reply to reach my office by April 10, 1968. It is imperative that we have your reply by this date.

Since this testimony will be on a Federal legislative issue, the vote of individual States shall be made known to any interested party in accordance with section IV, paragraph 3 of the Conference Code. If you have any questions, please let me know.

INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES—POLL ON POINTS TO BE COVERED IN PROPOSED TESTIMONY ON THE 1969 APPROPRIATION REQUEST

In favor of testimony covering points indicated in transmittal _____
Not in favor of testimony covering points indicated in transmittal _____

_____
(Signature)

_____
(Title)

_____
(State)

_____
(Date)

SUMMARY OF CHANGES—GRANTS TO STATES APPROPRIATION REQUEST, FISCAL YEAR 1969 OVER FISCAL YEAR 1968

	Positions	Amount
1968 enacted limitation	290	$556,932,000
Estimated program supplemental		14,295,000
1968 limitation, revised	290	557,227,000
1969 estimate	290	616,573,000
Total change		59,346,000

Mandatory items (increases):	
To provide funds needed to finance the increase in personal services costs resulting from statewide compensation plan changes effective in fiscal year 1968 and increments to be paid in 1969	+$35,529,000
To provide funds needed for the increased cost of OASI taxes provided by the Social Security Act, and adoption of or increases to State retirement and health benefit plans	+5,565,000
Increase due to growth in unemployment insurance program coverage	+1,170,000
Tax workload is expected to increase because of an estimated growth in the number of subject employers from 2,570,000 in 1968 to 2,610,000 in 1969.	
Increase due to higher unemployment insurance workloads	+7,000,000
To provide for growth above the 1968 base appropriation in unemployment insurance workload due to an increase in State-insured unemployment to 1.1 million in 1969 and an increase in number of benefit payments made for former Federal employees and ex-servicemen from 1,466,000 in 1968 to 2,065,500 in 1969.	
To provide funds needed to finance increased postage costs under Public Law 90-206	+1,500,000
Total mandatory items	+50,764,000
Program items (increases):	
To provide additional funds to augment resources now being devoted to management improvements to serve all levels of employment security operations through the establishment of an automated reporting system, a State-based evaluation system, the installation of a planning system at the State and local level to provide a means of allocating resources to meet State and local needs; the implementation of an accrual cost accounting system; and further development of automatic data processing techniques (p. 53)	+8,484,000
To provide funds to cover full-year costs of operating the expanded veterans program in fiscal year 1969 (p. 44)	+98,000
Total, program items	+8,582,000
Total change	+59,346,000

INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES

MEMORANDUM

APRIL 12, 1968.

To: All State administrators.
From: G. A. Foster, executive secretary.
Subject: Results of the poll on the points to be covered in proposed testimony on the 1969 appropriation request.

On April 2, 1968, the State agencies were polled to determine their approval or disapproval of the points to be covered in the testimony on behalf of the interstate conference before the House and Senate Appropriations Subcommittees on the fiscal year 1969 request for grants to States.

The State agencies by a vote of 52 in favor, none not in favor, and one not voting approved the inclusion of the following points in the testimony:

1. The testimony will support the full amount of the request for grants to States of $616,573,000. This is an increase of $59,346,000 over funds available in 1968; $50,764,000 is to cover increased costs of a mandatory nature, the largest single item of which is $35,529,000 for additional State salary costs; $8,582,000 of the total increase is for program items.

2. The testimony will emphasize the need for $35,529,000 to provide funds needed to finance the increase in personal service costs resulting from statewide compensation plan changes effective in fiscal year 1968 (financed from contingency funds in 1968) and increments to be paid in 1969. It will also emphasize the need for the $8,582,000 for program increases; $8,484,000 is to provide State agencies with additional resources for management improvement through the establishment of an automated reporting system, a State-based evaluation system, the installation of a planning system at the State and local level which would provide a means of allocating resources to meet State and local needs, the implementation of an accrual cost accounting system and the further development of automatic data-processing techniques. $98,000 of the program increase will be to annualize the cost of operating an expanded veterans program in fiscal year 1969. A supplemental in the amount of $295,000 for the balance of fiscal year 1968 has already been sent to the Congress.

TABULATED RESULTS OF THE POLL

	Number of State agencies	Percent of total covered workers [1]	Percent of total covered employers [2]
In favor	52	99.87	99.64
Not in favor	0	0	0
Not voting	1	.13	.36
Total	[3] 53	100	100

[1] Total workers covered under the State unemployment insurance laws as of June 1967.
[2] Total employers covered under the State unemployment insurance laws as of December 1967.
[3] Includes the District of Columbia, Puerto Rico, and the Virgin Islands.

Mr. HARDING. Mr. Chairman, my name is Curtis P. Harding. I am administrator of the Employment Security Agency in Utah and past president of the Interstate Conference of Employment Security Agencies. This is the recognized organization of the State employment security agency administrators and their agency officials. I am appearing at the request of the current president of the conference, Mr. Jack B. Brown, of your Commonwealth of Pennsylvania, who sends his personal regards to you and regrets his inability to be present today due to another commitment as president of the conference. I am here to advise you that the conference and its member State employment security agencies strongly support the full amount of the appropriation request of $616,573,000 for grants to States to operate the employment security program for fiscal year 1969.

This $616 million is State grants.

In accordance with conference rules the position of the conference on matters of this kind must be determined at its annual meeting or by a poll of the member State employment security agencies. In this instance our conference polled the State agencies on April 2, 1968, to determine their approval or disapproval of the points to be presented in my testimony today. Of the 53 member State agencies (50 States, Puerto Rico, Virgin Islands, and District of Columbia) 52 voted approval; one did not vote. No member agency voted disapproval of the points to be presented. The State agencies voting approval represent 99.87 percent of the workers and 99.64 percent of the employers

covered by the State unemployment insurance programs. The State agency not voting represented the balance, 0.13 percent of the covered workers and 0.36 percent of the covered employers. Copies of the poll and the aggregate responses are attached to the copies of my testimony.

The State agencies' overwhelming support of the position I am presenting here today reflects their growing concern over an increasingly serious problem of inadequate resources to effectively carry out the important and growing responsibilities given them by Congress and the administration during recent years.

As we understand the request it represents an increase of $59,346,000 over the amount available in fiscal year 1968. The increases consist of the following:

1. To provide additional funds to augment resources now being devoted to management improvements to serve all levels of employment security operations through the establishment of an automated reporting system, State-based evaluation system, the installation of a planning system at the State and local level to provide a means of allocating resources to meet State and local needs, the implementation of an accrual cost accounting system; and further development of automatic data processing techniques	$8,484,000
2. To provide funds needed to finance the increase in personal services costs resulting from statewide compensation plan changes effective in fiscal year 1968 and increments to be paid in 1969. This cost is of a mandatory nature	35,529,000
3. To provide funds needed for the increased cost of OASI taxes provided by the Social Security Act, and adoption of or increases to State retirement and health benefit plans. This is also a mandatory cost	5,565,000
4. To provide funds needed to finance increased postage costs under Public Law 90-206, a mandatory cost	1,500,000
5. Increase due to growth in unemployment insurance program coverage. Tax workload is expected to increase because of an estimated growth in the number of subject employers from 2,570,000 in 1968 to 2,610,000 in 1969. This is also mandatory in nature	1,170,000
6. Increase due to higher unemployment insurance workloads. This cost is mandatory also	7,000,000
7. To provide funds to cover full-year costs of operating the expanded veterans' program in fiscal year 1969	98,000
Total increases	59,346,000

Since it is central to the efficient and effective operation of the employment security system, I should like to spend the major portion of my time discussing the first item which requests an additional $8,484,000 to augment our resources being devoted to management improvement.

Our field of administrative responsibility has expanded considerably in the past few years, and in the process has become very complex.

In the field of unemployment insurance, we administer the State unemployment insurance programs, the unemployment insurance programs established for Federal workers and for war veterans

We also operate an interstate benefit payment system, and administer the readjustment allowance provisions of the Trade Expansion Act of 1962 and the Automotive Products Trade Act of 1965.

In our Employment Service manpower complex, not only do we continue to have the responsibility of helping employers staff their operations and helping workers find jobs, but we also operate special

programs to assist the youth, the older workers, the handicapped, the unskilled, the untrained, and recently the dejected and rejected, whether they are on or off welfare, able or unable, willing or reticent.

I should add we have a special program for veterans.

Our job is to find them, to help them, to get them jobs. You will recognize the programs as I name them:

There are the many on-the-job and institutional training programs under the Manpower Development and Training Act; the work incentive program under the amended Social Security Act; the new careers program under the Nelson-Scheur Act. Under the Economic Opportunity Act or other legislation are still other programs such as the Job Corps, the Neighborhood Youth Corps, the concentrated employment program, model cities, youth opportunity centers, and the vocational improvement program.

We in the States, in truth, have become administrative agencies responsible for many programs, assisting in others, and accountable to the various Federal and State bureaus for whom we work and from whom we get our administrative moneys.

Such a complex must be carefully managed. Fiscal responsibility cannot be taken lightly.

Some 2 years ago in recognition of the size of the problem, the Bureau of Employment Security obtained the services of a management consultant firm and obtained from this firm—Cresap, McCormick & Paget—recommendations on how the overall management of the employment security program could be improved. A task force composed of both State and Federal officials reviewed the recommendations, adapted them where they were appropriate, and added to the concept—the result was a design for a comprehensive management system.

Let me review what this is.

The Bureau and the States decided they would together establish and operate a planning, budgeting, operating and evaluation system which would provide a means for assigning responsibility for the accomplishment of national as well as State and local objectives. The firm also recommended that a management information system be developed and installed. This system would include an interrelated cost accounting and activity reporting system to measure accomplishments in terms of services provided to individuals and employers and identify the actual cost of providing such services. The firm's recommendations emphasized that automatic data processing should be used to the fullest extent possible in the operation of the system.

The plan of service concept is to translate National and State objectives into operating actions for the States and their local offices. For example, the employment service system is requested to provide more service to youth, or to provide increased service to returned Vietnam servicemen, or to find jobs for welfare recipients. The States relate these objectives to local conditions and develop plans of service outlining the manner in which these objectives are to be attained. When approved, these plans are not only blueprints of action but they also provide a basis for budgeting as well as for subsequent evaluation as to how well the plan was carried out.

The recommended cost accounting system presently being devised with the help of another contractor, Touche, Ross, Bailey & Smart, will provide for the measurement of efficiency of performance as well

as supply information necessary to manage resources in response to changing needs.

It also represents an essential support for the plan of service and budgeting system by providing the cost information which must be a primary consideration in the development of operationl plans. It is the means by which an accurate price tag can be attached to any plan of operation. In addition to assisting management in making decisions as to which methods can be most efficiently used to execute a plan, the cost information will also permit accurate judgments on the returns to be achieved from the expenditure of resources based on where and how they are used.

The evaluation system is somewhat unique in that it is based on self-appraisal by the State agencies with monitoring by the Federal partner.

In this system, the States will evaluate their operations and accomplishments. They will evaluate how effectively and efficiently they have achieved the goals and carried out the actions they proposed in their plans of service. Outlines and criteria for the evaluations, developed jointly by the States and the Bureau, will be used to obtain uniformity in the system. We, the States, will summarize the results of our evaluations in terms of actions to be taken or modifications to be made in operational plans for transmittal to the Bureau so that it may keep abreast of accomplishments on a national and State-by-State basis. The Bureau will monitor the State's evaluation system, first, to insure that the system is fully operative and, second, to insure objectivity and uniformity in the application of criteria.

When these varied efforts are fully accomplished there will be operative throughout the employment security system (1) a comprehensive management information program to serve as a tool for determining needs, evaluating and measuring accomplishment, and modifying plans when conditions warrant, (2) plans of service at each operating level to serve as blueprints for local action, tools for budget management, and bases for evaluation, and (3) a systematic evaluation program which will enable the identification of less efficient and more costly operations.

The recommendation that automatic data processing should be used to the fullest extent possible is being pursued with the assistance of another contractor, the Auerbach Corp.

This is a major undertaking and is longer range compared to the management systems. The project has been underway now since July of 1967 in the three model States of Florida, Utah, and Michigan. In addition, specialized aspects of the project are underway in New York, California, and Wisconsin.

In Florida, Utah, and Michigan, we are attempting to automate all operations which it is practical to automate—from establishing the monetary eligibility for unemployment insurance claims to locating a very specific job or training opportunity that will match the special requirements of a disadvantaged job applicant. The objective is to design, implement, and test model systems in these three States which can be exported to other States, thereby avoiding duplication of effort and excessive expenditure of funds. These three States were selected because they represent small, medium, and large size employment security operations.

In New York, California, and Wisconsin, specialized aspects of the project are being implemented and tested. The New York project will provide a model system to serve large multi-State areas with emphasis on locating training and job opportunities for the severely disadvantaged through the use of automation. The California project covers occupations with high skill requirements in a complex of geographically separated cities.

Wisconsin is to develop techniques which will permit applicants to be identified by their total range of skills and abilities in an automated system.

These activities are well underway; some in terms of development, others in varying states of initial implementation.

It is urgent that we move forward and it is for this reason that we fully support the budget request of $8,484,000 to finance the efforts.

I should now like to very briefly mention the other areas wherein increases are requested. These need little or no discussion, since their justification is largely self-evident and the increases are mostly of a mandatory nature.

With respect to item No. 2, these funds are needed to finance the increase in personal service costs resulting from higher wage levels in State agencies. These are the funds we must have, just to maintain our present level of staffing. While this increase in total represents a substantial amount, it reflects only the annualization for a full year of salary increases already approved plus a conservative estimate of expected increment. The committee is aware that under a long-standing policy of our Federal partner, State agency salaries may be no more than comparable with those of similar jobs in other State departments. While State salaries as a whole have been improving in recent years, many of our State employment security agencies are having difficulty recruiting and retaining the caliber of personnel needed to adequately staff their expanded services and programs; this is largely due to the fact that State salaries have not been competitive with salaries for comparable jobs in the private sector of the State.

Items 3 and 4—funds for increases in OASI taxes, State retirement and health benefit plans, and postage costs—are built-in costs. I am sure each of you fully appreciates the situation and understands the need for additional moneys in these areas.

Items 5 and 6—increases due to growth in unemployment insurance coverage and higher work loads—as the work load increases so do the costs to handle it.

Item 7—funds for an expanded veterans program—does not represent a great amount of money, but it will enable us to continue the improvements which we started this year in our services to veterans, most of which are of immediate and critical importance to those veterans returning from Vietnam many of whom have not had a previous work history in civilian life before having entered into service to their country.

Mr. Chairman, in concluding my statement, I appreciate very much the opportunity of appearing before the committee and I thank you for your time and courtesy. I hope that I have contributed to your understanding of our need for these moneys in selected areas to carry out the Employment Security program for fiscal year 1969.

I would remind you that this request is not for moneys over and

above the resources available as a result of the revenue to the Federal Government under the selective tax levied upon industry to finance the administration of the Employment Security System. It is, however, a request to fully employ that limited tax revenue in support of what we believe are the purposes for which it is collected.

On behalf of the State agencies I sincerely hope that you will approve the full amount of this request since it represents in our opinion the minimum amount necessary to carry out the important responsibilities which we have been given.

Thank you so much.

Mr. FLOOD. Thank you. Your statement measured up to your introduction.

Mr. HARDING. Thank you again.

Mr. BURTON. Thank you, Mr. Chairman.

HIGHER EDUCATION BUDGET

WITNESS

STEPHEN A. McCARTHY, EXECUTIVE DIRECTOR, ASSOCIATION OF RESEARCH LIBRARIES

Mr. FLOOD. Our next witness will be Mr. Stephen A. McCarthy, the executive director, Association of Research Libraries.

Mr. MCCARTHY. Thank you.

Mr. FLOOD. How do you wish to proceed?

Mr. MCCARTHY. I would just like to read the statement, if it meets with your approval. It is not very long.

Mr. FLOOD. Very well. We will do it your way.

Mr. MCCARTHY. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, my name is Stephen A. McCarthy. I am executive director of the Association of Research Libraries. The Association of Research Libraries is an organization of 79 major university, private, and government research libraries whose purpose is to assist in the development and strengthening of member libraries in support of education, research, and scholarship.

The association wishes to go on record in support of the appropriations recommended in the President's budget for title II, parts A and B, of the Higher Education Act of 1965. Part A provides matching funds for the purchase of library books for colleges and universities. This title has substantially increased the availability of library materials in many small colleges and universities and has been of limited assistance to the larger institutions. An appropriation at the authorized level of $50 million is needed.

The amount in the budget is $25 million and that is what I am supporting at this point.

Part B provides funds for the training of librarians, research on library problems and the development of library schools. This program is an important element in the effort to cope with the serious shortage of professional librarians and the budgeted sum is needed to increase the supply of professionally trained librarians.

My particular interest in appearing before this subcommittee is to discuss the appropriation for title II–C of the Higher Education Act of 1965, "Strengthening College and Research Library Resources through the Library of Congress." I wish to recommend on behalf of the Association of Research Libraries that the appropriation for this title for the next fiscal year be at the amount authorized for fiscal 1968, $7,700,000.

I am sorry that the sum is no larger in view of the very large sums we have been hearing about. It seems like I am taking your time with a very small matter. It is an important one.

This program has been in operation for about 2 years. The program has never been funded at the authorized level and yet it has not only enabled the Library of Congress to strengthen its collections substantially, but it has increased its cataloging output by more than 50 percent. The level of cataloging production projected for the current year by the Library of Congress is 180,000 titles. In 1965 the Library of Congress cataloged 110,000 titles.

The shared cataloging program is an example of applying leverage at a critical point. A relatively small investment of Federal funds enables the Library of Congress to expand its acquisitions and speed up its cataloging. This strengthens and improves the Library of Congress. At the same time the side effect of this program is of great assistance to college, university, and research libraries all over the country. This is an outstanding example of the efficiency of doing a job once and thoroughly and making the results of that effort, the cataloging copy, available to all who have need for it.

According to a study recently made at the University of Michigan Library, local cataloging costs are reduced by 75 percent if Library of Congress cataloging copy is available. The University of Wisconsin Library points out that the great advantage which it derives from this program is the speed with which new books can be made available to readers. If Library of Congress copy is not available, books are frequently set aside and may not be cataloged for a period of a year or more. With Library of Congress copy at hand, books are cataloged promptly and placed on the shelves for use by students and faculty members.

In the library field, as in many other fields, there is an acute shortage of highly specialized manpower. Librarians with the full range of language competence, which the modern university library program requires, simply are not available in many of the university libraries of the country. By concentrating the cataloging of books in difficult foreign languages in the Library of Congress, the library community is able to conserve and use to best advantage the skilled manpower available.

Moreover, as this program has been developed by the Library of Congres, it makes extensive use of the cataloging effort put forth by the national bibliographic agencies in the various foreign countries from which these books are acquired. In this way, the Library of Congress is utilizing to the fullest possible extent work that is already done by these foreign bibliographic agencies. Unnecessary repetition of work is avoided.

Mr. FLOOD. How is the translating done?

Mr. MCCARTHY. They are actually cataloged in the language in which the book is written.

This is true in even the oriental languages. In the oriental languages they superimpose what is called romanization; namely, putting into the Roman alphabet the sounds of, say, Chinese words, Chinese names, Japanese, and so on. As far as French, German, Swedish, Russian, Italian, and so on, the books are cataloged in these languages.

In addition to the economies effected through this centralized cataloging service, the existence and strengthening of this program makes it possible for college and university libraries to be more selective in their own acquisitions of foreign publications. The books are acquired by the Library of Congress and are entered in their published catalogs. This means that college and university libraries have a record of the materials so acquired by the Library of Congress and with this information available to them they can, in many instances, defer purchase until there is an evident local need. In some cases libraries can safely decide not to acquire publications at all since they know these books are available in the Library of Congress. From the point of view of our foreign trade balance, this is an aspect of the program which should not be overlooked.

The Association of Research Libraries has had reports from its member libraries located in all parts of the country testifying to the value of this program in improving their local library services and enabling them to devote their limited resources to more effective service to readers. Carl Jackson, director of libraries at Pennsylvania State University, for example, has written as follows regarding the shared cataloging program:

> Prior to this program, only about 35 to 50 percent of the needed catalog copy was available from the Library of Congress. At present, over 70 percent of needed copy is available. We hope and believe that this figure must continue to rise as the program expands. This program speeds much needed publications to the university's teachers, researchers, and students. We are, through this program, gaining a higher quality and greater uniformity of cataloging due to international cooperation and due to the centralized effort.

Mr. Chairman, the shared cataloging program is a success. As you know, it is a modest program. It is still a new program. It has never been adequately funded. But even with these limitations, it has been of great benefit to college and university libraries. The dollars spent in this program flow out over the country into the college and university libraries in the form of Library of Congress cataloging copy. In this way these libraries are improved. Such library improvement is a key element in providing quality education in our colleges and universities.

Mr. Chairman, I wish to thank you for the privilege of presenting the views of the Association of Research Libraries on this subject.

Mr. FLOOD. You did it very well. Thank you.

Mr. MCCARTHY. Thank you, Mr. Flood.

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Office of Economic Opportunity

WITNESSES

MISS ELEANOR A. EATON, ASSISTANT SECRETARY, COMMUNITY RELATIONS DIVISION, AMERICAN FRIENDS SERVICE COMMITTEE

MISS FRANCES NEELY, FRIENDS COMMITTEE ON NATIONAL LEGISLATION

Mr. Flood. We will now hear from Miss Eleanor Eaton, assistant secretary, Community Relations Division, American Friends Service Committee.

Miss Eaton. This is Miss Frances Neely of the Friends Committee on National Legislation. I am with the American Friends Service Committee.

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

Miss Eaton. If it is acceptable to you, I would like to read it. It is short. I hope that it is concise. I might take more of your time if I rambled.

My name is Eleanor Eaton. I am assistant secretary of the Community Relations Division for the American Friends Service Committee. I speak on behalf of the American Friends Service Committee and the Friends Committee on National Legislation. The two organizations speak for themselves and for like-minded Friends. No person or organization can speak officially for the total membership of the Religious Society of Friends.

We appreciate the opportunity to appear before this committee and to put before you a few illustrations of the need for full funding of the Economic Opportunity Act for fiscal year 1969. These illustrations come from the actual experience of some of the over 60 field staff of the American Friends Service Committee at work in rural areas and the urban ghettos of our Nation.

We believe that even the amount authorized for the Office of Economic Opportunity in fiscal year 1969 is grossly inadequate to today's needs. Anything less than full funding of the authorized amount of $2.18 billion would be a serious blow to the health of the Nation already damaged by aroused hopes and a disappointing level of delivery.

The National Advisory Commission on Civil Disorders, a nonpartisan, nonpolitical body, has challenged the Congress and the people of the United States to finance a massive program of jobs, education, housing, and empowerment of the currently unempowered. From our field experience in the West Side of Chicago; in Oakland, Calif; San Francisco; Boston; Pasadena, Calif; and Atlanta we support the urgency of this call. Full funding of OEO is at least one small step in response.

Currently there is enthusiasm for stopgap programs in our urban ghettos. These are needed. But so also is a realistic understanding of the cause of the fires in our cities. When an oil well catches fire, water and other fire dousing measures are of little avail. The problem must be attacked at its source. This, we believe, is what OEO, through its urban and rural programs, seeks to do. But it needs money to work at these problems at their source.

The lack of money seems to be a matter of priorities. The priority of human needs can no longer be ignored. A tax increase solely for funding programs that attack the problems of hunger, poverty, and human need would be the best investment our Government could make for the future of our country and would have our wholehearted support.

OEO's Headstart program attacks multifaceted problems of the poor family, rural and urban. Our staff in Mississippi have seen families held together when their young children began to receive instruction, fellowship, and medical care which these families were too poor and too uneducated to give, when mothers and fathers became part of the Headstart team, learning themselves and earning from $25 a week as a cook to $65 for serving as apprentice teachers. These programs, particularly that of the child development group in Mississippi, could be better if so much time of experienced staff and directors did not have to be spent in pursuing the intricate procedures for refunding or readjusting programs because of drastic cuts. Today most of these centers are limping along on a volunteer basis because of delay in refunding.

The three major Headstart programs in Mississippi served 15,877 children in 1967. Current refunding offers would reduce the number by at least 4,000 children and a large number of people employed in the program. It is clearly obvious to our Mississippi staff and to others that the number served should instead be at least 31,000 children. The recent report of the Citizens Board of Inquiry on Hunger and Starvation painted a grim picture. The 20,000 children, who would not be served if there is an cut—and their parents for whom a cut in funding of Headstart programs would in effect mean no employment, no training, no income and no hope, are some of the people referred to in this citizens report.

Mississippi is but one State out of many in which Headstart programs mean the difference between hope and despair; between life and possible starvation. In western Washington, our staff reports rejection of a desperately needed Headstart proposal for the Quileute Tribe of Indians because of lack of funds. Other regions of our organization report similar rejections of requests.

We urge the committee to recommend funding the full $380 million requested for the Headstart programs.

In four Kentucky counties, shortage of funds for the Neighborhood Youth Corps has resulted in a 12-month program being reduced to 6 months and 10 percent of the enrollees who were the sole support of their families being dismissed. Also an important educational component which provides for 1 day of study out of five for some young people will be eliminated.

I have some very moving stories that some of these young people have written now that they have been cut off.

We suggest the members of this committee would be deeply moved if they could go to the hollows of Kentucky and see the economic privation there and see what the Neighborhood Youth Corps has done

for young men and women who were bitter and without hope until the NYC came to the area.

In Macon County, Ala., the Neighborhood Youth Corps has been cut over 10 percent because of insufficient funds. In the rural areas of this county over 80 percent of the people are in poverty. In many instances the NYC was the sole income for a family. Where young people were cut from the program, if they had the cost of transportation, they left for the ghettos of the North hoping to find work or some way of securing an income. The cutoff of the NYC for them meant increased bitterness and anger.

We urge the committee to recommend full funding of the $375 million authorized for the Neighborhood Youth Corps.

In California and western Washington, in Florida and undoubtedly in other places, legal services for Indians and for migrant farmworkers mean the difference between hope and despair, between a future and no future.

California Indians are in a no man's land. The legal status of reservation and rancheria Indians in California is more complex and less well understood than that of Indian people in other States. Rural Indians in California are extended few, if any, Federal services, yet the normal services extended by the State rarely reach them either, partly because of their geographic and social isolation, and sometimes because of overt discrimination, sometimes because of genuine uncertainty as to whether or not they are entitled to these services. Indians who have land or property are generally not in a position to develop it advantageously because of the legal complexities surrounding their status. Indians who have no land or resources generally are the poorest of the rural poor in California. A recent comprehensive survey by the State commission on Indian affairs documented the fact that rural California Indians have greater problems of health, education, water, poverty, and community disorganization than any other identifiable group in California.

Indians in California are continuing to go without services to which they are entitled and which they desperately need. More important, they are rapidly losing their one asset, the asset which has the potential to help them out of poverty: their land. The need for legal services to help them retain and protect their land and protect their rights is urgent, and time is short. These legal problems are peculiar and require a special branch of legal knowledge which is just beginning to be accumulated or could be accumulated in the University of California Law School.

In spite of OEO approval, and strong support from Indian groups which are united for the first time in a common cause, the program for a statewide legal services program for Indians has remained a paper program. The reason: no funds.

In western Washington over a year ago an application for an imaginative legal services program for the Indians of that area costing $396,000 was enthusiastically supported by many tribes and by OEO analysts. But the program lies on the administrator's desk, unsigned. Reason: no funds.

In Florida, our staff writes:

Migrant legal services here are providing migrant workers with perhaps their brightest ray of hope. They are learning that they can actually have their say in the white man's court. The most flagrant abuses of human rights occur in the municipal courts of the South and under the cloak of legality. The presence of a lawyer representing the poor changes the whole atmosphere of a court. But even more important is the change in outlook it is bringing to the people. The educational process is just beginning. After this first ray of hope it would be criminal to let it all fade away and revert to the old way where the cheapest thing to do is plead guilty and hope for the best.

Legal services also provide hope through class suits that have the possibility of doing away with entire systems of exploitation. This type of litigation takes time, sometimes years. It is therefore important that legal service programs have sufficient continuity to see this type of litigation through.

We urge full funding of the modest $43 million authorized for OEO sponsored legal services programs. This program is urgently needed by those struggling to get out of poverty. In addition such legal aid is a necessary adjunct to rural credit and consumer education programs.

Finally the migrant program under title III (B) is the one OEO program which really reaches the rural poor. Already the limitations in its funds and the consequent specialization has meant that only large concentrated operations are being refunded and small new programs developed after careful analysis of need and involvement of poor people are not even reviewed. The rural poor are scattered and isolated. Modest programs often produce enormous results.

But these programs stand little chance of becoming operative. Reason: again, inadequate funds.

Just this morning I was told the economic opportunity rural loan funds administered by the Farmers Home Administration have already run out for 1968.

We earnestly urge this committee to appropriate the full authorized amount of $30 million for title III (B), the migrant program of the OEO.

From our field experience we could discuss the impact of inadequate funding on other programs, including day care centers, CAP programs, and low-cost housing efforts. But time does not permit. We would, however, like to emphasize in closing that the experience of our field staff in Oakland, Calif., in Jackson, Miss., in Lame Deer, Mont., and in Chicago, and in a number of other places. This experience emphasizes and reemphasizes the need for more money, for money that is flexible money that can be used by local groups to carry out effective and desired programs based on local needs. The needs of each situation vary. For example training programs are needed in one place; health centers in another; followthrough Headstart programs in yet another. But if the money is earmarked for other special impact programs, the community's needs remain unmet and frustration grows.

Our field experience also indicates the fact that limitation of funds increasingly makes for more rigid programs, puts the emphasis on highly visible projects and serves to eliminate the small private agency that works with the people in need and whose experimental and watchdog role has been so useful.

In summary, our experience in many parts of this country says to us, and we hope to you: The amount authorized for the EOA is tragically inadequate.

We strongly urge funding of the authorized $2.18 billion for the Office of Economic Opportunity in fiscal year 1969 and urge that none of these funds be transferred to other agencies nor earmarked for specific new programs.

To do otherwise will feel the fires of discontent and poverty. Full funding will eliminate some of the causes of poverty and go a little way toward meeting the challenge so well documented by the report of the National Commission on Civil Disorders.

With 3 years of experience, many local programs and people are just beginning to reap the rewards of careful planning and experimentation. It is economically wasteful to discard this investment. And furthermore, the waste in human terms is incalculable; it is a waste no moral society can choose to allow. Our very survival as a whole and sane society lies in the choices made in the Halls of Congress in these next few months. Congress has a unique opportunity also to hear directly from the poor as the Poor People's Campaign comes to Washington and we urge you to listen.

Thank you, Mr. Chairman, for letting me present this testimony on behalf of our organizations.

Mr. FLOOD. That is in the best tradition of your society. Thank you.

TUESDAY, APRIL 30, 1968.

PUBLIC HEALTH SERVICE PROGRAMS RELATING TO MEDICAL SCHOOLS

WITNESSES

DR. ROBERT C. BERSON, EXECUTIVE DIRECTOR, ASSOCIATION OF AMERICAN MEDICAL COLLEGES
DR. ROBERT H. FELIX, DEAN OF THE MEDICAL SCHOOL, UNIVERSITY OF ST. LOUIS
DR. FRANKLIN E. EBAUGH, DEAN OF THE MEDICAL SCHOOL, UNIVERSITY OF BOSTON
DR. CHARLES A. Le MAISTRE, VICE CHANCELLOR FOR HEALTH AFFAIRS, UNIVERSITY OF TEXAS MEDICAL BRANCH, AUSTIN
DR. JOHN PARKS, PRESIDENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. FLOOD. Now we have a really unusual array of talent.

Dr. Robert C. Berson, executive director of the Association of American Medical Colleges. I understand that you are the first spokesman, Doctor.

STATEMENT OF DR. ROBERT C. BERSON

Dr. BERSON. Mr. Chairman, I am accompanied by Dr. Franklin Ebaugh, Dr. Felix, Dr. Le Maistre, and Dr. Parks. With your permission, I would like to ask that the written statement that I have given to Mr. Moyer be introduced in the record. Instead of reading it, I will make a few introductory remarks and ask Drs. Ebaugh, Felix,

and Le Maistre to make a few remarks about this from the standpoint of their institutions.

Mr. FLOOD. Very well.

(The statement follows:)

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical College, which is made up of all the schools of medicine, 343 of the major teaching hospitals, and representatives of 28 of the major academic medical societies in the United States, is grateful for this opportunity to present its views on those items in the proposed appropriations for fiscal 1969 which directly affect the future health of the public through programs operated in the medical schools and teaching hospitals.

While many of our comments will focus on the need for, and the education of, physicians, which is the original, continuing and unique responsibility of the medical schools, and the need for strengthening the base of scientific knowledge in order to make prevention and treatment more effective, which is also a major concern of medical schools and inseparably linked with their educational programs, we want to emphasize at the outset the importance of and the need for large numbers of many categories of other trained health professionals.

A modern physician is far more effective than his predecessor was only a few decades ago. This is due, in part, to the fact that he is better educated and better trained, but it is also due in large part to the fact that biomedical research conducted in the past has produced more scientific knowledge which he can use. These two factors are enormously enhanced by the fact that the modern physician works as a member of a team of highly trained personnel in a large number of related disciplines, each of whom plays an important part in the delivery of health services and the maintenance of the health of our fellowmen. Highly organized teams of physicians and large numbers of people trained in related fields make a modern hospital possible, which, of course, requires facilities, skilled administration, and financial support in order to apply scientific knowledge to the problems of patients.

GENERAL COMMENTS

We realize that this committee will address itself primarily to the appropriations to be made for established programs within the limits authorized by the legislation which created them. Our specific recommendations will be directed to certain of those programs. However, we are also deeply concerned about the very large problems our country faces, which make decisions about the allocation of Federal resources enormously difficult and important at this time, so we would like first to make some comments about the origins of what a distinguished Member of Congress recently referred to as "the health crisis, borne of skyrocketing costs of health services and exacerbated by persistent and widespread shortages of trained personnel and by deteriorating or inadequate facilities."

There is no doubt whatever that the costs of health services are indeed rising very rapidly with no end in sight, and that the widespread shortages of physicians and other trained health professionals are linked to these rising costs. As concern over these matters grows, we have been hearing comments to the effect that "research" has been overdone and that we must now spend less on research and more on service and that we should turn out more "people doctors" and fewer physicians well-grounded in scientific knowledge.

The facts are that we know far too little about most important diseases. It is scientific knowledge which makes prevention and treatment effective, and there are so few physcians and other health professionals in relation to the demand for their services that they have little time to demonstrate their deep interest in patients as people. So it may be well to review briefly the development of attitudes toward and support for biomedical research, services to patients, and the education of health professionals in this conutry during the last quarter of a century.

Not long after World War II, broad agreement was reached that society stood to gain so much from biomedical research that growing investments in this activity were indicated, and that it was appropriate for the Federal Government to develop mechanisms for supporting research conducted in non-Federal institutions, based on its scientific merit and its relevance to a growing list of

problems declared to be of national importance and concern. This broad agreement led to and made possible the development and increasing support of the National Institutes of Health, the National Science Foundation, and other Federal agencies which, in turn, has led not only to great advances and knowledge which have already brought rich dividends, but also to the development of a broad base of scientific competence. It is alarming that some people now say that what we must now do is to apply what we know, as thought the answers were in. One must admit that we don't apply what we know to some segments of the population, but it is also true that we don't apply some of the things we know about education, housing, and recreation. The painful fact is that we still know very little about some of the most important diseases of mankind and that there must be an unrelenting drive to learn more about cardiovascular diseases, cancers, the rheumatic diseases, renal diseases, hepatitis, the psychoses and a host of others Intensive widespread research on them is not more than 10 or 15 years old and has a long way to go. The happy fact is that we now have a broad base of competence to carry on this effort, but we would be derelict in our duty to ourselves and to future generations if we did not carry it on and intensify it.

In the same period after World War II, serious proposals were made that the economic barriers, thought to prevent substantial numbers of people from getting the health services they needed, be removed and a variety of specific mechanisms were suggested. There was not broad agreement as to the existence of those economic barriers or their importance, if they existed, and much less agreement about the specific mechanisms suggested. The lack of agreement on these points obscured the third important factor, which is the adequacy of the supply of physicians and other trained health professionals.

The national consensus about the support of research and the lack of agreement about the adequacy of the health services and the future supply of physicians and other workers to provide those services, put the medical schools and teaching hospitals in difficult positions. As they demonstrated competence in scientific investigation, they received support for the development of their research and found it difficult indeed to obtain support for their educational programs and their efforts to provide hospital and clinic care for patients unable to pay for it themselves and to modernize and expand facilities for these purposes.

By the early 1960's, pretty broad agreement had been reached that there was a need for a modest increase in the number of physicians and other health professionals. Many studies and reports focused on the number of physicians in relation to the total population on the apparent assumption that the relative demand for health services would remain about the same. A number of medical schools expanded their enrollments modestly and several new medical schools were planned. In 1963, the Congress passed the Health Professions Educational Assistance Act of 1963, providing matching grants for the construction of educational facilities.

It was not until 1965 that sufficient agreement had been reached about the need to make health services available to additional segments of our population, and the Congress passed the amendments to the Social Security Act, which created medicare and medicaid. This was added to the fact that increasing numbers of people are covered by hospital and medical insurance as individuals or through the terms of their employment. By now, it is broadly accepted that health services of high quality should be available to all citizens in a way that is considerate and convenient for them.

It was also in 1965 that the Congress passed the health Professions Educational Assistance Amendments of 1965, providing basic and special improvement grants for the operation of schools in the health professions and scholarship and loan funds for their students. To be eligible for the basic improvement grants, the schools were required of expand their enrollment by 2½ percent or five students. This was done in a vast majority of cases and planning for some additional new medical schools went forward.

It is now abundantly clear that the demand for health services is far greater than most people would have predicted, and that we are desperately short of physicians and other health professionals with which to provide those services. The operation of many of our hospitals is heavily dependent upon foreign medical graduates serving as interns and residents. In 1967, 8,540 foreign medical graduates, about two-thirds of whom were from developing countries, entered this country, while only 7,743 individuals graduated from U.S. medical schools. It is true that there are advantages to the individuals and to their native countries for these physicians to have some training in hospitals in this country

but it is alarming for our hospitals to be so dependent on the services of these individuals; and it is particularly distressing that our medical schools do not now have the educational capacity to admit substantial numbers of young Americans interested in and well qualified for the study of medicine. The broad agreement that now exists about the need for more physicians and other health professionals is illustrated by the fact that representatives of the executive council of the Association of American Medical Colleges and of the board of trustees of the American Medical Association recently issued a joint statement which "emphasized the urgent and critical need for more physicians if national expectations for health services are to be realized. National policy which could best meet this need and would be consistent with the American ideal of equal opportunity for all would provide such educational resources that every young person interested in and qualified for entry to the study of medicine would have this opportunity."

The hospitals of this country have stretched their resources to the limit in providing services to patients who had no other recourse and many of them in providing education for many categories of health workers. They have not had the money with which to replace, modernize, or expand their facilities nearly enough to meet the current and future demands of society. The needs for modernization and expansion are particularly severe in teaching hospitals. For example, a recent study showed that in 214 of the teaching hospitals, which contain a total of 115,00 beds, 35 percent were over 35 years old and another 16 percent are between 21 and 35 years old; 120 of them plan to replace 27,500 beds and 142 plan to add 24,000 beds in the next 10 years. The cost of construction in these hospitals is estimated at $4 billion over a period 10 years.

At this time, when so many of the demands and expectations of society can only be met by increases in several of the outputs of medical schools and teaching hospitals, the resources of these institutions are stretched to the limit. A year ago, we reported to this committee, "Every university medical center in the United States, both State and private, is in trouble financially and some are in desperate straits." The Congress did increase the appropriations slightly over the previous year and in this fiscal year, for the first time, the basic improvement grants to eligible schools will be paid at the full amount authorized by Congress and a small number of special improvement grants will be made. In the meantime, the pressure on institutions from rising costs and increasing demands has increased.

In the last year, a major American university announced the closing down of its school of dentistry. University after university is finding it necessary to sever all fiscal relationships with its medical school because of the financial drain on university funds and the damage that drain has done to other components of the university. There is grave concern that some medical schools will be forced to close for lack of funds.

We realize that adequate support from the Federal Government so that schools of the health professions and teaching hospitals can move decisively toward meeting the expectations and demands of society must await not only the enactment of that new enabling legislation, which fortunately is now being considered by other committees of the Congress, but also new fiscal developments affecting our whole economy or radical reassessment of national priorities. We felt a responsibility, however, to report to you fully and frankly the magnitude and severity of these problems as background for your consideration of what can be done this year about appropriations within authorized limits for established programs.

APPROPRIATIONS FOR 1969

Support of research

We urge that the full amount recommended by the administration for the support of the program of the National Institutes of Health be appropriated. We would emphasize the fact that when the increases for the regional medical programs are subtracted, the increase recommended is actually below last year's rise in costs. The great dividends research has given us in the past are well known. One can calculate numbers of lives saved or prolonged by the discovery of the antibiotics or the cases of death and paralysis prevented by the discovery of polio vaccine. It is obvious that innumerable hours of trained personnel would have been needed to care for crippled patients if a vaccine for polio had not been developed. There are a number of areas in which there is great promise that investigations now underway will bring great benefits in the saving of life, the prevention of suffering or the reduction of costs. Even more important than the

specific investigations is the maintenance of the broad competence in biomedical science which has been built up during the last two decades. It would be tragic, indeed, if the support of research were reduced to the point that significant numbers of people trained as investigators had to turn to other activities. The individuals would find ready employment, but it would take many years to rebuild the present level of competence.

General research support awards

In addition, we strongly urge that the appropriations for research be increased to such a point that the full 15 percent of NIH funds authorized by Congress for general research awards can be allocated without reducing the amounts recommended for the support of research projects. These awards give the institutions flexibility in the use of funds for the support of research and are particularly important in making the necessary adjustment when research projects or programs are not renewed because of lack of funds, and they considerably strengthen the stability of the institution. Last year the administration authorized the use of approximately 8 percent of each Institute's funds for general research support awards. We assume that it contemplates doing the same in fiscal 1969. We are, therefore, asking you to increase the appopriation of each Institute by 7 percent, so that the equivalent of 15 percent will be available for general research support awards.

Special improvement grants

A second item of appropriations which can have a decided effect in helping institutions cope with current problems is that concerning educational improvement grants authorized by the Health Professions Educational Assistance Amendments of 1965.

The basic improvement grants are awarded to eligible schools on the basis of a formula. To be eligible for a basic improvement grant the schools were required to increase the enrollment in their entering class by 2½ percent or five students, whichever was larger, over the highest enrollment in the entering class during the period 1961–65. Nearly all of the schools did increase the enrollment of their entering class by at least that much, except a few for which this requirement was waived by the Secretary, as provided in the legislation. Unfortunately, the Congress did not appropriate enough money to fully fund the basic improvement grants until the current fiscal year. In fiscal 1966 only 70 percent of the amount of the formula indicated could be awarded to each eligible school, and in fiscal 1967 only 95.5 percent could be awarded. The schools had assumed that the Congress fully intended to appropriate the funds the formula it had established would require, if the schools met the requirement of expanding enrollment. They also felt that when they had agreed to accept students, they were obligated to do so and to continue them in enrollment throughout medical school if their performance was satisfactory. In fiscal 1968 the full formula amount has been awarded to eligible schools and special improvement grants totaling about $17 million will be awarded.

For fiscal 1969 the administration has recommended that $66 million be appropriated for these two types of grants. Of this, $33.7 million would be required for the basic improvement grants and $32.3 million would be available for special improvement grants.

We urgently request that you appropriate the full amount authorized for these two types of grants, which is $80 million. These special improvement grants, which are limited to not more than $400,000 per school, go first to those schools where they will mean the most.

They will not by any means solve our problems. They may, as we have said, help many schools buy the time we need.

Those schools in imminent danger of closing may well find such grants to be lifesaving. A second group of schools to whom they could mean everything would be those in danger of losing their accreditation because of serious weaknesses in one or two departments. Loss of accreditation, I must explain, is about equivalent to being closed down. Still a third group of schools to whom such grants could mean a great deal are those now doing a really creditable job but with whole areas of development of importance to their communities and to the Nation which they would like to enter but cannot because of lack of funds. These could be undertakings such as that of community medicine or the use of computers or the recruitment of full-time clinical faculty or the discharge of that new responsibility now confronting our schools, the provision of continuing education for physicians out of school a decade or longer. Any and all such under-

takings could, along with other values, help us to new ways of coping with the rising costs of medical care.

Full funding of this particular item in the budget is, perhaps, the most important contribution this committee can make to our medical schools this year.

Construction of health educational facilities

The third specific appropriation which we urge you to increase to the full amount authorized concerns the construction provisions of the health professional educational assistance amendments which provide matching grants for construction.

We are aware of the fact that the inflationary effect of expenditures for construction plague both the administration and the Congress. We are even more aware, however, of the fact that the replacement or expansion of facilities is a necessary prelude to expanding the educational capacity of these institutions. Since this program was authorized, a great many of the eligible schools have developed plans for expanding enrollments, they have invested substantial amounts of time and money in planning facilities, and they have arranged for the non-Federal matching funds required.

The Congress authorized a total of $480 million for this purpose over a 3-year period. Of this, $135 million was made available in fiscal 1967, $175 million in fiscal 1968, and the administration has recommended the appropriation of $75 million for fiscal 1969. We urge that you increase that $75 million by $95 million to bring the total to the full $170 million authorized and urgently needed. Even that amount will fall short of providing the Federal share of applications approved and not funded plus those pending action by council, so the plans of some schools will necessarily be delayed. We also urge that you strongly recommend that the administration promptly allocate all of the funds appropriated for this purpose.

MEDICAL SCHOOLS AS NATIONAL RESOURCES

The medical schools, and schools in the other health professions, have long made vital contributions to our Nation and its purposes. Their outputs of physicians, medical scientists, trained individuals in the allied health professions, exemplary care for large numbers of patients in hospitals and clinics, and improved methods for caring for patients which could be applied in many other settings after they were perfected, have been of vital importance. Until fiscal 1966 these activities were supported, in the main, by universities, State and local government, foundations and donations from individuals and corporations. By fiscal 1966 the support of these regular operating programs from those sources amounted to a total of $367,977,000. In that year, for the first time, the Federal Government provided support directly intended for these regular operating programs in the form of basic improvement grants and the total amount of money which went to medical schools in the form of these grants was about $4.3 million.

It is, of course, true that substantial amounts of Federal funds do flow to medical schools in the form of grants or contracts for research and training for research. In fiscal 1966 this totaled about $405 million. It is also true that these programs are of vital importance to the institutions and to society, as we have mentioned earlier. They have enormously enriched the educational environment and increased the scientific competence of the institutions and they have contributed importantly to the output of medical scientists and of physicians trained in some fields such as psychiatry and neurology. Individuals supported in whole or in part by these programs have contributed importantly to the teaching of medical and other students, and the oportunity to do research is literally vital to the recruitment and retention of medical school faculties. But it seems important to emphasize two characteristics of these programs. The first is that they are very unevenly distributed among the medical schools for the very sound reason that they are awarded on the basis of scientific merit, which is also very unevenly distributed. The second is that these are cost-sharing grants and contracts in keeping with the stated intention of Congress that the institutions share the cost of each project and program.

The AAMC is convinced that the support of medical schools should continue to come from the variety of sources which have made possible their development thus far. It is also convinced, however, that each medical school is, to some extent, a national resource and that each should do what it can to respond to national needs and demands. Medical schools have done so in the past and can be depended upon to make every effort to do so in the future, but we believe

it is logical and necessary for the Federal Government to substantially increase its support of the regular operating programs of medical schools in proportion to the national needs for the several outputs of medical schools. We do not think it is logical or realistic to expect State or local governments, universities, foundations, individuals or corporations to increase their support of medical schools quickly enough or in large enough amounts to respond to national needs as they develop.

Dr. BERSON. As you know, the Association of American Medical Colleges is made up of all the medical schools in the country, plus 343 of the major teaching hospitals and 28 of the major academic medical societies.

Mr. FLOOD. Do we have biographical sketches of all of these gentlemen?

I would like them for the record. If you don't have them, would you send them to us?

Dr. BERSON. We will be delighted to do so.

(The information follows:)

BRIEF BIOGRAPHY OF ROBERT C. BERSON, M.D.

Born in Brownsville, Tenn., in 1912.

A.B. degree from Vanderbilt University in 1934; M.D. degree from Vanderbilt University in 1937.

Clinical training in internal medicine at Vanderbilt Hospital and Baltimore City Hospital.

Captain AUS, 1942–46.

Assistant in medicine—Vanderbilt University School of Medicine 1942–46.

Assistant professor for medicine and assistant dean, University of Illinois, 1948–52.

Associate director, survey of medical education, 1949–52.

Assistant professor of medicine and assistant dean, Vanderbilt University, 1952–55.

Vice president for health affairs, University of Alabama, 1955–62.

Dean, South Texas Medical School, University of Texas, 1962–64.

Executive director, Association of American Medical Colleges, 1965 to present.

BRIEF BIOGRAPHY OF ROBERT H. FELIX, M.D., ST. LOUIS, MO.

Born in Downs, Kans., in 1904.

M.D. degree from the University of Colorado, 1930.

Training in psychiatry, Colorado Psychopathic Hospital in Denver, Colo.

Master of public health degree, Johns Hopkins University, 1942.

Director of the National Institute of Mental Health, 1949–64.

Professor of clinical psychiatry, Georgetown University School of Medicine, 1949–64.

Dean of the School of Medicine, St. Louis University, St. Louis, Mo., 1964 to present.

BRIEF BIOGRAPHY OF FRANKLIN G. EBAUGH, JR., BOSTON, MASS.

Born in Philadelphia, Pa., in 1921.

M.D. degree, Cornell Medical School, 1946.

Training in hemotology and metabolic diseases, New York Hospital and Evans Memorial Hospital.

Associate director of laboratories, Mary Hitchcock Memorial Hospital, Hanover, N. H., 1955–64.

Associate professor of clinical pathology, Dartmouth Medical School, 1958–64.

Dean of the Boston University School of Medicine, 1964 to present.

BRIEF BIOGRAPHY OF JOHN PARKS, M.D., WASHINGTON, D.C.

Born in Muskogee, Okla., in 1908.
M.D. degree from the University of Wisconsin School of Medicine in 1934.
Training in obstetrics and gynecology at the State of Wisconsin General Hospital, Madison, Wis.
Chief medical officer in obstetrics and gynecology, Gallinger Municipal Hospital, Washington, D.C., 1938–44.
Professor of obstetrics and gynecology, George Washington University School of Medicine, 1944 to present.
Dean of the School of Medicine, George Washington University, 1957 to the present.
President of the Association of American Medical Colleges, 1967–68.

BRIEF BIOGRAPHY OF CHARLES A. LEMAISTRE, M.D., AUSTIN, TEX.

Born in Lockhart, Ala., in 1924.
A.B. degree from University of Alabama, 1943; M.D. degree from Cornell University Medical College, 1947.
Internship, New York Hospital, 1947–49.
Assistant resident in medicine, New York Hospital, 1948–49.
Assistant in medicine, Cornell University Medical College, 1948–49.
Public Health Service post-doctoral research fellow, Cornell University Department of Medicine, 1949–51.
Assistant physician to OPD, New York Hospital, 1949–54.
Instructor of medicine, Cornell University Medical College, 1951–53.
Senior assistant surgeon, Epidemic Intelligence Corps, 1951–53.
Assistant professor of medicine, Cornell University Medical College, 1953–54.
Assistant professor of medicine, Emory University, 1954–55.
Associate professor of medicine, Emory University, 1955–59.
Professor and chairman, department of preventive medicine and community health, Emory University, 1957–59.
Professor of internal medicine, University of Texas, Southwestern Medical School, 1959–66.
Associate dean, University of Texas, Southwestern Medical School, 1965–66.
Vice chancellor, University of Texas System, 1966 to present.

Dr. BERSON. I might add that Dr. Felix is the dean of the School of Medicine of St. Louis University. Dr. Ebaugh is the dean of the School of Medicine of Boston University. Dr. Le Maistre is the vice chancellor for health affairs at the University of Texas.

I will be delighted to send you a summary of their biographies.

We are fully aware that this committee will address itself primarily to what appropriations to make for specific programs within levels authorized by the legislation that created them. My specific recommendations will be in that context.

We are deeply concerned, as many people are, about the very large problems our country faces and the very serious fiscal problems that make the allocation of resources difficult indeed. We are particularly concerned about what a distinguished Member of Congress recently called the "health crisis," born of skyrocketing costs of health services exacerbated by persistent and widespread shortages of trained personnel and deteriorating or inadequate facilities. We feel the responsibility to report to you fully and frankly about the basic problems in supplying the health manpower to meet the very obvious needs. There is no doubt at all but what we are very short indeed, not only as regards physicians but with respect to many other categories of trained health

personnel. Our remarks will be mostly related to the education of physicians but we are as much concerned about the education of dentists, nurses and the whole category of health personnel.

To illustrate how short we are, I might mention one simple fact, one illustration about how very short of physicians we are. For example, in 1967, 8,540 forign medical graduates entered this country. About two-thirds of them are from developing countries, not the highly developed countries of Western Europe. In that year we graduated only 7,743 physicians.

Mr. FLOOD. Most of those have to go back home?

Dr. BERSON. Yes.

The duration of their stay varies, and statistics on how long they stay are pretty inadequate. A very substantial number of them do stay. In that same year, 1967, about 1,800 got licenses to practice medicine here and presumably will stay the rest of their lives.

A growing number of these physicians come in under immigrant visas rather than exchange visas.

There are many other facts that could be cited to illustrate this shortage. It is so severe that the representatives of the executive council of this association and the trustees of the American Medical Association recently issued a joint statement which emphasized the urgent and critical need for more physicians if national expectations for health services are to be realized.

Last year we reported to you that every university medical center in the United States, both State and private, is in trouble financially and some are in desperate shape. The Congress did increase the appropriation slightly over the previous year and this was helpful. But in the meantime the pressure on these institutions from increasing demands, increasing consciousness of how far we are from meeting the future needs of the public, plus rising costs have increased the financial pressure on these institutions.

Last year a major American university regretfully closed down its school of dentistry. At the present time, one university after another is finding it necessary to sever all financial relationships with the medical school because the financial drain is too severe for university funds to bear longer.

There is grave danger that some medical schools will be forced to close down for lack of funds. This is a very disturbing thing indeed at a time when what we especially need is much more in the way of the output of physicians and other things that medical schools do. We need a good many more medical schools rather than losing any.

To turn for a moment to the specific things that we do recommend, there are four relevant to this appropriation.

One is that we strongly urge that you appropriate the amount requested for the support of NIH programs. Actually, if you subtract the increase recommended for the regional medical programs, this represents a less than cost-of-living increase over last year's appropriation. We feel very strongly that a continued effort to solve the problems that we face, to gain more knowledge about the long list of diseases which plague mankind, must be unrelenting and must be continued.

First, we would recommend that the amount the President has recommended for NIH programs be appropriated.

The second thing we would recommend is that you add to the appropriation recommended enough money to make it possible for the full amount authorized for general research support awards to be actually awarded. Last year the administration allocated about 8 percent of the funds appropriated for research projects to general research support. The authorization has long been 15 percent. We would urge you to add 7 percent to the NIH appropriation so these flexible research support awards can be increased to the amount authorized.

Mr. FLOOD. You realize that we have no way of compelling the executive to spend appropriated funds.

Dr. BERSON. We do, indeed. We hope and believe that NIH would make this allocation if the committee expressed its intent and appropriated the funds. We can't compel them to either.

The third thing that we would recommend is perhaps even more important. It is that you appropriate the full amount authorized by the legislation for the basic and special improvement grants in the Health Professions Educational Assistance Act. In the current fiscal year, 1968, for the first time, the full amount that the formula for basic improvement grants provides is actually being awarded and there is some money for special improvement grants.

In the other 2 fiscal years this has been in operation there has not been enough money for the full amount of the formula. This has been disturbing and handicapping to the medical schools and to their efforts to meet the public need by expanding enrollment. The legislation authorizes $80 million. The President has recommended an appropriation of $66 million. We would urge that the full $80 million be appropriated. That would make it possible for a good many of the eligible schools to get special improvement grants up to a ceiling of $400,000 per school, which the legislation provides. This would be tremendously helpful. It could be lifesaving to the schools that are in the financial trouble. It could be tremendously helpful to the other schools.

As the fourth item of appropriation we recommend, we urge that you appropriate to the full amount authorized for the construction of health education facilities.

We are conscious of the fact that both the administration and the Congress worry about the inflationary impact of construction expenditures. On the other hand, the plans of these institutions to expand enrollment cannot be implemented until they can get facilities in which to do the job. Many an institution has invested time and energy and money in developing plans and putting in applications, they have raised the matching money—non-Federal money—and then found that there is not enough money available for the Federal share.

We would urge that you appropriate the full amount authorized for the construction program so that we can make some progress towards meeting the future needs of society.

Mr. Chairman, if it would meet with your approval, I would like to ask Dr. Ebaugh to comment on these matters from the particular vantage point of his position and responsibilities.

STATEMENT OF DR. FRANKLIN G. EBAUGH

Mr. FLOOD. Dr. Ebaugh?

Dr. EBAUGH. Mr. Chairman, my name is Franklin Ebaugh, dean of Boston University School of Medicine. I have a statement which I would like permission to have inserted in the record.

Mr. FLOOD. Yes.
(The statement follows:)

STATEMENT TO THE SUBCOMMITTEE ON LABOR, HEALTH, AND WELFARE OF THE COMMITTEE ON APPROPRIATIONS, APRIL 30, 1968

My name is Franklin G. Ebaugh, Jr., M.D., dean of the Boston University School of Medicine, 80 East Concord Street, Boston, Mass.

Boston University School of Medicine is in serious financial difficulties. For the past 3 years the actual budget figures of the medical school reflect approximately a half a million dollar deficit per year out of a total instructional budget of $1.2. This does not include sponsored research. The situation over the last 3 years is actually more serious than indicated above since the school has only been able to keep financially afloat by additional help for faculty salaries from private foundations for a limited period of time of approximately $100,000 per year. We were able to receive this support primarily because of a new 6-year medical school program which makes it possible to receive both the M.D. degree and the A.B. degree 6 years after graduation from high school. Thus over the last 3 years our institutional income covered only 65 percent of the cost of the operation of the medical school. The remaining 35 percent, or half a million per year, to make up our deficit has come from the parent university. This half a million dollars per year represents a serious financial drain and threat to the survival of Boston University since, although it is the fourth largest privately endowed university, its endowment is one of the smallest, amounting to a total of $20 million; and, therefore, this half million dollars has to come essentially from tuition paid by students attending the other schools of the university.

Our deficits will increase substantially in the next 5 years so that, for the projected budgetary year commencing July 1, 1968, we will have a deficit of $450,000 which will increase progressively to $1.7 million by 1972–73; that is, by 1972–73 the expenses of operating the medical school insofar as education of medical students is concerned will be $3.4 million whereas our projected income will be $1.7 million. These projected deficits assume a fully funded Federal special improvement grant and basic improvement grant through the years 1968 to 1973. They also reflect a commitment of over half our general research support grant fund to support faculty salaries. The above costs do not include depreciation of buildings or equipment. The projections are based on 54 percent of the basic science faculty salaries coming from the university and 46 percent from research, training, and career development grants. The projections for the clinical faculty are based on 25 percent of their salaries from the university, 29 percent from the hospital, and 46 percent from research, training, and career development grants. Our financial difficulties have occurred for the following reasons:

1. Our medical school had not built a new instructional building for 75 years and was faced with a decision in 1964 of either building a new physical plant or closing its doors. In order to obtain Federal matching funds to build a new medical school, we needed to commit ourselves to an expansion of our student body of 24 percent by 1969. This will result in a near doubling of our plant costs alone from $273,000 per year to $512,000 per year and increasing our faculty to maintain the present student-faculty ratio and standards of education at an additional cost of $250,000 per year.

2. Our current cost for educating a medical student per year are several times more than the tuition received.

3. The cost of living and, therefore, the cost of operating the medical school are increasing at a greater rate than our income.

4. Substantial increase in expenditures will be needed if we are even to maintain the present quality of our education, let alone improve it over the next years.

What are the present solutions:

1. Close the medical school and thus deprive the Nation of approximately 96 graduating physicians per year. This would be a tragedy since in order to establish a new medical school the cost would be somewhere between $33 million and $44 million ("Developing Medical Schools: An Interim Report by Cheves McC. Smythe," Journal Medical Education, vol. 42, p. 991, November 1967). Furthermore, once a decision was made to start a new medical school, the average time before a physician has been graduated has been 10 years and during this 10-year period the budget for just developing the school before graduating physicians is of a similar order of magnitude as the budget to run this medical school turning out 96 physicians a year. Thus, we really would lose approximately

a thousand physicians if our medical school were to close, and in order to obtain an equal number of physicians the cost would be several order of magnitudes greater than it would take to keep our medical school financially solvent.

2. Raise approximately $40 to $50 million of endowment, income from which could make up the deficit. Although theoretically possible over a long period of time, this obviously is impractical over the next several years. The medical school currently has a $3 million endowment which has been raised over the period from 1872 to 1968 which includes market appreciation of its securities. The university as a whole, including the medical school endownment, has been able to raise $20 million, including market appreciation from its establishment in 1869 to the current date.

3. Raise the tuition of medical students to meet the cost of their education. This would be extremely undesirable since it would make it impossible for many students to enter medical school even if they were willing to go into debt, and would particularly prevent the disadvantaged segments of our population from becoming doctors, which is at this time a vital national need.

4. Find a cheaper way to educate a medical student. Inasmuch as Boston University is among the 10 lowest schools in terms of expenditure per year for education of a medical student, it would not seem we could reduce our cost any further without seriously impairing the quality of the education given to the medical students.

5. Receive subsidy in one form or another from the Commonwealth of Massachusetts. This does not seem possible in view of the fact the Commonwealth is starting a new State medical school at a cost of somewhere between $50 and $75 million with a substantial annual operating budget.

6. Increase support for medical education from the Federal Government as outlined in Senate bill S. 3095 and H.R. 15757. This is an excellent bill and represents a very satisfactory solution to the financial problems of medical schools. However, it would not appear that this bill will be operable in terms of full funding a year or two. A more immediate solution would be to appropriate the fully authorized amount, or about an additional $14 million, making it possible to fund the special improvement grants at the $400,000 level to additional medical schools and to fully fund the authorized amounts allowable under the basic improvement grants. Another helpful and possible immediate solution would be to make additional appropriations to allow full funding of the general research support grants to the authorized level of 15 percent. This increase in moneys would allow the schools to pay research expenses which they are now bearing from institutional funds and thus use the spared funds for the operation of the school for educating medical students.

Mr. FLOOD. How old are you?

Dr. EBAUGH. Forty-six.

Mr. FLOOD. How long have you been dean at Boston University?

Dr. EBAUGH. Three and a half years.

For the last 3 years, we have been able to meet only 65 percent of our regular operating costs. The deficit of about half a million dollars being made up by funds from the parent university which in turn has come from tuition paid by undergraduate students going to that university, since our university has a very small endowment.

We have scraped by in the last 3 years by making sure that over half of our general research support funds could properly support faculty salaries and by raising money from private foundations to help us keep going for at least these few years. In the next 2 years, our situation will become even more serious because in 1964 we had not built a new building in 75 years and we had to make the decision at that time when I became dean to either close our doors or build a new medical school. The latter decision was made. This new building will open up next September and allow us to increase our output of physicians by one-third. Coincidental with this expansion, we will become in an even more precarious financial position since the cost to educate a med-

ical student per year is nowhere nearly met by the tuition that the medical students can afford to pay.

Having teetered on the brink of financial disaster, this expansion may well push us right over the cliff and onto the rocks since our expenses are going to far outstrip our ability to increase our income.

We are running our school in about as good a fashion as is possible. We are the 82d lowest school out of 88 schools in terms of the money that we are able to spend per medical student educated per year. It is not as if we had not been trying to find quicker and more direct ways to educate physicians: In the last 7 years we have had a program that will allow a high school graduate to receive his A.B. and M.D. degrees 6 years after high school instead of the classical 8 years it now takes in most schools.

As I see it, until the pending legislation—House bill 15757—hopefully is passed and fully funded, our only hope for survival is an increase in general research support funds to the authorized level of 15 percent, since if this were done it would amount to about $200,000 of additional funds which we could use to pay the legitimate research expenses which we are now having to pay from regular operating funds. This could allow us to continue until further Federal help.

I thank you very much for the opportunity to present directly the plight of our school.

Mr. FLOOD. Do you have that combination course there?

Dr. EBAUGH. Yes; it is a combined course leading both to an A.B. and M.D. degree in 6 years.

Mr. FLOOD. It has been suggested it might be a good idea if other schools pursued it.

Dr. EBAUGH. I think it would. It does save about three-quarters of the time and total cost to the student. You turn out more doctors per given period of time with the same physical plant.

Dr. BERSON. I would like Dr. Felix of the University of St. Louis to comment briefly about this from the viewpoint of his responsibilities.

STATEMENT OF DR. ROBERT H. FELIX

Dr. FELIX. Mr. Chairman and gentlemen, I assumed the deanship 3½ years ago upon my retirement from the Public Health Service where I was Director of the National Institute of Mental Health. This is my first time back in this capacity at the table where I sat for 21 years.

Mr. FLOOD. We are very well acquainted with you. And this subcommittee has always thought highly of you.

Dr. FELIX. Thank you Mr. Chairman. Mine is a private institution also with an enrollment at the present time of 451 medical students. We are committed to go to about 480 by 1970. Our freshman class this fall of 128 was chosen from 810 applicants. It is one of our agonies that there were an equal number to those chosen who could just as easily have been chosen because of their ability, motivation, and aptitude, if we had had the space for them.

Our school receives no subsidy from the State of Missouri. As a private school, we consider ourselves essentially a national resource. Our freshman class this year comes from 20 States, the top 10 of which are not just in our area—Missouri, Ohio, Illinois, New York, Cali-

fornia, New Jersey, Massachusetts, Pennsylvania, Washington, and Kentucky.

Our present student body comes from 33 States, about the same distribution of the top 10 that I have given you.

Between 1950 and 1960, we graduated 1,247 students and they are located in all 50 States of the Union. This year we will graduate about 109 seniors if all goes well, and we are committed to go to about 115 by 1971 if we remain in existence. I use that phrase deliberately because we are not sure we will. We like Boston University and some dozen others, are in a desperate financial situation. Our tuition this year for a freshman is $1,800. This meets less than 15 percent of our budget. We have just gone to $2,100 beginning next year, which cuts out a number of students because they cannot afford to go to school at that price. This will only meet about 15 to 16 percent of our budget.

Mr. FLOOD. Is Tufts in trouble?

Dr. FELIX. Yes.

Our expenses last year were over $6.3 million and we had a deficit of $1.1 million. We estimated a deficit of $1.2 million for this year. It is a matter of great concern to our trustees that in the 7 fiscal years between 1964 and 1971, we incurred a total deficit of $8.5 to $9 million. This is coming out of the basic resources of our school and has meant that other schools in our university—law, engineering, liberal arts, divinity, and others—have not been able to develop as they should. It has now gotten to the point where last year the trustees were faced with the terrible decision as to whether or not the medical school or some other school should be discontinued.

Because of the desperate need for physicians, it was decided that since both schools were in trouble, they would close the school, or phase out, I should say, the school of dentistry. The school of dentistry will receive no new class this fall. Ours is the one Dr. Berson mentioned a moment ago which will phase out of existence. Therefore, this country will have one less dental school. I would like to underline the fact that this by no stretch of the imagination assures the existence of the school of medicine. We are still incurring from $1.1 to $1.4 million deficit as we look into the future. The university can't stand this for very long. I don't know what the future is going to hold. I would like just for a moment to give you some idea of what it means for a medical school to close.

A recent study done by the Association of American Medical Colleges was to the effect that it is about 5½ years from the time a new school is authorized to open and when it receives its first students. This means 9½ years until you get your first graduate, about 10½ years until a student has completed his internship. It costs between $25 million and $50 million in capital improvements, depending on whether you use old buildings or build new buildings, whether you build in a city or out in a rural area. It costs between $4 and $5 million in salaries while you are building up your faculty. It will cost, in loss of doctors for a medical school to close today, on the average of about 1,000 doctors before you can replace them by the new school getting into operation. This is to say that every one of us who closes will cost the American people about $50 million and about 1,000 doctors whom they cannot replace under a decade to a decade and a half. We are aware of this. We are desperately concerned. We don't know where to turn unless

we can buy time until pending legislation is acted upon and made effective by the Senate and the House.

If, as Dr. Berson says, the special improvement grants and the general research support awards grants can be funded at the legal limit, this will buy us time. It will help us to find all possible avenues of assistance. Without this, I don't know what is going to happen in my school or others.

I feel quite sure that within 5 to 7 years, if something is not done, you are going to be somewhere between six and 12 schools short of what you are now.

We have gone to the limit of our resources. I went to St. Louis University after having been on the other side of the fence in the Federal Government and I was literally appalled at the financial needs that I encountered. I am sure that had I known what these were I would have thought twice before I undertook this really herculean task of trying to keep this school afloat.

I hope that I have been able to show you something of the needs of one private school and that you can understand our desperate plight.

Thank you.

Mr. FLOOD. I don't know about these other members; but in my opinion, if you cannot persuade the Congress, nobody can.

Mr. LAIRD. Mr. Chairman, I would like to discuss with Dr. Felix the improvement grant program.

There is a provision that the requirement that there be an increase in students to qualify can be waived by the Surgeon General or the Secretary?

Dr. BERSON. The Secretary.

Mr. LAIRD. So that in order to help medical schools such as Boston University, St. Louis University, University of Marquette, just to keep their doors open and maintain their current enrollment, you would have to waive that provision because these schools can't increase their enrollment and may not even be able to stay in operation during this period. Could your own school increase its enrollment?

Dr. FELIX. No. We are up now to 128. I cannot increase any more unless I get more faculty and space. We have equipment in the halls. We have an inadequate number of lecture rooms. We must have more faculty before we could teach adequately.

Dr. BERSON. I think this is a very real point, but actually as regards the basic improvement grants now in effect, this is the third fiscal year, and a very long list of medical schools have agreed to increase their enrollments above the baseline period of 5 years, which I think was 1961 through 1965. A short list have received waivers of that requirement.

Dr. FELIX. I might say that our school has increased its enrollment in compliance with that.

Dr. BERSON. The point is that if the school already met the commitment or had the commitment waived it would be eligible for basic improvement grants in fiscal year 1969.

Dr. EBAUGH. Our school is committed to a 33-percent increase since we were going to build a new building, but you have to replace a shabby plant. It would be the height of folly not to build a building big enough to make a reasonable increase. We can do the increase if we can get the money for the additional faculty.

Mr. FLOOD. Where would you build? Downtown?

Dr. EBAUGH. We are building right in Roxbury, adjacent to Boston City Hospital, where we have been since 1872.

(Dr. Felix's formal statement follows:)

Mr. Chairman, my name is Robert H. Felix. I am dean of the School of Medicine at St. Louis University in St. Louis, Mo. I appreciate very much being afforded the opportunity to present to you the truly critical situation of my school as a part of the testimony being presented by the Association of American Medical Colleges.

St. Louis University is a private institution made up of 13 colleges and schools. The School of Medicine has an enrollment of 451 medical students. We are committed to increasing this number to 478 by 1970. We are presently admitting 128 students each year to our freshman class. For the class entering in September 1968, these students were chosen from 1,810 applicants. Approximately one out of 14 applicants was successful in gaining admission. Of those who were not admitted approximately 7 percent or as many as were accepted, appeared from the data available to the Admissions Committee to have the intelligence, aptitude and motivation to successfully complete the course of study for the M.D. degree. They could not be admitted, however, because of insufficient facilities, faculty and funds necessary to meet minimal requirements for adequate instruction.

As a private school which receives no subsidy from the State of Missouri, our students come from all parts of the United States and our alumni are providing medical services over an equally wide geographic area. The freshman class to enter this fall come from 20 States, with Missouri, Ohio, Illinois, New York, and California being the largest contributors, followed by New Jersey, Massachusetts, Pennsylvania, Washington, and Kentucky. Our present student body come from 33 States of which the leading 10 are: California, Ohio, Missouri, Illinois, New York, Massachusetts, Pennsylvania, New Jersey, Connecticut, and Washington. As I just stated, alumni from St. Louis University are widely dispersed among the States. Those who graduated between 1950 and 1960, which means those who have completed their graduate training and their military obligation, unless they are in the regular services, are to be found in all 50 States. There were 1,247 students graduated during that period of time.

Thus, it can be seen that my school has filled and continues to fill a national need. We will graduate 109 seniors this year and our present plans call for graduating classes of about 114 by the spring of 1971. Thus, between the spring of 1968 and the spring of 1980 we should have produced 1,400 new physicians if we remain in existence.

That last qualifying phrase is not said idly. This school is one of those in the United States in serious financial difficulty. For fiscal year 1966–67 our income from all sources was over 5.2 million of which tuition of $1,800 per student and fees account for over $800,000 or 15 percent. Parenthetically, in an effort to deal with our financial problem, the trustees have increased tuition for medical students to $2,100 per year, effective next academic year. Our expenses were over $6.3 million resulting in a deficit of over $1.1 million. This money has come from the general resources of the university and has resulted in curtailment of necessary growth and development of essential programs in other schools and colleges of the university. If this were a nonrecurring deficit it would be unfortunate but not critical, but this is not the case. The school of medicine has been a deficit operation for some time and the projections for the future give promise of little improvement unless some hitherto untapped sources of funds are discovered. The deficit for the last 3 fiscal years has been over $2.9 million. In the current fiscal year it is estimated the deficit will be over $1.2 million. Our best estimates for the next few years are little different.

The above projections are based on continued operation at the present level; but, this cannot be. At the present time several departments are so inadequately manned and equipped that the student is not being prepared as he should be. There are clinical departments manned entirely by volunteer faculty, dedicated and able men, who, however, must earn their living from their private practice, so that but a fraction of their time can be devoted to teaching duties. There are also areas of critical importance to the education of the modern physician to which is devoted only a token amount of time or no time at all. These areas must

be adequately covered if the school is to maintain its accreditation which is fundamental to staying in operation.

All of this means that, in order to do only a minimum job of teaching, faculty must be added, and new facilities must be constructed to provide adequate space for teaching and study. Presently our facilities are so overcrowded that equipment must stand in the halls.

This present and projected increased financial drain cannot continue without seriously endangering the fiscal structure of the entire university. If some relief cannot be found, the school of medicine must either close or bring the entire university down with it in financial collapse.

The fiscal situation has become so acute that during the last year the trustees of the university were faced with a Solomon-like decision. Consideration was given at that time to ending the existence of the school of medicine, but, keenly aware of the critical need for many more physicians, the trustees decided against reducing at this time the annual national output by 100 to 118 graduates from our school. I can add that owing to the fiscal situation in the university, the trustees found it necessary to discontinue the school of dentistry because they lacked resources to maintain it at a creditable level. So, now there will be one less school of dentistry. Even so, the financial drain of the school of medicine cannot be tolerated for more than a few years, and its fate remains uncertain.

Gentlemen, if the special improvement grant could be funded in the full amount authorized, it would provide some relief and buy time until legislation now pending in the Senate could be acted upon by that body and by the House of Representatives. I cannot emphasize too strongly that the very life of my school and of a number of others hangs in the balance. This statement is in no sense an exaggeration. If assistance is not forthcoming soon we will disappear from the scene. It is not a question of how many more students we can accept, but if we can accept any at all.

Recent studies have shown that the time interval between the authorization of a new school of medicine and the acceptance of the first students is, on the average, 5½ years. That means 9½ years until the first physician is graduated—10½ years until he has completed his internship. Further, the initial enrollment in these new schools is about one-third of the projected enrollment, which means several more years until the school is producing at full capacity. Further, the average capital cost varies from $28 million where existing facilities are used to $44,500,000 where largely new facilities are constructed. To this must be added operating costs during the 5 years between authorization and the admission of the first student. This averages over $4 million. The total money outlay averages between $32 million and $48,500,000.

If a school of medicine fails to admit a freshman class, it has signed its death warrant. Both faculty and students know the significance of such a decision. All faculty who can do so, which means all of the best, seek positions elsewhere as quickly as possible. This means that if the decision is made not to admit a class, the effects are irrevocable. The school will inevitably close. We have proof of that now in the case of our school of dentistry.

Since the production of physicians is inadequate, and all authorities agree that it must be increased, and since the closing of a medical school will decrease the production from 80 to 90 physicians a year on the national average, the old school must be revived or a new school must be authorized, which for all practical purposes amount to the same thing. The net effect of all this is that if a school cannot continue for financial reasons it will cost the American people 800 to 900 physicians and $32 million to $48,500,000.

Gentlemen, my school and many others are extending themselves to the breaking point to prevent this from occurring. We find now that we cannot carry on much longer without assistance. We are appealing to you for that assistance while there is yet time, but with the gnawing realization that it is later than many people think.

STATEMENT OF DR. CHARLES A. LE MAISTRE

Mr. FLOOD. Now we have Dr. LeMaistre.

Dr. BERSON. Dr. LeMaistre is vice chancellor for health affairs at the University of Texas. I would like him to make a few comments.

Mr. FLOOD. What is a "university system"?

Dr. LeMaistre. Mr. Chairman, it is the totality of schools which constitute the University of Texas. The medical school units included are nine in number.

Mr. Flood. Proceed.

Dr. LeMaistre. Mr. Chairman, my name is Charles LeMaistre. I am vice chancellor for health affairs for the University of Texas system. There are nine institutions in the University of Texas system devoted to education of health professionals; these nine institutions are responsible for expenditure of almost one-half of the money spent in the entire system.

Response to the health manpower crisis by the Texas Legislature and the University of Texas system has been substantial and has moved at an accelerated pace. This response has been based on continued Federal participation in the financing of this response. Nowhere is the need for continuation of past commitments more urgent than in medical education.

I will describe the situation in the State-supported medical schools for which I am responsible. These have been well supported by the Texas Legislature and are believed to be representative of the situation of many State-supported medical schools.

Currently our two existing medical schools, in Galveston and in Dallas, are expanding enrollment as fast as resources will allow. Our new medical school in San Antonio will open in September 1968 with four times the number of students originally projected for the opening date. Furthermore, creation of a fourth State-supported medical school has been requested of our legislature.

By the early 1970's, physician production by University of Texas system medical schools will be increased by one-third if our present schedule is not interrupted. If a new medical school is authorized as requested, we will double our production by 1975.

In addition to acceptance of responsibility for physician manpower, the University of Texas system has authorized our medical schools in Galveston and Dallas to substantially increase manpower production in the allied health professions.

Federal participation in the financing was essential in permitting the undertaking of such an ambitious response to the health manpower need—and is even more essential for continuance of these efforts. Interruption and loss of momentum would squander carefully nurtured resources. Three areas of financial need reflect accurately the areas in which continued Federal participation will be necessary for continuation of these contributions to solution of State and National health manpower needs. They are—

1. Full authorization for special improvement grants.
2. An increase of 7 percent in the budget of each national institute of health so as to permit the full funding of "General Research Support Grants."
3. The full authorization for medical educational facility construction funds.

Thank you.

Mr. Flood. Mr. Casey?

Mr. Casey. You need the full appropriation?

Dr. LeMaistre. Yes, sir.

Mr. CASEY. Mr. Chairman, I am pretty well aware of the good work they are doing down there, and the State of Texas is very grateful for the Federal participation in this and in the support of the medical schools.

Mr. FLOOD. Thank you very much, gentlemen.

Mr. LAIRD. Mr. Chairman, I see Dr. John Parks here, president of the Association of American Medical Colleges. I think the record should show he is masterminding the appearance of these people here. He is the president of this association.

TUESDAY, APRIL 30, 1968.

TITLE II OF ELEMENTARY AND SECONDARY EDUCATION ACT

WITNESS

BROTHER EMMETT CORRY, O.S.F., CHAIRMAN, SCHOOL LIBRARY SUPERVISORS SECTION, THE CATHOLIC LIBRARY ASSOCIATION

Mr. FLOOD. Brother, you are our next witness.

Brother Emmett Corry, chairman of the social library supervisors' section, Catholic Library Association.

I think that you should know that our mutual friend, Congressman Carey, has spoken to us in your behalf. I suppose that you know that?

Brother CORRY. I did know that.

Mr. FLOOD. We think that you should know how highly he speaks of you and thinks of you and how highly we think of Congressman Carey. This makes a nice package for you.

Brother CORRY. I certainly share your thoughts on Congressman Carey.

Mr. Chairman, I would like to read this short presentation.

Mr. LAIRD. We are certainly getting a lot of letters that you generated. I think we have had over 650 today.

Brother CORRY. Alone?

Mr. LAIRD. Yes. It is a pretty good drive you have going on title II.

Brother CORRY. We hope that whatever action is taken to persuade Congressmen is done mainly in the constituencies.

Mr. LAIRD. Many of these are from my constituents. I am glad. It gives me an opportunity to explain how the executive branch has reduced this program.

Brother CORRY. Good.

Mr. FLOOD. Proceed.

Brother CORRY. Mr. Chairman and gentlemen of the committee, my name is Brother Emmett Corry, O.S.F. I am a Franciscan teaching Brother in the Roman Catholic Diocese of Brooklyn. I have been an elementary school teacher for 7 years, a high school librarian for 6 years, and I am presently working in the school office of the Diocese of Brooklyn to help implement ESEA title II. I also work with the Board of Education of the city of New York, and the education department of New York State, as a member of the title II advisory committees. I am also the national chairman of the school library supervisors section of the Catholic Library Association.

First of all, I would like to thank you for the invitation to address you. I am here this afternoon to urge that the budget recommendation for 1969 for title II be restored to at least the level of the fiscal year of 1968.

As a librarian and a teacher, I believe that title II, of all the ESEA titles, will have the most lasting effect on the long-range education of the Nation's students. I have seen title II provide the impetus in the establishment of many school libraries where there have been none before. Since 1966, our Catholic elementary schools in Brooklyn have built a total of 53 new central libraries to house the title II materials loaned to our students. It is safe to say that the majority of these libraries might never have come to being without the impetus of the Federal program. The requirement in the law, that schools maintain local effort, and that title II funds not supplant this effort, has been a wise one. It has caused our administrators to budget and expend funds for learning centers in larger amounts than ever before. The advantages of these libraries or learning centers are extensive.

1. They provide a variety of learning materials within a school-building and make these materials readily available to teachers and students during the school day. These materials provide a wide range of new curricular experiences and make possible more interesting and individualized learning experiences. Students grow in the ability to work more independently because they are no longer dependent on one textbook. This is especially important for the disadvantaged student. These children must have the possibility of successful learning experiences early in their lives if they will ever be able to move on to more sophisticated problems and more involved materials. If they have ready access, with the help of competent and warm teachers, to a variety of good, well chosen materials, then the chances of their achieving this early success, are more probable.

In this context, a parent states, "I cannot overemphasize the benefit of the learning center. I have seen growth and independence in my son's works that were not demonstrated in my older child who lacked this opportunity."

2. Students who are underachievers, and many advantaged students are in this category, need to have enthusiasm about learning materials. They need to be assisted to find out how interesting a book can be. Once these youngsters become excited about being able to go ahead on their own, learning suddenly becomes rewarding. An elementary school with a really good library is apt to have a special sort of "hum," a sense of "everybody doing something" which is especially important to children from homes where reading is not ranked high (or at all) on the scale of useful or enjoyable activities, and where adult models often do not read easily, if at all.

It is for this reason that we have consistently asked the Board of Education of the City of New York to reallocate a portion of title II materials from our more advantaged schools to schools containing a high percentage of disadvantaged students. In addition, we have also taken into account, the relative need of these schools for the materials being loaned. In each of the title II fiscal years, the Board of Education has allowed us to implement this policy.

3. Administrators have been made aware of the importance of learning centers.

I would like to add, I consider this personally to be the most important effect of title II. It has made administrators, especially our Catholic school superintendents, more than aware of the importance of libraries, or learning centers within schools.

In the not too distant past, a number of administrators believed that libraries and materials centers were largely supplementary and luxury items. The wisdom of Congress in including title II in the Elementary and Secondary Education Act, has convinced many administrators and principals, that libraries or learning centers must play a central role in the curricular development of their schools. They have come to realize that these materials, and the wise administration of them, has opened new potentials for learning to their students.

4. Title II has also had a strong influence on the faculties of our schools. The need to establish priorities in applying for title II grants has happily forced librarians to enlist the support and assistance of their faculties. This has had a very good influence on one critical aspect of school library development. The American Library Association has long felt that there is a need for new avenues of communication and cooperation between librarians and faculty members. I believe that title II has given us a push in the right direction.

5. The parents of our students have also become involved in title II. When these materials first came to our schools, it was evident that they had to be cataloged and housed so that our students could have ready access to them. Our parent organizations in many parishes came to our assistance. I offer these pictures taken in 1966 in Holy Rosary Parish in Brooklyn, as an interesting commentary on this point.

I think that you will see these pictures were taken by amateurs rather than by professionals. The quality of the pictures even in the negatives made it impossible to use them in our local newspaper, however, I think they do serve to show the interest of parents when they built a library to house materials for their children, including the shelves and tables.

Although the accomplishments of title II are much in evidence, I believe there is still a great deal that this Federal program can accomplish. The first annual report on title II makes it evident that there are still about 36,000 public elementary schools that do not have libraries, and far more fall below the national standards established in 1960. A national survey of Catholic schools in 1965, showed that only about 47 percent of these schools had libraries. This figure has risen steadily in the last 3 years. In Brooklyn we have 204 parish elementary schools but only 75 have central libraries; and 53 of these were added since 1966. Although these figures are local, they reflect a similar national trend.

To again add comments here, I wish that we had national records of the increase of school libraries in the Catholic schools under the impetus of title II. This is information we do not have but we do need and we are going to try to get that information as soon as possible.

Good work has been started, but I emphasize, it has only been started. If the vision of Congress in 1965 is to be fulfilled, the Elementary and Secondary Education Act must be allowed to accomplish its purpose, and I submit that that purpose is to provide as many children

as possible with the learning materials that are essential in these troubled times.

I thank you very much.

Mr. FLOOD. Thank you very much.

WEDNESDAY, MAY 1, 1968.

NEUROLOGICAL DISEASES AND BLINDNESS

WITNESSES

RAY HEIST, MEMBER, BOARD OF DIRECTORS, NATIONAL PARAPLEGIA FOUNDATION

ALAN REICH, MEMBER, BOARD OF DIRECTORS, NATIONAL PARAPLEGIA FOUNDATION

JAMES SMITTKAMP, EXECUTIVE DIRECTOR, NATIONAL PARAPLEGIA FOUNDATION

Mr. FLOOD. The committee will come to order.

We have with us the National Paraplegia Foundation. Who will testify?

Mr. REICH. Both of us.

Mr. FLOOD. And you are Alan Reich, a member of the board of directors, and with you is Mr. Ray Heist, a member of the board of directors of the National Paraplegia Foundation?

Mr. REICH. Yes.

I do not have the printed text which Mr. Smittkamp will bring.

STATEMENT OF MR. ALAN REICH

Mr. FLOOD. All right, you may proceed, Mr. Reich.

Mr. REICH. I am Alan Reich of Sudbury, Mass., a manager with Poloraoid Corp., and a member of the board of directors of the National Paraplegia Foundation.

Mr. Chairman, our foundation is most grateful to this subcommittee for the privilege of presenting our program for paraplegics. The National Paraplegia Foundation is a not-for-profit corporation made up of persons interested in promoting the well-being of the estimated 100,000 American men, women, and children who are paraplegics. Our membership is largely, but not exclusively, paraplegic and we are the only organization working for all paraplegics in this country.

Paraplegia is the paralysis of a person from approximately his waist down and there may be some involvement of the abdominal or trunk muscles, as well as impairment of internal functions. Quadriplegia, in contrast to paraplegia, involves paralysis from approximately the neck down and always will affect the upper extremities to a varying degree.

Mr. FLOOD. How did you pick it up?

Mr. REICH. In my own case, sir, I had a diving accident in 1962, and was most fortunate in having had excellent immediate and long-term medical care, a loving family consisting of my wife and four children, help from my friends, good insurance coverage, and a job to which I returned 9 months later in a wheelchair.

Mr. FLOOD. I knew a kid years ago who went out at night and dived into a pool and the water was not in it. It resulted in the same thing.

Mr. REICH. Mine was a similar accident.

The consequences of loss of voluntary motion of two—or four—extremities are obvious and catastrophic. But the not-so-obvious consequences of loss of sensation and normal organic function are even more serious and probably have a greater effect on persons so afflicted. Most paraplegics and some quadriplegics can learn to cope with the motor losses after adequate training. However, the losses of sensation and normal organic function can create far more serious problems and even threaten life itself. At the very least these conditions require a lifelong regimen of preventive measures and constant vigilance. They are probably a greater cause of psychological problems than the mere physical disability involved suggests.

Mr. FLOOD. Medication is not of much help I suppose in this, is it?

Mr. REICH. No. It certainly helps preserve life, but not in the amelioration of the condition; no, sir, not at the present state of knowledge.

Of the estimated current total of 100,000, approximately 10,000 (10 percent) are veterans and entitled to care in the VA hospitals. Mr. Barrie, chief examiner, rehabilitation, Liberty Mutual Insurance Co. in Boston, estimates that another 10,000 (10 percent) are covered by workmen's compensation. The remaining 80 percent either have no financial means or inadequate financial means with which to deal with this terribly expensive problem, which can cost more than $50,000 in individual cases.

Mr. FLOOD. I suppose the man who just came in is Mr. Smittkamp, the executive director of the foundation.

Mr. SMITTKAMP. Yes, sir; and Mr. Harry Schweikert is with me, who is another member of our board of directors.

Mr. REICH. As has been stated, the impact of paraplegia on the individual victims is catastrophic. In addition, there is the impact on society caused by the cumulative problems of 100,000 people who need help and cannot afford it themselves.

The number of new cases resulting from automobile accidents, sports accidents, bullet wounds, et cetera, is estimated to be in the neighborhood of 5,000 to 10,000 per year.

Our foundation has two goals which we believe are shared by everyone concerned:

1. We have observed the operation of the VA spinal cord injury
2. We seek help for paraplegics to enable them to return as quickly and as completely as possible to a normal and productive life.

In attempting to formulate programs likely to lead to the realization of our goals, we have taken steps to ensure access to the advice of the most knowledgeable people:

1. We have observed the operation of the VA spinal cord injury centers in this country.

2. We have consulted with Professor Sir Ludwig Guttmann, founder and long-time director of the Stoke Mandeville Spinal Cord Injury Centre in England, one of the most important paraplegia centers in the world. Incidentally, our foundation just brought him to this country to consult with American neurological surgeons and others interested in paraplegia.

(An article written by Dr. Guttmann describing his center follows:)

HISTORY OF THE NATIONAL SPINAL INJURIES CENTRE, STOKE MANDEVILLE HOSPITAL, AYLESBURY

(By Sir Ludwig Guttmann, C.B.E., M.D., F.R.C.P., F.R.C.S.)

Creation and development of the centre during World War II.—It is an accepted fact that any war, while creating devastation and great suffering to mankind, nevertheless brings within its wake advances in the medical field. In no medical subject could this be more true than in that of traumatic paraplegia and tetraplegia, which throughout the centuries was one of the most depressing and indeed neglected subjects in medicine. Even in the early stages of World War II, when the modern conception of rehabilitation of the disabled was generally accepted for amputees and other crippling disabilities, spinal paraplegia was not included in this concept. I recall a symposium on rehabilitation following injuries of the central nervous system held in November, 1941 in the neurology section of the Royal Society of Medicine where four speakers discussed rehabilitation following brain injuries and one following peripheral nerve lesions. The subject of spinal paraplegia was hardly mentioned. Yet a fundamental step forwards in a new approach to the management of spinal paraplegia was taken in Great Britain by the peripheral nerve committee of the Medical Research Council under the leadership of Dr. George Riddoch, neurological consultant to the British Army, Ministry of Health and Ministry of Pensions, when it was decided to congregate spinal cord casualties in special units. For it was generally agreed that the possibilities for a systematic study of the many problems concerned with the treatment of spinal paraplegics throughout all stages was infinitely more favorable in such a unit than when these patients lay scattered in general medical or surgical wards, from which, as a rule, they were transferred to chronic wards or homes for incurables. Even if they were admitted to neurological, neurosurgical, orthopedic or urological units, the facilities available were limited to specialized problems and short-term treatment only. These units were so busy with the management of many other afflictions in their respective specialties that, as a rule, it was quite impossible for both the medical and nursing staff to give paraplegics, let alone tetraplegics, that meticulous care and attention which these patients need day and night, especially during the acute stages. However, the first spinal units did not prove satisfactory as they were attached to neurosurgical or orthopedic units and no one member of their staff devoted more than a part of his time to the care and management of spinal injury patients. In those days it had not been generaly recognized that in order to prevent spinal units from becoming merely an accumulation of doomed and demoralized cripples certain conditions were indispensable:

I. The supervision of such a unit by an experienced surgeon or physician of whatever speciality who was prepared to devote his full time to the work, in order to organize and supervise the many aspects of management and, in particular, to correlate the sometimes conflicting interests and approach of the various medical and surgical specialists concerned, in particular, with the early treatment of these patients.

2. Adequate technical facilities for the specialized care and rehabilitation of these long-term patients, including physiotherapy, occupational therapy and prevocational training to promote independence, and return to social and professional activities.

3. Nursing and auxiliary staff sufficient in number to cope with the many details of management and, in particular, avoidance of the usual practice of changing nursing staff from one department to another at short intervals.

4. Arrangements for adequate domestic and industrial resettlements for paraplegics.

In 1943, it was contemplated to set up a spinal unit at the Ministry of Pensions Hospital, Stoke Mandeville, in Aylesbury, as one of the medical preparations for the second front, as many more spinal cord casualties were anticipated. With the opening of this unit on February 1, 1944, a new era began for these spinal cord sufferers. The basic principle of the new approach was the idea to provide for the spinal paraglegic and tetraplegic patients a comprehensive service from the start of their injury or disease and throughout all stages to rescue these men and women from the human scrap heap and to return them, in spite of their profound disability, to the community as useful and respected citizens. Two groups of patients were admitted:

1. Those in the acute stages of parapelgia following gunshot injuries, fracture-dislocations, and transverse myelitis. These patients were of particular importance to prove that it was in fact possible to avoid those complications which, throughout the ages, were considered as inevitable and the causes of the paraplegic's early death, namely sepsis, due to pressure sores and ascending urinary infection leading to renal deficiency. It may be noted that many of these patients arrived with associated injuries to other parts of the body. In due course, the number of paraplegics and tetraplegics admitted immediately, or within the first few days after injury, has increased immensely since it was proved, without any shadow of doubt, that pressure sores can be altogether avoided, and in a very high percentage the same also applies to the prevention of urinary infection.

2. Those in later stages of paraplegia suffering from many complications as a result of incompetent initial treatment, lack of proper facilities, or sheer neglect. Their condition was often extremely serious, demanding greatest vigilance and prolonged intensive efforts on the part of all concerned with their management to restore them both physically and mentally.

Radical changes in the medical and psychological approach to the problem of spinal paraplegia, as a whole, were introduced and, as in any pioneer work in medicine, dogmas and many prejudices had to be overcome. I still recall the question that was put to me with almost monotonous regularity by visitors in the first 2 years of our work: "Is it really worthwhile?" It was quite unorthodox in those days to reject the conventional methods of recumbancy and immobilization of traumatic paraplegics in plaster casts and plaster beds, as well as hasty operative procedures such as laminectomy and open reduction as initial treatment of the broken spine, and replacing them by new methods aimed at the mobilizing of the natural forces of repair and readjustment. It was a new approach to both medical and nursing staff to teach that bedsores resulting in osteomyelitis and sepsis or infection of the paralized bladder resulting in asascending infection and renal deficiency are by no means inevitable consequences of spinal paraplegia, but that those complications could, by introducing new methods of management, not only be controlled but altogether prevented. Above all, it was quite revolutionary to teach and impress on the auuthorities of medical and social services, in particular the Ministry of Labor and Housing Authorities, that the mere fact that a person was a paraplegic did not justify care in one of the institutions for "incurables," but that in spite of his severe physical handicap, rehabilitation to a useful life and employement was possible in the great majority of cases. In this connection the first experiment to prove that paraplegics could work side by side and in competition with able-bodied workers was carried out with our first six rehabilitated paraplegic ex-servicemen at the end of 1944.

It was also during the war that sport and regular work were introduced as essential parts in the medical treatment of these patients which, in due course, proved so very successful for their physical, psychological and social rehabilitation.

Postwar Development of the Unit into a National Center.—Already at the end of the war the number of beds of the unit was gradually increase to 100 as several of the original spinal units were dissolved and their patents transferred to Stoke Mandeville, and after the war the number of civilian paraplegic men, women, and children steadily increased. By 1951, when Stoke Mandeville Hospital was taken over by the National Health Service, the unit had a compliment of 160 beds. There were increased in due course to 195 beds and the unit was designated as a national center, admitting patients from all parts of the United Kingdom. The patients are accommodated in six male, two female, and one children's wards. Thanks to a grant of £35,000 from the "Sir William Coxon Trust," a special annex for children was built, indeed a great improvement for their accommodation and management.

As a result of a memorandum which I submitted to the Ministry of Health emphasizing the great need for hostels in the proximity of spinal units for tetraplegics and other severely handicapped spinal cord sufferers who, for one reason or another, cannot be accommodated in their own homes, a pilot scheme of 30 beds was agreed, and this hostel was opened last year. It is connected to a workshop which enables the residents to carry out some remunerative work under sheltered conditions, thus the center has now a total of 225 beds.

With the growth of the center the facilities of auxiliary services were also greatly increased. This applied in physiotherapy, occupational therapy, and vocational training as well as school education for the children. Moreover, the facilities for sport and recreation were also greatly improved by the building of a recreational hall where training in indoor archery and table tennis could be carried out and also by the building of a large indoor swimming pool.

The medical staff of this center consists of a clinical director (Dr. J. J. Walsh, after my retirement in 1966), three consultants, a senior registrar and four junior grades. It also has its own records department, secretarial staff, welfare officer and almoner. Since 1954, the center has had its own research department, consisting of a biochemical and physiology laboratory with a biochemist, technician, and senior research assistant carrying our research work in cooperation with the clinical staff under my direction.

For the 225 patients (including the 30 residents of the hostel) there is a nursing staff strength of 163, comprised of all grades, including student nurses and orderlies.

In addition to the 225 patients at the center and its hostel there are several auxiliary units affiliated to and medically guided by the NSIC.:

(1) Spinal unit at the Star'& Garter Home for ex-servicemen. Richmond, Surrey, set up in 1946 (24 beds).

(2) Chaseley Home, Eastbourne, for paralyzed ex-servicemen, stated in 1946 (35 beds).

(3) Duchess of Gloucester House, Isleworth, Middlesex, this is a hostel with, 78 beds (72 male and 6 female) opened in 1949 by the former Minister of Pensions and Minister of Labor for those paraplegics who are able and willing to take up full employment outside the hostel.

Advantages of a spinal unit as part of a general hospital.—For some years it has been argued whether a spinal center should be part of a general hospital or a specialized hospital. It was feared that a spinal unit of larger size in a general hospital might be a hindrance to the development of other specialities. The Stoke Mandeville Center has proved beyond all shadow of doubt that a center, even of this size which, as a national institution, has served the whole country for many years, has been no detriment to other medical or surgical specialities in a general hospital. On the contrary, for those specialities serving the local and regional population such as medical, surgical, pheumatic, pediatric, plastic surgery, geriatric units, etc., the existence of this center, far from being a hindrance, has afforded facilities which these units have been able to utilize most advantageously for their own purposes. On the other hand, the spinal center has been using the facilities of the general hospital such as X-ray department, operating theater, pathology laboratory, etc., as any other unit and has enjoyed throughout the years the close cooperation with the consultants of other units who have been readily available if the need arose. Therefore, from all our experience, it can be concluded that the setting up of a spinal center in a general hospital, as a speciality of its own, represents an ideal solution.

Statistics on the clinical work since 1944.—More than 4,000 paraplegics and tetraplegics have been treated at this center. As already pointed out, the turnover of both inpatient and outpatients has steadily increased since Stoke Mandeville Hospital was taken over by the National Health Service and table I shows the turnover of patients from 1952 to 1964. The majority of patients are admitted by road or rail, but in recent years transport by helicopter, especially of cervical patients and those associated with other injuries, has greatly increased, and indeed proved a lifesaving measure in some of these patients. Moreover, patients from abroad, in particular service personnel of the British forces, who sustained traumatic spinal cord lesions overseas, have arrived at the center within 48 hours of injury from as far afield as Germany, Aden, and Singapore. Needless to say how this improved transport has not only saved lives but prevented many complications.

TABLE I

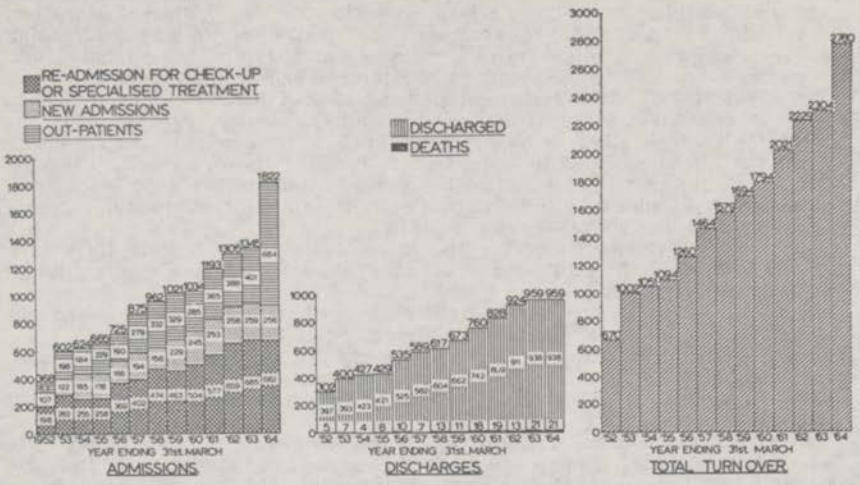

TABLE II.—NATIONAL SPINAL INJURIES CENTER, STOKE MANDEVILLE HOSPITAL—ANALYSIS OF 3,000 CASES

	Servicemen and pensioners	Civilians	Total	Percentage
Traumatic lesions	753	1,210	1,963	65.4
Transverse myelitis	34	125	159	5.3
Poliomyelitis	89	63	152	5.1
Vascular processes	11	95	106	3.5
Spina bifida		62	62	2.1
Multiple sclerosis	41	80	121	4.0
Disc lesions	6	27	33	1.1
Miscellaneous	66	338	404	13.5
Total	1,000	2,000	3,000	100.0

TABLE III.—TRAUMATIC LESIONS

	Servicemen and pensioners	Civilians	Total	Percentage
Cervicals				23.6
Complete	36	99	125	6.8
Incomplete	86	245	331	16.8
T1–5				9.8
Complete	62	84	146	7.5
Incomplete	18	27	45	2.3
T6–12				43.1
Complete	198	419	617	31.4
Incomplete	113	115	228	11.7
Cauda equina	240	221	461	23.5
Total	753	1,210	1,963	100.0

The clinical work of the center was analyzed on the first 3,000 cases admitted by May 1963 divided in ex-service personnel and civilian. From the statistics it is clear that the majority (65.4 percent) are traumatic lesions at various levels (table II). The column headed "Miscellaneous" consists of nontraumatic patients other than transverse myelitis and polios such as thrombosis of the spinal artery, haematomyelia, tuberculosis, tumors, syphilis, epidural abscesses, degenerative and congenital processes. It also includes mishaps after surgical procedures. Table III shows an analysis of the 1963 traumatic lesions according to the level of the lesions. Already at the time of that statistic there was a relatively high percentage of cervical injuries. This percentage has further increased, and a later statistic published in 1964 on 2,780 traumatic lesions of all levels showed 506 or 24.4 percent tetraplegics. In the majority, spinal cord injuries occurred between the ages of 16 and 35 and the two major causes are road accidents, by motorcar and motorcycle, and sports accidents, in particular diving into shallow water.

Table IV.—Mortality: Total material, 3,000 cases

	Percent
496 deaths	16.5
343 corrected figure	11.4
Traumatic patients (total, 1963):	
331 deaths	16.9
242 corrected figure	12.3
Servicemen and pensioners (total 753):	
180 deaths	23.9
132 corrected figure	17.5
Civilians (total 1,210):	
151 deaths	12.5
110 corrected figure	9.0
Analysis of servicemen and pensioners:	
World War I (total 67):	
39 deaths	58.2
15 corrected figure	22.4
World War II (total 468):	
125 deaths	26.7
103 corrected figure	22.0
Post-war period from 1946 (total 218):	
16 deaths	7.3
14 corrected figure	6.4

The mortality rate amongst the 3,000 patients is given in table IV. These statistics include every patient who died either during treatment in this center or after discharge home or in other institutions. The uncorrected figures include causes of death unrelated to paraplegia such as tuberculosis, cancer, cerebral hemorrhage, etc. These statistics revealed a very low mortality rate of both ex-servicemen and civilians admitted after World War II but even amongst the traumatic paraplegics from World War II, so many years after injury.

TABLE V.—EMPLOYMENT STATISTICS ON 3,000 PATIENTS

	Available for employment	Percent
Full time	1,097	54.5
Part time	222	11.0
Home occupations	399	19.9
Subtotal	1,718	85.4
Not working	294	14.6
Total	2,012	100.0

TABLE V.—EMPLOYMENT STATISTICS ON 3,000 PATIENTS—Continued

	Analysis of employed	Percent
Full time	1,097	63.9
Part time	222	12.9
Home occupations	399	23.2
Total	1,718	100.0

ANALYSIS

Deceased	496
Retired and overage	103
Physically unfit (including 64 cervicals)	143
Under treatment at Stoke Mandeville	151
Under treatment at other hospitals	54
Not traced	41
Subtotal	988
Available for employment	2,012
Total	3,000

Since 1947 I have published statistics at regular intervals on the domestic and industrial resettlement of paraplegics and the number engaged in remunerative work has varied between 69 and 82 percent of those discharged from the center and who were available for employment, the majority being full-time employed. Table V gives an analysis of the employment of 2,012 patients, out of a total of 3,000, available for employment at the time of the latest statistics in 1963 from which it will be seen that altogether 85.4 percent are gainfully employed, and of these 54.5 percent full time, in a variety of jobs; that is business, professional, and open industry. Table VI demonstrates the employment statistics according to the levels of the lesions. Table VII shows the domestic resettlement of the survivors of the 3,000 patients, from which it is clear that the great majority are living in their own homes, which have been adjusted to their disability either privately or by the local authorities. This includes the building of garages for their motor vehicles.

TABLE VI.—STATISTICS ON 2,012 PATIENTS AVAILABLE FOR EMPLOYMENT

	Full time	Part time	Home occupations	Not working	Total
Cervicals:					
Complete	9	13	37	1	60
Incomplete	84	31	89	27	231
T 1–5:					
Complete	77	20	19	14	130
Incomplete	43	7	14	6	70
T 6–12:					
Complete	270	75	114	106	565
Incomplete	206	20	43	64	333
Cauda equina	277	35	52	61	425
Polio	99	6	16	4	115
Miscellaneous	32	15	15	11	73
Total	1,097	222	399	294	2,012
Percentage	54.5	11	19.9	14.6	100

TABLE VII—*Domestic resettlement of 3,000 patients*

Living at home	2,059
Living in paraplegic settlements, hostels, and homes for the disabled	240
Subtotal	2,299
Patients under treatment at Stoke Mandeville	151
Patients under treatment in other hospitals	54
Deaths	496
Subtotal	701
Total	3,000

Routine aftercare following discharge.—A systematic out-patient service was organized to deal with routine clinical checkups for the increasing number of patients discharged to their homes and other institutions, in particular, for those who had found employment and were anxious to have as little time off work as possible. This has proved to be a most essential part of our work in detecting and treating any deterioration in a paraplegic's condition and thus keeping as many of them as possible at their work. Table I shows a very great increase in this aftercare service over the years between 1951 and 1962, and which is still continuing commensurate with the steadily increasing number of survivors. When distance prevents an out-patient check-up the paraplegic or tetraplegic is readmitted for a day or two for the necessary check-up.

Research.—From the beginning, intensive clinical and experimental research has gone hand in hand with the clinical work. Research workers from this country and abroad have visited the center and some of them cooperated in research on certain physiological problems of the spinal man. It is beyond the scope of this survey to give details of the many research problems which have been dealt with throughout the years. The results of the research have been published in well over 100 publications in many leading journals, including monographs and chapters in textbooks (see references).

Meetings of medical and scientific organizations such as the neurological and orthopedic section of the Royal Society of Medicine, the British Biochemical Society, the British Society of Biological Engineering and sections of International Congresses have been held at the center throughout the years. Regular International scientific meetings of paraplegia have been held since 1954 on the occasion of the annual International Stoke Mandeville Games. As a result of these meetings the International Medical Society of Paraplegia was founded in 1961 at Stoke Mandeville, which has its own international journal published by E. & S. Livingstone of Edinburgh.

Teaching.—Throughout the years the Center has been engaged in teaching undergraduates and postgraduates of the medical profession as well as nursing, physiotherapy, and occupational therapy professions, and this activity has immensely increased in recent years:

1. *Medical Staff, Welfare Officers and Administrators.*—Physicians, surgeons, and medical students as well as administrators have visited the Center from many hospitals in this country and abroad, and the Center takes part in the regular postgraduate courses arranged by the British Council, organized by the Royal National Orthopedic Hospital Stanmore, Middlesex, the National Hospital for Nervous Diseases, Queens Square, London, the Royal College of Surgeons and Medical Services of the Army and Air Force, and Administrative Medical Officers of the Ministry of Pensions and Social Insurance, Ministry of Labor, as well as regional hospital boards of the Health Service.

2. *Postgraduate Courses for Nurses.*—Apart from regular visits of groups of nurses sent to the Center for formal lectures from the Royal College of Nursing, 3-monthly postgraduate courses have been introduced since 1953 which are attended by nurses from this country and from all over the world. Some of these postgraduate nurses continue working in the Center after the course to gain more detailed experience. The Center is also included in the training program of student and pupil nurses of the Aylesbury Nursing School.

3. *Physiotherapy and Occupational Therapy Staff.*—In addition to full-day visits of individuals and groups of physiotherapists and occupational therapists from teaching schools, annual postgraduate courses for physiotherapy are held

which have become quite popular and are greatly supported by the British Chartered Society of Physiotherapy.

4. *Teaching outside the Center.*—Throughout the years, members of the medical and physiotherapy staff as well as the lay administrator and welfare officer of the Center have given very great number of lectures to teaching hospitals, training schools, Government departments and many other organizations.

Members of the medical staff have been invited to lecture at international congresses and visited other countries to lecture on the problems of paraplegia.

Sport.—Since the inception of the Stoke Mandeville Center, sport has played a very important part in the physical, psychological as well as social rehabilitation of the paralyzed, and the profound value of sport in preventing these patients from retiring into inactivity cannot be exaggerated. As I have already pointed out, sporting activities are included in the medical treatment and this has encouraged many patients to continue sport for their physical well-being and recreation after discharge from hospital. Interest and enthusiasm in competitive sport increased steadily, and in 1948 the Stoke Mandeville Games were founded as a sports movement for the paralyzed. These games, which at first were held annually as a national event, have developed since 1952 into the first organized annual sports festival for severely disabled people in the world. A Paraplegic Sports Endowment Fund founded with voluntary contributions has become responsible for financing the games and has built throughout the years accommodation and sports facilities such as basketball pitches, bowling greens, et cetera, on the sports ground of Stoke Mandeville Hospital. The most recent development is the permission from the authorities of the National Health Service to build the first indoor sports stadium for disabled sportsmen, women, and children in this country and, indeed, the world. The idea of sport for the disabled has spread all over the world, and the International Stoke Mandeville games are held annually at Stoke Mandeville, but every fourth year in the country and place where the Olympic games take place. Thus these games have become the equivalent of the Olympic games for the paralyzed.

As off-shoots of these games the British Commonwealth Paraplegic games and more recently, the Pan-American Paraplegic games have been founded. Moreover, for some years annual sports events have also been organized by other spinal units in this country and abroad. Sports clubs have been founded in many parts of the country by the paralyzed and other severely physically handicapped themselves, and they meet regularly for training and play throughout the year.

Sports organizations for the able-bodied have taken a great interest in the development of the Stoke Mandeville games. In 1956, during the Olympic games in Melbourne, the International Olympic Committee awarded the Fearnley Cup, an Olympic award presented for outstanding achievement in the service of the Olympic idea, to the organization of the Stoke Mandeville games. There could have been no better evidence of the dramatic change which has taken place in the whole concept of paraplegia than this recognition of paraplegic sportsmen and women by society.

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Mr. REICH. We have recently convened our Medical Advisory Committee made up of leading doctors and researchers concerned with paraplegia.

(List of members and statement follow:)

NATIONAL PARAPLEGIA FOUNDATION MEDICAL ADVISORY COMMITTEE, 1968

Dr. Percival Bailey, director of research, retired, Illinois State Psychiatric Institute, 731 Lincoln Avenue, Evanston, Ill.
Dr. Paul C. Bucy, Chairman, professor of surgery-neurosurgery, Northwestern University Medical School, 251 East Chicago Avenue, Chicago, Ill. 60611.
Dr. James B. Campbell, research professor of neurological surgery, 340 East 24th Street, New York, N.Y. 10010.
Dr. Louis B. Flexner, professor of anatomy, University of Pennsylvania, School of Medicine, Philadelphia, Pa.
Dr. L. W. Freeman, professor of surgery and director, Surgical Experimental Laboratories, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis, Ind. 46207.
Dr. Lyle A. French, professor and director of neurosurgery, University of Minnesota Medical School, Department of Surgery, Division of Neurosurgery, Minneapolis, Minn. 55455.
Dr. B. Herold Griffith, associate professor of surgery, plastic surgery, Northwestern University Medical School, 251 East Chicago Avenue, suite 1029, Chicago, Ill. 60611.
Dr. Henry L. Heyl, associate professor of anatomy, Journal of Neurosurgery, editor, Dartmouth Medical School, Hanover, N.H.
Dr. Justus F. Lehmann, professor and chairman, University of Washington School of Medicine, Department of Physical Medicine and Rehabilitation, Seattle, Wash. 98105.
Dr. Vernon L. Nickel, medical director, Rancho Los Amigos Hospital, 7601 East Imperial Highway, Downey, Calif. 90242.
Dr. Guy L. Odom, professor of surgery (neurosurgery), Duke University Medical Center, Durham, N.C., chairman, American Academy of Neurological Surgery.
Dr. Eric Oldberg, professor and head of the department of neurology and neurosurgery, University of Illinois, School of Medicine, Chicago, Ill.
Dr. James H. Semans, professor of urology, Duke University Medical Center, Durham, N.C.
Dr. Raymond W. Waggoner, professor of psychiatry, University of Michigan, Ann Arbor, Mich.

STATEMENT OF NPF MEDICAL ADVISORY COMMITTEE

One of the serious unsolved problems in the United States is that of the thousands of individuals paralyzed annually by injury to their spinal cords. Adequate facilities are not now available to save their lives, give them optimum care immediately after injury, and rehabilitate them promptly. This can be done now. If proper research is undertaken the care now available can be improved. It appears likely that in many cases the paralysis can be cured and all-paraplegics and quadriplegics can be helped. To attain these ends it is recommended by the National Paraplegia Foundation Medical Advisory Committee that:

The National Paraplegia Foundation should create a strong central organization which will:

1. Greatly expand the membership of NPF;
2. Inform the people of the United States of the neglect of the spinal injured paralyzed citizen and of what can be accomplished by improved, centralized, and specialized care;
3. Urge upon the Federal Government the need to provide facilities for centralized, special care of the paraplegic and quadriplegic and the need for additional funds for research in this area; and
4. In every way promote the welfare of the spinal cord injured.

CARE

1. Adequate care of the patient paralyzed by spinal cord injury is not now available in the United States except in very few and isolated instances.
2. The United States has been woefully negligent as compared with some other countries in the world in providing and improving such care.
3. Adequate care means that:
   (*a*) The spinal injured patient need not die as a result of his injury;
   (*b*) The paralysis from spinal injury can be lessened or relieved in many patients;

(c) Complications such as bedsores, deformities, infections of the kidneys and bladder, psychological disturbances, and many others can be avoided; and

(d) The spinal injured can be restored to a useful, gainful existence in a short time and converted from a helpless, chronic, hopeless invalid into a self-sustaining individual with pride in himself and his accomplishments.

4. To attain adequate care, regional spinal injury centers must be established. These centers:

(a) Must have a medical and nursing staff and other specially trained personnel interested in and competent in the care of the spinal injured patient;

(b) Be specially designed and equipped for the care of the spinal injured from the moment of injury onward;

(c) Must be in general medical centers where all the special medical facilities and abilities are available;

(d) Must have research interests and facilities to provide for a better understanding of the injured spinal cord and to bring about improved care;

(e) Must provide training for medical and other personnel in caring for the spinal cord injured patient;

(f) Must provide a followup service for medical consultation and help and advice after the patient has left the paraplegic center; and

(g) Should publish and circulate data contributing to better early treatment and handling of these patients.

5. These centers must be open and available to everyone with no regard to social or economic circumstances, race, creed, or color.

6. Such spinal injury centers would, through improvement in care and through research, improve the possibilities for recovery of many patients with other paralyzing neurological and muscular diseases.

7. By concentrating a number of paraplegic patients in one center their varied problems will be obvious and will stimulate research and improvement in care in a way that is not otherwise possible.

8. Such spinal injury centers will reduce the cost of the care and maintenance of paralyzed patients, shorten the time now required between injury and rehabilitation, and by making most of these individuals self-supporting, reduce the economic burden on the entire country.

9. These centers must be equipped with improved transportation facilities—ambulances, aircraft—staffed with specially trained personnel.

(a) This will avoid further injury to the acutely paralyzed patient which can be fatal or can greatly aggravate the original injury, and

(b) This will make possible prompt care which will insure the maximum recovery possible and greatly reduce the development of undesirable complications.

TO PROMOTE RESEARCH

1. Spinal injury centers must be developed to present to interested scientists the problem needing investigation.

2. Research facilities to conduct such investigations must be made available to interested scientists.

3. Funds to support spinal injury research must be made available.

4. The National Institute of Neurological Diseases and Blindness is interested in providing such funds but Congress must be convinced that additional funds for spinal injury research should be made available to that Institute.

Research must have as its ultimate goal cure of the paralysis. This may at present be distant and visionary for some patients but may be a reality soon in others. However, these objectives can never be realized without research. In the meantime such research will certainly provide for improved care, and lessening of disability for all patients.

Mr. REICH. This was a meeting held at Harvard Business School on the 29th of January. We are advised that research discoveries in this area can also benefit sufferers of other related neurological diseases.

4. We have sought the advice of the American Association of Neurological Surgeons.

(Copy of resolution follows:)

THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS (FOUNDED AS THE HARVEY CUSHING SOCIETY IN 1931)

Be it resolved:

(1) Adequate care for civilians suffering from paralysis as the result of injury to the spinal cord and spine is not commonly available;

(2) A better understanding of the structure and function of the spinal cord and its responses to injury are essential to further improvement in the care of those with injury to the spinal cord;

(3) The best possible care and the opportunity to investigate the problems the patient with injury of the spinal cord can be obtained only in well equipped and staffed spinal cord injury centers:

The Congress of the United States is urged to indicate to the National Institute of Neurological Diseases and Blindness or other appropriate Federal agency its interest in the spinal cord injured and to appropriate funds adequate to provide for research in this field and to provide for special centers for research and patient care.

Mr. REICH. We have sought the advice of the American Academy of Neurological Surgery.

(Copy of letter follows:)

DUKE UNIVERSITY MEDICAL CENTER,
Durham, N.C., April 24, 1968.

Mr. JAMES SMITTKAMP,
Executive Director, National Paraplegia Foundation,
Chicago, Ill.

DEAR Mr. SMITTKAMP: As you know, I am chairman of the committee on paraplegia of the American Academy of Neurological Surgery. Our organization has been interested in the care of the civilian paraplegic, and has been attempting to promote facilities for better care and research in this field.

It is hoped that the Federal Government will support regional paraplegia centers in the United States. As it now stands, there are not adequate facilities available even though one may have large sums of money, to help care for the financial burden which occurs in these situations. We have been in contact with the National Institutes of Health and the Veterans' Administration, and we hope that the Federal Government will find some way to aid in his unfortunate situation.

Yours sincerely,

GUY L. ODOM, M.D.,
Professor and Chairman, Division of Neurological Surgery.

Mr. REICH. We have participated in a paraplegia workshop conducted by the National Institute of Neurological Diseases and Blindness.

(Copy of minutes follow:)

PARAPLEGIA WORKSHOP—SPONSORED BY THE NATIONAL INSTITUTE OF NEUROLOGICAL DISEASES AND BLINDNESS

PARTICIPANTS

The attendees of the paraplegia workshop are as follows:
Dr. Arthur S. Abramson, Albert Einstein College of Medicine, Bronx, N.Y.
Mr. David Barrie, Liberty Mutual Insurance Co., Boston, Mass.
Dr. Benjamin Boshes, Medical School, Northwestern University, Chicago, Ill.
Dr. Paul C. Bucy, Medical School, Northwestern University, Chicago, Ill.
Dr. James B. Campbell, New York University, New York, N.Y.
Mr. Charles E. Caniff, 828 Davis Street, Evanston, Ill.
Dr. Shelley Chou, University of Minnesota, Minneapolis, Minn.
Dr. Kemp Clark, Southwestern Medical School, Dallas, Tex.
Dr. Clifford H. Cole, Bureau of State Services, Washington, D.C.
Dr. L. W. Freeman, Indiana University Medical Center, Indianapolis, Ind.
Dr. B. Herold Griffith, Northwestern University, Evanston, Ill.
Dr. Henry L. Heyl, Dartmouth Medical School, Hanover, N.H.

Dr. Marilyn K. Hutchison, Division of Chronic Diseases, Bureau of State Services, Arlington, Va.
Dr. Harry Kessler, Veterans' Administration, Washington, D.C.
Dr. Philip A. Klieger, Vocational Rehabilitation Administration, Washington, D.C.
Dr. Robert Rhamy, Vanderbilt University, Nashville, Tenn.
Dr. Donald B. Spangler, Vocational Rehabilitation Administration, Washington, D.C.
Mr. James Smittkamp, National Paraplegia Foundation, Chicago, Ill.
Dr. Shannon Stauffer, Rancho Los Amigos Hospital, Downey, Calif.
Dr. Elane Wilcox, Rancho Los Amigos Hospital, Downey, Calif.

The following attended from the National Institute of Neurological Diseases and Blindness:

Dr. Edgar A. Bering, Jr.
Mrs. Ruth Dudley
Dr. Miriam Neff
Dr. Larry A. Pearce
Dr. Alan K. Percy
Dr. George B. Riley

The following were invited but were unable to be present:

Dr. Richard Masland
Dr. William Caveness
Dr. Joseph Ransohoff
Dr. Howard A. Rusk
Miss Mary E. Switzer
Dr. Clinton Woolsey

Minutes of the Paraplegia Workshop

On November 4, 1966, the NINDB paraplegia workshop was held. The purpose of this workshop was to review the needs of the civilian paraplegic and decide what steps should be taken for the implementation of complete care for those who do not have access to the Veterans' Administration facilities or are not covered by insurance.

The problem was stated by Dr. Paul Bucy in his opening remarks. He underscored the purpose noted above and emphasized the need for immediate attention from the entire medical community.

Mr. James Smittkamp of the National Paraplegia Foundation reviewed the available data on the size of the problem. Including both paraplegic and quadriplegic patients, prevalence estimates range from 60,000 to 125,000. Based on the total number of industrial paraplegics, incidence was estimated to be on the order of 3,000 to 3,500. It is recognized that these estimates are crude and the numbers are increasing. However, it was felt that one should base proposed programs on a figure of 100,000 paraplegics requiring some form of care.

The cost-of-care estimates for paraplegics was reviewed by Mr. David Barrie of the Liberty Mutual Insurance Co. They feel that the initial hospital treatment per patient is $15,000. The annual maintenance is about $2,000 per year. Using various estimates including a life expectancy of half normal, they arrive at a lifetime cost of $52,000 for care and a wage and tax loss of an additional $189,000. Thus, the total loss to the Nation is $241,000 per patient. Using 100,000 cases, this represents $24,100 million loss to the Nation, or about $1,333 million annually. It was noted that these estimates represent a minimum and may, in fact, be too conservative.

The Care Needs of the Paraplegic

The care problems of the paraplegic can be divided into three stages: (1) crisis, which includes the injury and its immediate treatment; (2) adaptation, which includes the psychic adaptation of the patient to the fact that he is a paraplegic, and the biological adaptation of the body to the disaster which has occurred; and (3) stability, which involves the development and maintenance of a continued productive life after adaptation has taken place. Each of these phases has certain different needs, but above all, it must be emphasized to the paraplegic that the care of the center, and the specific "therapist" is directed at him. Goal orientation must be stressed and the paraplegic must be stimulated to increase his self-care.

The best alternative for dealing with this problem seems to be a series or network of regional centers, which, because of their regional nature, would probably have to be funded through Federal programs. The treatment of mental patients and tuberculosis through publicly financed hospitals was cited as a precedent for dealing with a medical problem of this magnitude.

We are dealing with a relatively young segment of the population, whose productive years have been sharply curtailed if not stopped. The return to society of a productive citizen through proper care and rehabilitation represents a sound investment for such a program. For purposes of public education and justification, comparison of the advantages of the rehabilitated to the non-rehabilitated patient should amply support this premise.

REQUIREMENTS FOR A PARAPLEGIA CENTER

The paraplegia center should be able to provide care from the earliest possible moment after injury until death. Because of the total number of centers, they would probably be of two kinds: (1) provide only treatment; (2) combine treatment and research. This means they are built around a core of clinicians, neurosurgeons, neurologists, and urologists, plus internists, plastic surgeons and orthopedists who are able to give a considerable fraction of their time and interest to this center. There will be rehabilitative services, physical medicine, and vocational training. In addition, there will be psychiatrists, a very strong social service, and adequate nursing staff to take care of the in-house patients. Teams will be available to travel for acute injuries (both for treatment, but primarily for transportation), for house calls, other acute conditions, and consultation services as needed. In particular, the physical facilites would have to be especially designed for this particular problem. There is need for considerable study of problems of nerve regeneration and electronic bladder drainage. These are only two of the areas where research can provide assistance.

It must be stressed that the establishment of two types of centers need not imply two levels of sophistication. What is implied, is that by their very location, certain centers will be better able to carry on highly integrated research programs whereas others will be confined to providing the same high level of care. As experience is gained, both types of centers will be yielding valuable new information in clinical and basic areas.

It must also be stressed that while these centers are designed to provide the highest level of care to the uninsured, civilian paraplegic, care will also be available to the insured, to the veteran, and to military personnel.

In addition to care and research, these centers should provide education relating to the paraplegic. This is not only education-rehabilitation for the paraplegic patient, but education for those who have to take care of him. There is education for the paramedical people, the ambulance drivers, the State police, the fire department, and others involved in performing first aid. There will be instruction for people in other hospitals nearby and for the physicians who are taking care of the paraplegics as private patients. Prevention programs would form an integral part of the public education.

It is recognized that a network of centers would have to be built slowly. It was felt that the first step should be to build from one to five ideal centers, and using the experience gained from these, enlarge as indicated. It was further decided that more data on the statistics of the problem should be obtained, particularly relating to the geographical distribution of the number of paraplegics—where centers would need to be placed.

It was emphasized however, that the development of an ideal center should not await the completion of any survey. The survey made by Dr. Donald Spangler of the Vocational Rehabilitation Administration, pointed out the difficulties in making such an analysis, and it was felt that little could be done to improve on that study. Mention was made of obtaining relevant information from the British National Health Service. Enlarging upon this, one might also solicit information from the Swedish National Health Service. It could be helpful to obtain information from the rehabilitation services of 20 or 30 hospitals and/or medical centers in order to assess their experience in terms of incidence, acute and chronic therapy, and long-term goals. Coroner's statistics would be helpful regarding the percentage of fatal, acute lesions. The acquisition of data on the life expectancy of individuals with various levels and degrees of spinal injury can also be helpful in calculating the cost of care. Statistics on the incidence of congenital paraplegia and current costs should also be gathered.

It was suggested, in addition, that spinal cord injury registries patterned after the State tumor registries could provide accurate and informative data.

CARE OF THE PATIENT IN THE CRISIS STAGE

There should be facilities available to reach any hospital in a given area and transport a patient to the paraplegia center for definitive, initial treatment. These people would be specialists in transportation and would require the proper equipment. This would include transportation services from ambulance to helicopter. Under certain conditions, they could provide definitive treatment in an outlying hospital, but this would be discouraged. We hope to move the patients to the center as soon as possible for definitive treatment. Rehabilitation and social service will be started immediately.

It was pointed out that all considerations have been given chiefly to the traumatic paraplegics—those resulting from industrial and automobile accidents. There are a great many paraplegics resulting from other kinds of disorders, particularly multiple sclerosis and the congenital paraplegics. Each year, there are some 18,000 babies with gross malformations of the central nervous system, including, hydrocephalus, and myelomeningoceles. There are 406,000 patients with multiple sclerosis, at least 25 percent of whom are paraplegics in the sense that they have no motor control of their legs. Their problems are slightly different in that their sensory function is affected to a much lesser degree.

THE CENTER MODULE

The size of the unit should probably be a module of the order of 50 in-patients. The patient's initial stay is approximately 6 months—this means the ability to accept 100 new patients a year. In the stable stage, there must be facilities for the patients to return at regular intervals and staff to insure that patients do return. For those patients who live far away, transportation will be provided for followup visits, but adequate interim care must be arranged at the local level. The possibility of achieving rapid rehabilitation (3 months or less) would effectively increase the annual case load.

It is estimated that outpatient facilities should be available to carry about 10 times the number of in-house patients or about 500 patients. How big an area such a module could cover, would be dependent upon the number of paraplegics in the region.

A central planning group is essential in order to insure that all the facets of care are included. Goals must be established in any program of such magnitude and import, and the planning group will be charged with the responsibility of keeping the program on course.

A careful survey of existing facilities will assess their adaptability to such a program. Existing facilities include Veterans' Administration and PHS hospitals, university centers, and other public and private institutions.

FUNDING

The funding of these centers could take two possible courses: 1) to fund existing centers and expand them; or 2) to build an entirely new group of facilities. The need for new funds is emphasized, and special legislation should be encouraged, but in the meantime, the development of existing funds should be explored.

DISTRIBUTION OF MINUTES

The review of the distribution of the minutes of this meeting was considered. It was felt that it should be sent to the council of the regional medical centers, to the National Advisory Council of NINDB, the Vocational Rehabilitation Administration, the Bureau of State Services, other Federal agencies concerned with services, and the Citizens Committee for Neurological Diseases. Henry Heyl, M.D., editor of the Journal of Neurosurgery felt that it might be appropriate to include these proceedings or an editorial about the meeting in the Journal of Neurosurgery. Serious consideration should be given to the various methods and maneuvers required to pass the legislation needed to support this program.

SUMMARY

The National Institute of Neurological Diseases and Blindness (NINDB) sponsored a paraplegia workshop on November 4 1966. The purpose was to review the needs of the civilian paraplegic and decide what steps should be taken for the implementation of satisfactory care.

The initial phase consisted of a review of the magnitude of the problem in terms of incidence, prevalence, and cost of care. The participants agreed that the ideal means of handling these problems would be through the establishment of regional centers. These highly integrated units would be capable of managing both the acute and long-term care of the paraplegic, that is, total patient care. The physical facilities should be capable of handling 50 inpatients and about 500 outpatients. All medical-social specialties would be involved from the first visit. Research fould ve closely allied and appropriate to sound patient care.

Future planning must include the establishment of demonstration centers and the placement of the final network and the development of satisfactory arrangements for funding.

Mr. REICH. On the basis of our experience, observations, and the aforementioned advice, we have concluded that the most promising approach to this problem is a series of regional spinal cord injury centers throughout the country. These centers should be a part of or convenient to large medical centers to provide access to all necessary skills and facilities. They will need to be specially designed to accommodate wheelchairs. This will usually mean new construction rather than trying to use or adapt existing buildings.

These centers should be available to paraplegics when needed, from the onset of their paralysis until their death. The fact of the existence of these centers and their ready availability will shorten hospital time for paraplegics by preventing complications and by solving problems before they become serious. The paraplegia workshop (exhibit No. 5) divided paraplegia care into three sequential phases. The centers should provide care within each as follows:

1. Crisis. This starts at the time and place of injury and first involves the transportation of the victim from the site of the accident to the center. The use of skilled personnel and modern transport, including aircraft, are vitally important to prevent further damage and insure the maximum possibility of recovery. At the center there will be a need for knowledgeable doctors representing many specialties to attend to the paralysis and its cause as well as any other injuries or complications which may apply. The concern here is lifesaving, prevention of further damage, and assurance of the best possible recovery.

2. Adaptation. When the crisis is past and the victim is ready, the adaptation or rehabilitation phase can begin. He will then be given such treatment as required to exploit any recovery and/or make maximum use of residual faculties. Attention will be given to physical therapy, psychological problems, and social and vocational adjustment. The goal here is as much self-sufficiency as possible. At some stage, paraplegics must begin preparations for leaving the center and reentering the mainstream of life. It may be necessary to provide some orientation for families so that former roles can be resumed as smoothly as possible.

3. Stability. After paraplegics leave the center they must be followed for as long as they live with regular checkups designed to catch problems while they are small to prevent their becoming serious. Some sort of social service is needed to see that paraplegics are satisfactorily situated in terms of a place to live and adequate finances. For some, permanent custodial care may be necessary.

As an integral part of the center operation provisions must be made for research not only to improve care but also to seek the only satisfactory solution to this problem—a cure. The concentrations of para-

plegics in the centers will provide an atmosphere conducive to research by presenting the problems to be investigated in quantities sufficient to be useful, as I mentioned earlier.

At this stage we can only speculate about the scope and cost of programs that will eventually be required to provide care to all paraplegics who will need and want it. We are aware that this cannot, and we believe that it should not be done all at once. But there is a vital need to get started and to start with that part of the total program most likely to produce results which may reduce the scope of the program ultimately required. We propose that initial efforts be directed to the crisis stage because it is here that current knowledge applied and new knowledge gained will be most promising in the reduction or elimination of neurological losses. This will insure the victim's earliest possible return to a productive life thus effecting an economy in money invested, efforts expended, and human suffering avoided.

To begin, we propose two or three small centers of about 10 beds each devoted to research in spinal cord injuries at the acute stage. We would thus be able to direct the initial attack on the problem at its most strategic point and we will gain the experience needed to make subsequent centers more efficient and effective as well as providing training for future center personnel.

Specifically, we are requesting the following:

1. That Congress direct the National Institute of Neurological Diseases and Blindness to support research in the area of the injured spinal cord;

2. That Congress appropriate $1 million for that specific purpose; and,

3. That Congress authorize the Division of Health Research Resources and Facilities to provide the full cost of construction for such spinal cord injury research centers or at least liberalize the matching fund requirement from the present 50–50 ratio and that Congress appropriate $2 million for this purpose.

These requests, if granted, would enable a beginning and a beginning must be made. We are far behind many other countries (including England, Canada, Australia, and New Zealand) in providing adequate care for our paraplegic citizens in spite of our far greater resources. In addition to the very obvious humane reasons for getting started, there are also good economic reasons. Again quoting Mr. David L. Barrie, his company has long ago discovered that an investment of $1 in relatively good medical treatment and rehabilitation saves $2.75 in cumulative and indemnity costs. It is imperative that we get started.

Ultimately, of course, the other aspects of paraplegia will require more attention than is currently the case. We urge that when the programs, as I mentioned earlier, are considered for funding that such funds be accompanied by a directive that all paraplegia programs be coordinated to make the best possible use of available money and personnel.

The ultimate beneficiaries of these proposals are all of us. First, of course, are the 100,000 paraplegics and their families. Next are the concerned professional people who will be able to do better and more satisfying job. But all of us will benefit if we convert as many as possible of the 100,000 recipients of benefits into productive citizens.

In closing, Mr. Chairman, I would like to point out that it is somewhat ironic that progress has given rise to the problems of paraplegia and the National Paraplegia Foundation. Prior to World War II, there was no problem because paraplegics simply did not survive. Speaking as one quadriplegic and on behalf of all paraplegics and quadriplegics in this country, I assure you we are grateful for the medical advances that have made it possible not only for survival, but for the pursuit of productive lives.

We now urge you to help us bring to bear the necessary talent and resources of our Nation so that we may look forward to even greater progress over the next quarter century in meeting these great human needs.

Thank you.

Mr. FLOOD. Thank you very much.

Mr. Heist, do you have something to say?

Mr. HEIST. Yes, sir; I have a prepared statement here.

Mr. FLOOD. We will place that in the record and you proceed.

(The statement follows:)

STATEMENT OF MR. RAY HEIST

I am Ray Heist of Wayland, Mass., a vice president of the Liberty Mutual Insurance Co., and a director of the National Paraplegia Foundation, with admittedly a self-interest in the goals of the foundation and in this hearing. On July 26, 1966, at about 6 p.m. my 21-year-old son Robert, graduated from Tufts University 2 months earlier, and awaiting orders from the U.S. Army, had an accident while water skiing and broke his necek at the fifth cervical vertebra. He is now quadriplegic. So, from experience and observation I am qualified to speak specifically about the treatment and economic problems presently associated with this catastrophic injury.

We were fortunate in our family to have immediate, skilled care available. This is the exception—not the rule. Completely paralyzed, unable to move any part of his body, Rob had good emergency care and expert transportation to a small suburban hospital. I was notified, went there immediately and the doctors, trying to explain the seriousness of the injury, advised that the hospital was not equipped for this problem and recommended immediate transfer to Boston. As you may know, my company has been interested in the treatment, care and rehabilitation of spinal cord cases since World War II, and to this end, helped in the development of a spinal cord section at Boston University Medical Center. I telephoned our rehabilitation manager who made all the arrangements for admittance to the medical center, and upon arrival there we were met by the medical-surgical team who took over the management of the case. Following 4 months of hospital care, surgical and medical attendance, Rob was ready for intensive rehabilitation and was moved late in November to the Rusk Institute in New York City. There he was taught to use the strength and motions he had recovered—mostly biceps and shoulder power—including a course where he was taught to drive a car again.

He returned home in April 1967, 9 months after his injury, confined to a wheelchair with limited arm and hand motion, and total loss of motion or control of his fingers. In spite of these handicaps he found full-time employment, and has been working steadily since last June. He can dress and undress himself, drive his own car and has regained a high degree of independence. His dressing routine will serve as a good example. While still in bed, he adjusts his leg bag (an outside urinary device), puts on his underwear, and trousers (about 20 minutes). Then, using a slide board, he transfers from the bed to his wheelchair (5 minutes). He puts on socks and shoes (10 minutes) washes, shaves, brushes his teenth and combs his hair (15 minutes). Puts on a shirt (5 minutes). Tucks in the shirttail (5 minutes). Puts on a clip-on tie and coat (5 minutes) and is ready for breakfast. Not too long ago this procedure required over 2 hours, but with practice Rob can now accomplish it in just over an hour, and looks forward to further improvement.

My real purpose here is to compare Rob's progress with other cases I have seen where the victims have no function, no independence, and no hope. And, in most, if not all of these unfortunate cases, the difference seems to lie in the lack of adequate early care and treatment. The spinal cord section at the Boston University Medical Center, providing only 15 beds, is almost unique; its existence is not universally known. There are few lay people in New England, or in fact in Boston itself, who know of its availability. And, strangely, very few medical men not connected with the Center, transfer their cases there for treatment. This may be through ignorance.

We believe such competent care should be readily available to all our citizens. It was made available to Rob Heist only because of my good fortune to be associated with an employer who has pioneered in the management, treatment, and care of people with spinal cord injuries.

What about the economics? Because of our rare good fortune, competent care has reduced the cost of Rob's surgical, medical, hospital, and rehabilitation requirements. Still, the cost to date is about $35,000. The average case must cost much more. The inflationary trend in hospital and medical costs places adequate care beyond the means of the average family—even those with Blue Cross or hospital-medical insurance. And, while fortunately Rob's condition is not progressive, the impairment of bodily function makes him exertmely vulnerable to complications. His breathing, for example, is abdominal, so that a simple chest cold can cause a real problem (he has lost the simple ability to cough). This vulnerability makes him ineligible for medical-hospital insurance, and so this sense of security is denied him.

Remember, not too many years ago these injuries were fatal—there was no treatment at any cost. Now, thank God, life can be preserved, and when the conditions are right, victims can be restored to a happy, useful, productive life. We believe our society has the obligation to provide this restoration. It is now being provided by people in other parts of the world far less financially able than we.

In the long run, it may not be costly at all. The number of cases is increasing daily—the injury is a rather common one in highway accidents—and the victims are surviving. If they do not receive competent early care—admittedly costly care—the chances are good that they will be welfare cases for as long as they live. Like most of the victims now alive, they will be dependent upon society for support in contrast to my son who is now self-supporting, making his contribution to society, and determined to expand that contribution. Proper early care can convert this economic drain to an asset, and, of course, the humane implications for hope here are staggering.

Speaking of hope, the only hope Rob has (shared of course by his mother and me) of restoration to a normal life is a medical breakthrough that will lead to a cure, or even partial cure. Our Medical Advisory Committee has stated that spinal cord injury centers must be developed to present the problem to scientists, that research facilities must be made available, and that funds be provided.

Our presentation today involves a highly complex social-economic problem. We can only touch on the complications. We suggest that the answers are likely to be as complicated as the questions. We sincerely believe that the learning process cannot begin unless the project has your support. We earnestly solicit your concern, your interest, and your leadership.

Mr. HEIST. Actually, this is the statement that covers my personal experience with a son who, at the age of 21 and just having graduated from Tufts University, and while waiting for assignment to the U.S. Army, had a water skiing accident and broke his neck at the fifth cervical and was totally paralyzed. We consider ourselves very fortunate because I happen to be the vice president of Liberty Mutual and our company has, since World War II, been interested in getting good medical care to spinal cord cases because we have many of them under compensation. Because, and only because of this connection I think I was able—when I was called to the hospital you can imagine a father seeing his son completely paralyzed. About all he could do was move his eyes, and he was terribly frightened and I was terribly frightened, and I could not think too clearly, but I did call our

rehabilitation manager and he was able then to take over the management of this very serious problem.

Mr. Reich, it happens, was taken to the same hospital in Boston, which has an unusual and I think rather unique spinal cord section in the Boston University Medical Center. This, as a matter of fact, was more or less sponsored by our company years ago for a special purpose, since such a facility was not available, but because of the good luck as a result of this association my son, after some 9 months of hospital and rehabilitation care, was able to return home and he was able to, after about a year, find full-time employment. While he is confined to a wheelchair and he has quadriparaplegia, which means he has very limited use of his fingers and hands, nevertheless this young man now is able to dress himself, as I described in the statement. He can drive his own automobile. He was taught to do this in New York. He works every day. He has been doing this for almost a year and he is going to pay some Federal income tax for last year as a result of his ability to work.

The point I want to emphasize is that this is a matter of luck. I have seen so many other cases since I have been involved in this one, in the hospitals and rehabilitation center where my boy has been, where there have been cases completely hopeless where the recovery has been practically nil. I know of cases where some of these people have no more power, for example, than to shrug the right shoulder. I firmly believe had there been available to these people at the time of the accident or soon thereafter a good facility where they could treat this total problem, that the end result would have been substantially different.

I know of quite a few cases that I could recite that are in their present form almost hopeless because they did not get adequate early medical care.

I would like to emphasize again in this part of my statement what Alan referred to, that this is a recent problem and that it was not until medical science was able to solve the problems of the urinary and bowel problem that victims could survive at all—this is part of the problem that may be distasteful to speak of, but nonetheless few people understand it. When this accident occurs, the spinal injury, depending on its location, cuts off all communication from the brain to that part of the body below the level of the spinal injury. So when the injury is in the neck, for example, this means that practically all of the communications, both sensory and motor, are cut off from the brain and into, for example, my boy's lungs. He breathed with his abdomen. While it is not a progressive condition, it is important nonetheless, to understand that because of the serious impairment, these people are very vulnerable to further complications.

My boy, for example, cannot cough, so a simple cold to him is a real problem. He cannot spit up the phlegm. It was not until medical science broke through with the control of the bladder and urinary and bowel problem that these cases were able to survive, but they are now able to survive, and I think my boy is a living example of the ability of good, good medicine today to provide a good recovery, of a return to as normal a life as you could expect under conditions such as this.

So I am urging that we do what we can to provide this kind of care and make it available to anyone who is unfortunate enough to have this very catastrophic accident.

We had a very fine neurosurgeon and early attention. About the second day this neurosurgeon called me aside and asked if I understood the gravity of the problem, and I told him I thought I did. He told me at that time he treats only very sick and very ill people, and he wanted me to understand in his opinion there was no condition that he treated or handled that he considered any worse than this one. He admitted to me that he did not believe he could possibly stand the condition himself.

These I think are the things that we must have you people understand; these are the things that somehow our foundation must bring to the public's attention.

I would like to emphasize again, since we know now how to keep these people alive, we are getting more of them. We do not know how many. The automobile is a good cause of this kind of condition, and sports accidents, as you yourself have had knowledge of, create this condition. It is a growing problem; it is a very serious economic one.

I would emphasize that in our case we think we were extremely lucky because we had good medical management. Our case to date has cost probably around $35,000, and I believe that would be considerably under the average because of its management. And having in mind (that we know) in inflationary trend we are seeing in hospital and medical costs, this kind of a case is well beyond the means of the average family. It is something I think that our citizens need help on. I would be glad to answer any questions.

Mr. FLOOD. I would not know what to ask you after a statement like that. Thank you very much.

Thank you, gentlemen.

Mr. HEIST. May I add that I think the only hope really that Alan Reich has, the only hope my son has, which my wife and I share, the only hope of a better life is to encourage research into this problem. We know there can be answers, but it is going to require time and it is going to require money.

Our medical advisory committee has recommended that these regional centers be established for the care of these cases because they believe that this would bring the problem to the scientist who could work then in an attempt to solve it.

The importance here I think is very apparent because the drain on society in these cases must be tremendous. A case without proper attention must have lifetime welfare. There can be no question about it. On the other hand, my boy who had, as I say through good fortune—and Alan Reich will tell you he was lucky because he was taken to the same medical institution in Boston almost by accident. This we believe had a good deal to do with his present condition.

Mr. FLOOD. I think the Foundation is very fortunate indeed to have a man in your position, who is so concerned because of your own tragedy and does what he can to help out, which is not always the case.

Thank you, gentlemen.

WEDNESDAY, MAY 1, 1968.

NATIONAL HEART INSTITUTE

WITNESSES

HON. HALE BOGGS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA
DR. GEORGE BURCH, PRESIDENT, AMERICAN COLLEGE OF CARDIOLOGY
DR. ELIOT CORDAY, PAST PRESIDENT AND CHAIRMAN, LIAISON COMMITTEE WITH CONGRESS, AMERICAN COLLEGE OF CARDIOLOGY
WILLIAM D. NELLIGAN, EXECUTIVE DIRECTOR, AMERICAN COLLEGE OF CARDIOLOGY

Mr. FLOOD. We now have the privilege and the pleasure of having with us our colleague, the Majority Whip of the House, the gentleman from Louisiana, Mr. Boggs, who will be followed by a distinguished group of doctors.

STATEMENT OF THE HONORABLE HALE BOGGS

Mr. BOGGS. Mr. Chairman, thank you very much.

It is my privilege to come here today to introduce to the committee and to you and the staff two very distinguished physicians:

Dr. George Burch, who is head of the Internal Medicine at Tulane University, and who has recently been elected president of the American College of Cardiology. I have a particular interest in Dr. Burch. He has been my own physician for a good many years and I consider him one of the really great doctors in the United States. I think that that judgment has been borne out by many other people.

In addition to that, he has had a tremendous interest in the development of programs to prevent heart trouble and heart diseases and other programs involving medicine generally. He is a man that I consider totally dedicated, unselfish and a real credit to the medical fraternity.

He is accompanied by the immediate past president of the American College of Cardiology, Dr. Eliot Corday, who I think has testified before this committee proviously. Dr. Corday is from Los Angeles and is as equally well known as Dr. Burch. These gentlemen are versed in the subject you are interested in and there is no point in my trying to add to their statements.

Here also is the executive director, Mr. Nelligan.

Thank you, Mr. Chairman.

Mr. FLOOD. Thank you.

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I understand, Dr. Corday, that you will present the first statement.

Dr. CORDAY. It is a great honor for me to be here again before you, sir. We appreciated the opportunity in previous years. I would like to present a statement from the college for the record.

Mr. FLOOD. Before you start, the biographical sketches of Dr. Corday and Dr. Burch will be made a part of the record.

(The documents follow:)

GEORGE E. BURCH, M.D.

Born: January 10, 1910, Edgard, La.

Education: Tulane University, 1927, 1929, and 1935, B.S.; Tulane University Medical School, 1929–33, M.D.

Internship: Charity Hospital of Louisiana, 1933–34.

Fellowship: Fellowship in cardiovascular research at the Hospital of the Rockefeller Institute for Medical Research, 1939–41, Guggenheim fellowship, 1953.

ACADEMIC APPOINTMENTS, TULANE UNIVERSITY SCHOOL OF MEDICINE

Assistant, department of medicine, 1934–35.

Instructor, department of medicine, 1935–42.

Assistant professor of medicine, 1942–43.

Director of courses in cardiovascular diseases.

Henderson professor and chairman, department of medicine, October 7, 1947, to present.

Honorary academic appointments: Visiting professor of cardiology, faculty of medicine and surgery, University of Santo Tomas, Manila, Philippines, 1961 to present.

HOSPITAL APPOINTMENTS

American Hospital in Paris, member advisory board in America, 1961 to present.

Charity Hospital, New Orleans, La., assistant visiting physician, 1934–36; visiting physician, 1936–44; senior visiting physician, 1944–53; consultant, 1954; physician in chief, Tulane unit, 1947 to present.

Field Memorial Community Hospital, Centerville, Miss., consultant in medicine, 1964 to present.

Hotel Dieu, New Orleans, La., consultant in medicine, 1950 to present.

Huey P. Long Charity Hospital, Pineville, La., director, department of medicine, 1964 to present.

Illinois Central Railroad Hospital, consultant in medicine and cardiology, 1954 to present.

Mercy Hospital, New Orleans, La., consultant in medicine, 1953 to present.

Michoud Operation Medical Department, consultant in medicine, 1963 to present.

Ochsner Clinic, New Orleans, La., consultant in cardiovascular disease.

Southern Baptist Hospital, New Orleans, La., consultant in medicine, 1962 to present.

Touro Infirmary, New Orleans, La., consultant in medicine and cardiology, 1943 to present.

U.S. Public Health Service hospital, consultant, 1958 to present.

Veterans' Administration hospital, New Orleans, La., consultant in cardiology, 1946 to present; dean's committee, 1955 to present.

NATIONAL AND INTERNATIONAL COMMITTEES

Advisory Committee on Animal Resources, chairman, 1963–66.

Advisory Committee on Environmental Medicine, Department of Army, chairman, 1958–63; emeritus member, 1963 to present.

Advisory Committee on Influenza Research, 1958 to present.

Chairman, cardiovascular study section, National Institutes of Health, Public Health Service, 1952–53.

Army Medical Service of Graduate School, 1951.

Life Insurance Medical Advisory Board, 1960–1965, chairman, 1965.

NASA Manned Spacecraft Center, Houston, Tex., consultant, 1964 to present.

National Advisory Heart Council, 1954 to present; Committee on Graduate Training, 1956–60; Planning Committee, 1957–61; Committee on Establishing Primate Colony, 1957–61; Committee on Chronic Disease, 1957–61.

National Research Council, Committee on Medicine and Surgery, 1955–57; Subcommittee on Cardiovascular Diseases, 1954, chairman, 1955 to present.

American Board on Internal Medicine, 1955–62, emeritus member, 1962 to present.

Board of Scientific Counselors, National Heart Institute, 1959–63.

World Health Organization, Expert Advisory Panel on Cardiovascular Diseases, 1960 to present.

Certified by the American Board of Internal Medicine in internal medicine and subspecialty of cardiovascular disease, 1941.

Diplomate of the National Board of Medical Examiners.

Licensed to practice medicine in the State of Louisiana since 1933.

HONORS AND AWARDS

Alpha Omega Alpha, Tulane University School of Medicine, 1933.

Gold Medal Award, AMA, 1947, for exhibit on radio-elements, and mechanism of congestive heart failure using radiosodium, Na^{24} and Na^{22}, with Dr. P. B. Reaser.

Southern Medical Association Research Award, 1947.

Modern Medicine Award, 1953, for contribution to the diagnosis and treatment of heart diseases.

Modern Medicine's "Contemporary of the Month," February 1963.

Southern Medical Association Distinguished Service Medal Award, 1961.

Susan and Theodore Cummings Award for participation in first international circuit course in cardiology, sponsored by the U.S. State Department and American College of Cardiology, 1961.

MEDICAL AND SCIENTIFIC ORGANIZATIONS

American Association for the Advancement of Science, 1950.

American Board of Internal Medicine.

American College of Cardiology, fellow, 1961, President 1968–69; president-elect, 1967–68; vice president, 1963–64; trustee, 1964; long range planning committee, 1966–67; awards committee, 1962–63; Special Committee for Liaison with Congress, the Surgeon General and NIH, 1965–66.

Overseas Education Committee, 1966–67, Executive Committee (chairman), 1968–69.

American College of Chest Physicians, 1957; vice chairman, Committee on Hypertension, 1963; chairman, Committee on Hypertension, 1966; member, Council on Cardiovascular Disease, 1966.

American College of Clinical Pharmacology and Chemotherapy, fellow, 1965.

American College of Physicians, 1941.

American Federation of Clinical Research, 1943.

American Geophysical Union, member, 1962.

American Heart Association, Assembly, 1953–56 delegate from section on circulation, 1958, board of directors, 1953–58; Committee on Auscultatory Phenomena, 1953–56; Committee on Electrocardiography, 1953–54; Committee on Professional Education, 1956–58; Committee on High Blood Pressure, 1952; Council on Circulation:

Vice chairman, 1953–54.

Executive committee, 1954.

Chairman, 1953–54.

American Medical Association: AMA representative on the study group on bioclimatology of the American Meteorological Society, 1962; Committee on Diseases of the Body as a Whole of the Editorial, Advisory Committee, 1953–54; registry for reporting untoward reactions on therapeutic, agents, 1955; section on experimental medicine and therapeutics; secretary, 1953–56; vice chairman, 1957–58; chairman 1957–58.

American Public Health Association, 1953–55, 1964; professional examination service, 1953–55.
American Society for Clinical Investigation, emeritus vice president, 1954.
American Therapeutic Society, 1954; vice president, 1958–59.
Association of American Physicians, 1949.
Association of University Cardiologists (founder), 1961.
British Cardiac Society, corresponding member, 1964.
Central Society for Clinical Research, 1945; vice president, 1951; president, 1952.
Colombia Heart Association (South America), honorary member, 1965.
Gorgas Memorial Institute of Tropical and Preventive Medicine; advisory scientific board, 1965–66.
Harvey Society, 1940.
Institute of Radio Engineers, Medical Advisory Committee of Professional Group, on Medical Electronics, 1957.
International Society of Bioclimatology and Biometereology, 1957.
Jacob Aron Research Committee, Touro Infirmary.
Louisiana Heart Association, 1948; board of directors, 1954–57.
Louisiana State Board of Health, 1952.
Louisiana State Medical Society; chairman, section on heart, 1957–59.
Japanese College of Angiology, honorary member, 1963.
Macy Conference on Cold; cold, 1951; shock, 1951.
National Association on Standard Medical Vocabulary, 1962.
National Multiple Sclerosis Society, Metropolitan New Orleans Chapter, Medical Advisory Committee, 1963.
National Society of Biophysics; steering committee, 1956.
New Orleans Academy of Sciences.
New Orleans Academy of Internal Medicine.
New Orleans Graduate Medical Assembly, 1953, vice chairman, section on medicine, 1954; chairman, section on medicine, 1955.
New York Academy of Sciences, 1946; fellow, 1955.
Orleans Parish Medical Society, 1940.
Pan American Medical Association; diplomate, section of internal medicine, 1964.
Republic of China Society of Cardiology, honorary member, 1964.
Sigma Xi, 1938.
Sociedad Argentina de Cardiologia; corresponding member (honorary), 1953.
Society for Visiting Scientists, Ltd. (London), 1961.
Society of Nuclear Medicine, 1956.
Society for Experimental Biology and Medicine, 1938.
Southern Medical Association; Research Medal Committee, 1948.
Southern Society for Clinical Research, 1946; council, 1953–56; president, 1954.
Pavlovian Society of America, 1961.
Royal Society of Medicine, 1958.

PUBLICATIONS

Over 375 articles in medical and scientific journals.

CHAPTERS

Burch, G. E., "Anatomy and Physiology of the Respiratory Tract," in Derbes, Vincent J. and Englehardt, H. T.: "The Treatment of Bronchial Asthma," Philadelphia, J. B. Lippincott, Co., 1946, chapter 5, pages 75–98.

Burch, G. E., "A New Sensitive Portable Plethysmograph," in Potter, Van R.: "Methods in Medical Research," Chicago, the Year Book Publishers, Inc., 1948, section II, volume 1, chapter IV, pages 166–176.

Burch, G. E., "A Method for Recording and a Study of the Venous Occlusive Technic for Measuring the Time Course of the Rate of Inflow and the Time Course of the Rate of Outflow in the Finger Tip of Man During a Single Pulse Cycle," Ciba Foundation Symposium, "the Peripheral Circulation in Man," London, J. & A. Churchill, Ltd. 1954, pages 23–44.

Burch, G. E., Ray, C. Thorpe, and Threefoot, S. A., "Studies of the use of RB^{86} as a Tracer of Potassium in Man," Proceedings of International Conference on

Peaceful Uses of Atomic Energy, volume 10, Radioactive Isotopes and Nuclear Radiation in Medicine, 1956, pages 458–468.

Burch, G. E. and Phillips, J. H. "Peripheral Vascular Diseases—Diseases Other Than Atherosclerosis." Handbook of Physiology, Circulation (vol. II) Chapter 36, pages 1215–1249, published by American Physiological Society, Washington, D.C. 1963.

Burch, G. E. and DePasquale, N. P. "The Spatial Vectorcardiogram as a Supplement to the Electrocardiogram in the Diagnosis of Myocardial Infarction." "Modern Trends in Diseases of Coronary Arteries and Ischemic Heart Disease," edited by Charles K. Friedberg, Grune and Stratton, New York, 1964, pages 136–153.

BOOKS

Burch, G. E. and Winsor, Travis "A Primer of Electrocardiography," Lea & Febiger, Philadelphia, 1945; second edition, 1949, third edition, 1955, fourth edition, 1960.

Burch, G. E. and Reaser, Paul. "A Primer of Cardiology," Lea & Febiger, Philadelphia, 1957, second edition, 1953, third edition, 1963.

Burch, G. E., "A Primer of Venous Pressure," Lea & Febiger, Philadelphia, 1950.

Burch, G. E., Abildskov, J. A. and Cronvich, J. A.: "Spatial Vectorcardiography," Lea & Febiger, Philadelphia, 1953.

Burch, G. E., "A Primer of Congestive Heart Failure," (American lecture series) Springfield, Charles C. Thomas, 1954.

Burch, G. E., "Digital Plethysmography," New York, Grune & Stratton, 1954.

Burch, G. E., "Of Publishing Scientific Papers," New York, Grune & Stratton, 1954.

Burch, G. E., "Of Research People," New York, Grune & Stratton, 1955.

Burch, G. E. and DePasquale, N. P., "A Primer of Clinical Measurement of Blood Pressure." St. Louis, C. V. Mosby Co., 1962.

Burch, G. E. and DePasquale, N. P., "Hot Climates, Man and His Heart." Springfield, Ill., Charles C. Thomas, 1962.

Burch, G. E. and DePasquale, N. P., "A History of Electrocardiography." Chicago, the Year Book Publishers, Inc., 1964.

Burch, G. E. and DePasquale, N. P., "Electrocardiography in the Diagnosis of Congential Heart Disease," Lea & Febiger, Philadelphia, 1965.

EDITORIAL BOARDS

American Hearth Journal, associate editor, 1955–59, editor, 1959.

American Journal of Medical Sciences, editor, progress of medicine section, 1948.

American Journal of Medicine, associate editor, 1961.

AMA Archives of Internal Medicine, 1947–62.

Audio-Digest, 1954.

Book of Health, guest editor of "Chapter on Heart and Circulation," 1952.

Cardiovascular Diseases International Board of Editors, 1956.

Circulation, 1951–56.

Clinical Cardiopulmonary Physiology, 1958.

Conns' Current Therapy, consultant, 1956.

Excerpta Medica-Cardiovascular Diseases, 1957.

GP, 1949–56.

Journal of Clinical Investigation, board of reviewers, 1950–55.

Medical World News, editorial advisory board, 1962.

Journal of Laboratory and Clinical Medicine, 1947–52, board of reviewers, 1954–56.

Modern Concepts of Cardiovascular Disease, advisory committee, 1950.

Psychosomatic Medicine, 1958.

U.S. Pharmacopedia Panel on Cardiac Drugs, 1956.

CURRICULUM VITAE—ELIOT CORDAY, M.D., FACP, FACC, FCCP

Date and place of birth: June 29, 1193, Prince Rupert, British Columbia, Canada.

Graduated in Medicine from the University of Alberta, 1940.

PRESENT POSITION

1. Past president, American College of Cardiology.
2. Attending physician in medicine, Cedars of Lebanon Hospital.
3. Associate clinical professor of medicine, University of California School of Medicine, Los Angeles.
4. Regent, American College of Chest Physicians.
5. Executive committee of the board of directors—Los Angeles County Heart Association.
6. Board of directors, Association for the Advancement of Medical Instrumentation.
7. National consultant in cardiology to the Surgeon General, U.S. Air Force.
8. Special consultant to Public Health Service, National Institute of Neurological Diseases and Blindness.
9. Secretary, Council on International Affairs, American College of Chest Physicians.
10. Assistant secretary, scientific assembly, American Medical Association.
11. Board of Governors, Los Angeles County Medical Association, Beverly Hills.

CHAIRMAN

1. Committee for postgraduate overseas education, American College of Cardiology.
2. Committee on liaison with medical schools, Los Angeles County Medical Association.
3. Special committee for liaison with Congress, the Surgeon General, and the National Institutes of Health, American College of Cardiology.
4. Appointments and promotions subcommittee of the Cedars-Sinai Medical Center Research Committee.

OTHER COMMITTEES

1. Bethesda conferences committee, American College of Cardiology.
2. Research committee, Cedars of Lebanon Hospital.
3. Professional relations committee (ethics), Los Angeles County Medical Association.
4. National advisory council for Jules Stein Eye Institute.
5. Committee on medical education and research, American Therapeutic Society.
6. Committee on public relations, American Therapeutic Society.
7. Medical executive committee, Cedars-Sinai Medical Center.
8. Medical advisory committee, Visiting Nurse Association of Los Angeles.
9. National committee on membership, American College of Chest Physicians.
10. Long range scientific program planning committee, American Collge of Cardiology.
11. Executive committee, American College of Cardiology.

ASSOCIATE EDITOR

1. Journal of Nuclear Medicine.
2. Diseases of the Chest.
3. Journal of Angiology.
4. The New Physician.
5. American Journal of Cardiology.
6. International Journal of Electrocardiology.
7. Journal of the AAMI.

Consultant Editor.

FELLOW

Journal of the American Medical Association, 1963–64.

1. American College of Physicians.
2. American College of Chest Physicians.
3. American College of Cardiology.
4. American Society of Nuclear Medicine.
5. American Geriatric Society.
6. New York Academy of Science.
7. Council on clinical cardiology, American Heart Association.
8. American Academy for the Advancement of Science.

MEMBER

1. American Medical Association.
2. California Medical Association.
3. Los Angeles County Medical Association.
4. American Heart Association.
5. Los Angeles County Heart Association.
6. American Therapeutic Society.

AWARDS

1. Honorary professor of medicine, University of Santo Tomas, Manila, Philippines.
2. Del Amo visiting professorship, Universities of Barcelona and Madrid 1957, Seville 1959.
3. Cummings humanitarian award, 1963–65.
4. Exceptional service award, Los Angeles County Heart Association, May 1966.
5. Outstanding achievement award, University of Alberta Medical Alumni Association, 1966.
6. Distinguished fellowship award, American College of Cardiology.

Author and coauthor of 115 articles and 3 monographs.

Honorary fellow Philippine, Hellenic, Republic of China, Polish, Chile, Uruguay, and Argentine Heart Associations.

PERSONAL

Intern, medicine, University of Alberta Hospital, 1939–41.

Resident, cardiology:

1. Bellevue Hospital, New York City, with Dr. Dickinson Richards (Nobel Laureate), 1946, 6 months.
2. Mt. Sinai Hospital, New York City, with Dr. Arthur Master, 1946–47.

Served in Royal Canadian Air Force from June 1941 to December 1945; rank, wing commander; position, principal medical officer, Northwest Air Command.

Naturalized American citizen, 1951.

Certified by the American Board of Internal Medicine, 1951.

Private practice limited to internal medicine and cardiology, Los Angeles, Calif., 1948 to present date.

Chief of cardiology, Cedars of Lebanon Hospital, Los Angeles, 1950–61.

Mr. FLOOD. Please proceed, Dr. Corday.

Dr. CORDAY. I am Eliot Corday, chairman of the committee for liaison with Congress, the Surgeon General, and the National Institutes of Health, and with me are Dr. George E. Burch, president of the American College of Cardiology, and Mr. William D. Nelligan, the executive director of the college.

Each year we continue to lose over 600,000 Americans from coronary disease. Many are dying at a young age.

Einstein once stated, "Anything man can imagine—man can do." When we graduated from medical school but three decades ago, we could not imagine that heart valvular disease could be repaired, patients could be resuscitated from apparent death, or that polio, TB, and infectious diseases could be conquered. How we used to dread the polio scourge each summer. Its dramatic conquest was accomplished by the imagination, basic research and ingenuity of American scientists. This and other modern miracles make us believe we can also conquer coronary disease.

There have been a few new breakthroughs in the field of heart attacks, and other studies appear promising. We are referring to the new aggressive coronary care unit concept which has been developed by the ingenuity of the Heart Disease Control Program of the National Center for Chronic Disease Control of U.S. Public Health Service. Some 600 units have been established in the Nation's 7,000 hospitals, but 6,400 still must be activated.

For some years Dr. Claude Beck, of Cleveland, has insisted that most of those who succumb after a coronary attack have hearts that are just too good to die. He imagined the amount of heart damage which sets up the fatal heart arrest is often so slight, that if we could just restart the heartbeat many would make a complete recovery. Thanks to the imagination of our medical scientists, hundreds are now resusitated each day, and are well enough to return to normal life and pay their taxes. Many of our leading medical educators have had their life restored in the coronary care units, and have again provided dynamic leadership in medical education and research for this Nation.

Two hundred and fifty thousand Americans die of a coronary attack before they can reach a hospital. On June 24, 1967, the chief of the Medical Branch of the Aritificial Heart-Myocardial Infarction Program of NIH called an ad hoc committee together to review sudden death due to myocardial infarction. This august committee recommended that there was an urgent need for added research designed to improve methods of prevention and treatment. They advised nationwide studies to determine if sudden death could be prevented by the administration of certain drugs. If these deaths are due to the sudden chaotic heart rhythm, drugs should be provided to the higher risk patients with coronary artery disease to prevent their demise. A search for proper drugs and a cooperative study to determine if such a plan could be adopted nationally would cost $5 million per year for 3 years.

The committee also recommended that research studies be initiated to provide cardiac ambulances, or mobile coronary care units for earlier service of the stricken patient. Such studies have already been initiated in Ireland, but they require scientific confirmation in the setting of our large metropolitan cities and rural areas. Such feasibility studies which could set up guidelines and training techniques that could be adopted nationwide would cost $2 million per year for 3 years.

We are losing about 300,000 coronary patients each year because of shock and heart failure. Congress recognized the need and provided funds to set up five myocardial infarction research units to study the mechanism and new forms of treatment of this grave killer. This research is most sophisticated and requires the most outstanding brains and talent in which our country is so rich. Five units have already been established, but many other equally capable cardiologic institutes are anxious to tackle this dreaded problem. The National Heart Institute recently reviewed 37 applications from leading institutions who wish to become partners in this important endeavor. It is our considered opinion that the manpower is now available, and should be unleased to attack the problem. The crusade could pay fantastic dividends in human life.

In 1967 Congress provided $13 million for the artificial heart-myocardial infarction program to search for more adequate treatment for the failing heart. The recent developments in artificial hearts and heart transplantation proved that if we can provide a satisfactory pump, many lives can be saved. The problems of transplantation are many and include the need for research in storage of the donor's heart. Heart transplantation has clearly brought to light the need to amplify the artificial heart program and more aggressive research in the problems of rejection of the transplant. The byproduct of such studies in rejection phenomena might assist in the conquest of

cancer, arthritis, kidney, and other disease processes. As a worker in the field of the artificial heart program, it is my firm conviction that the time is almost at hand when circulatory assist devices and artificial hearts will be able to sustain life. When the program was first funded, authorities expressed an anxiety that America did not have enough talent to man the program. It is now quite obvious that the talent of our great biological and engineering institutes such as Cal-Tech and MIT, are available and ready to unleash their ingenious space scientists to conquer the problem. Unless this program is provided with more adequate funding, the solution will be delayed.

Obscure muscle disease of the heart continues to strike down thousands of Americans each year. More intensive research must be launched into the cause and the diagnosis of this little-understood problem.

We recommend that a further $12 million which the National Heart Institute originally requested of the Bureau of the Budget, be reinstated for the artificial heart-myocardial infarction crusade. The cost of intensifying the battle merely represents the price of one and one-half B–52 bombers.

Congress can be assured if they provide the tools, America's scientists will accomplish the job.

Our college recommends that the heart disease control program be given $6 million for projects which could pay the country great dividends in gross national product. I am listing them as follows:

(1) Primary prevention of rheumatic fever: There are approximately 15,000 deaths annually from rheumatic heart disease, mostly under the age of 65. One hundred and one thousand patients were hospitalized with this incurable disease in 1965. It is obvious that a primary prevention program could reduce this scourge. We recommend that $1 million in additional funds be granted to heart disease control for this problem.

(2) Prevention of coronary heart disease in children: It is unlikely that currently recommended changes in diet and physical activity, if applied to the adult population only, will be adequate to solve the enormous public health problem of coronary heart disease. Even if all of these measures prove to be effective in lowering risk, it is known that the atherosclertic process begins in adolescence or before which implies that optimal preventive efforts may best be started in childhood. Hence, if dietary habits or physical activity levels are changed in adult life, it may be too late to accomplish optimal results. To attack the problem $1 million is requested to establish five community risk reduction programs for children.

(3) Coronary heart disease prevention and rehabilitation through individually prescribed programs of increased physical activity: Accumulated data reveal that physically active individuals have less frequent and less severe coronary heart disease than individuals of the same age who are less active. Evaluation of several studies of men who have had heart attacks indicates that individually prescribed programs of physical activity are the best means of improving the individual's heart function and feelings of well-being.

With over 150,000 deaths occurring each year from coronary heart disease among persons under age 65, it is of utmost urgency that more operational research, demonstrations, and evaluations be undertaken to

determine how best to apply the encouraging preliminary results of pilot projects at Penn State University and the Universities of Minnesota and Wisconsin in this field. The heart disease and stroke control program has been the main focus for stimulating, coordinating, and supporting this research but has had less than $250,000 available for grants, contracts, and direct operations in this regard.

With a $1 million addition, 10 new physical activity community or industrial pilot projects in primary and secondary prevention could be initiated. These projects would provide much needed data on how best to activate various groups of individuals and how to retain their participation in physical activity programs over extended periods of time. Also, exercise stress testing evaluation units at five institutions could be established to provide more accurate assessment of coronary risk status in communities. Training capabilities could be developed in two of the institutions to meet the need for a definitive intervention study proposed for 1971 and to provide skilled personnel for the supervised community intervention programs of the future.

It is estimated that the increased operational knowledge derived from these projects would promptly repay the cost of the development investment.

(4) Mobile coronary care, communications and consultation: Although no mobile coronary care units presently exist in the United States, Dr. Pantridge in Belfast, Ireland, has demonstrated the feasibility of such a system. There, the ambulance is staffed with specially trained physicians and nurses and equipped in such a manner that the full benefits of the coronary care unit can be taken not only to but within the patient's home. Complications are treated by the trained ambulance staff in the home where the patient's condition can be stabilized prior to his transfer to the hospital. This approach must also include continuous monitoring and prompt therapy for the patient enroute to the hospital with development of a sophisticated system of medical signal telemetry and consultation.

Mobile coronary care service must be studied from the standpoint of economic feasibility, personnel requirement, and technological needs. One million dollars additional support would permit the setting up of six such units in varying circumstances and an ongoing national evaluation and improvement program.

(5) Precoronary unit care: One-half of all deaths from coronary heart disease occur before the patient reaches the hospital. It has been well documented that many of the patients who died before reaching the hospital had sufficient symptoms to allow them to get to medical help in time, if they had only heeded these early warnings.

The reasons that patients do not reach the hospital involve a number of factors about which little specific information is available. Some of these factors include:

1. Reluctance of patients to visit their doctor for psychological, social, economic, or cultural reasons.
2. Delay in the physicians seeing the patient, misinterpretation of symptoms, and limited, insufficient diagnostic tests.
3. Poor transportation systems, unable to cope with emergency situations en route.
4. Delay and insufficient observation of the patient in the emergency room or admitting area of the hospital.

Further study of all factors delaying the patient's entry into the coronary care unit must be carried out if remedies are to be found.

One method of overcoming delays involving the admission of a patient to a coronary care unit is the cardiac surveillance unit. This is envisioned as a relatively small, pleasant reception area within the hospital, set a side for the early admission of patients with various early warning signs and symptoms, where continuous monitoring of the electrocardiogram is combined with frequent, competent observation by specially trained nurses. Thus patients who may not necessarily have a heart attack and are still ambulatory, can receive immediate care because their symptoms, even though transient, may suggest the possibility of some increased risk of an acute episode. A short stay of 8 to 48 hours in the cardiac surveillance unit and simplified, rapid admission, and discharge procedures would produce a rapid patient turnover rate, thereby making these beds easily available to appropriate patients at a relatively low cost. The concept of the cardiac surveillance unit needs further development and implementation for which $600,000 would permit eight units to be established and evaluated as part of the national coronary care system that needs to be developed as rapidly as possible.

(6) Automated medical signal system for cardiac care units: Because of the very large number of acute coronary attacks occurring annually, there is a tremendous demand for trained personnel. It is very improbable that a sufficient number of highly trained nurses and other paramedical personnel could be prepared within the next several years to take care of all acute coronary attacks in the United States. To maintain high quality patient care, automated systems must be developed.

The function of the automated system would be as follows:

1. Sample the ECG and other signals at appropriate intervals and describe the pattern, rate, and rhythm.

2. Characterize the measurements statistically, derive normal limits for each patient, derive their trends, and produce a statement of ECG status and significant changes.

3. Immediately note important transient events and signal the staff of their occurrence.

The system will function as a trained, tireless electrocardiographer-statistician and thus allow earlier preventive action and treatment as well as supplant the need for intensive human data observation and reduction. The investment of $1,400,000 would permit the completion of present design with the construction and use of two data processing systems and the support of their operation under a careful evaluation and improvement program.

In summary we note in the President's message to Congress that a 2-percent increase is proposed for the National Heart Institute for fiscal 1969. We are shocked to note that this $2 million will not allow for an increase in the number of research projects. Because of the increasing cost of labor and technical equipment, 800 important heart research projects which, after intense competition have been approved for funding, cannot be activated.

Heart research in the United States has been moving forward dynamically, making it preeminent in the world. However, it now appears that this effort has plateaued out. We appeal to you to recog-

nize the fact that we face a 26-percent reduction in all heart projects from 1966 to 1969.

Heart disease can only be conquered by man's mind and we can definitely stretch the mind with proper Federal support. We appeal to you to amplify the heart budget so that many lives can be saved which will in turn contribute to the Nation's economy.

Mr. FLOOD. Thank you.

Is there anything you want to add, Dr. Burch?

Dr. BURCH. I would like to say a little something about the training programs, support of training. I say this through my own experience at Tulane Medical School as professor of medicine.

One of the difficulties of bringing to the patient the best of medical care is the requirement that you have the best of knowledge in the doctor who is caring for the patient. We find a considerable shortage in funds for training not only research people, but clinicians; that is, doctors who go to the bedside. Well-informed and well-trained physicians should be available in various units around the country. These physicians could provide further training for the doctors in the community. Once you develop a nucleus of teachers in all communities of the United States, they in turn could help with the training of family physicians in their respective communities.

There is a tremendous shortage of training funds. The kind of funds that are available usually are not given by foundations and the like, but we have to depend on our Government to help.

With the development of new medical schools, the expanding of medical schools, and with the shortage of faculty, we are facing physician shortages. We feel that this is one of the ways to help train, not only in one aspect of cardiology but across the board in cardiology.

I would like to bring this to your attention. I am sure you have heard this already.

Mr. FLOOD. A very great deal.

Dr. BURCH. I am sure you have.

Mr. FLOOD. Thank you, gentlemen.

Dr. BURCH. Thank you.

WEDNESDAY, MAY 1, 1968.

HEALTH MANPOWER EDUCATION

WITNESSES

DR. WILLIAM RUHE, DIRECTOR, DIVISION OF MEDICAL EDUCATION, AMERICAN MEDICAL ASSOCIATION

PAUL R. M. DONELAN, ATTORNEY, LEGISLATIVE DEPARTMENT, AMERICAN MEDICAL ASSOCIATION

Mr. FLOOD. We now have Dr. William Ruhe, the director of the Division of Medical Education of the American Medical Association. Do you have somebody with you?

Dr. RUHE. Mr. Paul R. M. Donelan, who is an attorney in the AMA's legislative department.

Mr. FLOOD. All right. You may proceed, Doctor.

Dr. RUHE. Mr. Chairman and members of the subcommittee, I am Dr. C. H. William Ruhe, director of the Division of Medical Education of the American Medical Association. I wish to relate to you the grave concern of the American Medical Association that Federal legislation providing for medical education should be financially supported as fully as possible to meet the pressing need which exists today for an increased number of physicians. With me is Mr. Paul R. M. Donelan, an attorney in the association's legislative department.

An urgent need exists in this country for more physicians to meet the health care needs of the American public. This need can only be met effectively by a major increase in the capacity of American medical schools to educate more physicians. A recent joint statement of AMA and the Association of American Medical Colleges has endorsed the policy that the collective enrollments of all medical schools should be expanded to a level that will permit all qualified applicants to be admitted.

A substantial increase in medical school enrollments is therefore essential. This can be achieved in two ways: through expansion in the size of existing medical schools, and through the development of new medical schools. Both mechanisms are now being implemented, but the rate of increase is not adequate in view of the urgency of the need. New medical schools are certainly desirable, and many are being developed, but the length of time required for the establishment of new schools means that significant production of physicians by these schools will not be achieved for many years.

Expansion of existing schools can result in much more prompt increase in physician production and therefore constitutes the more practical means of dealing effectively with the present crisis. All existing medical schools are accordingly being encouraged to increase their student enrollments as fully and as promptly as possible.

There are, however, many medical schools which are not in position to increase enrollments because of limitations in facilities, faculty or operating support. Some of these schools, in fact, are in precarious financial balance at the present time and will require increased financial support if they are to maintain their present physician output; there is real concern that a few might even be forced to suspend operations unless additional help is obtained. Others are able to sustain their present enrollments, but would not be able to expand without substantial financial assistance.

Under the proposed Health Manpower Act of 1968 (S. 3095), institutional grants would be made available to medical schools for support of their educational programs, with certain incentives provided for expansion of enrollments. However, the assistance forthcoming from the legislation would not become active until 1970. Some effort must therefore be made to secure the essential immediate increase in financial support through increased appropriations under existing legislation.

There are several mechanisms through which this is possible:

1. Under the Health Professions Educational Assistance Act and amendments, matching Federal funds are available for construction of facilities for new medical schools and to permit expansion of existing medical schools. There is currently a backlog of applications ap-

proved but not yet funded under this act. It is our understanding that applications for Federal matching funds approved but not funded, for medical schools alone, total $65.4 million, with only $7 million currently available in fiscal 1968 to meet the requests. Furthermore the advisory council at its June meeting will consider applications from all health schools eligible under the act for a total of $83 million additional. If even half of these applications are approved, the total approved but not funded will exceed the total of $7 million available in fiscal 1968 plus the $75 million requested in the administration budget for fiscal 1969. And this does not take into consideration anticipated requests totaling over $300 million which will be considered by the Advisory Council during fiscal 1969.

The amounts authorized by the legislation for the current 3-year period totaled $480 million. The amounts appropriated for 1967 ($135 million) and 1968 ($175 million) and that requested for 1969 ($75 million) total only $385 million, or $95 million less than authorized by the legislation. If the full amount authorized could be appropriated and made available, the situation would be much improved. Even the full amount will not meet the total need for fiscal 1968 and 1969; but anything less than the full amount will further increase the backlog of applications approved but not funded and will further hamper the effort to produce more physicians.

2. Under the Health Research Facilities Construction Act, matching Federal funds are made available for construction of research facilities in new and existing medical schools. Here there is also a backlog of applications approved but not yet funded, the current amount being $54 million for the Federal dollar share for all eligible health schools. Since only $8 million has been requested in the administration budget for fiscal 1969, and nothing remains from the 1968 appropriation, it is obvious that not even the current backlog will be cleared.

While the relation between the construction of research facilities and the increase in medical school enrollments may not be so apparent, the fact is that the construction of facilities for medical education is inextricably intertwined with the construction of facilities for research and for medical libraries as well. Recognition of this fact has led to the proposal of an omnibus bill embracing all three in the current S. 3095, Health Manpower Act of 1968. Pending the successful enactment of that legislation and its implementation, failure to meet the need for that portion of research facilities construction which is related to medical school construction will inevitably hamper and restrict efforts to increase medical school enrollments.

3. The Medical Library Act also authorized funds which are vital to the construction of new medical schools and in many instances to expansion of existing schools. The library is an indispensable part of any medical school, and plans for the construction or enlargement of the library are essential components of the plans for new or enlarged medical schools. It is estimated that the present fiscal year will end with 16 projects approved, but not funded under this act, totaling in excess of $15 million in Federal matching dollars. Since only $1.25 million will be available from the $3.75 million appropriated for 1968, and nothing has been requested in the administration budget for 1969 for this purpose, an important element in medical school construction is left without the support the Congress intended when the law was passed.

4. Under the current Health Professions Educational Assistance Act and amendments, both basic and special improvement grants are authorized for the support of educational programs in the health schools. However, these have never fully been implemented because of inadequate appropriations. Basic improvement grants are now being awarded in the full formula amount in fiscal 1968 for the first time but only $17 million in special improvement awards is available. For fiscal 1969, the legislation authorized $80 million for these two types of grants, but the administration budget has recommended that only $66 million be appropriated. We urge that the full $80 million be made available in order that all eligible medical schools might receive both basic and special improvement grants.

The particular importance of the special improvement grants is that such funds can be applied directly to the educational programs of the institutions and that they can be awarded first to the institutions which have the greatest need. This could mean the salvation of those institutions which are in precarious financial balance and are having difficulty maintaining present enrollments. It could further enable other institutions to increase enrollments and to experiment with curricular innovations which could shorten the total time for training.

5. The general research support award authority of NIH permits the use of up to 15 percent of the research funds at any institute for such an award, but NIH has never before used more than 8 percent. The general research support award can be used by an institution for the general support of any research activity in that institution. Almost every institution uses some of its general operating funds for the support of research, or for the overhead costs associated with the conduct of research, or for personnel necessary for the conduct of research. If the full general research support award could be made to each medical school, the institutional funds now used for general or fringe support of research could then be directed to the support of education. If the appropriations committee added enough money and made its wishes known to NIH, substantial additional funds could be made available to medical schools through this mechanism.

Mr. Chairman, the American Medical Association is indeed grateful for this opportunity to present its views with respect to appropriations which would fund legislation adopted by the Congress in support of medical education. One consideration of national concern at the present time is the rising costs of health care. We believe it essential to increase the number of physicians if we are to work toward arresting this trend. A greater number of physicians is also essential if we are to meet adequately the health needs of the future.

In closing, Mr. Chairman, we recognize the present concern of the Congress and the Nation for an overall reduction in Federal expenditures. However, we believe that the urgent need for more physicians merits the funding, to the fullest extent possible, of legislation supporting medical education.

Mr. Donelan and I would be pleased to attempt to answer any questions which you or members of the subcommittee may have.

Mr. Flood. I do not think that is necessary, Doctor. Thank you very much.

Dr. Ruhe. Thank you, sir.

WEDNESDAY, MAY 1, 1968.

KIDNEY DISEASE ACTIVITIES

WITNESSES

DR. GEORGE E. SCHREINER, CHAIRMAN, LEGISLATIVE LIAISON COMMITTEE, NATIONAL KIDNEY FOUNDATION
DR. IRA GREIFER, MEDICAL DIRECTOR, NATIONAL KIDNEY FOUNDATION
MRS. SIDNEY ROSEN, PRESIDENT, KIDNEY FOUNDATION OF NEW YORK; ASSISTANT SECRETARY, NATIONAL KIDNEY FOUNDATION

Mr. FLOOD. We have with us Dr. Schreiner of the National Kidney Foundation.

Who is with you?

Dr. SCHREINER. This is Dr. Ira Greifer, who is the medical director of the National Kidney Foundation and director of pediatrics at the hospital of the Albert Einstein College of Medicine, and chairman of the advisory board, kidney disease, Institute of New York; and Mrs. Sidney Rosen, who is head of the New York Chapter and is assistant secretary of the National Kidney Foundation.

I am Dr. George E. Schreiner, Professor of Medicine, Georgetown University, chairman of the legislative liaison committee of the National Kidney Foundation, and chairman of the medical advisory board of the Washington, D.C. Chapter of the National Kidney Foundation.

Mr. FLOOD. We are glad you are here. How do you wish to proceed, Doctor?

Dr. SCHREINER. We thought informally, if it pleases you. We have brought in some written materials. They include statements that were made by the foundation. You know we have been appearing here since 1965.

Mr. FLOOD. You have gone so far in a short time.

Dr. SCHREINER. Yes indeed.

(The materials referred to follow:)

THERE IS A THIRD WAY

(By George E. Schreiner, M.D.)
(Presidential address at the Southern Society for Clinical Investigation)

An important problem which is a source of concern for most academicians and clinical investigators is the role of the medical school and of the academician-investigator in developing, refining, and delivering the fruits of biologic research. Louis Fieser, Ph. D., inventor of Napalm, said, "An inventor cannot be responsible for how other people use his inventions." I would paraphrase this thought by saying that a clinical investigator cannot be irresponsible about the nonuse of his discoveries.

I would like to start with a concrete problem—how to accomplish the management of patients with end-stage renal disease when research has developed not one, but two, effective modes of therapy which are capable of adding years to useful life and rehabilitating a substantial fraction—perhaps even a majority—of those who are treated. Although the problem may seem specialized at first glance, it contains all of the ethical and economic conflicts which apply to other new develoments.

The extent of the problem in terms of numbers may be surmised from a series of impressive statistics. These include the following: In 1964, 27,345 persons

were recorded as dying of nephritis and nephrosis, renal infection and polycystic disease in the United States. Uremic deaths comprised an unknown percentage of the 69,634 deaths ascribed to various entities causing arterial hypertensive vascular disease. Uncounted thousands have died a renal death from diabetes mellitus, lupus erythematosus (LE), poisons, shock, and a host of other diseases, which never get into the kidney statistics. In Georgetown Hospital between 1953 to 1959, primary uremic deaths constituted 16.2 percent of the deaths due to medical causes and 19 percent of all the autopsies performed on patients who died while being cared for by physicians on the medical service of the hospital.

The first biologic dialyzer, or artificial kidney, was built in the laboratory in 1913. In 1946, Kolff had reported his first 15 patients. By 1960, we had maintained on hemodialysis in our laboratory 27 anuric patients for longer than 20 days and five patients longer than 60 days. On March 9, 1960, the first chronic uremic patient was launched on maintenance dialysis by Scribner. He is still living.

Ullman and Carrell in 1902 performed the technical feat of autotransplantation of kidneys to the necks of dogs and goats, where the kidneys made clear urine. The first attempt to transplant a kidney in man was made by Voronay in 1936, just 31 years before the first heart transplant. A small series of kidney transplants were reported in Paris in 1951. In 1953 a patient with a live-donor kidney lived for 23 days.

In 1955, the group at the Peter Bent Brigham Hospital reported their first series of nine transplants. Four of those functioned for 37 to 180 days. The first successful transplant between identical twins was reported in 1956, and now more than 1,400 renal transplants have been done throughout the world.

If we apply the most stringent medical criteria, including the rather arbitrary age selection (15 to 54), about 20 percent of persons dying from renal disease would be considered "ideal" candidates for dialysis or transplantation.

Thus, 32 years after the first human transplant and 24 years after the successful use of clinical dialysis, we are taking care of about 10 percent of the selected patient load and about 3 percent of, what I judge to be, the potential load.

The serious dimensions of this problem were underscored by the formation for the first time in history of a Medical Advisory Committee to the Bureau of the Budget. The first meeting was held July 8, 1966, in the Executive Office of the White House. A report was completed September 14, 1967, and was released in December 1967.

This Committee took into careful consideration all of the organizational, scientific, manpower, ethical, and financial problems involved. They called for a federally financed national program for the treatment of uremia in all persons for whom it is medically indicated, with a commitment to its continuation, and they drew the blueprint of one plan whereby this could be accomplished within the existing constraints of facilities and manpower. The capabilities of such a program are indicated in the table and figure. The estimated cost for such a program for the next 6 years is believed to be between $800 million and $1 billion.

I have drawn out in specific detail this example of the "delivery gap" in medical care because we have solid data rather than speculation. It takes but little imagination to realize that the same logistic problems with an even greater delivery gap, and the same philosophical questions, will be presented by further technical developments, such as strict environmental control by the LI (Life Island) in burns and in the chemotherapy of leukemia; artificial ventilation in emphysema; artificial hearts, electronically operated replacements for limbs, organs, and the major senses; and current heart, liver, bowel, and ovarian transplants.

What has been the reaction of the academic and governmental community to this progressive widening of the delivery gap in medical care? It is readily discerned from an unprecedented array of opinions. Most of the reactions are, I believe, unfortunately polarized. The anionic or negative group are opposed to any systematic action to close the gap. Their reactions range from frank opposition and unwillingness to discuss the subject or to encourage any planning activity all the way to the more subtle techniques such as smothering with silence, the use of "straw men" arguments, and the recurrent appeal to self-interest. This is essentially a philosophy of fear, fear of competition for research funds, of emphasis shifting from the so called "basic" research, of competition for manpower, of increasing the nursing shortage, of the decisionmaking involved in medical triage, and of disruption of existing structures and

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organizations. Added to this is the basic distrust of any organized plan by personalities that lean toward a strong individualism. In general, the anionic position is an understandable expression of territoriality.

The cationic, or positive group, feels compelled to asume the treatment burden themselves. Frustrated by the personal tragedies that occur daily because of the delivery gap they plead for investigators to roll up their sleeves and pitch in. "If you can't treat them all, treat some" or "If you can't do it well, do it poorly, but do it." Their social concern is unassailable; their call to action is urgent and desperate; their appeal is deeply emotional and powerful. Their case is abetted by officials in high places who give the impression that our medical schools are huge storehouses of unsed manpower, just waiting to be utilized by the systems analyst who has the doctrinal blessing to etablish social priorities.

I shall not take time for a detailed refutation of these polarized positions. Donald Seldin amply dealt with the cations when he said, "The price for the solution of community service requirements may be the inexorable erosion of academic activity."

As for the negative viewpoint it is strongly reminiscent of the early stand of organized medicine during the fight against medicare. The distinction of themselves as "basic" scientists is in itself suspicious, for as Ernest Chain put it, "Science is not really divided into basic and applied. It is either useful or useless. It is a good science or bad science." All of us would agree that both kinds are found in all disciplines. The image of unenlightened self-interest presented by the anions is a demeaning one, unworthy of the medical scientist in an academic setting. The outcome of such a line of argument is predictable.

So much for the polarized views. I would now submit that there is a third way to approach this vital question. The medical scientist can effectively demonstrate his social concern without being overwhelmed. He can give of his scientific talents often a unique and occasionally a priceless gift. In clarifying the distributive problems, designing and test designing alternative solutions, analyzing constructive plans, documenting their ramifications from direct experience, and exercising his objectivity learned in research training, he can bring ingenuity and inventiveness to bear on the development of more imaginative solutions than we get from the routine health planners who often do not have roots in experimental medicine. He can use his skill as an educator to define the problems for those less expert and for the laymen who seek leadership in closing the delivery gap.

In the very act of maintaining a dialog on the delivery of new advances, the academician is already helping to reduce the frustrations experienced by patients throughout the Nation who are becoming more aware of the gap between the flowing promises of progress in medical technology and the inadequate realities of the corner clinic.

There are many stimulating and productive examples of the third way in operation today. The work of the Bureau of the Budget Committee is a prime example.

Another would be the task force with its chairman, Louis Welt, M.D., to design a university nephrology center capable of delivering the benefits of modern technology without destroying the integrative function of the departments which now exist in our medical schools. Still another would be the "Drug Efficacy Study" of the National Academy.

Recently, Senator Henry Jackson, of Washington, and Congressman Edward Roybal introduced a bill entitled, "The Artificial Organs, Transplantation, and Technological Development Act of 1968." Dr. Schreiner, a member of the Committee on Chronic Kidney Disease to the Bureau of the Budget and chairman of the National Kidney Foundation's legislative liaison committee acted in an advisory capacity to Senator Jackson and Congressman Roybal. This bill provides for a national commission to evaluate the full range of medical, legal, social, economic, technical, and humanitarian problems which involve the role of the Federal Government in transplantation and artificial organs. It also provides $20 million the first year and $30 million per year thereafter for the establishment of training and treatment centers in teaching institutions for transplantation and dialysis which will eventually relate to community dialysis centers and home dialysis programs.

CAPABILITY

Fiscal year	Pool size	Dialysis (percent)	Transplant (percent)	Total (percent)
1970	7,345	20	10	30
1971	7,540	25	16	41
1972	7,800	50	22	72
1973	8,120	70	31	101
1974	8,490	81	40	121
1975	8,895	91	47	138

Note: Probable flow of cases under varying treatment programs with expected survivorship.

I feel confident that the members of the Southern Society for Clinical Investigation and other similarly orientated societies, long accustomed to bridging the fundamental and the medical disciplines, will choose the third way by supporting this bill. They can constructively help in the analysis and interpretation of its provisions and in implementation of its features in their communities. They can see the plan as one model for solving the dilemma of the delivery gap and envision the usefulness of this model for future breakthroughs in therapeutic capability. They can communicate their expertise and feelings to elected officials. (Such communications have a powerful effect in Washington.) Most important, they can support this bill as scientists with social concern without losing one stride in the quest for new knowledge on whose breadth and depth will depend the validity of future progress. In doing these things, they will be taking the third way.

SUPPLEMENTAL TO PRESENTATION BY THE NATIONAL KIDNEY FOUNDATION FOR KIDNEY PROGRAMS UNDER THE DIVISION OF CHRONIC DISEASES

The attached presentation was used as the base of testimony before the Labor-HEW Subcommittee of the House of Representatives on March 23, 1965. It is the opinion of the National Kidney Foundation that this material remains valid and pertinent and that its basic premises deserve implementation with support from funds allocated to the Department of Health, Education, and Welfare.

The Foundation is gratified that the House of Representatives approved the recommendations of its Appropriations Committee and allocated funds over and above the original 1966 budget provisions for the support of programs in the area of kidney diseases. It is our interpretation of the House action that the following allocations have been authorized by it:

$3,400,000 for activities in the field of hemodialysis to be administered by the Division of Chronic Diseases. (This is an increase of $2 million over the 1966 budget.)

$2 million (overall budget request) for activities in connection with the development of a better artificial kidney to be administered by the National Institute of Arthritis and Metabolic Diseases.

House Report 272 calls attention to the fact that witnesses at the public hearings recommended approximately $5 million for the first part of the allocation and therefore the $2 million increase was considered conservative. The second section of the allocation was actually in addition to the basic request of the National Kidney Foundation and was suggested during verbal testimony rather than as part of the prepared presentations.

The appropriations as determined by the House are exciting advances in view of the fact that similar appropriations had not been made heretofore. Nevertheless, the National Kidney Foundation finds it necessary to reemphasize two important phases of its recommended program which are not specifically or amply provided for in the format of the House appropriation.

I. FUNDS FOR TRAINING PURPOSES

A major deterrent to an increase in facilities for patients requiring the use of the artificial kidney as a life-prolonging therapy is the serious lack of trained

personnel to operate every phase of proposed dialysis centers. Training is required at three levels and funds must be made available to the Division of Chronic Diseases for this purpose:

A. Physician: Professional education programs aimed at securing physician acceptance and utilization of hemodialysis are needed.

B. Professional: Education and training of physicians and nurses who will direct dialysis centers is a vital need.

C. Technicians: Funds for the training of technicians, aides and other paramedical personnel are needed.

It is the opinion of the National Kidney Foundation that the addition of funds in the amount of at least $750,000 for training purposes is not contrary to the spirit in which the House subcommittee report was presented to the full committee and the House of Representatives.

II. FUNDS FOR DETECTION, PREVENTION, PROFESSIONAL AND PUBLIC EDUCATION

In the recommendations originally presented by the National Kidney Foundation, attention was called to the enormous potential expenditures which might be required for the dialysis programs. In order to attempt to eliminate some major portion of this potential expenditure, the foundation urged detection and prevention programs which would attempt to keep patients from reaching the end-stages of uremia which required either dialysis or transplantation. Carefully defined research into these areas of detection, prevention, professional education, and public education have established procedures which might be utilized in a number of pilot projects if funds were available.

In any chronic disease category, it is common practice to attempt to prevent end-stage conditions. However, no funds have been available in the area of kidney disease.

The National Kidney Foundation believes that at least $750,000 for these purposes should be added to the appropriations already approved by the House.

Full documentation of the need for and the feasibility of these requests may be found in the original presentation by the National Kidney Foundation.

Comments

A. *Activities to develop a better artificial kidney.*—The National Kidney Foundation is pleased with this allocation. However, with full cognizance of the fact that the subject of patients, licensing, and industry cooperation in research is described by legislative action, we would like to call attention to possible deterrents to the fullest realization of the goals set by this allocation. It is our hope that a careful review and reevaluation of patent and funding policies of Federal agencies administering grants to industry for health activities will be able to find ways and means to make it possible for more industrial involvement in creating a more effective artificial kidney.

B. *Programs within the division of chronic diseases.*—In the original presentation, the National Kidney Foundation calls attention to the fact that no programs for kidney disease exist within the Division of Chronic Diseases. At the time this statement was made, certain general funds from the community services and facilities program for the chronically ill and the aged were used to fund two or three regional dialysis centers. However, no earmarked funds for kidney disease were available and no office or individual was responsible for the actual implementation of kidney disease programs.

Since March 1965 when the presentation was made, we have been informed that a renal disease activity has been established within the Division of Chronic Diseases and that limited funds are available for necessary administrative purposes. With the increase in activity which will result from the appropriations anticipated by favorable Senate action, examination of the funds for administration of the programs should be undertaken with a view to providing sufficient amounts for effective utilization of the major funds allocated.

[Article printed in the New York Times, June 11, 1966]

KIDNEY MACHINES PROVING WORTHY—71 PERCENT OF PERSONS WITH ILLNESS CAN LEAD AN ACTIVE LIFE

(By Harold M. Schmeck, Jr.)

WASHINGTON, JUNE 10.—Regular periodic treatments with artificial kidney machines not only can keep doomed patients alive but also can restore a high percentage of them to an active life, a nationwide survey indicates.

Well-trained teams to conduct the treatments and a careful selection of patients are vital keys to this success, according to a specialist of the U.S. Public Health Service whose unit made the survey.

As of June 1, it was estimated that some 400 patients who would otherwise inevitably die of kidney disease were being treated by artificial kidney machines. A few of the patients have been under treatment 6½ years, most for much shorter periods.

About 100 patients are being added each year to artificial kidney treatment programs. Specialists estimate that 3,500 others who would be suitable for this kind of treatment die each year because of lack of facilities.

The method was first used for incurable patients about six and a half years ago. While it has gradually been gaining acceptance among physicians, many have expressed doubts as to the length of time such patients can be maintained and the degree to which they can return to useful, productive lives.

THE OTHER APPROACH

There has also been some debate as to the merits of this method as compared to kidney transplantation, the only other hope for such patients.

Experience to date indicates that 97 percent of properly chosen patients can be maintained for 12 months with artificial kidney treatments and that 74 percent can be expected to survive 4 years, said Dr. James R. Kimmey, chief of the Kidney Disease Branch of the Health Service's Division of Chronic Diseases.

As to rehabilitation, he said the data show that 71 percent could be restored to active life, including a full-time job or activity as housewife or student, and that 18 percent more could be partly rehabilitated. All must maintain rather strict diets.

"Although these figures are based on relatively small numbers, they show that carefully selected persons can be rehabilitated to a significant degree," Dr. Kimmey said in an interview.

He reported on artificial kidney programs last month in Baltimore at a joint meeting of the Clinical Society and Commissioned Officers Association of the U.S. Public Health Service. He has been updating the data since then.

About two-thirds of the patients are being treated in programs supported by the Health Service or operated by the Veterans' Administration.

The treatments, done once or twice a week for most patients, do not cure the underlying disease.

Instead, the machines cleanse the blood of the wastes the kidneys would normally get rid of. Thus, they substitute for normal kidney function.

All the patients in the artificial kidney programs are incurably ill and would be expected to die with a month if the treatments were discontinued. Until recent years all such patients did die.

Today, they have two choices of treatment; treatment in an artificial kidney program, provided one is available to them, or restoration of their kidney function by a transplant.

STATEMENT OF THE SCIENTIFIC ADVISORY BOARD OF THE NATIONAL KIDNEY FOUNDATION

Diseases of the kidney and urinary tract are much more prevalent than generally realized. The impact of urinary tract diseases expressed in terms of dol-

lars or time lost from work is disproportionate because these diseases occur in younger people, unlike cancer and stroke. It has been estimated that over 6 million people per year are affected acutely with diseases of the urinary tract. The exact mortality is unknown, largely because of the tendency to report it on death certificates under other diagnostic terms such as diabetes, high blood pressure, etc. The total number of deaths in the United States each year caused by kidney failure is at least 30,000 and may be as high as 200,000. A new approach is necessary to deal with a problem of this magnitude.

The rate of expansion of facilities for research and training and for the treatment of kidney diseases should be much greater. The current level of support is adequate only to maintain the facilities already begun with funds appropriated by this committee. Unless an increase in appropriation occurs, no further expansion can be anticipated. If an orderly expansion, which we believe is necessary, is to be achieved, then additional funds are urgently needed at this time. Such funds should be designated in such a way as to make their expenditure most effective in terms of future expansion and to meet some problems which have been already encountered in present programs.

The lack of physical facilities and the dearth of trained professional and technical personnel at all levels now act as a definite deterrent to expansion in this field. Correction of these defects requires realistic leadtimes ranging up to several years.

If the appropriations for the coming fiscal year are not substantially increased, it will be impossible to continue in a logical fashion the excellent beginning which was made this current year.

For these reasons the Scientific Advisory Board of the National Kidney Foundation believes that kidney programs could realistically use an increased appropriation of at least $8 million over and above the amount in the current budget.

I am Robert J. Smythe, executive director of the National Kidney Foundation, a voluntary nonprofit organization established primarily to support and encourage research into the incidence, causes, prevention, treatment and cure of all kidney diseases.

Deaths totaling nearly 100,000 Americans each year, according to the estimate of the National Kidney Foundation's Scientific Advisory Board, are the result of kidney disease. The national Center for Health Statistics attributes slightly less than 25,000 fatalities to kidney disease in 1964, the latest year for which figures are available, but this total does not take into account deaths caused by such conditions as hypertension or stroke which are often the consequence of kidney ailments.

The mortalities, shocking enough at a time when the lives of most end-stage kidney disease patients can be preserved through dialysis, are merely the beginning of the story. The 1963–64 National Health Survey found that acute genitourinary tract disease—excluding venereal disease and menstrual disorders—was responsible for restricting the activities of 6.7 million people for a total of 3.9 million days. Chronic genitourinary disease limited the activity of another 1.1 million people, making chronic genitourinary disease the fourth most common cause of nonorthopedic impairment in people under the age of 45.

Of the estimated 3.3 million people in this country carrying infectious organisms in their urinary tract, a significant number will never know of their condition until survival is no longer a possibility.

I don't wish to belabor these statistics but they are necessary to establish the fact that the problem of kidney disease is an important one in both humane and economic terms, more important than a casual glance at the official mortality rate shows.

The small amounts of money Congress has thus far appropriated for the fight against kidney disease have been largely directed to end-stage therapy—dialysis and transplantation. Yet an estimated 4,000 to 6,000 medically suitable dialysis candidates still die each year because dialysis was not available to them. True, emphasis has been placed on research and development in dialysis technology. Between 1960 and 1965 our average yearly population net growth rate was 14.6 per 1,000, by no means the highest but high nevertheless. Improvements in dialysis technology will certainly lower the cost of dialyzing individual patients but there will be, if only as a function of population growth, a great many more patients. Not only is dialysis or transplantation for all these people likely to require a vast investment but, in the long run, concentration on end-stage therapy lacks logic.

The answer to this burgeoning problem is prevention or, where preventive methods do not exist, early detection and effective therapy. At present only a few of the diseases afflicting the kidneys can be prevented in the primary sense of that word. Research can undoubtedly lengthen the list. A number of others are susceptible to early detection and therapy, called secondary prevention in medical parlance. For the rest there is only dialysis and transplantation therapy, which at this point in time is available only to a few.

The kidney disease control program of the National Center for Chronic Disease Control has done a very commendable job of developing a preventive program, considering the budgetary restrictions under which it has been forced to work. But not enough has been done. I am tempted to use the phrase "too little too late," but of course it is only too late for those already suffering from advanced chronic kidney disease or those who soon will be.

It is, however, becoming too late for more and more and more people. Most kidney ailments remain poorly understood, the extent of the problem in the population remains largely undefined, better methods of detection await development, the natural histories of most kidney disorders are yet to be clarified, available modes of therapy await definitive testing while new modes await discovery, and comprehensive kidney disease prevention centers are only a hope for the future.

The kidney disease control program has made a start in all these areas, but only a start. And the passage of time means serious illness, debilitation, loss of productivity, and loss of income for millions of people.

I respectfully suggest that this serious threat to the heatlh of our citizens requires a greater national investment. The sums of money needed compared with nearly 8 million people ill with genitourinary disease in 1963–64 are trivial.

STATEMENT OF THE NATIONAL KIDNEY FOUNDATION

The exact mortality rate from diseases of the kidney is unknown but lies between 25,000 deaths from primary kidney disease to perhaps 100,000 deaths from related conditions such as diabetes, hypertension, gout, or stroke which are often the cause or effect of kidney disease.

The mortalities, shocking enough at a time when the lives of most end-stage kidney disease patients can be preserved through dialysis, are merely the beginning of the story. The 1963–64 National Health Survey found that acute genitourinary tract disease—excluding venereal disease and menstrual disorders—was responsible for restricting the activity of 6.7 million people. Chronic genitourinary disease limited the activity of another 1.1 million people, making chronic genitourinary disease the fourth most common cause of nonorthopedic impairment in people under the age of 45.

Of the estimated 3.3 million people in this country carrying infectious organisms in their urinary tract, a significant number will never know of their condition until survival is no longer a possibility.

These statistics are necessary to establish the fact that the problem of kidney disease is an important one in both humane and economic terms, more important than the official mortality rate shows.

The small amounts of money Congress has thus far appropriated for the fight against kidney disease have been largely directed to end-stage therapy—dialysis and transplantation. Yet an estimated 4,000 to 6,000 medically suitable dialysis candidates still die each year because dialysis was not available to them. True, emphasis has been placed on reseach and development in dialysis technology. Between 1960 and 1965 our average yearly population net growth rate was 14.6 per 1,000, by no means the highest but high nevertheless. Improvements in dialysis technology will certainly lower the cost of dialyzing individual patients but there will be, if only as a function of population growth, a great many more patients. Not only is dialysis or transplantation for all these people likely to require a vast investment but, in the long run, concentration on end-stage therapy lacks logic.

The answer to this burgeoning problem is prevention or, where preventive methods do not exist, early detection and effective therapy. At present only a few of the diseases afflicting the kidneys can be prevented in the primary sense of that word. Research can undoubtedly lengthen the list. A number of others are susceptible to early detection and therapy, called secondary prevention in medical parlance. For the rest there is only dialysis and transplantation therapy, which at this point in time is available only to a few.

It is, therefore, becoming too late for more and more and more people. Most kidney ailments remain poorly understood, the extent of the problem in the population remains largely undefined, better methods of detection await development, the natural histories of most kidney disorders are yet to be clarified, available modes of therapy await definitive testing while new modes await discovery, and comprehensive kidney disease prevention centers are only a hope for the future. Basic research is, therefore, a continuing goal of the National Kidney Foundation and must be increased along with expenditure for therapeutic success. It is obvious that the overall quest for the prevention and cure of kidney disease cannot progress any faster than the basic research that provides the foundation for increasing knowledge.

We respectfully suggest that this serious threat to the health of our citizens requires a greater national investment. At least $30 million additional could be spent in the kidney area to support renal stations, training programs, and basic research. The sums of money needed, in view of nearly 8 million people ill with genitourinary disease in 1963–64, are trivial.

STATEMENT OF DR. GEORGE E. SCHREINER

Dr. SCHREINER. Mr. Flood, you asked me a question last year about some of the bioengineering developments and the progress made by mixing clinical investigators with engineers in the scientific group that met in Philadelphia in April with the bioengineering objective in mind (the American Society for Artificial Internal Organs), we had some 900 mixed kidney and heart researchers and engineers at an annual scientific meeting. At the same meeting this year, we had registered 1,374, almost half again as many. The exhibit doubled, the papers, and the abstracts increased from the preceding year. So the rate of growth is geometric.

Mr. FLOOD. Very good.

Dr. SCHREINER. But our prime interest for the Kidney Foundation, as you know, is that we would like to see stimulated in this area the five-point program: One, of research; two, of training; three, of prevention; four, of what we would call development research, and that in research in the delivery of applications of medical care, and ,last, of course, the direct benefits for patients.

I did summarize some of these thoughts in an address in New Orleans, of which we have given you a copy.

I think the first paragraph is something that you would be sympathetic with.

So we are concerned that all of these areas be moved along. In a field that is growing this fast, it is important not only to have motion in a particular area but also to have balance in the overall development. Nephrology is a new field. As you know, we do not have much subspecialty recognition; we do not have an institute, we do not have any board of certification among the medical specialists. It is a totally new area of medicine and for this reason we feel it is important that the programs we support be stimulated in as balanced as possible a fashion.

We would like to stress that all five of our objectives go along together. We see as the long-term solution to the patient care and the developmental problem something along the lines of that which was stated in the Roybal-Jackson bill which is in the hopper, but we realize under the present scheme of economy that there may be some difficulty in implementing that type of a measure in the very near future.

Mr. FLOOD. That is an understatement.

Dr. SCHREINER. I hope it is not too much of an understatement but we do recognize the realities.

We do hope that you will see your way clear in the deliberations of the Appropriations Committee to stimulate supplemental funds, particularly in this area of developmental research and training, which we feel is necessary for a rapidly growing specialty.

The basic research and, for example, traineeship programs in NIH are well directed in this area, although we feel that they could be very well increased in virtue of the manpower needs which we have.

At the present time there is no real easy mechanism for doing the developmental type of research or for stimulating some of the experiments in prevention.

I think that is all I have to say unless you want some questions. Dr. Greifer has some ideas about some of the things that are going on which are rather stimulating.

STATEMENT OF DR. GREIFER

Dr. GREIFER. Mr. Chairman, I am happy to be here. As the medical director of the National Kidney Foundation, I have a unique opportunity in a way to travel around the country to see what is being done.

One of the things that has always been asked by not only Congress but by legislatures throughout the United States about our investment in research is, what does it produce and how do you in a sense evaluate the delivery of medical care? What parameters can be used?

In the kidney field we have a most outstanding example of some kind of measurement. Research, so poorly supported, has developed some unique machinery and unique treatment. This can be measured in fact that we say in reality. Both from the point of view of a physician and the point of view of a human being. Dialysis and renoplantation are in a sense extending life from absolute death. If delivery of these modes of therapy is finally made, we can take the developments of this research and the developments of the manufacturers of the equipment, the development of certain techniques in detection to the people for which they were produced, we can in a sense even name the individuals who will get this result. In fact, we were stating the other day in the Midwest that practically in any congressional district or legislative districts we can pick out those people who would be helped by appropriations in this field, the names of individuals who actually will be alive a year from now who would be dead under the present circumstances of nondelivery.

In other words, from the point of view of the deliverer of medical care and from the point of view of the consumer of medical care, the question that has always been asked by Congress and always by legislatures and always by people, what are the results of research? And I think we have produced results which are clearly visible.

I think the tragedy is that these results are not being delivered. For the first time in a sense throughout the States and through Congress, Congress which has said so many times, or individuals who have said so many times, what is the result of all of this research funds, and we say this is the result but it is not being delivered.

So I think the onus now is not on the medical profession. For the first time in a sense, the onus is on the Federal Government, in the

delivery of this care. So I think that the basic problem is that we are in the most unique position in medical history and that is of essentially changing absolute death to prolonged life.

I think the tragedy of our time is that only 5 percent or less of the population in need of it can receive this aid and that it can be measured. Every kidney patient can be identified who has or who needs artificial kidneys and transplantation.

Second, is that obviously with the great results in research, the cutting of funds for research will hamper again the delivery of this care because the only way this medical delivery can be made is through improvements in this technique.

In a sense we are charging Congress with the fact there is production in research in the kidney field, there are results of the research in the kidney field, there are methods of delivery in the kidney field, and all of this can be measured almost down to the individual. I would seek and really cajole some support, more than has been given to this field. I think that completes my statement.

Mr. FLOOD. Thank you.

STATEMENT OF MRS. SIDNEY ROSEN

Mrs. ROSEN. As a volunteer, I must say what Dr. Greifer said, this tremendous gap between the development of research and availability to the public, we do know that there are at least 100,000 people in the United States with kidney-related disease. If the money was available, at least 10,000 of these lives could be saved. We work and raise money and have done enough to do the real job and there is a crying need for this help to be had.

Mr. FLOOD. Thank you. We will try.

Mrs. ROSEN. Thank you.

Mr. FLOOD. Thank you, gentlemen.

Dr. SCHREINER. Any questions?

Mr. FLOOD. No.

Dr. SCHREINER. Thank you very much for having us.

Mr. FLOOD. Thank you.

WEDNESDAY, MAY 1, 1968.

GALLAUDET COLLEGE

WITNESSES

DR. LEONARD P. SIGER, PROFESSOR OF ENGLISH, GALLAUDET COLLEGE
JAMES A. OSTER, SENIOR, GALLAUDET COLLEGE
J. J. DUNLEAVY, FRESHMAN, GALLAUDET COLLEGE
BRENDA CLARK, SOPHOMORE, GALLAUDET COLLEGE
MARK HARRIS, JUNIOR, GALLAUDET COLLEGE
FRED B. WALLACE, JUNIOR, GALLAUDET COLLEGE

Mr. FLOOD. Our next witness is Dr. Leonard P. Siger, professor of English at Gallaudet College whose appearance was arranged by another member of the committee on appropriations, Congressman Long of Maryland.

Dr. SIGER. May I bring my group to the table with me?

Mr. FLOOD. Yes.

Dr. SIGER. I have with me a group of people, each of whom has a very short statement to make. The order that we would like to follow, with your permission, so that we can go through and cover the topic as quickly as possible, is to begin with James Oster, who will introduce himself, then John Dunleavy from Boston, then Brenda Clark, then myself, and finally Mark Harris, from California. If that is OK, we can begin.

Mr. FLOOD. Yes.

Dr. SIGER. Jim.

STATEMENT OF JAMES A. OSTER

Mr. OSTER. Mr. Chairman, my name is James A. Oster of 200 East Colter Street, Phoenix, Ariz. I am a product of institutional upbringing from the age of 9. I am now a senior at Gallaudet College and an English major.

I come before you as a student and as an individual. I want to emphasize that there is a great gap in communication between every segment of the Gallaudet community, which I feel worsens as time goes by. Gallaudet College is now a campus of sheer isolation. Communication between administrators, faculty members, and students has deteriorated so much that we no longer find any way to air our views except to higher authorities such as the Committee on Appropriations.

Recently we invited two distinguished speakers on the Vietnam crisis. The dean of the college, a man named Dr. Detmold, tried to block the discussion by calling up the speakers and telling them not to come. It was all very embarrassing and disgusting for us because, although the lecture was a complete success, the panel was one sided. One speaker was there, but our guest from the State Department did not come .

I have experienced harrassments which I do not consider normal or appropriate. One campus officer, Mr. Kilroy, has often gone around telling people that I am a "kook." I have had little to do with him and have often wondered what's with him. But curiously enough, and this may be closer to his true mind, this same man has come to me and complained about the deans of the college.

There have been several occasions when I have wondered who will be competent to give references when I seek for jobs after graduation. At one point, I was informed that the administration of the college thinks my mental stability is "shaky." How much longer, may I ask, will I and other students have to put up with such nonsense?

As I see it, it will last as long as nothing is done to crack down on the communication gap. One way of doing something, however, is for you members of the committee to see to it that Gallaudet gets a deaf majority on the board of directors, faculty, and administrative staff.

Thank you, sir.

STATEMENT OF JOHN P. DUNLEAVY

Mr. DUNLEAVY. Mr. Chairman and members of the committee, my name is John P. Dunleavy. I live at 16 Lawrence Road, Swampscott, Mass. I am a freshman at Gallaudet College.

Before I came to Gallaudet College, what I expected was a clean place to live and decent food that you can eat. I expected a well-stocked library, because I do a lot of reading. But every time I return to the

college from Massachusetts, I get diarrhea. I have made trips to Washington before becoming a student at Gallaudet and on those occasions, when I stayed in a hotel or motel, I did not contract that disease.

The library has very few books that can be called up-to-date. Many were written about 1925—and probably haven't been touched since that time. The least they could do is buy some books that would interest the students. Very few of the undergraduate students bother going to the library unless they have to. It's not just from apathy, but because the library doesn't have books on the topics that they would be interested in.

I also expected, before I came to Gallaudet, some mature social life—not a lot of kiddy parties. The administration runs the place like a bunch of maiden aunts. At many other colleges, for example Catholic University, students are permitted to bring liquor to their room without fear of reprisal as long as they conform to the laws of the District of Columbia. At Gallaudet College I am faced with expulsion if I am caught with so much as half a can of beer.

These are criticisms; now for suggestions. First, I suggest that they get somebody who knows how to cook, not a bunch of rejected Army cooks. I wish they would hire some competent exterminators to do something about the cockroaches and rats in Ely Hall, where more than 100 students live. The custodial staff does the best it can, but the administration simply does not provide the manpower necessary to do the job. Second, remove from the shelves those books that students never touch and buy some books that the students would be interested in. Finally, I suggest that they loosen up the college regulations concerning liquor. I think it's OK if the college punishes a student for getting raving drunk on campus, but if a student is going to do a little social drinking—not hard drinking—it should be permitted; because we are not a bunch of brats in nursery school.

Thank you.

Mr. FLOOD. Thank you.

Dr. SIGER. Brenda?

STATEMENT OF MISS BRENDA C. CLARK

Miss CLARK. Mr. Chairman and members of the committee, my name is Brenda C. Clark, and my address is Route 7, Bowling Green, Ky. I am a sophomore at Gallaudet College.

I want to give you a picture of the social life at Gallaudet College. The majority of the students feel that it is pretty bad. To name specific things, we have a snackbar that closes at 5 o'clock and is closed all day Sunday. The only type of recreation that you find in the student union building is two pool tables and two bowling alleys. They are closed all during the day. For a long time there was no music. We just got a new jukebox, but it stays locked up in the recreation office, in the student union. The swimming pool is open only 4 hours a week, for the students. And that is our recreation program period.

We are supposed to have one party a month, but it doesn't always work that way, and we have had only three free dances this year with a live band, and that covers 7 months. The funny part of it is we paid $40 per student at the beginning of the year to cover recreation, and with 1,100 students, that's quite a bit of money. And we only have 800 of them left, and they didn't get their money back, so it must still be somewhere. Or is it?

Many of the students that I talked to have said it's fact they don't have money to go off campus for recreation, so they have to find it on campus. I talked to a freshman girl and what she said was really good. She said that Gallaudet College was nothing but a gossip factory and that student's opinions were repressed as if they were under the government of Russia. When Jim Oster, who is here today, wrote to Dean Phillips to get the basement of Dawes House for a student dancehall, Phillips said "No." And when you go to the student government you find out that it is not representative of the student body.

Now, as to solutions, money is not the problem. Because you have given money, and if you gave more to the college, as represented by Elstad, Detmold, and Phillips, it would still not help, because we wouldn't see it. I want the money to go to the students for their recreation program and not to the administration for them to use at their own pleasure.

Mr. FLOOD. Thank you.

STATEMENT OF DR. LEONARD P. SIGER

Dr. SIGER. Mr. Chairman and committee members, my name is Leonard P. Siger, I live at 214 5th Street NE. I have been since 1956 an English teacher at Gallaudet College. Every day of my association with the college has been a source of pleasure and satisfaction. I come before you, therefore, with a deep sense of gratitude for your past efforts in behalf of the college, and I hope you will make these sentiments known to the full membership of appropriations.

As you see, we do have deaf people who are concerned and articulate about the welfare of themselves and their colleagues in the academic community. I would respectfully ask at the outset of these brief remarks that they suffer no reprisal as a result of their expression of interest in the affairs of their college. The particular ax which I have to grind will become evident when I say that Gallaudet College today is an academic mediocrity.

This is no fault of the State school superintendents meeting at this moment in the auditorium on the campus of the college. I have had the good fortune of getting to know some of them through the years, and it is always good to see them again. Indeed, our beloved president, Dr. Elstad, was himself once a superintendent of the State School for the Deaf in Minnesota. The work that he did there for handicapped children is legend. At Gallaudet College, his every effort has been to build and to improve.

It was, accordingly, a tragic day in the recent history of the college when apparently he was stripped of all effective administrative power by the board of directors—with power being transferred to the lower office of the dean, in such violation of normal structure as this House would never tolerate.

The result of this unnatural transfer of power has been catastrophic for the educational program at Gallaudet College. The effects are readily seen in a shackled curriculum, nonexistent counseling, gravelike recreational facilities, a demoralized preparatory class, apathetic underclassmen, a tyrannical environment, and a downgraded athletic program.

Who are the deaf? They are our sons and daughters, mothers and fathers, cousins and friends. For their further education Gallaudet

College has been provided as the copestone of a national system. We do not come here this afternoon to ask you for college funds. Nor do we come to you with the expectation that you will institute a new and meaningful program of education for us. We ask only that you be aware that today neither freedom nor fairness has life on our campus.

But if we did have a request, it would be that such action be taken as to insure that the top control and management of Gallaudet College be in the hands of deaf men and women. I have no doubt whatsoever in my own mind that it is they who have the understanding, the capacity, and the will to redeem Gallaudet College from the moral squalor that has overtaken its top direction during the past half decade.

Mr. FLOOD. Thank you. Have you ever appeared before what we call the legislative committee as distinguished from the appropriations committee on any matter like this?

Dr. SIGER. No. I have been before Congress on roads but never before on education.

Mr. FLOOD. I meant on this specific kind of problem.

Dr. SIGER. No.

Mr. FLOOD. I am not sure that the students would understand this but I think you do. The kind of thing that you are addressing yourself to today deals, as you have well stated, with the administration of the college itself. It deals with the function of the deans and the faculty as administrators, the policy of the college as distinguished from the request for funds made by their spokesmen annually.

This is the Appropriations Committee. We cannot write law. Under our rules this committee can not act until there is a law, until there is what we call an authorization act. The Congress must first pass a law establishing something or other; and then if funds are required, in that very same law the Congress will authorize x dollars for whatever it might be. Our job is to appropriate funds as against the authorization, not to write law.

If in the appropriation bill we put one sentence which the Parliamentarian would construe as law, an objection by one Member would throw it out because it would be legislation in an appropriation bill, and that is contrary to the rules of the House. That is why this kind of problem is not truly a problem of appropriations. This is not a question, as you said, of money. This is a question of what can be done to change the course of conduct and the administrative procedures of this college. If the legislative committee saw fit to take jurisdiction over this kind of thing, then they could by law declare how this faculty should be set up, how the administration should be conducted, and so forth. Then this committee would act accordingly upon this congressional action insofar as the required money is concerned.

I think that you are in the right church but the wrong pew. This kind of statement belongs before the proper subcommittee of the legislative Committee on Education and Labor.

STATEMENT OF MARK HARRIS

Dr. SIGER. Would you like to hear Mark Harris next?

Mr. FLOOD. Of course.

Mr. HARRIS. Mr. Chairman and members of the subcommittee, I would like to tell you what happens to students at Gallaudet College. In February, I was in the infirmary for 4 days, complaining of lack of nutrition. I am not used to complaining, but a man my age should have the right to know his problem from the doctor. When I asked the campus doctor, there was no answer. He called the psychiatrist, Dr. Mackenzie, to come and see me. He couldn't find anything wrong with my head, so it must have been malnutrition, as I said the first time. Within 2 months after I came to the college, I lost 20 pounds.

I sent seven letters to top executives who I thought would help me, including the President of the United States. I also made out a petition with 500 names. As a result, Mr. Nance, the business manager, invited me into his office and promised me that I would be able to have a complete checkup to see what was wrong in front of witnesses. A few days later he turned me down. My question is, Who is boss at Gallaudet College and are students to be rejected each time?

For example, I took a special course in playmaking. One of the students wrote two short plays, and I was chosen producer. I tried to get in contact with every person who I felt would allow me the chance to use college facilities. Each one wanted to have nothing to do with it, including the top executives. Where does one go to get something started in education of the deaf or in the welfare of the students? Certainly not to President Elstad, certainly not to Dr. Detmold, who immediately says it's not possible, whatever it is.

My demands are not that demanding. All I really want is a decent meal a few times a day and a chance to pursue my line of academic interest. I am convinced that progress can be made but certainly not through the present system and the men in charge. And now their new high school is planned without consent or the slightest consideration for the college students, while the life of the college itself disintegrates. Perhaps a greater Gallaudet College with decent men able to initiate a higher and broader education is the solution.

STATEMENT OF FRED WALLACE

I also have the testimony of Fred Wallace. I would like to submit his testimony to you. He couldn't appear because he has a broken arm.

Mr. FLOOD. All right.

(The statement referred to follows:)

TESTIMONY OF FRED B. WALLACE, MAY 1, 1968 (SUPPLEMENTARY TESTIMONY)

Mr. Chairman, my name is Fred B. Wallace. I live at 2052 South 74th East Avenue in Tulsa, Okla. I am a junior at Gallaudet College. I wish to take this opportunity to put before you my thoughts on a problem at Gallaudet, a problem of great importance and the rectifying of which I feel would have the greatest beneficial effect on the higher education of the deaf in America or wherever else such a task might be undertaken.

First, I wish to make one point clear: I am not feuding with the administration or faculty, and they have not taken at this time any action against me to cause me to desire to submit to you critical testimony in that regard. My grades are such that, if my present level of work is maintained, I will graduate with honors. Coming from a family dedicated to the teaching profession, I have nothing but the highest regard for members of that profession. I mention all of this with the hope that you will understand that what follows is an honest and well-reasoned complaint and that I do not submit it to you out of a sense of "grinding an ax."

My grievance is with the curriculum of Gallaudet College. My feeling is that it bears absolutely no reality to the educational needs of the deaf. Specifically (*a*) language requirements. The idea, as commonly put forth in "oral" or "normal" colleges and universities, is that a foreign language will probably be useful to the student some day. This is, practically, nonapplicable to the deaf. We have enough problems with the Queen's English. When one considers that the deaf community's obvious difficulties in acquiring foreign language skill prevents many students from attaining their degree (because it is a rigid requirement), then you will understand how ridiculous the proportions of the problem have become. (*b*) Audiology. This course of study consists, speaking admittedly in general terms, of "confronting the student with his own problems." It is insulting. Teaching audiology, by requirement and not by volition, to a deaf person is like teaching art appreciation to the blind. It is rather like rubbing salt in old wounds. (*c*) Physical education. It must be remembered that the phenomenon of hearing impairment is often accompanied by other physical difficulties. There are a number of students, of whom I am one, who are on written orders from family doctors, regarding physical education activity. However, the administration does not see fit to excuse anyone, for any reason, from this "requirement."

In conclusion, my feeling is that the present administration has precious little awareness of the needs of the deaf, despite their many years of "service." They have ideas, perhaps, about making Gallaudet this and that kind of college. They wish to make Gallaudet College as much like an oralist college as they can—a proposition which is clearly impossible. Gallaudet College is different. It was founded on the proposition of difference and exists today, or must be brought again to exist, as a function of that concept. What is needed, clearly, is administration of the deaf by the deaf. As it stands now, the sources of authority are maintained by people who hear. The policies put forth by the college administration are indicative of the "oralist" leanings of these people. If higher education of the deaf, however, is ever to be anything but a mediocrity, then their education will have to be under the supervision of people sharing their own problems and outlook. This can be achieved if the administration of Gallaudet College is handed over to the deaf themselves.

Mr. Flood. Thank you very much.

Dr. Siger. Thank you, Mr. Chairman.

Thursday, May 2, 1968.

Food and Drug Administration

WITNESS

RUTH DESMOND, PRESIDENT, FEDERATION OF HOMEMAKERS

Mr. Flood. We will now hear from Mrs. Ruth Desmond, president, Federation of Homemakers.

Do you have a prepared statement?

Mrs. Desmond. Yes, Mr. Chairman. I would first like to introduce the ladies who accompany me. This is Mrs. A. I. Malstrom, board chairman, proud grandmother of nine; Mrs. Arnold Singer, our youngest board member; and Mrs. Fishbein, a charter member and mother of four active boys.

I do not know whether it will embarrass our youngest member; but she is the mother of two young children. She is a graduate of Maderia and Smith colleges.

With this background and an Army background, this young mother had her last baby at home with an obstetrician and a midwife and though the little baby is now over a year old, she is still nursing her. She looks so young and vital. We are so proud. This young girl, so well educated, from such a fine background, grinds her own wheat, makes her own fresh bread nearly every day. We are so pleased because usually it is said that only peasants do this sort of thing.

Of course, we are just delighted to have Mrs. Singer help the federation.

Mr. FLOOD. Is there something wrong with peasants?

Mrs. DESMOND. No; I think they are fine, but not status symbols.

I want to say further, Mrs. Singer has drafted the resolution which I will insert later. She is the secretary of our federation.

Mr. FLOOD. Please proceed with your statement.

Mrs. DESMOND. I am Ruth Desmond, president of the Federation of Homemakers, a nationwide organization of concerned as well as public-spirited individuals.

This is the ninth appearance of this organization before the members of your subcommittee to urge an appropriation for FDA—the consumers' agency—which will permit it to effectively protect the public. When federation officers first appeared here in 1960 FDA's appropriation was so meager, its facilities so inadequate, its staff so overburdened that the first citizens' advisory committee to survey its problems was alarmed for the well-being of the public—actually feared a national catastrophe. It has been encouraging to us to note the steady increase in FDA's budget these past years. We hope it will keep pace with the ever-increasing responsibilities and duties of this agency—responsibilities largely the result of technological progress.

Federation officers made appearances before congressional committees and wrote letters to Members of Congress studying the need for FDA's first laboratory-office building here in support of its construction. An economy-minded Congress appropriated funds for a facility which was outgrown by the agency before completion. Consequently FDA administration and its Bureau of Medicine are housed in office buildings in nearby Virginia. Many fine FDA scientists and staff are still housed at the South Agriculture Building and in temporary quarters.

It is a sharp disappointment to learn that construction has not yet commenced on the first FDA laboratory scheduled to be constructed at Beltsville, Md., on land donated by our Federal Government. Our officers had hoped construction would be nearly completed by now. May we point out that the health—physical and mental—perhaps the lives of the public depends largely on the protection this agency exerts? Its experiments, the techniques it develops—its appraisal of scientific research must be valid. It must have the most modern and precise tools—facilities.

In the matter of effects of pesticide residues on humans, especially infants and the unborn FDA research and conclusions are desperately needed to protect a captive public whose environment has been invaded with these modern chemicals. At the conference on biological effects of pesticides on mammalian systems—conducted by the New York Academy of Sciences last May it was emphasized that answers pertaining to genetic damage, cumulative effects over a lifetime, et cetera of persistent pesticides must be determined by our Federal agencies since it is apparent, after twenty years of use of certain of these, industry has made no attempt to obtain these answers.

Therefore we suggest that FDA be allocated sufficient funds to learn the effects of these persistent pesticides on mammals as well as to continue its present pesticide research. Because our officers read (Chemical Week; Food Chemical News; Chemical & Engineering News, NAC

News) of the ever-increasing amounts of economic poisions being applied by farmers in this country and now around the world, it seems essential for FDA inspectors to continue with no cutback in their examination of interstate shipments of fruits and produce to detect excess residues. Human errors in pesticide applications must not be discounted.

FDA has confirmed to our officers that its menus and methods in conducting its publicized market basket testing for pesticide residues have been improved over the past 4 years.

After the first publicity of the first market basket survey, this organization consulted with FDA scientists and learned that the particular menu selected was the one used to determine radioactive fallout in foods. And also it was the menu for a poor southern boy. It was not at all the average diet and contained very few fresh fruits, vegetables, lettuce, anything like that, and at that time, after the food was prepared for the table, it was all dumped into huge blenders, along with the beverages, even carbonated drinks, which could give an inaccurate result, we were told by certain scientists. So we were the ones who went there and complained. Probably because of the questions we raised, they now have more funds for these tests and they have a realistic menu. I was assured when I phoned FDA recently that it now takes these foods and has them prepared for consumption by humans by a diet facility. After preparation for serving they are divided into categories. All the dairy products are together, the meat products together, and the vegetables together. They are all separated into perhaps five or six categories in the blenders and not all dumped in one blender to produce a very optimistic result.

In 1958 officers of this group attended many of the Kefauver investigations of drugs, and later the Oren Harris drug hearings—also the Humphrey hearings—conducted after the tragic effects of thalidomide became known. When possible these same officers attend the Nelson drug hearings.

Senator Hart's recent hearings revealed the misuse by a certain group of physicians on the appetite-depressing pills resulting in deaths of certain patients. These same appetite-depressing drugs have been given routinely for more than a decade to the pregnant to keep the weight down and produce thin newborn. Yesterday our local papers had headlines such as this: "Bad Diet Found Stunting IQ of Unborn." Surely this calls for FDA study and reporting on these drugs when used to control weight gains of the pregnant. Perhaps these drugs should be banned for this particular use. Seven years ago, when my own daughter was expecting a baby, I met many young pregnant women on diets of 400 calories a day and less who were also taking these amphetamines. Often I have wondered if their babies were healthy on such a restricted program.

We were at a Red Cross baby education program for prospective young mothers to learn how to care for their first babies. This was where I met these young mothers to be. Some of them at 7 months did not look pregnant and I have often wondered about the health of their new born.

Many of these young women also were taking a physician-prescribed vitamin-mineral supplement which contained the vitamin K factor, now known to cause still births, jaundice necessitating several complete

blood transfusions, or mental retardation. It is our understanding this particular K factor is now eliminated from the supplement.

I must say I am certainly glad I went to the Kefauver drug investigations and also the Humphrey hearings on thalidamide, from testimony given at the Humphrey hearings I realized I had protected my own pregnant daughter.

I had misgivings about amphetamines and any drugs by a certain drug manufacturing firm. Her obstetricians prescribed amphetamines and this particular vitamin substitute supplement. They told her if she wanted to eat only 300 or 400 calories a day it was fine provided she took the supplement.

I checked with these obstetricians about both the calories and the vitamin supplement.

They verified the 400 per-day calories with the prescribed vitamin-mineral supplement.

Of course I would not permit her to take the brand prescribed since I have boycotted all of its drugs since the Kefauver investigation and I still am. If I had not attended the drug hearings and been forewarned, my daughter probably might have produced a baby that was mentally retarded. Federation officers are gravely concerned at the risks the public takes because doctors are so impressed by the talks of the drugs detail men.

This Federation supports wholeheartedly therefore the $2.4 million increase and the needed 85 new positions asked by FDA to continue its study of drug hazards, and to intensity drug-plant inspections.

We urge the Congress to allocate to FDA the funds it requires to work for control of *Salmonella* contaminations of our foods.

I know something about this. My mother is in a nursing home. We have noticed how they have changed now the dinnerware and are not giving these patients dried milk drinks anymore. They are giving them fresh milk. It is no doubt because of the *Salmonella* contamination—I recall the many so-called viruses that were going through this home. Probably they were caused by the dried milk drinks that were being given them. This is my suspicion.

A USPHS forecast states this particular contamination may not be under control until 1980. Through reading FDA's papers, trade journals, and attending congressional hearings where this problem was aired and other conferences—our officers are aware of the magnitude of this problem. Deaths of infants and the elderly in nursing homes as well as hospital patients have been attributed to contaminated eggs, egg drinks, and instant nonfat dried milk. Now we learn that even drain cleaners used in meat and poultry processing plants have been found to be contaminated with *Salmonella*. FDA has warned produce shippers not to use crates which previously transported live poultry—because of this contamination. Live chickens have this *Salmonella* and it can get onto our vegetables through reusing these crates. Cattle have been found on feed lots contaminated badly with *Salmonella*. Turkey is another product to be cautious about. Pet foods, children's candies—medicines—some have been found to be *Salmonella* contaminated. Only recently have our busy physicians started to diagnose correctly these illnesses—probably previously thought to be virus attacks. Along with the *Salmonella* problem this agency must work to keep under control staphylococcus,

shigella, and mycotoxin contaminations. Even to control aflatoxin mold. With ever-increasing use of frozen precooked foods in U.S. homes and restaurants—it is vital that these foods be free from said contaminations.

The public is aware, through a release by its USDA, that many people in this country of agricultural abundance are malnourished—some not because of low income—but because of poor food habits—bad selections of food categories. People who are on unbalanced diets for a lengthy period probably become under par in health and vigor. Surely these malnourished individuals require food free from the contaminations referred to; otherwise the consequences could be serious, even fatal.

I understand from Food and Drug that people who are weak, ill, could even have fatal consequences from *Salmonella* contamination. People who are in average health can throw it off after 2 or 3 days' illness.

For your personal reading I am including pages 137–140 of Morbidity and Mortality Weekly Report for week ending April 20, 1968. This shows the reported deaths from *Salmonella*. Dr. Goddard believes we have ever so many more than are reported.

Mr. Chairman, for several years now we have brought before the congressional appropriation subcommittees the problem of additives being permitted, apparently under the Food Additives Act of 1958, in infant foods, despite several warnings by the World Health Organization that such additives have no place in infant care. We wish, if they are needed, funds for FDA to set up a separate classification of additives to be permitted in infant foods. We feel the agency should appeal for a legislative amendment to this 1958 Additives Act if there is industry disapproval of changes in the FDA regulations and pertaining to this problem. We also urge that FDA have responsibility for additives and preservatives in infant meats; instead of the USDA. There is no scientific or moral justification for sodium nitrite in infant meats, especially when it is stated by USDA this preservative is used merely to give a pink coloring to the meat. I include for your reading and perhaps inclusion in the record this article "What's Cooking Overseas" in the February 5, 1968, U.S. News & World Report.

(The article follows:)

From U.S. News & World Report, Feb. 5, 1968. Reprinted by Federation of Homemakers

WHAT'S COOKING OVERSEAS

American firms whose business is food are trying out a wide range of recipes for success overseas.

In Spain, National Dairy Products Corp. has just gained a majority stake in Industrias Lacteas Leonesas, S.A., a dairy firm based in Leon. Now it is a milk-and-butter business. Eventually it is expected to add many other items in National Dairy's Kraft Foods Division line.

In Thailand, Foremost-McKesson, Inc., has scheduled a $1.4-million dairy-products plant in Bangkok. It already has a 79 percent share in a Thai fluid-milk plant.

In Australia and Italy, National Biscuit Co. has major expansion plans under way for its bakery ventures.

Also in Italy: H. J. Heinz Co. is scheduling a big new food factory to be completed south of Rome in 1969. One reason, says a Heinz executive: "The Italian baby-food market is growing dramatically, taxing our present capacity in Milan."

Heinz is prospering with baby food elsewhere, from Britain to Canada. It claims a nearly 4-to-1 lead over its nearest competitor in the Australian market.

"Corn Products Co. doesn't overlook the babies either. It began selling Gerber baby foods in Italy on an imported basis in 1967, already had them on the shelves in Britain, France, Germany. Two well-established local firms give the Gerber entries some trouble in Germany. But, overall, Corn Products labels the baby food potential "tremendous."

English per capita consumption of baby food is about 50 percent of that in the United States. In Germany, consumption is estimated to be about 50 percent of the English level—and in France, it is only 50 percent of the German rate.

Mrs. DESMOND. This reveals that our U.S. infant foods are invading European countries—a big push.

We wondered why everyone in Government and Congress whom we contacted about this baby food problem has remained completely negative and silent. It may be because of all this tremendous industry push. We are very upset that this problem of additives in infant food continues to exist.

Crib deaths of infants in this country occur in families of adequate income as well as those of low income. There are groups of parents forming local groups to study this mystery of crib deaths. It can be assumed they are not all caused by the same conditions or culprits. Some could be caused by respiratory infections, or allergies, or fumes—even spinal damage.

If there is need for funds, we urge that FDA be provided with sufficient to study advertisements, labeling, warnings of over-the-counter drugs. Frequently over radio or television comes the appeals for funds, contributions to organizations dedicated to preventing blindness. We learn that blindness is increasing swiftly in this country—especially glaucoma. People are enlightened as to need for tests—so that glaucoma will be detected in time for treatment. But there never is any warning to look at drug labels to see if a glaucome victim or glaucoma-prone individual is taking an over-the-counter drug containing either belladonna or atropine which would aggravate the condition or initiate it.

I would like to give you this, Mr. Chairman. Even our younger members find it hard to read the warning on that label. It was purchased by my elderly mother when she was about 85 and under treatment for glaucoma.

There is a warning not to take it if you have glaucoma. She could not possibly see it. I noted it, and took it away from her.

I hand you this package containing a laxative which can be purchased at any drugstore. Note the tiny print containing the warning about glaucoma victims. This particular laxative was purchased by an elderly woman being treated for glaucoma who could not read this warning but who had confidence in the drug manufacturer. These drugs are needed for treating certain illnesses—a calculated risk—but should belladonna and atropine be sold over the counter for colds, for indigestion, as laxatives—even as tranquilizers?

I do sometimes have to refer to the experiences of my family and friends. This is how average housewives discover problems from personal knowledge. Our members realize we must bring these matters to Congress.

My husband's battle with cancer introduced me to congressional committee hearings. I had read a book by a cancer authority, Dr. Sokolov, of Florida Southern College. He warned about the persistent pesticides, carcinogenic possibilities. When I called up Food and Drug, Mr. Janssen, then in public relations, said, "If you are so

worried about these matters, why aren't you over at the Hill, hearing a congressional committee on matters concerning cancer?"

I replied, "Well, I didn't know anything about it."

You see, I had gone to hearings before the House and Senate but never subcommittee hearings. I attended a Health and Safety Subcommittee hearing where scientists, physicians, and researchers, especially in cancer, were advising the subcommittee members on possible effects of chemical additives. From then till now, I have tried to attend congressional hearings dealing with health protection and appropriations for FDA despite the expense and difficulty of getting to them.

Mr. FLOOD. It is very inexpensive, expert advice.

Mrs. DESMOND. You are right there. I will tell my husband this; that is an excellent argument.

With regard to atropine and belladonna, they are needed for certain illnesses, especially ulcers.

Mr. FLOOD. Did you know at the turn of the century the great actresses used belladonna in their eyes to dilate their pupils?

Mrs. DESMOND. And I wonder if they suffered the consequences.

We are questioning should these be sold over the counter for colds, indigestion, laxatives, and even as tranquilizers, and if they are to continue to be sold over the counter, then should not the warnings be in print easily read for those suffering from glaucoma and other eye conditions? As a source regarding the eye hazards of taking atropine and belladonna: "A Manual of Pharmacology and Its Applications to Therapeutics and Toxicology," 1957, W. B. Saunders Co., pages 382–384. We also have learned that certain drugs predispose to eye cataracts, too. Yet the public is not warned.

From time to time scientists in the field of health present research which indicates that various items or substances in this modern world cause the destruction of vital vitamins in human bodies. Alcohol, as an illustration, taken in excess is believed to destroy certain B vitamins. Fumes from paints and toxic solvents may destroy vitamins—also excessive use of tobacco, or coffee to excess. Researchers claim there is proof that vitamin C is good in controlling certain infections and for strengthening blood vessels. Should not FDA learn if these experiments are valid?

It seems to us that humans living in this contaminated world are entitled to any information which will help them to survive these environmental risks with a maximum of buoyant health.

Mr. Chairman, a member phoned me this morning and said, "Tune in channel 4; Ralph Nader is on."

I tuned in on "Today" and it was toward the end, sorry to say, of his comments, but it is really the one which would be most interesting to us, where Mr. Nader called for young lawyers just getting into practice to pursue this aspect of public service. He was questioned how they would be financed. He replied the money could come from consumer organizations, or it could come from foundations. This we were simply thrilled to hear because it has been a worry to us where the public would find experienced, dedicated lawyers to speak in its behalf at congressional and FDA and other pertinent hearings. We had learned through our participation in FDA hearings that certain attorneys for special interests assist congressional committees in drafting so-called consumer legislation, then help regulatory agencies write the regulations for enforcement and then return with their clients. This is cer-

tainly unfair to consumers who cannot even afford such expert legal advice.

This is a real problem. Perhaps the following suggestion could help remedy the situation:

Whenever a special industry or group of manufacturers wish to "cooperate" with FDA they usually suggest an advisory committee composed of members in their specialty and FDA specialists, scientists, ecetera. Only recently such a committee has been suggested by manufacturers who attended FDA's conference on "indirect" additives. Never is there any suggestion made that representatives of consumer organizations be on such advisory committee. Frequently FDA administrators are questioned closely by chairmen of congressional committees to ascertain if they are cooperating with the industry or manufacturers involved in the legislation under consideration. Again, never is there any query about the consumers' representation.

We suggest that there be formed this coming fiscal year a Consumers' Advisory Committee by FDA with adequate funds allocated for its functioning. This Committee would represent the consumers' interests. It is strange that this agency which must protect the public's health and endeavor to prevent food adulteration as well as contamination does not already have this type of advisory committee to stand back of its efforts to enforce consumer protective regulations. The type of Consumer Advisory Committee suggested would be composed of dedicated and public-spirited individuals who would serve without compensation—except expenses when attending meetings.

We would like to suggest names of individuals to serve on this FDA Committee: Ralph Nader, consumer advocate; Wilhelm C. Hueper, M.D., cancer authority; Morton S. Biskind, M.D., recognized allergist; Eloise Kalin, M.D., allergist; Francis Silver, consulting environmental engineer; F. J. Schlink, president, Consumers' Research, Inc., C. Beatrice Trum Hunter, writer and lecturer on consumer problems. Mrs. A. I. Malstrom, board chairman, and Mrs. Arnold Singer, secretary of the Federation of Homemakers together with officers of other recognized consumer organizations.

It is the feeling of this federation's officers that this regulatory agency which must enforce legislation passed by the Congress and cooperate with manufacturers of the products it must regulate—yet somehow manage to protect the public and safeguard it from exploitation—should have the advice, cooperation, and backing of a group of dedicated consumers. The composition of the suggested Consumer Advisory Committee comprises experts in certain fields together with grassroots consumers who have served the public's interests. A consumer committee of this composition would show compassion for the sensitive and allergic individuals who are steadily on the increase. This suggested committee could be helpful to the agency in drafting labels for consumer products—keeping in mind the need for the purchaser to have full information in order to make wise food or drug selections.

At this time I would like very much to have included in this statement the resolution passed by the board of management of this federation last June 9 on the need for specific labeling of food additives.

I think this is very important, Mr. Chairman, because when we attend conferences of the Food and Drug Law Institute—and these are very knowledgeable people—they are always speaking to the effect that the Food Additives Act means that all our additives are safe and there

is no need at all to have any labeling of products on food for which a standard is passed.

This is completely ignoring the fact that physicians write in to Food and Drug constantly saying they need more information in order to protect their patients.

Mr. FLOOD. Thank you very much. The resolution will be included in the record at this point.

(The resolution follows:)

RESOLUTION

Whereas consumption of food additives has grown more than 50 percent in the years 1955 to 1965, and it is estimated this use will increase to 1.03 billion pounds by 1975, and

Whereas the Food Additives Act of 1958 exempts all additives that have been "generally recognized as safe" (GRAS) prior to this act, and thus FDA has not set tolerance levels for these additives; and

Whereas many individuals may prove to be sensitive or allergic to additives proven "legally" safe—such as antioxidants for preserving fatty emulsifiers; and

Whereas the medical profession cannot protect these allergic persons if complete, specific information is not given on the label of each product; and

Whereas every consumer has the right to be fully informed regarding the specific kind and nature of the ingredients including processed food ingredients used in preparing food products sold or offered for sale in all channels of trade; now, therefore, be it

Resolved, That the Board of Management of the Federation of Homemakers, a nationwide group of public-spirited individuals, deems it most urgent and therefore requests that all food ingredients, including food additives, no matter how insignificant, be listed clearly in specific terms on said food labels, even when a standard of identity has been established, to inform the public and to safeguard its health.

CAROL MOORE MALSTROM,
Chairman of the Board.
RUTH GRAHAM DESMOND,
President.

JUNE 9, 1967.

Mrs. DESMOND. We do hope, Mr. Chairman, this Consumer Advisory Committee will have serious consideration. We do not see how this Agency can protect us without it.

HIGHER EDUCATION ACTIVITIES AND BROYHILL AMENDMENT

WITNESS

JOHN F. MORSE, DIRECTOR, COMMISSION ON FEDERAL RELATIONS OF THE AMERICAN COUNCIL ON EDUCATION

Mr. FLOOD. This is Mr. John F. Morse, who is the director of the Commission on Federal Relations, representing the American Council on Education. I see you have a statement, Mr. Morse. How do you wish to proceed?

Mr. MORSE. Mr. Chairman, I have discovered that when I summarize I take much longer than when I read a statement.

Mr. FLOOD. You may proceed then.

Mr. MORSE. Mr. Chairman and members of the subcommittee, I am John F. Morse, director of the Commission on Federation Relations of the American Council on Education.

The American Council on Education, speaking in behalf of 1,284 junior colleges, colleges, and universities and 251 associations con-

cerned with higher education in this country, feels it must express its grave concern over the inadequacy of proposed funding for certain programs essential to higher education.

Since the passage of the National Defense Education Act in 1958, three administrations and six Congresses have affirmed, through formal statements and a series of legislative enactments, a belief that the future strength and indeed the long-term defense of this Nation depend on a strong and expanding system of higher education.

We are just as aware as other segments of our society of the terrible pressures on the Nation's resources created not only by the Vietnam war but also by competing demands on the home front. But to seek to relieve those pressures by imposing a starvation diet on the institutions which have played so large a part in building the economic strength of this country occurs to us pennywise and poundfoolish.

In particular we would focus on two programs which we in education and you in the Congress have always accorded high priority. The first is the academic facilities program. Last November, the Office of Education stated that academic space per student in colleges and universities is definitely the lowest since 1952 and probably the lowest at any time in our history. Subsequent to that statement, facilities funds were cut for the current year by one-third and the budget request for 1969 proposes still further cuts. Funds available in fiscal year 1968 are approximately $639 million short of need as indicated by applications. Furthermore, it is estimated that in fiscal year 1969 the fall-short for title I alone will be $400 million if no more than the funds earmarked in the President's budget is appropriated.

It may be helpful to remind the committee that funds appropriated this year will not, in general, result in buildings until 1972. By that time enrollment projections indicate that full-time equivalent enrollment should increase from the current level of 5.4 million to 6.7 million. Without major help from the Federal Government we see not the slightest possibility of being able to provide space for that number. The decision this committee makes now will have no effect on current college enrollment—nor on next year's expenditures. But it will have a profound effect on 14- and 15-year-old youngsters now in high school who are looking forward to a chance for higher education when their turn comes. It will also have a profound effect on men now in Vietnam who, ironically, will have the benefits of the new GI bill and face acute competition for opportunities to use these benefits.

The authorizations for academic facilities in fiscal year 1969 total $1.45 billion. Even though it may be unattainable in view of the other demands on the budget, we believe this figure to be a realistic reflection of actual need. The very least we would urge is a return to the appropriation level of fiscal year 1967, consisting of $453 million for title I grants, $60 million for title II grants, and $300 million for title III loans.

A second area of major concern is the inadequacy of budget requests for the three-pronged student aid program. During the current year the Office of Education fell short of funding the approved requests for the work-study program, the opportunity grant program, and the NDEA loan program by $80.5 million. Next year if only the amount requested in the President's budget is appropriated, the fall-short will be $142 million. Assuming an average student aid package of $1,000–

$1,500, made up of a combination of work, loan, and grant, there will be 100,000 to 150,000 able young people, fully qualified for college, who will be denied a chance to attend. Quite aside from the injustice of the situation, this seems an indefensible waste of scarce and greatly needed human talent—a talent that is not likely to be recaptured when these young people drift off into the unskilled and semiskilled labor force.

Let me make one more earnest plea, Mr. Chairman. High on our list of priorities for the future is adequate funding for the International Education Act. This has nothing to do with commitments overseas. It has nothing to do with the dollar drain. It has only to do with an effort to make an attack on our own national illiteracy about other societies and particularly non-Western societies. As a nation we are simply not prepared to cope with the international responsibilities that we have undertaken or that have been thrust upon us. With your permission I should like to insert in the record at this point a statement prepared by our Commission on International Education.

Mr. Chairman, this is the third time we have made a plea for funding for the International Education Act, at least at the token level requested by the President. This act underwent more searching scrutiny by the education committees of the Congress than any legislative proposal I have been familiar with. It was supported by substantial majorities in both Houses of Congress. We urge that sufficient funds be voted to breathe some life into the program with the hope that when our fiscal problems become less acute, we may set about accomplishing the objectives the Congress had in mind.

Thank you, Mr. Chairman, for giving us this opportunity to express a few of our concerns.

Mr. Flood. Without objection, the statement referred to will be included at this point.

(The statement follows:)

Statement on the International Education Act—Commission on International Education, American Council on Education

The Congress has already given its support through authorization to the purposes of the International Education Act of 1966. The act has the broad and enthusiastic endorsement of the academic community. The problem before us is the implementation of the act through appropriations.

In our view, the argument for implementing this act rests upon the urgent need to increase the literacy of Americans with respect to the complex world which surrounds them. The objectives of the act are simply stated—to strengthen American colleges and universities in the area of world affairs, to the end of raising our people's competence. The need is critical.

It is not necessary to enlarge on the unprecedented position of power and responsibility which the United States now occupies in the world. What we do, or do not do, has the most profound effect upon mankind as a whole, and our own best interests are daily defined by that fact. There is, therefore, the highest possible premium upon the competence we bring to our actions. In the end, that competence depends upon a range of knowledge about other peoples culture, and their motivations which we do not now possess.

That competence is required of us not only at the decisionmaking level in public affairs. It is required of us throughout the broad electorate, upon whose endorsement, ultimately, every public policy depends. In our largely Western-oriented educational process, we simply do not now possess that competence.

Last December, this Commission posed a series of pertinent and specific questions in a published policy statement. We said, in part:

> Today, even if a detente were reached in Vietnam, where are the American skills and insights needed to help build a lasting peace in

all of South, Southeast, and East Asia? Where is the knowledge to help us act responsibly and viably in the tangled and attenuated struggles of the Middle East? Do we understand how partnerships can be worked out with and among the Latin American nations which will permit and encourage social, economic, and political viability? What is our understanding of how the Uinted States can cooperate with its traditional neighbors in Europe to achieve a lasting political and economic stability in the Western World? Do we visualize sensibly how the United States can best contribute to the effectiveness of the United Nations and its regional affiliates in resolving international conflict without violence and in attempting through multilateral actions to cut away at the sources of global unrest?

As educators, we are convinced that we cannot give honest, affirmative answers to such questions. We believe that the United States, in short, possesses wholly insufficient intellectual capacity to sustain the enormous responsibilities it now bears. In our own interest, as this Commission earlier summarized its view, "We must be able to command the competence required to do what must be done."

The administration's request for appropriations to implement this act is modest—$10,820,000. Although this is new money, it is extremely important to stress that it is not money for a "new" program; a program which we could afford to defer in view of other pressures upon the national resources.

The program is already underway in our colleges and universities, but on an entirely insufficient scale. All authorizations in the act are now represented among on-going institutional programs. Indeed, in an institutional survey recently undertaken by this Commission, virtually every respondent reported plans to strengthen such programs in the next several years. Furthermore, virtually every respondent anticipated drawing the bulk of the required funding from sources other than the IEA. But, every respondent counted on IEA incremental funding to bridge the gap between a partial and inadequate effort, on the one hand, and an adequate effort, on the other.

Where we now stand, it seems to us, can be fairly described in this way. The need is starkly evident. In the authorizing act, the Congress had laid down an extremely important statement of policy—that the national interest requires Federal support to strengthen national competences in world affairs. The colleges and universities have already taken basic steps in this direction without direct Federal help, but must have incremental Federal funding in order even to approach a level of effort commensurate with the need.

We find the claims of this act to high public priority exceedingly persuasive. America is not building a short-range future. Here, as elsewhere, the best guarantee of a nation's progress in a chaotic world lies in the cultivation of its human resources—in the caliber of a people's comprehension and competence as well as in the depth of a peoples' determination. Here, as elsewhere in the world, the catalyst is education.

In the balance of the national interest, as we see it, we intend to serve that priority as best we can; but we know that Federal support through this act can mean the difference between success and possible failure.

Mr. MORSE. Now, Mr. Chairman, I would like to make a supplementary statement which has nothing to do with appropriations as such but which is within the purview of this committee. I refer to the so-called Broyhill or anti-riot amendment written into the fiscal year 1968 act.

The 1968 Health, Education, and Welfare Appropriations Act contains a provision which bans "all payments, assistance, or services in any form" for services appropriate to the act "to any individual convicted in any Federal, State, or local court of inciting, promoting, or carrying on a riot or any group activity resulting in material damage to property or injury to persons. * * *"

The appropriation involves almost every field of education, research, and medical health services. The reach of the language is uncertain. Universities and hospitals must be concerned with its consequences. Contrary to the orderly administration of justice in the courts, the pro-

vision adds loss of educational opportunity, of health, and perhaps even of emergency medical care. The provision is contrary to the responsibilities of universities and hospitals for education, research, and medical services.

We believe the constitutional objections to this provision are serious and important, and the objections on grounds of public policy are overwhelming.

Universities and hospitals have neither basis nor facilities from from which they could ascertain results of trials in thousands of courts over the country. As a matter of fact no one could be certain as to the form of judgment or determination which would fall either within or without the statute. The fact that the provision also applies to subcontracts and even purchase orders, the latter running into hundreds of thousands per year, simply underlines the total impossibility of knowing how to administer or enforce it.

What is said here in no sense excuses riots, illegal disturbance, and the destruction of property. This Congress as well as the various States have provided criminal sanctions to be administered within the judicial system. Sound public policy must confine the determination and penalty to that forum.

We urge that there be no comparable provision written into the fiscal year 1969 act.

That is my formal statement. I will be glad to answer any questions.

Thank you very much for giving us this time.

Mr. FLOOD. Thank you very much.

Are there questions?

If not, we appreciate your testimony.

WEDNESDAY, MAY 1, 1968.

CONSTRUCTION OF FACILITIES FOR THE MENTALLY RETARDED

WITNESS

HON. ROBERT TAFT, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. FLOOD. We are now pleased to have with us the gentleman from Ohio, the Honorable Robert Taft, Jr.

Please proceed in your own way.

Mr. TAFT. Mr. Chairman and members of the committee, I am appearing here today asking the subcommittee to consider increasing the appropriation requested for the construction of university affiliated facilities of the mentally retarded from $6.6 million to $11 million. The Department of Health, Education, and Welfare advises that, if such an increase in funding occurs, it would be sufficient for funding in 1969 of all four approved applications for such university affiliated facilities. As the committee undoubtedly knows, the authorization for this appropriation exists under part B, title I, of Public Law 88–164 and under the mental retardation amendments of 1967, Public Law 90–170, which authorized $20 million for fiscal year 1969.

The usual custom of the Department of Health, Education, and Welfare, has been to fund approved applications in the order of their approval. As I understand it, the presently approved applications, in order of approval, are: The University of Wisconsin, Ohio State University, University of Kansas, and the Children's Hospital of Cincinnati. Present estimates from HEW indicate that approval of the budget request of $6.6 million, plus $1.6 million already appropriated but unexpended, would not provide sufficient funds for funding the Children's Hospital of Cincinnati. The Department advises that the total needed for funding all four projects would be $12.6 million, which would leave new appropriations needed of $11 million, after deducting the $1.6 million already on hand. To arrive at this $11 million figure would require an additional $4.4 million to the budget request of $6.6 million.

I would like to ask the indulgence of the committee for a few minutes to set out reasons why it would seem advisable to fund the Children's Hospital proposal in full at this time. I would like to submit for the committee's consideration as exhibit A, a pamphlet entitled "The Children's Hospital Medical Center Development Program." I would especially like to call to the committee's attention, pages 7, 8, 12, and 27, relating to the convalescent and services pavilion. The Children's Hospital project differs from many of the other facilities being funded under this title, in that the university affiliated clinical facility for the mentally retarded is included in a larger unit entitled "The Convalescent and Services Pavilion." The percentage approved as qualifying for assistance under this legislation is 60 percent, of which under the legislation, 75 percent would be the maximum Federal reimbursement. I point this out because the delay in this particular research facility will have the effect of delaying the work on the entire pavilion, of which this is an integral part. With regard to the summary of cost and funding on page 12 of the exhibit, it should be noted that the research building, which will be used in part in connection with the pavilion, has already been completed and is currently going into operation.

It should also be noted that the next to last item "needed from gifts and pledges in the funding of the Convalescent and Services Pavilion" has been totally underwritten and pledged at this time and a delay could result in the loss of some of these pledges, not to mention the fact that cost increases, which seem likely in construction work over the next few years, might well necessitate additional gifts and pledges and, also, possibly an increase in the application for funds under the Mental Retardation Act; and possibly under Hill-Burton.

In view of these factors, it is submitted that it would be false economy to delay the funding of this already approved project beyond fiscal year 1969. On that basis, it is submitted that an increase in the appropriation from $6.6 million to $11 million would be appropriate.

(The attachments follow:)

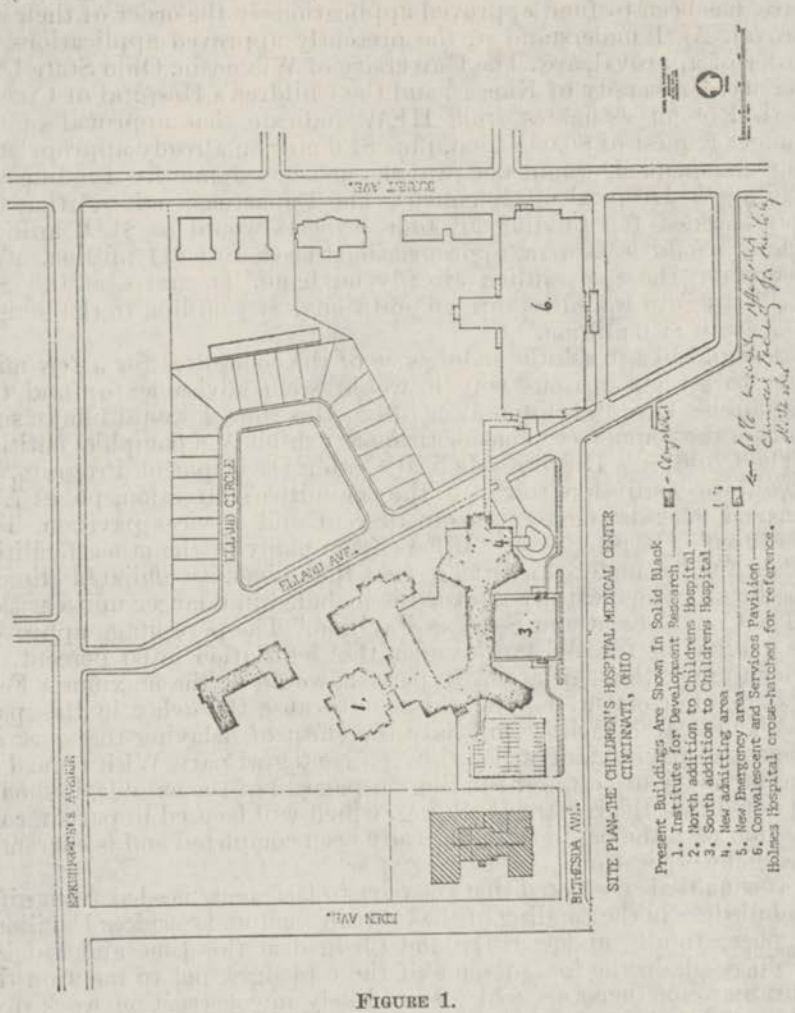

FIGURE 1.

THE CONVALESCENT AND SERVICES PAVILION

THE AGENCIES NEEDS

Six prominent child-care agencies of Cincinnati will be housed in a new pavilion in the Children's Hospital Medical Center. They are:

Convalescent Hospital for Children.
Hamilton County Diagnostic Clinic for the Mentally Retarded.
Neuromuscular Diagnostic Clinic.
United Cerebral Palsy of Cincinnati.
Cincinnati Speech and Hearing Center.
Children's Dental Care Foundation.

The several geographically separated facilities of the agencies listed above, as they presently exist, have resulted in—

Inconvenience to the patient and his family.
Difficulties in patient transfer.
Risk of patients not completing prescribed programs.
Risk of patients "falling between" agencies.

Inflexibility of services.
Incomplete services which are often disease oriented rather than patient oriented.
Disregard for the "whole child."
Neglect of other types of handicapping conditions.
Poorly balanced emphasis between services and community needs.
Duplication of some services.
Inefficient use of skilled personnel due to dividing time between several locations.
Housing of facilities in substantially inappropriate and overcrowded quarters which are often converted residences.
Restricted programs of professional education.
Reduced opportunities for research.

The new pavilion across Elland Avenue joined to the Children's Hospital will concentrate the services and programs of these agencies in a single building and become a vital segment of the Children's Hospital Medical Center.

The architects are Potter, Tyler, Martin & Roth of Cincinnati.

PROPOSED CONVALESCENT AND SERVICES PAVILION OF THE CHILDREN'S HOSPITAL MEDICAL CENTER

The convalescent and services pavilion will provide all of the agencies coming into the center with a new home planned for a maximum coordination of their separate activities. The new expansion and remodeling of the hospital proper will return greater benefits from the investment by supplying central services for the pavilion; including X-ray, laboratories, record library, accounting, food services, laundry, maintenance, engineering, etc.

As presently conceived, lower levels will house laboratories, diagnostic and treatment facilities. Just above the main clinics will be a floor devoted to special education for handicapped and convalescent children. The upper level will be reserved for longer term patients of the convalescent hospital.

The Children's Hospital Medical Center development program

COST AND FUNDING

Total cost of the medical center development (100 percent)	$19,709,390
To come from Federal grants (34.3 percent)	6,753,157
To come from agency assets, endowments, etc. (37.9 percent)	7,465,343
To come from gifts and pledges of friends (27.8 percent)	5,490,890

RESEARCH BUILDING

Cost:	
New building under construction (completed) (to house the Institute for Developmental Research)	3,040,000
Funding:	
Financing arranged: NIH grant	2,074,657
Other available funds	965,343
Total funding	3,040,000

HOSPITAL EXPANSION AND REMODELING

Cost:	
Architect's estimate for construction	8,008,390
Equipment	500,000
Total estimated cost	8,508,390
Funding:	
Hill-Burton grant awarded hospital	727,500
Endowment transfer to building fund	5,000,000
Total funding to date	5,727,500
Needed from gifts and pledges	2,780,890

The Children's Hospital Medical Center development program—Continued

CONVALESCENT AND SERVICES PAVILION

Cost:	
Architect's estimate for construction	$7,861,000
Equipment	300,000
Total estimated cost	8,161,000
Funding:	
From various agencies' endowments, sale of land, buildings, etc.	1,500,000
Hill-Burton (estimated grant)	300,000
Application pending with HEW	3,651,000
Total funding to date (pending)	5,451,000
Needed from gifts and pledges (underwritten and pledged)	2,710,000
Total needed from gifts and pledges	5,490,890

HAMILTON COUNTY DIAGNOSTIC CLINIC FOR THE MENTALLY RETARDED

PURPOSE

The Hamilton County Diagnostic Clinic for the Mentally Retarded was started in July of 1957 to provide a thorough evaluation of the mental and physical status of children and adults referred to it because of suspicious concerning their mental development. The clinic has grown rapidly since 1957; and, as a part of the Children's Hospital Medical Center, will expand its scope and operations into that of a university-affiliated clinical facility for the mentally retarded. The purposes of this new and expanded facility will be:

1. *Professionalist training.*—To expand the pool of much-needed professional personnel through university-supervised, interdisciplinary, educational programs for the specialized training of those persons and disciplines desiring to serve the mentally retarded of all ages.

2. *Patient services.*—To offer a complete program of outpatient and inpatient interdisciplinary programs for the habilitation and rehabilitation of mentally retraded individuals from birth through adolescence, and to develop mechansms for their transfer to adult programs.

3. *Research.*—To provide a university-affiliated research program in the field of mental retardation in conjunction with Childen's Hospital Research Foundation and the Institute for Development Research. The university-affiliated cliniial facility for the mentally retarded will eventually be able to complement and supplement the research program and the biological sciences of the Institute for Developmental Research by its own program of basic research in the behavioral sciences.

4. *Demonstration rograms.*—To provide projects demonstrating the new techniques and specialized services and diagnostic treatment, education, training, or care of the mentally retarded.

Mr. FLOOD. Thank you, Congressman. I do not think we have any questions. We know something about this.

Mr. TAFT. I am sure you do, sir.

Mr. FLOOD. Thank you.

THURSDAY, MAY 2, 1968.

FAMILY PLANNING

WITNESS

HON. JAMES H. SCHEUER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. FLOOD. We now have the pleasure of hearing our good friend and colleague, the Honorable James Scheuer, of New York.

Mr. Scheuer, I understand you have a prepared statement which you wish to insert in the record. That we will do.

(The statement follows:)

Mr. Chairman, I very much appreciate the opportunity to appear before this distinguished subcommittee this morning to discuss the subject of funds for family planning programs in the Office of Economic Opportunity and the Department of Health, Education, and Welfare.

It has been most encouraging to those of us who have been concerned with this subject to note the increasing receptivity of the Congress to the need and desirability of expanding family planning activity, both at home and abroad. This receptivity has been reflected in language authorizing or mandating Federal aid for family planning in the Food for Peace Amendments of 1966, the Foreign Aid Authorization Act of 1967, the Social Security Act Amendments of 1967, and the Economic Opportunity Act Amendments of 1967. I am proud to be the author of the amendment to the Economic Opportunity Act which made family planning a program to be given "special emphasis" within the community action program and it is to that program to which I wish to address myself first this morning.

Mr. Chairman, during the consideration of the OEO authorization there was considerable debate as to whether or not the Congress ought to authorize specific sums for specific programs or whether we should simply provide overall maximums to allow flexibility in what is still largely an experimental program. We decided to do the latter. However, in order to provide the agency with some guidance on which direction the program should take, we provided a list of "special emphasis" programs. These were programs which we felt had been most successful or which were particularly needed. The list included Headstart, comprehensive health services. Follow Through, and family planning among others. The committee felt that these programs were the ones most in need of expansion. We knew that funds were going to be limited. We expected that there would be enough money to permit some extension of these programs.

It didn't work out that way. As is well known, the appropriation bill provided a lump sum for OEO. There was not a specific appropriation for each title. The President decided to reallocate to the job programs in title I $124 million intended for the community action programs in title II. Since there was not enough money to continue existing title II programs, it became virtually impossible to get any money for new programs. Indeed, it took a major effort to get enough money to fund on an annual basis in fiscal year 1968 those family planning programs which started after the beginning of fiscal year 1967. There was no money to fund new programs or expand existing ones. The total allocated for family planning by OEO increased from $4.5 million to $6.5 million.

Mr. Chairman, this is a paltry sum for a program which has shown such an enormous return to society, in relation to the resources expended. A report by Arthur A. Campbell of the National Center for Health Statistics of the U.S. Public Health Service entitled "Family Planning and the Reduction of Poverty in the United States," shows that it costs about $30 to provide one woman with family planning services for a year. For each 10 women served, one unwanted birth is prevented. By a very complicated process, Mr. Campbell has concluded that each such unwanted birth prevented results in avoided expenses and additional earnings totaling $7,795. At a cost of $300, there is a cost-benefit ratio of 26 to 1. Mr. Campbell's report is dated June 1967. While both costs and savings have probably gone up in the interim, the cost-benefit ratio should remain substantially unchanged.

In addition, Mr. Campbell's statistics assume a normal child. However, since a large proportion of unwanted children are born to poor mothers, the recent report of the National Institute of Neurological Diseases and Blindness, indicating a relationship between prenatal malnutrition and the incidence of birth defects suggests that there are a large number of subnormal and abnormal children among unwanted births. The cost to society of caring for these children is incalculable. I do not wish to suggest that attempting to reduce the birth rate among the poor should be anything but an ancillary reaction to this shocking discovery. Our main effort must be directed toward eliminating malnutrition so that all babies will be born and raised with equal access to the opportunities offered by our society.

It is because most unwanted births occur among the poor that I feel that OEO is uniquely qualified to reach the women most in need of family planning services.

Just to make such services available is not enough. Clinics must be opened at times and places which make them accessible to the poor. The clinic must undertake a vigorous educational program to make the women in the community aware of the existence of the services. This is, of course, a logical extension of existing OEO programs.

A recent survey completed by my office reveals the following information regarding the communities' interest and readiness to start or expand family planning programs through local OEO agencies.

At the present time, 61 new proposals are awaiting funding. These proposals amount to approximately $5,128,795. Due to cumulative caseloads, existing programs in 105 localities are requiring increases amounting to 10–15 percent over their last year's funding figures. This requires an additional $625,000 annualization rate for fiscal year 1968. In addition, there are a number of existing programs (21) which have developed plans to extend services to a considerably larger group in need. These programs in attempting to meet the recognized demand within the community are requesting $3,174,000 in additional funds.

According to our survey, which reflects only our limited knowledge of the situation throughout the country, the total additional requests awaiting funding amount to $8,927,795.

For the information of those interested, I would request that the list, which is far from complete, be included at this point in the record.

(The list follows:)

NEWLY DEVELOPED PROPOSALS PENDING FUNDING

State	Community	Amount
California	Los Angeles	$935,000
	Orange County	50,000
	San Diego	127,000
	San Mateo	65,000
Colorado	Boulder	11,000
	Las Animas	32,000
Florida	Jacksonville	81,000
	Sarasota	24,000
Georgia	Columbus and vicinity	170,000
Illinois	East St. Louis	61,786
	Waukegan	43,963
Kentucky	44 eastern counties (Berea)	250,000
	Louisville	95,000
Louisiana	Ruston	15,000
Massachusetts	Several communities	350,000
Michigan	Detroit	100,000
	Flint	73,000
	Macomb County	31,000
	Monroe County	26,000
Mississippi	Ashland	2,415
	Clarksdale	64,148
	Jackson	127,000
	Senatobia	98,045
	Winona	59,806
	Zazoo City	56,411
Missouri	Springfield	5,775
Nebraska	Lincoln-Omaha	200,000
New Hampshire	Hanover	12,000
New Jersey	Camden	25 000
	Essex County	99,000
	Middlesex	20,000
	Monmouth County	75,000
New Mexico	Portales	11,052
New York	Dutchess County	4,000
	Peekskill	14,000
North Carolina	Sylva	11,262
Ohio	Columbus and vicinity	250,000
	Hamilton	35,000
Oklahoma	Guthrie	24,517
	Jay	85,301
	Lone Wolf	28,603
	Shawnee	23,691
	Stilwell	79,528
	Tulsa-Oklahoma City	125,000
Pennsylvania	Montgomery County	60,000
	Philadelphia	200,000
South Carolina	Aiken and vicinity	70,000
	Ridgeland	50,000
	Waterboro	175,000
Tennessee	Knox County	50,000
	Oak Ridge	44,000

NEWLY DEVELOPED PROPOSALS PENDING FUNDING—Continued

State	Community	Amount
Texas	Cotulla	$35,000
	Del Rio (Val Verde County)	28,400
	El Paso	71,092
	Henderson	45,000
	Level Land	15,000
	Lubbock	33,000
	Rio Grande	25,000
	Sequin	31,000
	Wichita Falls	109,000
West Virginia	Keyser	10,000
Total		5,128,795

EXISTING PROGRAMS CALLING FOR SUBSTANTIAL INCREASES

State	Community	Additional amount requested
Alabama	Huntsville	$23,000
Arizona	Tucson	100,000
Arkansas	Blytheville	21,000
California	Alameda County	70,000
	Santa Barbara	80,000
Connicticut	Bridgeport	10,000
Florida	Cocoa	246,000
	Miami	108,000
Georgia	Atlanta	49,000
Iowa	Statewide	700,000
Kansas	Kansas City	100,000
Louisiana	New Orleans	1,070,000
Michigan	Ann Arbor	15,000
	Kalamazoo and vicinity	100,000
	Muskegon	10,000
	Saginaw	15,000
New York	Suffolk County	267,000
Oklahoma	Stigler	16,000
	Altus	32,000
Texas	Fort Worth	32,000
Virginia	Statewide	110,000
Total		3,174,000

Mr. Chairman, the $13 million requested for OEO family planning activities includes only $6.5 million of new money. That amount will not begin to meet the need. It is the very least that should be appropriated. Furthermore, in order to avoid a repetition of this year's sad experience, and to insure that family planning activity will be increased, I think that it is absolutely necessary that these funds be earmarked specifically for this purpose.

I would now like to turn for a moment to Children's Bureau programs. The 1967 social security amendments included a provision which requires the States to make family planning services available to public assistance recipients who want such services. This provision will necessarily result in an increased need for such services to be provided by State and local health agencies and hospitals, both public and private. In addition, I think that one of the most effective methods of expanding family planning services is integrating such services into hospital obstetrical services. There is no better candidate for family planning services than a woman who has just had a baby.

The best vehicle for meeting these needs is the maternal and infant care project grants. The $18.5 million in new money requested for family planning is also a minimum figure which should be granted in full and, in order to avoid erosion, earmarked.

To indicate the need, I would like to point out that this is a new program, authorized less than 5 months ago. Guidelines have not yet been issued, nor are application forms available. Nevertheless, I am informed that the Children's Bureau has already received applications for grants totaling over $11 million.

Mr. Chairman, these are small programs which yield large dividends. They deserve the enthusiastic support of the entire Congress.

Thank you again for your courtesy in hearing me.

Mr. FLOOD. It is my understanding you have some comments to make.

Mr. SCHEUER. Mr. Chairman, I am deeply grateful for your courtesy in inviting me here to testify this morning. I will speak informally and briefly because I think my thoughts are fairly well outlined in the above statement.

I am delighted to appear before this distinguished subcommittee and its extremely distinguished chairman to discuss the subject of funds for family planning programs in the OEO and in HEW.

Congress has become increasingly receptive to the concept of family planning, as has the administration. I think the last four Presidents have expressed their support of family planning activity around the world 30 or 40 times in the last decade. The Congress has specifically included language on family planning activity in the Food for Peace Amendments of 1966, the Foreign Aid Authorization Act of 1967, the Social Security Act Amendments of 1967 and in the OEO Amendments of 1967.

I was the author of the amendment to the OEO which made family planning a special emphasis program. That amendment was reported out of the committee and passed by the Congress with absolutely no dissent at all.

I want to urge as strongly as I can that the very, very small budget proposed for family planning in OEO, including the $6.5 million of new money, be maintained.

First of all, I doubt if there is an expenditure anywhere in the whole Federal Government that has a higher cost-benefit impact than family planning.

Arthur Campbell of the National Center for Health Statistics of the U.S. Public Health Service, in a study entiled "Family Planning and the Reduction of Poverty in the United States," indicates that it costs about $300 a year to prevent one unwanted birth. Apparently it is necessary to give family planning or birth control services to 10 women at a cost of about $30 a year per woman to prevent an unwanted birth.

In terms of expenditures for the child through the age of 18, they avoid any additional money that the mother can earn through not having that additional child, Dr. Campbell estimates that value of avoiding that birth for that family is about $8,000. That means the cost-benefit ratio to the family is about 26 to 1. In other words, for every dollar we invest in family planning, a poor family has a $26 return now. There is no other program in the poverty program, and no other program I know of anywhere in the whole Federal hierarchy for expenditures that has such a fantastic cost-benefit ratio. That doesn't even count the benefits to society from avoiding the unwanted birth. It is quite apparent that much of our juvenile delinquency, much of our educational disadvantage, much of our crime on the streets, a very large proportion of our mental retardation and our emotional disturbance in children, occurs among those who come from poverty families with a large number of children.

The benefits to society in terms of avoiding expenditures a decade or a decade and a half hence, for problems of juvenile delinquency, various institutions for children who commit serious crimes, the cost of probation, parole, correction, rehabilitation, and the cost of institu-

tionalizing children who are mentally retarded or emotionally disturbed is almost incalculable.

This is a most compelling justification for these excessively modest programs. I wish that family planning programs were 10 times as large as what is proposed here.

At present we are only serving about 10 percent of the low-income mothers in childbearing years who need family planning services. All of the programs in OEO and in HEW taken together are desperately, painfully, and shamefully inadequate.

I would urge this committee to make at least a small and, hopefully, a promising beginning by approving these desperately inadequate and paltry new fundings.

Mr. FLOOD. I might say you certainly have a command of your subject. Many who appear here do not. Thank you very much.

Mr. SCHEUER. Congressman, you are one of the great and noble Members of Congress to whom I have looked for counsel and guidance since I first came here 3⅓ years ago and perhaps I have learned well from you. I am flattered by the thought that I have.

Mr. FLOOD. You are very kind.

Mr. SCHEUER. Thank you very much, Mr. Chairman.

Mr. FLOOD. Thank you.

THURSDAY, MAY 2, 1968.

COMMUNITY ACTION PROGRAMS

WITNESS

HON. EARLE CABELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. FLOOD. We now have the pleasure of hearing from our good friend and colleague, the Honorable Earle Cabell.

Do you have a statement, Mr. Cabell?

Mr. CABELL. I do not have a statement. I have a chart here, which I would like to put in the record, if I may.

Mr. FLOOD. We will do that.

(The chart follows:)

TOTAL OBLIGATIONS RECORDED FROM JULY 1, 1964, THROUGH NOV. 30, 1967, FOR CAP, SUMMER HEADSTART AND WORK EXPERIENCE, AS RECORDED BY OEO INFORMATION CENTER, WASHINGTON, D.C.

City [1]	Standard metropolitan statistical area population [2]	Standard metropolitan statistical area poor [1]	Community action program	Headstart	Work experience	Total obligated	Amount per poor person	June 30, 1967
Syracuse	564,000	63,000	$6,344,015	$615,108	$992,100	$7,951,223	$126.21	$115.72
Newark	1,689,000	247,000	16,894,018	2,237,937	6,095,977	25,227,932	102.41	91.65
Los Angeles	6,039,000	857,000	73,627,030	4,317,249	8,424,984	86,369,263	100.78	77.34
Detroit	3,762,000	637,000	33,852,481	3,874,793	8,273,761	46,001,035	72.21	68.47
Phoenix	664,000	231,000	10,059,197	2,213,275	1,438,201	13,700,673	59.31	----------
Atlanta	1,017,000	382,000	16,887,871	1,770,418	2,251,700	20,909,989	54.74	----------
El Paso	314,000	125,000	5,122,985	804,447	0	5,927,432	47.42	35.54
Houston	1,243,000	357,000	13,566,646	3,277,866	0	16,844,512	47.18	----------
New Orleans	907,000	529,000	6,399,127	1,582,347	1,241,652	9,232,126	17.44	----------
Dallas	1,084,000	356,000	3,641,836	339,025	0	3,980,861	111.8	10.17

[1] Listed in order of largest number of dollars per poor person.

[2] All figures for population are based on SMSA. Dollars reflected are for each city named and for the county in which it is located. Other cities within the countries may receive additional dollars.

Mr. CABELL. I will try to keep my comments as brief as possible in order to conserve your time.

I am not here to in any way suggest to this committee whether it shall increase or decrease the overall appropriation. I have been a supporter of community action programs, as the record will indicate, and of the OEO program, seeking to cure the cancer rather than to put a band aid on it.

However, I would like to call the attention of this committee to what we believe is a very serious inequity and discrepancy in the manner of allocating funds for the various community action programs. I think it was the intent of the Congress at the time the original poverty program was passed, to try to treat all areas as nearly equal as possible, insofar as its relationship to the total number of the poor is concerned, within the respective communities.

Now the present situation we are facing in Dallas—I have kept very close contact with them, because I felt a personal responsibility, and have sought to gain public confidence and public support—which has been accomplished. That Community Action Committee was rather slow, and deliberately slow, in asking for funding of their initial projects. They did not go out in a pell mell fashion and just try to grab money because it was available.

The projects were carefully screened and as a result, their first year or two pattern was not one of excessive spending. I could cite actual instances of where the State director would call the local director and say, "Look, you are going to lose some money if you do not get in here quick with a project."

Well, they were not about to resort to that, just because the money was available and then cook up anything.

Now, with any cuts that come, it becomes a percentage across the board, and those units that have been conservative in their approach and have been frugal, are penalized because of that frugality, because then they are cut in the same percentage ratio that others are, and you have, on the one hand, an excessively high amount spent per poor person in the area, according to the records furnished by OEO themselves.

Now I would like to call your attention, for instance, to this. Some of these figures may be challenged to some extent but they were furnished by OEO and they have not been challenged in any large amount.

Take the city of Syracuse. Up through November 30, 1966, it had funded $126.21 per poor person within that area. At the bottom of your list, here, is Dallas, which is my county and district: $11.18. Now there is a spread that is absolutely just incomprehensible.

I would call your attention to the handwritten figures, at the extreme right-hand side of the chart.

These are the amounts funded up through June 30, 1967. Your column to the left is that funded through November 30, 1967, or just 5 months later.

Now here is the dangerous connotation of these fundings. This is getting out and getting among the people, the workers, the poverty program people.

If you do not have a first-class riot, you are going to get no money. The facts bear this out.

Look at the jump in these areas where they had trouble in the summer of 1967. You jumped $11 per person in the city of Newark. In other words, there was $11 per poor person more funded, additionally for the 1968 year, more than had been allocated or funded for Dallas for the entire 3-year period.

You have a similar jump in Syracuse. You had an $11 jump in funding between June 30, 1967, and November 30, 1967. You had a $23 jump in the city of Los Angeles. Well, there was only a $4 jump in Detroit.

You had a $12 jump in El Paso.

That is just a mad scramble, obviously, to provide funding to a squeaking wheel, instead of an honest, valid attempt to make an equitable distribution. Because I would assume that using the same criteria, the poor people of one area should receive an equal amount of attention to the poor people of another area.

I cannot find any valid reason why that should not be the case.

I very sincerely ask your consideration of these facts.

Now if this were made known to my newspapers, it would kill the public support for OEO in my area, because they are not about to stand still for their taxes, their pro rata part, being as inequitably distributed. They can do this job on their own, if they were not having to pay taxes for these others who are getting 12 times as much per poor person as is being returned to them.

That is my story, Mr. Chairman. That is the purpose for my coming before you here.

Now this might fall in the realm of legislation which, of course, is forbidden to the Appropriations Committee.

Mr. FLOOD. Have you talked to the Washington Office of Economic Opportunity people about this at all?

Mr. CABELL. I talked at some length with Mr. Shriver. I do not have the articulation to put up much argument with Mr. Shriver. He is too fast for me.

Mr. FLOOD. However, he is not there any more. Have you seen Mr. Harding, the Acting Director?

Mr. CABELL. I have not seen him. The change has been so quick and there has been so much going on that I have not had the opportunity. Generally they will say, "Well, I haven't got my feet wet yet."

Mr. FLOOD. This fellow has his feet wet. He has many years' experience with the Federal Government.

Mr. CABELL. I will talk to him. But it is a shame for a unit that is doing a good job and which has tried to conserve, and not throw money around like a bunch of drunken sailors, to be penalized because of their efforts at being fair and honest.

Mr. FLOOD. Let me ask you this: How could you tell the difference between a bona fide case, as you present it for Dallas, and a case of sheer negligence where they just did not get off the ground? How would you know that?

Mr. CABELL. That has to be a matter of administration. There has to be some administrative discretion in there to be able to determine that. That is a very valid question and it is one that cannot be answered academically.

Mr. FLOOD. You are aware there are such cases where they come in a year late?

Mr. CABELL. Yes. I do not mean that those, or even the people in my area, that they should be backdated, but I do say it would be equitable where there is a functioning, efficient community action committee, that they should have new projects funded in preference to these others adding additional new projects that are already out of balance.

Mr. FLOOD. What do you mean by out of balance?

Mr. CABELL. I mean with reference to the funding per poor person.

Mr. FLOOD. Suppose city A, as bona fide as Dallas, they came in in time—they are identical with Dallas—and they have so many going programs. Now shouldn't they be continued?

Mr. CABELL. Not necessarily.

Mr. FLOOD. Why not?

Mr. CABELL. Because—and I think you will agree with me— that a program of this sort, anything that is an innovative as this, that there are bound to be , by the law of averages, certain programs that are not producing results. But the problem is getting anyone who has once started something and who has his hooks in it, to admit it.

That comes down to strong supervision, again.

Mr. FLOOD. Suppose city A gets off the ground in time with a program and is doing a good job. They have three programs that are sound and good and everybody admits it. They want to continue their programs.

It is a "gung-ho" outfit, they are red hot, they have been going well, and these are three good programs. They have been planning and they have been assured they will be able to continue these programs.

Shouldn't they receive the funds?

Mr. CABELL. In some cases I do not think it follows that they have to.

Mr. FLOOD. Well, why should they be penalized?

Mr. CABELL. If you have three children in your family and you are hard put to make both ends meet and then the fourth one is born into the family, are you going to say, "Well, now, we cannot cut back a little on the other three in order to let this new one have some food."

Mr. FLOOD. That is a valid argument.

Mr. CABELL. I think that you have to judge those things on their merits.

Mr. FLOOD. Thank you very much.

We know the problem.

Mr. CABELL. We know the problem, and I throw the solution into your hands.

THURSDAY, MAY 2, 1968.

SCHOOL ASSISTANCE IN FEDERALLY AFFECTED AREAS

WITNESS

HON. ED REINECKE, REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. FLOOD. We have now the privilege and pleasure of hearing from our friend and colleague, the Honorable Ed Reinecke, of California.

Mr. Reinecke, I see you have a prepared statement. How do you wish to proceed?

Mr. REINECKE. I would appreciate it if we could submit the statement for the record and I will make my comments as brief as possible.

Mr. FLOOD. That will be done.

(The statement follows:)

STATEMENT BY HON. ED REINECKE, OF CALIFORNIA

Mr. Chairman, the opportunity to testify before this committee today is most welcome, for I regard full funding under Public Law 874 as an essential item in the budget. The support of current operating expenses in school districts in federally affected areas has been one of the Government's most notable efforts in the field of education. It has enabled many hundreds of school districts to provide quality education to the children in their jurisdiction, despite the heavy burden imposed on them by Federal activities in the area.

The passage of this legislation in the fall of 1950 constituted tacit congressional recognition that the Federal Government has an obligation to compensate school districts suddenly and severely overburdened by a great influx of students or by a loss of tax base due to large-scale Federal activities in the area. In many instances the children attending these schools are the sons and daughters of servicemen fighting to defend this country. We cannot let them down. We cannot ask men to risk their lives in defense of their country, while refusing to educate their children at home.

The support of federally affected districts is a task which the government rightfully assumed and which now it cannot rightfully ignore. The continuing impact of Federal presence in many districts is attested to by the fact that the program has grown consistently since its inception. While some of this growth can be attributed to the eligibility of new districts and an increase in payments made, there are still many districts which have continuously received money under the program year after year since it began. The heavy burden of too many students and insufficient finances caused by the Federal presence has been regularly alleviated by Federal funds. The program has almost always been funded to the level of full entitlement, and school administrators have come to regard these funds as a relatively stable item in their budgets. Last year, because of cutbacks in Federal spending, many districts were left without funds they had planned on—and many were forced to sharply curtail operations or suspend them entitrely, because they did not have the money they needed. Even had they received all of the money which was originally appropriated, many districts would have been underfunded in fiscal 1968 for that appropriation of $416,200,000 was $70,155,000 short of the full entitlement of all districts. For fiscal 1969, full entitlement is over $500 million, yet the budget requests only $395,390,000. The same amount was spent last year, after the cutbacks were effectuated. Obviously, the same amount of funds this year cannot be enough to meet the needs of any district, as many will be receiving about 70 cents from the Government for every dollar of need.

While all school districts are going to be adversely affected by this insufficient funding, those areas which were hardest hit by last year's cutback will suffer most. I am thinking especially of districts where the majority of the children have parents who both live and work on Federal property. These districts have little or no tax base or source of other revenue from which moneys could be obtained to make ends meet, and "economies" at the Federal level are clearly disastrous to them. If appropriations for Public Law 874 must be below full entitlement for all districts, then I strongly support seeing that school districts which are predominantly on Federal property and a majority of whose students have parents living and working on Federal property receive as close to full entitlement as possible.

I would far prefer, however, to see all federally affected school districts receive full entitlement under Public Law 874 and have cuts made in other, less essential programs. Not only is there a tradition of Federal obligation involved here, but we are jeopardizing the very future of our country by whittling away thus at the foundations of its strength. Full funding for Public Law 874 does not mean simply "more icing on the cake" for eligible districts; it provides the bread and butter of their educational programs. "Economizing" on funds for Public Law 874 is a specious concept. It can only be extremely costly in the long run.

Whatever the ultimate decision on the amount of moneys to be appropriated this year, I believe it to be of the utmost importance that the appropriation made

here be final. Any future efforts at cutbacks in Federal spending should not affect Public Law 874 moneys. By prohibiting any cuts in this program once the funds are appropriated, we can at least promise school districts a stable sum for their budgetary consideration. It is the height of fiscal irresponsibility to promise support for a school's operating expenses and then, when the school year is underway and the moneys are committed, to cut off aid as was done by the administration under the discretionary authority legislated by Congress last year. By prohibiting such cuts in the program, school administrators will at least have the assurance that they are planning on a sure item in their budget.

Public Law 874 has been one of the most effective education programs of the Federal Government. It can continue to be so, but if we assure school districts of sufficient funds—and sure funds—for their needs. Mr. Chairman, I respectfully urge this committee to appropriate funds for Public Law 874 equal to the full entitlement of all eligible districts and to prohibit any future cuts in these funds, once appropriated.

As an appendix to my statement, I am submitting for your consideration the results of a Public Law 874 survey which I undertook in the 27th Congressional District earlier this year. I think these facts and figures, which were furnished by the school administrators, graphically reflect the adverse impact of budgetary manipulations on their educational programs.

Thank you.

Mr. REINECKE. Mr. Chairman, I am principally concerned about Public Law 874 and the funding of it. You are undoubtedly aware of the problems that we have had already this year in this regard, namely, that we did not get the funding through the conference and it is my understanding it is being reconsidered for funding under another supplemental. I have several areas in my district that are extremely heavily impacted; as a matter of fact, two school districts that are totally on military reservations.

Mr. FLOOD. These are bona fide impacted districts?

Mr. REINECKE. Yes, indeed. As a matter of fact, I sent questionnaires out to these various school districts requesting some data from them regarding the actual amount of funding that they depend upon from Public Law 874. The highest percentage that was returned was from the China Lake School District. This is on the Naval Weapons Center in China Lake, Calif. This is an isolated desert community, 70 or so miles from the nearest town of 5,000 or 6,000, yet this little community has 12,000 or 15,000 people in it and the entire school district is on the China Lake unit. Forty percent of their funding comes from Public Law 874. This is a class-A school district. The returns which I have here, six or eight of them, vary from 40 percent down to 1.85 percent, but I want to emphasize and try to reemphasize what I think is a real necessity, not only in the case of China Lake because I have other districts as well. Edwards Air Force Base falls within my district and that school district as well as outlying school districts where the breadwinner of the family is employed on the base, and yet the children may go to school in non-Federal——

Mr. FLOOD. I think you should know this subcommittee unanimously is strongly in favor of funding those districts which are under the original intent of the act. You should know the act has been stretched and prostituted beyond all reason. As far as this subcommittee is concerned, we believe strongly in the position that the bona fide districts connected with the bases must be taken care of as long as there is such a law.

Mr. REINECKE. It is the old question of priorities, I believe, and we are facing too many needs for the available resources that we have.

I recognize many problems are very urgent but I hope that we won't

in the name of expediency, take away what is, I think, a very sound, long-range solution to some of our fundamental problems. And the funding of these, particularly these class A 874 districts I think is mandatory. I would hope we would be able to get at least some funding for the other school districts that have, as you say, attached themselves to this law, but particularly those which are totally located on military stations, I think it would be a real crime if we do not act in the case of China Lake.

Mr. FLOOD. As far as this subcommittee is concerned, we could not agree with you more. We are not sure how we are going to cut up this pie, but you are 100 percent right concerning the "A" category, in the opinion of this committee.

Mr. REINECKE. I certainly thank the chairman and the committee for its attitude. I think this is extremely important and I hope somehow you will be able to prevail and establish priorities that will fund these items.

Mr. FLOOD. I hope you get your hope.

Thank you.

THURSDAY, MAY 2, 1968.

SCHOOL ASSISTANCE IN FEDERALLY AFFECTED AREAS

WITNESS

HON. CLARENCE J. BROWN, JR., REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. FLOOD. We have the privilege and pleasure of having our good friend and colleague, the distinguished son of a very dear and distinguished colleague, the Honorable Clarence J. Brown, Jr., of the great State of Ohio.

Do you have a statement, Mr. Brown?

Mr. BROWN. Yes, and I think if it is all right with you, I will let you read this at your leisure. It has some length to it and perhaps we can discuss the problem which you and Mr. Reinecke have already spoken to.

Mr. FLOOD. Without objection, your statement will appear in the record at this point.

(The statement follows:)

STATEMENT OF CONGRESSMAN CLARENCE J. BROWN, JR.

Along with a number of my colleagues, I am deeply distressed and concerned over the failure to provide adequate funds for the operation and maintenance of federally impacted school districts under Public Law 874 and for school construction under Public Law 815 in federally impacted areas. School districts all over the country which had included the full anticipated entitlement in their budgets find themselves seriously affected by the suddenness and poor timing of these cutbacks. Most of these school districts made up their budgets on the assumption that the total or full entitlement under Public Law 874, or nearly that amount, would be paid. In Ohio, for example, by law the school districts were required to submit their 1968 budgets by July of 1967. Now in the middle of the school year, these districts have no way to replace this money they expected to receive from the Department of Health, Education, and Welfare.

The amount which would have been required for fiscal year 1968 to fully fund the impacted school districts program would have been $486,355,000. Two reduc-

tions in this figure were made, the first by the Bureau of the Budget with the apparent acquiescence of the White House and the second by the Department of Health, Education, and Welfare (also with the apparent acquiescence of the White House) as a result of the congressional passage of an across-the-board 5-percent reduction in appropriations for the Health, Education, and Welfare Department. The Bureau of the Budget reduction apparently indicates the attitude of certain officials in the Department of Health, Education, and Welfare that such nonpolitical formula programs as Public Laws 874 and 815 should be replaced by the more politically flexible grant programs of the Elementary and Secondary Education Act.

Under the provisions of Public Law 90–218, which called for the 5-percent spending cutback in the HEW appropriation for fiscal year 1968, HEW could have avoided any cuts in Public Law 874 funds and made these cuts elsewhere, but it did not exercise this discretion.

When the urgent supplemental welfare appropriation bill left the House and went to the Senate, the other body, not restricted by the rules of germaneness, added the $91 million necessary to bring 1968 appropriations of Public Law 874 up to 100 percent.

As you know, the urgent welfare supplemental appropriation bill contained funds for Public Law 874 in the amount of a little over $20 million as it first came from conference with the Senate. The House concurred in this addition although an effort to reject it in order to get the full $91 million almost carried. This bill is now tied up in a conference committee again because the Senate rejected the conference comprise and is insisting on the total of $90,965,000, which will be required to fund all Public Law 874 applications for fiscal year 1968 at 100-percent entitlement under the authorization in the act. I urgently request the inclusion of this full amount in the regular fiscal year 1968 supplemental appropriation bill for the Department of Health, Education, and Welfare.

Under the provisions of the House-approved conference on the urgent supplemental appropriation bill, the $20,810,000 item for federally impacted schools would permit payment of 98 percent of the entitlements only under section 3(a) of Public Law 874. Section 3(a) of the law applies to children who reside on Federal property with a parent employed on Federal property, etc. But, many seriously federally impacted school districts have no 3(a) students at all; and in some of these federally impacted districts without 3(a) students, one out of seven of the enrollees is a class 3(b) student. For example, in my district, only two of the 22 eligible school districts have significant numbers of class 3(a) students and would receive funding under the urgent supplemental.

It is true that something must be done to correct the abuses of a too loosely drawn law to guarantee fair treatment to the deserving school districts. But, in the meantime, failure to fund these school districts and deprive the children of federally connected employees and residents of communities adjoining federally connected installations of proper educational means and facilities will truly result in hurting those students who need the help the most.

Representing the Seventh District of Ohio, which contains Wright-Patterson Air Force Base, my district not only contains the highest number of impacted school districts in the State but also receives the largest amount of impacted school funds in the State of Ohio. The cutback in Public Law 874 funds this year represents a loss of Federal money to schools in my district alone of $314,000. In some instances, this represents between 6 and 7 mills on their total tax duplicate. In one district, the Beavercreek School District, which has no 3(a) pupils, 25 percent of the pupils are children of Federal employees or 3(b) students. In the Mad River Township School District, 18 percent of their funds come from Public Law 874. In the Fairborn School District, the cutback in Public Law 874 funds of $100,000 amounts to 7 mills on the tax duplicate.

The Mad River Township School District in Montgomery County, Ohio (right next door to WPAFB) is a district with a low-property evaluation behind each student. A relatively small percentage of the federally connected students which Mad River counts for impact funds are 3(a) students. The bulk of the federally connected students in Mad River Township are the children of Air Force personnel or civilians employed at the base who are living off base in modest rental units or trailers. Many of these employees are transient and can look forward to only a brief assignment at the base. As a result, their investment in housing is modest by comparison to those who can look forward to residing in a location more permanently. Many of these people, of course, live in trailer homes or rent apartments or live in modest dwellings of a similar nature which do not con-

tribute heavily to the tax duplicate as would the homes of less transient people or those who have previously contributed to the tax base over a period of years. This same situation is true of many areas containing a large installation with a concentration of military personnel. In these cases, when adequate housing at the installation is not available, employees must take up residence in adjoining villages or communities. The school districts are then expected to construct schools, provide the teacher personnel, and enlarge the curriculum to accommodate these children.

While it is argued by objectors to this program that these extra Federal employees do bring in more commerce to the community although they do impact the schools, this is not always the case. These federally connected people, it has been found, spend their money internally; that is, they spend it on the base for groceries, post exchange items, entertainment, and other supplies, and actually do not, in most cases, spend their money in retail stores in the community, particularly the smaller communities which, in this instance, have been so severely affected by the cutback in Public Law 874 funds. When these people do shop in retail stores, they go into the larger towns and cities near the installations rather than the small communities adjoining or surrounding them.

Mad River Township School District in Montgomery County, Ohio, for calendar 1968, will have a budget of $3,833,610, of which approximately $695,000 or 18 percent would be its entitlement under Public Law 874. To receive only 80 percent of the Federal amount would result in a reduction in income of $139,000. In order to replace this loss this year, the district will be required to put on the ballot a 3.3 mills operating levy in addition to whatever levy it may be planning at present for the ballot this fall. The other choice for the school district, of course, is to increase its class sizes in order to reduce staff. It may also be forced to curtail specialized programs. One of these programs is a unique one in the neighborhood of Air Force installations, a program for neurologically handicapped children. Through the CHAP program (children having a potential), Mad River School District has become well-known through the Air Force for accommodating Air Force personnel who have children appropriate to CHAP's training.

Another school district, Beavercreek schools, which has seen an increase of more than double in its 3(b) Public Law 874 pupils in the last 10 years, advises me that as a direct result of Public Law 874 reductions, the Beavercreek schools will be forced to operate next school year with 11 fewer teachers than planned. This includes seven teachers scheduled to be employed for an expected increase of 200 pupils (25 percent of them Public Law 874 eligible) and four teachers from the present staff.

As a result of these cutbacks, school officials are presented with two choices. They must either approach the voters with a large tax levy against the individual property owner or order cutbacks in educational programs. If cutbacks are ordered in educational programs, sons and daughters of not only the local citizens, but our military personnel as well, will suffer. If, of the other hand, taxes are increased, the relationship in the community between the military families and the local citizens, who will know why they are being taxed more heavily, may be an unhappy one.

Certainly, our national economic situation warrants careful expenditure of our moneys, but why should we cut reliable and proven necessary programs to replace them with new untried programs in the education field? But, as the number of people in uniform continues to rise, the administration plans continuing cutbacks in Public Law 874.

The President, in his educational message, "The Fifth Freedom," sent to the Congress on February 5, proposes many new elementary and secondary education programs and does not mention Public Law 874. This apparently represents an attitude in the Department of Health, Education, and Welfare of preference for grant programs over nonpolitical formula programs such as Public Law 874—an attitude with which I do not agree. Therefore, at this time, I should like to draw your attention to the request for funds in the fiscal year 1969 Department of Health, Education, and Welfare appropriation bill (the same as fiscal year 1968) under Public Law 874 and urge 100 percent entitlement for Public Law 874 and its operation and maintenance programs. As I understand it, while the Bureau of the Budget has requested $395,390,000 for fiscal year 1969, 100 percent entitlement will require approximately $550 million or $154,610,000 more than the budget request.

During the debate on item No. 6, aid to impacted schools, of the urgent welfare supplemental appropriation bill, again and again Members of the House reiter-

ated the need for action in realizing the importance of education as it relates to the crises in our urban areas and elsewhere. It is, of course, of prime importance to provide new, more comprehensive, specialized programs for the education of our youth in this hour of crisis. But it would be foolish to neglect our federally affected areas and not to come to the aid of these school administrators who, nowhere near being caught up in new, innovative, remedial/specialized education classes, are struggling to at least maintain the same quality of education in schools where the school population has doubled and students are subjected to overcrowded, understaffed, poorly equipped classrooms and half-day classes.

These federally impacted school districts have the responsibility of educating the children of the residents of their communities and the unusual burden of educating the children of our Federal employees. This is not a burden which has come gradually or will leave any time soon. Because of the war in Vietnam, many areas have become federally impacted by leaps and bounds. Many of these school districts are faced with double (and more) school enrollments, and, possibly, decreasing Federal payments per pupil. Certainly, it is to be realized, in view of our present war effort, that defense establishments and military bases are being expanded, more and more servicemen are moving their families with them, and thus, the impact on the education system is still great and growing in many areas.

This should not result in inferior education for the resident of the community and our Federal employee. Should we ask our school officials to approach the voters with a large tax assessment which could cause resentment and pin on our military personnel a label of "second-class citizen"? Are we not asking enough for the military man and his family to pull up roots every 2 or 3 years and adjust to a new educational environment? He should not, in addition, be asked to subject his children to second-rate educational facilities.

The history of the funding of Public Law 815 providing construction funds in impacted school districts is similar to that of Public Law 874. I would urge the inclusion in the 1968 supplemental and 1969 regular HEW appropriation bill of sufficient funds to totally fund the Public Law 815 construction applications. Under Public Law 815, $87 million is required to fund all eligible school construction applications received in fiscal year 1967. Further, it is estimated that $80 million will be required to fund all eligible applications for fiscal year 1968, or a total of $167 million, the required amount under Public Law 815 for the 2 fiscal years. I am also informed that the requirements for fiscal year 1969 are $80 million.

Presidents Eisenhower, Kennedy, and Johnson have repeatedly recommended a reexamination of the Federal assistance to impacted schools program. I agree that this is long overdue and it is time for Public Law 874 and Public Law 815 to be revised and improved. This will be possible next year before the legislation expires on June 30, 1969. The original intent of the Congress to assist school districts which carried an unusual burden of Federal personnel has been abused by a liberalization of the legislation which loosely defines the eligibility requirements to include large and wealthy metropolitan areas. This impact legislation must be corrected so that large, wealthy systems which have received a very low percentage of increase in federally connected students and which have a very small percentage of truly affected students, and have high tax duplicates behind each student, will not receive money from this program at the expense of smaller systems with a lower tax base behind each student, a higher percentage of federally connected students, and a student population impact which is growing at a significant rate. Changes in the formula, with adequate notice to the schools being affected, would result in proper legislation thus eliminating districts where Federal funds are not justified by severe need as a result of Federal impact so that we can give fair treatment to those districts where the Federal impact is clear and severe.

Mr. BROWN. Now I would like to state a couple of examples to underscore what Mr. Reinecke was saying. I have a somewhat different situation than he. I have Wright-Patterson Air Force Base in my district.

Mr. FLOOD. I know about it. I know it very well indeed.

Mr. BROWN. We have two school districts closely related to Wright-Patterson which will be taken care of, or would have been by the action of the conference funding only 3–A programs. I supported that action

on the floor and did not join in the effort to reverse it on the theory that to do so might have jeopardized not only the 3–B students but the 3–A students, also. However, I do have not only in those two school districts which were benefited but in other school districts in that same proximity, some very serious impact problems.

Mr. FLOOD. Are they all contiguous?

Mr. BROWN. Yes; they are contiguous to the Wright-Patterson Base and then there are a couple which are not contiguous but because of the growth patterns in the area and transportation patterns, have very high percentages of 3–B students in their districts, and low tax resources. I think we would all agree that the basic problem is what has been done to this legislation over the years.

I met recently with the executive heads in my congressional district, school heads, to discuss this problem and suggested to them there were some school districts which were now receiving impact aid in such small amount, and because of such a small number of students, that they really could not legitimately argue that they had been deleteriously affected by the enlargment or the existence of Wright-Patterson Air Force Base in the area.

I would like to present a couple of arguments with reference to this problem, if I may. One is that when a base as old as Wright-Patterson Air Force Base—and it has been there for, as you know, a number of years—I think going back to the period right around World War I—on a base as large as that—when a base has been as large as that for as long a time, that perhaps there is no impact that still exists, because there is a chance for commercial development in the area and so forth which would tend to put a tax base behind the pupils in the area.

In point of fact, this is not the case at Wright-Patterson Air Force Base. While there has been some commercial development there is still a tendency as is I think usual on any military installation or near a military installation where service personnel and civilians live, for them to utilize the post exchange facilities at the base, and even to enjoy their recreation at the base. This is quite a large base with a golf course, with swimming facilities and a lot of other recreational opportunities, so that the area around Wright-Patterson and the area immediately adjacent to it, while it has grown in recent years, has not had the commercial and industrial development one might expect.

There is another reason for this, too, in the case of Wright-Patterson Air Force Base, and perhaps this is peculiar to Air Force installations but we have zoned the area around the base so as to protect the flight patterns and so forth so that they are not taking off and landing over heavy concentrations, shopping centers and that kind of thing, so that the school districts have been adversely affected by other actions taken by local governmental agencies to protect the interests of the base.

In addition to this, we have, of course, a change in the mix of people who come and go from this base. Now when there is an activity of an experimental nature, where you have a bunch of young service personnel come in with their young families, you get more of an impact in the area than you do if you have just a routine scientific activity going on at the base that continues over a number of years, and you have, you know, the accumulation of older people with children who have graduated and so forth.

We have a lot of people who stay at that base for some time, that is true, but we also have, when a situation like Vietnam comes along, a sudden flux of people into that area. So that these problems continue to exist, they continue to affect in particular the contiguous or adjacent school districts.

I personally feel that perhaps we could rewrite this legislation to require that a certain percentage of impact must be involved before the school would qualify, and that the change of impact should be taken into account.

In other words, the change of that percentage. If that percentage increases——

Mr. FLOOD. That would be a hard thing to write, would it not?

Mr. BROWN. I think it would be very difficult to write, but I think it would get at the meat of what we really want to accomplish with this legislation because I see no reason to count postmen and Members of Congress and congressional secretaries as part of the impact problem and, as in the case of Montgomery County, Md., you know they are going to be there and when you know that the change is not rapid, or when there has not been a change, say, for some time. This is a thing that we ought to try to do.

Mr. FLOOD. I wish you would take a shot at it.

Mr. BROWN. I have requested my school people in the area, and they have advised me that they will accept this challenge.

Mr. FLOOD. You do have a little different situation there.

Mr. BROWN. We have almost every mix that you can imagine. They have said they will try to sit down and come up with some recommendations in this area. I told them that if the people who represent this broad mix in my area can write legislation which they think is fair and the Congress also thinks is fair, perhaps we can be a little pilot area.

Mr. FLOOD. If something is not done about this program, very soon, we will have a real problem with it.

Mr. BROWN. I agree with the Chairman, of course. And basically when they add cities like New York, Los Angeles, and so forth, which have low impact, and they are going to get 80 percent of additional money that they never had before, they are delighted. They are not going to complain and carry on, but when I have a school district with a very low tax base that gets only 80 percent, these districts are obliged in my area to go back and ask their residents, their constituents for as much as 7 to 8 mills just to keep the program going.

We have one peculiar circumstance. The Air Force uses one of those congressional districts as a location—rather uses Wright-Patterson Air Force Base as a location the send Air Force personnel who have handicapped children because of a unique program that one of the schools in the area has started called the CHAP program, I think it is. "Children having a potential" is what "CHAP" stands for. That is faced with a loss of 874 funds. It has a choice between dropping the CHAP program, which will affect a few Air Force personnel but perhaps Air Force personnel who in the interests of the Air Force should have such a program, or going to its people who are not associated with the base and saying "give us more money so we can supply this particular need for the Air Force," and this is a difficult decision for them.

Perhaps there is no answer to the question.

I am hopeful this committee will give consideration to the problem. The approach of funding only 3–A students certain had some merit but perhaps an approach which would permit the funding of districts with high percentages of 3–B students, if there should be additional money available, might be a legitimate way to look at this problem.

Mr. FLOOD. I think you would try the classical Brown hand at this thing, if you can do it.

Mr. BROWN. With the help of the school people in my area and with the patience of the committee perhaps we can come up with something. It will have to be submitted to Education and Labor, as I understand, for the substantive legislation but I think that we can do it.

Mr. FLOOD. Thank you very much.

THURSDAY, MAY 2, 1968.

OEO LEGAL SERVICES

WITNESS

HON. PAUL G. ROGERS, REPRESENTATIVE IN CONGRESS FROM FLORIDA

Mr. FLOOD. We now have the privilege and pleasure of hearing from our good friend and colleague, the distinguished gentleman from Florida, Mr. Rogers.

Do you have a statement, Mr. Rogers?

Mr. ROGERS. Thank you, Mr. Chairman.

I just wanted to make a few remarks.

I have furnished to some members of the committee and I understand it has been, or will be, made a part of your record, a statement on my concern and the concern of the people in my area, on the OEO migrant legal services program.

(The statement follows:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., April 25, 1968.

DEAR COLLEAGUE: As we discussed by telephone this week, attached is a memo on the migrant OEO project, as well as some additional background information.

I can see no evidence of cooperation between the grant applicants and the local bar and civic groups prior to funding, and little if any since then. The few cases handled appear to have been ones which were eligible for "public defender" action, and the current Jamaican case would be in the "fee generating" category, so that most of their cases seem to be ones which are improper for them to handle.

Based on their poor record, questionable tactics, and excessive budget, I feel there is no reason to continue funding the program. Certainly the OEO budget and the national budget picture require more prudent use of limited funds available.

Kind regards and all good wishes.

Sincerely yours,

PAUL G. ROGERS, *Member of Congress.*

ATTACHMENT NO. 1.—MEMO ON PROGRAM AND CURRENT COURT CASE

Funded by an $800,000 plus OEO research grant, this organization was set up to provide legal services for some 80,000 migrant farm workers in a six-county area.

The grant was opposed from the beginning. The county bar associations and county leaders were not contacted in advance of the grant application, and have not had proper representation on the board of directors. The agency is controlled by American Civil Liberties Union attorneys from Dade County.

Contrary, to law, the agency has, on numerous occasions, attempted to give legal representation in criminal cases, although public defenders and legal aid societies are available.

One such case resulted from a labor dispute between Jamaican sugarcane cutters and farmowners on January 1, 1968. A group of the workers were arrested on riot charges, while others were returned to Jamaica.

The workers were represented by the West Indies Labor Federation—which represents them as well as the Jamaican Government in all matters with the U.S. growers.

At first, the South Florida Migrant Legal Services, Inc., tried to represent some of the arrested workers in regard to the riot charges. These attempts were protested by the labor organization which had its own attorneys on the scene. It was also a violation of the OEO law. It soon became apparent that, while everyone else was working to have the charges dropped and the men returned to Jamaica, the poverty agency wanted the case to proceed. The charges were dropped.

Not satisfied, the poverty agency then filed a complaint with the U.S. Civil Rights Commission, and then filed a civil damage suit against the sheriff and the growers for $750,000.

The merits of the dispute are not being questioned here. If the workers, or their representative, or their Government, wished to protest, or sue, that course remains open to them. The involvement of the poverty program, however, is a serious matter. Surely it was not intended by the Congress or the Administration that this organization involve itself in a labor dispute between Jamaican workers and U.S. farmers, give Havana Radio a new issue to beam to Jamaica, or put the taxpayers of Palm Beach County to the expense of defending one of their public officials against charges filed by an agency which also receives its funds from the taxpayers.

ATTACHMENT 2.—COPY OF LETTER TO OEO IN 1967 DETAILING OBJECTIONS TO BOARD REPRESENTATION. IT REFLECTS THAT NO LOCAL BAR ASSOCIATION EXCEPT DADE RECEIVED ADVANCE INFORMATION ON THE GRANT REQUEST, OR PARTICIPATED IN THE DISTRIBUTION OF BOARD MEMBERSHIP. THE BOARD WAS SLIGHTLY CHANGED, BUT THE RESULT WAS THE CONTINUED CONTROL FROM ONE COUNTY

APRIL 22, 1967.

HON. SARGENT SHRIVER,
Director, Office of Economic Opportunity,
Washington, D.C.

DEAR SARGE: You will recall our discussions during your recent visit in my office about the migrant legal service grant. My letter to you of yesterday was in further regard to this matter.

After writing you yesterday, I was advised by OEO that the legal service grant would be released. It had been my understanding that you and I would have an opportunity to discuss this further before any release was made, and I would like to have that opportunity at your convenience.

To briefly outline the history of this problem and my concern, you will recall that the original migrant legal service grant was to be made to the Hardiman group organized along the lines of the Community Action Fund, Inc. At the joint request of the members of the Florida congressional delegation concerned, the grant funds were withheld. Since then, much effort has gone into the organization of a new group to take up this grant. Your people apparently thought it necessary to receive a release from Hardiman, who in turn set certain conditions for the new group.

A new application was received from a group in Dade County, which would have all but excluded meaningful participation by five of the six counties to be served. At my request, your people worked with local bar association representatives to work out a more equitable arrangement.

While I was away from Washington during the spring recess, a letter was sent to the parties concerned indicating that the grant would be made with several changes to meet some of the objections. I was furnished a copy of that letter and was surprised to see that it constituted a final action by OEO without invitation to me or any of the other parties to suggest improvements.

Since my return, to Washington, I have been trying to work out a solution—but apparently your legal services people are simply not willing to see our objections to their handpicked slate of "poverty" representatives.

To demonstrate my concern that your people have not made substantive changes in the original objectionable board of directors, both proposed boards are shown side by side on the attached scale. It is well to keep in mind, also, that the original Hardiman proposal contained many of the same groups. The president of the Dade legal services program, which sponsored their migrant legal program, was a part of the original Hardiman group.

The only changes, then, can be seen as a reduction in the representation of the Dade EOLS from five to one. Dade County representation, however, has not been cut to a proper proportion of the target population, since the plan would still permit Dade to have up to seven of the 17 members, or 41 percent, while they have only 12,000 of the 80,000 migrants, or 17 percent.

Of the six private organizations listed, three are OEO grant agencies. The EOLS of Dade County is also OEO funded, as are member organizations of the coordinating committee for farmworkers.

In addition, the Florida Christian Migrant Ministry, the Florida Council on Human Relations, Florida Citizens Committee on Farmworkers, NAACP, and perhaps others are board members of the CAF and many are associated together on CCFW.

The proposal would allow them individual representation and joint representation through their joint associations.

OEO/CAF/CCFW together and individually would exercise control of the new program. The six bar associations representatives would find themselves not only a minority, but a small minority.

Prior to hearing from you of the Hillsboro program which gives eight of the 12 board members to the bar. I had no strong feeling about the division of representation between six bar representatives and six representatives of the poor from each county. I did object, however, to the selection of the six representatives of the poor in several of the counties. I would call your particular attention to the designation by OEO of the American Friends Service Committee as the representation from Palm Beach County.

There is no local AFSC organization, other than the branch office of the federally funded migrant program from North Carolina. Of the 32 members of their executive committee, not one is from Palm Beach County. Naming an OEO grant agency as part of the governing board of another OEO grant agency—and calling it a local representative group—simply is not acceptable to the people of the area or to me.

I feel strongly about this matter, and I would appreciate the opportunity of discussing it with you in detail before funds are released.

Sincerely yours,

PAUL G. ROGERS, *Member of Congress.*

Original Dade proposal

EOLS of Dade County	5
Broward bar	1
Collier bar	1
Dade bar	1
Hendry bar	1
Palm Beach bar	1
Lee bar	1
Florida Citizens Committee on Aging Labor	1
Florida Christian Migrant Ministry	1
Interfaith Agency for Social Justice	1
Mennonite service unit	1
Community action fund	1
NAACP	1
Secretary of Agriculture	1
Total	18

Current OEO offered changes

EOLS of Dade County	1
Broward bar	1
Collier county	1
Dade bar	1
Hendry bar	1
Palm Beach bar	1
Lee bar	1
Florida Citizens Committee on Agricultural Labor	1
Florida Christian Migrant Ministry	1
Interfaith Agency for Social Justice	1
American Friends Service	1
Community action fund	1
NAACP	1
Secretary of Agriculture	1
Florida Council on Human Relations	1
Coordinating Committee for Farm Workers	1
Southwest Florida Self-Housing	1
Total	17

ATTACHMENT NO. 3.—OUTLINE OF PROGRAM BUDGET, INDICATING $500,000 IN SALARY AND 300,000 MILES OF TRAVEL, FOR A SIX-COUNTRY PROGRAM

The program is funded in excess of $800,000.

The grant budget reflects the following salaries:

1 Director	$16,584.00
1 Deputy director	15,036.00
1 Assistant director	13,632.00
1 Business manager	6,262.00
1 Research attorney	11,784.00
1 Research attorney	9,228.00
5 Staff attorneys	11,783.00
6 Staff attorneys	9,228.00
1 Investigator	7,596.00
1 Investigator	4,236.00
1 Legal clerk	6,252.00
10 Legal secretaries	5,664.00
? Part-time law students	6,000.00

This represents a salary budget of $535,000, in a six-county area said to contain 80,000 migrant farmworkers.

Travel in the six-county area is budgeted as follows:

Local travel at 10¢ per mile × 300,000 miles	$30,000.00
Conference travel	4,000.00
Per diem administrative travel	1,920.00
Staff training per diem	3,520.00
Board of directors travel	3,840.00
Per diem additional travel	3,072.00

This travel expense total is almost $50,000 for the six-county area. The budget also calls for $48,000 in telephone bills.

ATTACHMENT NO. 4. LIST SHOWING ORIGINAL GRANT APPLICANTS STILL IN CONTROL OF PROGRAM, DOMINATED BY AN INTERLOCKING GROUP OF ACLU MEMBERS AND OTHER OEO GRANT AGENCIES

Organizations and individuals associated with the south Florida migrant legal services program and various reported affiliations:

In the spring of 1966 a proposal to create an $806,000 program to be called Migrant Legal Services, Inc., was approved by OEO to provide legal services for 14 Florida counties. No advance information was provided to the bar associations, civic organizations, or the Members of Congress from the area concerned.

The officers and directors were to be:

President, Howard Garrett, an officer with Community Action Agency, Inc., OEO funded.

Vice President, Thomas Hardeman, president of community action fund, and said to be a member of ACLU.

Secretary, Jack Mansfield, of the community action fund, and reported to be a professional union organizer.

Other directors were to include four additional members of the ACLU, including Tobias Simon and Howard Dixon, as well as two more members of the community action fund, and four migrant workers.

At the time this grant was announced, community action fund was under investigation. All of the Members of Congress concerned (Fascell, Pepper, Gibbons, Haley, Cramer, and Rogers) protested the new grant to the Hardeman group.

OEO did not fund the grant, but according to Shriver was under an obligation to Hardeman which permitted him to recommend a new sponsor group.

Following an investigation by the General Accounting Office of union organizing and political activity of the Community Action Fund, Inc., Hardeman and the program director resigned. The grant has since been cut in half and redirected.

Again a grant was announced without congressional consultations, although by this time congressional interest was obvious. It now was called South Florida Migrant Legal Services, Inc., with the following leadership:

President, Lyle D. Holcomb, Jr., of the Dade County Bar.

Vice President, John Smith.

Vice President, Donald Castor, who has since left and is now reported to be with another OEO agency.

Secretary, Joseph Segor, of the ACLU.

Treasurer, Howard Dixon, also of ACLU.

The other directors consisted of interlocking organizations which control virtually all of the OEO programs in south Florida, including the community action fund, the American friends service committee, and the Dade County poverty agencies.

Of particular interest, prior to the grant release an agreement was entered into and sanctioned by OEO which named the Dade economic opporunity legal services program, as the managing group for the new program. Tobias Simon and Joseph Segor and Howard Dixon, all of the ACLU and all associated with the original Hardeman grant, moved into control of the new program. Simon became the representative of the Dade agency, and Segor and Dixon became the operating staff members, as well as being board members.

The result has been that the original grant, being denied to Hardeman, has ended up under the control of the same people who joined with his application.

As of the end of November 1967, and prior to the Jamaica case which they are now pushing, their Belle Glade office had three attorneys, four secretaries, and two investigators. They had handled one case in small claims court, three lottery cases, one shoplifting, one bootlegging, and one assault, according to one reliable check on their operations.

With a salary budget of over $500,000 and over 300,000 miles of travel authorized, their entry into the Jamaica situation is obviously well funded.

It has also been reported that staff has been traveling to Washington and Atlanta frequently, to investigate the records of the Department of Labor and the Department of Justice concerning the entire labor program.

ATTACHMENT NO. 5. LETTER FROM BELLE GLADE, FLA., ATTORNEY, INDICATING "I HAVE BEEN UNABLE TO FIND A SINGLE RESPONSIBLE LOCAL CITIZEN OR A SINGLE ATTORNEY IN THIS AREA WHO HAS BEEN CONSULTED BY THOSE PEOPLE

ALLEN, MATHEWS & BAKER,
Belle Glade, Fla., July 25, 1967.

Re South Florida Migrant Legal Services, Inc., 395 1st Street NW., Miami, Fla.

Hon. PAUL ROGERS,
The House of Representatives,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: The above OEO sponsored organization proposes to place four attorneys in the city of Belle Glade, Fla. There have been six private attorneys engaged in the practice of law in Belle Glade and two in Pahokee, Fla. We all devote considerable time to the problems of the indigent and poor. I was not alarmed when I though only one attorney would be placed in this area. However, with this new development, I would like to learn all possible about the above organization. It is interesting that I have been unable to find a single responsible local citizen or a single attorney in this area who

has been consulted by these people. (With the exception they may have consulted with a local attorney who has been in practice here 6 months and whom they hired.) Yet, they conclude four OEO attorneys are needed in this area.

So that I may be better informed and may furnish the information to other local attorneys, I would greatly appreciate the following information, if you could obtain the same:

(1) What was the amount of OEO grant to the above and for what period is this to cover?

(2) A copy of the application or petition for the funds (so that someone locally will know what are the limits of the program).

(3) A copy of the award or grant of the funds.

I appreciate very much your help in securing the above information as soon as possible.

With best personal regards, I am

Respectfully yours,

ROBERT E. MATHEWS, Jr.

ATTACHMENT NO. 6. LETTER FROM A BOARD MEMBER NOT INCLUDED IN THE "IN GROUP" INDICATING THAT MEETINGS ARE MOVED FROM PLACE TO PLACE, MEET IRREGULARLY, AND ON SHORT NOTICE

FRAZIER & TURNER,
Fort Lauderdale, Fla., February 1, 1968.

Re South Florida Migrant Legal Services Program, Inc.
Hon. PAUL G. ROGERS,
House of Representatives,
Washington, D.C.

HON. PAUL G. ROGERS: I want to furnish to you a copy of a notice that I just received pertaining to a meeting of the south Florida migrant legal services program in Immokalee, Tuesday, February 6, 1968. This notice was received in my office on February 1, 1968. I believe I remarked in my previous letter to you about the irregularity of meetings and short notice on some occasions. This is an example. The nature of the meeting, as explained in the notice, might also be of interest to you, and I will endeavor to attend and will report on the meeting.

Very truly yours,

CARL W. TURNER.

ATTACHMENT NO. 7. LETTER FROM AN ATTORNEY DETAILING SEVERAL CRIMINAL CASES HANDLED BY PROGRAM, CONTRARY TO THE LAW AND REGULATIONS. OTHER EXAMPLES ARE GIVEN IN SIMILAR LETTERS ON FILE

MINER & RAFTER,
Clewiston, Fla., October 19, 1967.

Hon. PAUL G. ROGERS,
Member of Congress,
Rayburn Office Building,
Washington, D.C.

MY DEAR CONGRESSMAN: Once again, I feel impelled to take up the cudgel in public against a wrong that needs righting. In so doing, I like to think I am a representative of the largest class of all, the average American taxpayer.

Recently, I was appointed by the court to represent the people of the State of Florida in a certain habeas corpus proceeding in which a Negro juvenile was seeking his freedom from incarceration ordered by the juvenile court in Hendry County. This juvenile was accused of aggravated assault. He had been adjudicated a delinquent child and was serving a period of 15 days in a juvenile detention quarters of the Hendry County Jail. The juvenile court record reflects that both the young man and his father were apprised by the court of the boy's right to remain silent and his right to legal counsel. The father elected not to employ an attorney to represent the son and the matter went to hearing. At the conclusion of the hearing, apparently all parties were in agreement that the court had been most lenient in the punishment imposed in view of the gravity of the offense.

No more was heard about the matter until an attorney from the South Florida Migrant Legal Services Program, Inc., petitioned the circuit court for a writ of habeas corpus after the young boy had served 9 of the 15 days imposed. A hearing on the petition was had and the writ was denied. I might add that the record of this hearing reflects pronounced racial overtones.

But, I digress. The foregoing is simply stage setting—the play's the thing and the thing that has this particular taxpayer upset is the fact that Federal dollars are being expended to provide free legal services to all and sundry by a private corporation that professes to exist to better the plight of the migrant laborer.

Lest it be said I and others like me fear the economic impact of free legal service on our practices, let me assure you that this is not the case so far as I am concerned. On the contrary, it stands to reason that the more litigation stirred up by this group, the larger the number of potential clients walking the streets. Many are the transgressions committed in the name of "principle" so I shall not speak in such noble tones. I'm concerned about dollars—not the dollars that may or may not find their way into my pocket, but the three-quarters of a million plus tax dollars nourishing this private corporation in the name of suffering humanity.

The father of the young man mentioned above was not at the time in question a migrant or agricultural worker. He has been an ordained Baptist minister for the last 30 years and is the head of a one Cadillac, one Rambler family. By his own admission, under oath, he had and has ample funds with which to employ private legal counsel. How this man could qualify for representation by this group is a secret forever locked away in the recesses of some bureaucratic mind bent on finding new ways to spend tax dollars.

Paul, this is no isolated instance. Some 4 or 5 weeks ago, this organization represented a union organizer in Collier County. This man was an employee of the community action fund and his weekly paycheck was twice the amount a migrant can make and still qualify for legal representation from this group. Last Friday in Belle Glade, an attorney for South Florida Migrant Legal Services, Inc., represented the owners and operators of an alleged gambling house on lottery charges before the magistrate's court. I'll wager that an independent, objective examination of the records of this organization would reveal countless similar instances.

It appears to me that those who dreamed up this project will go to any length to justify the existence of their program. To halfway justify the expenditure of their Federal grant, these people must have cases, cases, cases, cases. The occupations and financial status of their clients are apparently facts that would only serve to confuse the madeup mind.

Since I made you a wager above, I'll make you another. Eliminate domestic matters, trivial complaints and people who never should have been represented in the first place from the caseload of this organization, divide the remaining number of cases into the amount of the Federal grant, shake well and I'll bet you'll find a per-case cost that would stagger even the imagination of a public long since hardened to the mysterious ways of Federal spenders.

Paul, the truth is that our people are weary of such as I described above. Is it possible for some positive action to be initiated at the Washington level to bring these people to heel? I have every sympathy for the economically, educationally, and socially downtrodden. I have represented people from this walk of life before and I shall continue to do so. I am confident that the motives of those who seek to provide succor to the migrant laborers are pure. I am equally confident that those who approved the grant to this group could not have imagined in their wildest flights of fancy that a program so conceived could have degenerated into a training ground for civil rights advocacy.

For your interest and information, I am taking the liberty of enclosing a transcript of the habeas corpus hearing I referred to above together with copies of certain newspaper clippings.

Sincerely yours,

CHARLES E. MINER, JR.

ATTACHMENT NO. 8. THIS LETTER TO OEO REQUESTED SPECIFIC INFORMATION ON THE NATURE OF THE LEGAL CASES HANDLED. A FLOOD OF INFORMATION WAS RECEIVED IN REPLY, WITHOUT THE SPECIFICS REQUESTED

NOVEMBER 1, 1967.

Hon. SARGENT SHRIVER,
Director, Office of Economic Opportunity,
Washington, D.C.

DEAR MR. SHRIVER: This is in further regard to the information given Joe Hagan of your staff this morning, concerning the Florida migrant legal services program.

As you know, application for the migrant legal program was filed under Section 207 of the Economic Opportunity Act, "to provide migrant legal services, research, and study for south Florida." I have carefully reread the entire application, and find that it was the clear and stated intention of this program to serve migrant agricultural workers. It is so stated in the title of the grant request, in the first paragraph of the application, and throughout the document. Income levels were specified, as was the stipulation that no case would be handled where a public defender was available.

The information given to Joe this morning would indicate that there may be a pattern developing contrary to the grant request and the OEO understanding of the intent of the program. An urgent review of this situation is needed.

I need the information on the specific cases given to Joe as soon as possible, realizing that the following will require additional time.

I would like a current list of the members of the board of directors of this organization, showing the group they represent on the board, the manner in which they were selected by that group, and their own individual occupations. I would also like a list of the attorneys working for the migrant legal service, and their bar association affiliation. It would also be helpful to know the dates, times, and places of all meeting of the board of directors from the date the grant was released by OEO to date, and the names of the directors present and absent from each meeting.

In order to better identify the type of activity engaged in by this agency, I would like to know the amount of funds expended to date, how they were expended, and the number and nature of all the cases handled to date. This should include information as to the legal problem, action taken by the agency, and the income and occupation of each client. I would also like to know if the client is a local resident or a migrant.

I would also suggest that a review be made of the budget for this program.

You will recall my previous opposition to this particular grant. In reading the application once again, the objections which came to mind before were reinforced in light of the examples of cases being handled. This program is supposed to operate in six counties, one of which is already the beneficiary of a large CAP legal services project. Yet, 300,000 miles of travel is authorized, not counting conference travel, and other travel items which add up to an amazing $46,992 for travel in a six-county area. Another staggering item is for telephones: $48,000 for the same six-county area. And total salaries exceed $500,000.

After many conferences, your office arranged for more local representation of the areas and people on the board of directors of this grant agency. At the time, however, I pointed out that the grant request was drawn up by, and would be administered and controlled by a group from only one of the six counties. By their own figures, that county has only 14,000 of the 80,000 migrants it says they are to serve. Geographically, that one county is far removed from the main migrant area, and that county already has a large legal services program which could have been expanded if needed to cover the migrants in that area. The two largest of the remaining counties each had legal services applications under consideration at the time of the filing of the migrant application. None of the five counties were consulted in advance of the filing by the other one county.

Considering the background, it is not at all surprising that the program is off to a bad start. You will recall that it first originated with the Hardeman group. But there is no reason to permit it to continue.

Sincerely yours,

PAUL G. ROGERS, *Member of Congress.*

ATTACHMENT NO. 9. LETTER TO OEO REQUESTING A COPY OF A REPORT MADE BE THE PROGRAM TO A NON-GOVERNMENTAL GROUP. THE LETTER RESULTED IN A RESPONSE WITHOUT THE REQUESTED REPORT, SO AN ADDITIONAL LETTER RESTATING THE REQUEST WAS MADE. IT HAS NOT BEEN ANSWERED, SO YET ANOTHER REQUEST HAS BEEN MADE

JANUARY 9, 1968.

Mr. EARL JOHNSON,
Director, Migrant Legal Services Program,
Office of Economic Opportunity,
Washington, D.C.

DEAR MR. JOHNSON: In the absence of Congressman Rogers, who is in Florida during the adjournment of Congress, I am enclosing three letters from Immokalee concerning the south Florida migrant legal services program.

Mr. Rogers visited in Immokalee this week and asked that I write you requesting information on the connection between the OEO project and the Citizens Board of Inquiry into Hunger and Malnutrition in the United States. Mr. Rogers would like to have a copy of the report made by the OEO agency to this other group. He would also like to know if this activity is within the scope of providing legal services.

Kind regards and best wishes for the new year.

Sincerely yours,

ROBERT B. LOCHRIE, JR.,
Administrative Assistant to Paul G. Rogers, Member of Congress.

Mr. FLOOD. Which program do you refer to?

Mr. ROGERS. In Florida there are six counties.

Mr. FLOOD. This is the problem of migrant legal aid services?

Mr. ROGERS. Yes.

This program was funded in excess of $800,000.

Mr. SMITH. For Florida alone.

Mr. ROGERS. For these six counties. It was a 2-year program. For instance, local travel at 10 cents per mile; 300,000 miles of travel in six counties; $48,000 for telephone bills. You have $16,500 for the director. You have a deputy director, assistant director, five staff attorneys, six staff attorneys, and so forth.

Mr. FLOOD. Here is what you should do: I think you should get in touch with a man named Taylor in the Washington office of the American Bar Association. I wish you would talk to him about this problem.

Mr. ROGERS. We have already done so. They are not very helpful. I do not think they really understand the problem.

Now the State bar association is coming in on an overall State program, OEO; now, this is separate. This has been carried out under their research deal, where there are no rules, no law, a complete carte blanche for whatever they want to do.

In the grant it says, "You will not take fee-generating cases, nor criminal cases where there is a public defender." They have in effect been doing that.

Mr. FLOOD. They are taking criminal cases, now?

Mr. ROGERS. Yes, in spite of the fact that——

Mr. FLOOD. That is an expressed prohibition.

Mr. ROGERS. Where there is a public defender.

They had a case in Kluis, Tenn., which I provided for the record, a recent case where he went in to get a beer and wine license. That is a fee-generating case.

The city people in Belgrade were very much upset.

Mr. FLOOD. I thought the Congress imposed an express prohibition on this.

Mr. ROGERS. Well, they are doing it.

Mr. SMITH. And the judges in Florida do appoint publicly paid defense attorneys if the defendant is indigent.

Mr. ROGERS. Surely they will. They are required to by the Constitution.

I am just not getting any response.

Really, in looking back there is no evidence of cooperation between the grant applicants and the local bar and civic groups prior to funding and little if any since then. The few cases handled appear to have been one eligible for public defender action and the current Jamaica case would be in the fee generating category so most of their cases appear to be ones that are really improper for them to handle.

I would say based on their poor record, questionable tactics and excessive budget, I see no reason to continue funding for this particular program. Certainly the OEO budget and the national budget picture require more prudent use of limited funds available.

Mr. SMITH. No funding for what program?

Mr. ROGERS. For this migrant legal services program in this area of Florida. Now I think they took most of these funds from research, so it may have to include a limitation on the spending of these funds. You see, they will be coming back in for more money because it will soon run out. I wish you could recapture funds in that program. It has gotten to the point where—here is a case, now, that kind of brought it to a head: You know, they bring in Jamaican workers, which is agreed to by the Government of Jamaica and this country, and under a law passed by this Congress.

Mr. SMITH. Well, Florida has a citrus industry.

Mr. ROGERS. This is right and particularly in this area, sugarcane, It has worked fine. There is no problem.

They pay the wages that are determined in conjunction with the Department of Labor and the Department of Agriculture. So it is not a case of paying proper wages. They do pay whatever is directed by this Government to pay or they cannot bring them in. They have to provide benefits, they pay their travel back and forth and it has been a very well-run program and it has been helpful to the Jamaican people because this has been giving those people a means of income. They have their own organization which represents these people. They maintain constant counsel in Florida for any problems that arise.

Now some of them got stirred up and they thought they were going to have a riot. The sheriff came out and arrested some. Others were sent back to Jamaica which is a normal process.

OEO tried to come in and defend them even though they had counsel and although there was a public defender. They did not do it and the charges were dropped. But I think OEO wanted to continue to try to make something out of it.

Then they file a suit for $750,000 against the sheriff and against the sugar company and if that is not fee generating, I do not know whether it is.

Mr. SMITH. Do you mean the OEO attorney represented them?

Mr. ROGERS. The OEO people did this.

I had Earl Johnson who is head of this program over to the office

and he admitted "Yes, this is a fee-generating case and we should not have done it but we are going to try to get some lawyer to take it up."

Now this is not a proper function either, for them to go out and generate cases that are not proper when they could go to a lawyer if they wanted to, and if they were not represented but they are represented. Furthermore, now all of these people are back in Jamaica so to continue a case which they never should have started in the first place, they will have to expend Government funds to either go to Jamaica or bring those people back from Jamaica and it has just gotten to be ludicrous.

Mr. SMITH. What are they claiming the sugar company did that it should not have done?

Mr. ROGERS. I think it is mainly more against the sheriff for violation of civil rights. The payment I think they claim because they take out so much to give them some kind of insurance.

The whole program has not engendered support. They have other legal aid programs going on, in Dade County, in Fort Pierce, as well as the bar association.

Everyone should have a lawyer if he needs one, but this is an improper activity for any lawyer to get into, to go out and generate cases, particularly when there is a prohibition in their grant award. Yet we cannot get through to them. It gets to be frustrating.

Mr. SMITH. I specifically asked if any of this type of activity was going on and they specifically denied it.

Mr. ROGERS. Mr. Sisk has had great difficulty in his area.

Here is a letter from the Governor's office and they say, "If the thrust of the present OEO migrant funding in Florida continues—that is to say if OEO chooses not to participate in a coordinated effort—then we cannot accept responsibility for the anticipated result. Because of the urgency of this matter, we would like to have your decision by May 1, 1968. My staff and I stand ready to meet with you at any place and any time to explore the problem."

This was a letter that the Governor's man, who is in charge of trying to coordinate programs to meet the migrant problem, wrote to Mr. Klores, head of the Migrant Division. I will furnish this for the record.

Thank you very much Mr. Chairman and gentlemen.

Mr. FLOOD. Thank you.

(The information follows:)

STATE OF FLORIDA,
OFFICE OF GOVERNOR CLAUDE R. KIRK, JR.,
Tallahassee, Fla., April 2, 1968.

Mr. NOEL KLORES,
Director, Migrant Division, Office of Economic Opportunity,
Washington, D.C.

DEAR MR. KLORES: Although OEO does not request our participation in programs under title III–B, we feel compelled to bring our feelings about the organization "Community Action Fund" and about migrant activities in Florida in general to your attention. We do this with the spirit of helping the overall effectiveness of all OEO programs in Florida.

From all we can ascertain CAF has lost the rapport and the respect of the people they are supposed to be helping. Past action by CAF has caused communities to lose confidence in the agency, and instead of welcoming the efforts of CAF we find a great deal of distrust and hostility.

Past activities of CAF have had a deleterious effect on local Florida community action agencies due to the similarity of name and the fact that both are OEO funded. This has become a stigma that community action agencies have been unable to throw off. Another matter of concern, since CAF is being considered for refunding, is the new name for which they are applying, "Camp, Inc." The new manpower programs underway nationwide are known as Camps (Cooperative Area Manpower Planning System). Camps activity is very active in Florida and it is our feeling that the similarity of the two names would cause much confusion.

One of the primary jobs of our office is coordination of Federal, State and local programs. Our concern with the CAF application is that there is no evident proof of coordination between this agency and any of the public or other private agencies that are working with similar programs dealing with migrant problems.

Job qualifications of the personnel, as listed in the application, are noticeably absent or lacking in the area of migrant education. Except for the Director and the education coordinator, no qualifications are necessary for the other employees. This is an extremely important area and should be the job of highly qualified people commensurate with the funding level of over $1,670,000 for the past 3 years, and the proposed budget of $490,000 for the current year.

It is our feeling that OEO should not refund the community action fund since our evaluations lead us to believe that the program is essentially a waste of money which is causing more problems than it is solving.

We feel that a lesser amount of money used to involve a broad representation of agencies and groups directly involved in the welfare of the migrant and seasonal farm workers to meet high priority needs within the State of Florida would be far more beneficial. Notably the growers, State department of education, legislators, employment service, State department of agriculture, community action agencies, migrants, consumers, State health department, and other groups who have been and are committed to finding solutions should be involved in any effort to assist the migrants.

All too often creation of another agency, which tends to operate in a vacuum, is thought to be the answer to a problem. But isn't one of the ground rules of OEO to coordinate? Shouldn't we be trying to get maximum leverage from funds available? Shouldn't we be trying to recruit the efforts of all of those committed to improving the system?

We have just completed a major staff study of the migrant programs in Florida and find a disjointed, uncoordinated hodge-podge. There is overlapping, waste, and worst of all—the migrants themselves are benefitting little. State agencies with available and recognized resources have been leap-frogged. Intergovernmental relationships have been ignored. To accomplish a meaningful program, Florida is moving toward a statewide effort to initiate the coordination of all agencies, public and private, whose focus is on identifying and meeting the present and long-term needs of the migrant population. We have also embarked upon an interstate effort with New York State which must be expanded and implemented. Once identified, Federal and State funds must be routed to meet these needs and priorities. We must also conduct an on-going system of evaluation to determine if these needs are being met.

As long as agencies such as CAF are funded to essentially operate in a vacuum we will never be able to make any meaningful progress.

We are asking for your cooperation with the State of Florida and its legally recognized agencies to eliminate the presently fractured, fragmented, and futile efforts.

If the thrust of present OEO migrant funding in Florida continues—that is to say, if OEO chooses not to participate in a coordinated effort—then we cannot accept responsibility for the anticipated results. Because of the urgency of this matter, we would like to have your decision by May 1, 1968. My staff and I stand ready to meet with you at any place—at any time to explore this problem further.

Sincerely,

JAMES A. BAX.

WITNESS

HON. CARL D. PERKINS, REPRESENTATIVE IN CONGRESS FROM KENTUCKY

Mr. FLOOD. It is the subcommittee's pleasure at this point to welcome the distinguished chairman of the House Education and Labor Committee, the Honorable Carl D. Perkins. Chairman Perkins will present a statement concerning the funding of education programs.

Congressman Perkins, we know of your great interest in the education programs of this country and appreciate your appearance today before the subcommittee. We are pleased to hear your comments.

Mr. PERKINS. Thank you, Mr. Chairman, for your very kind words. I also would like to thank you and the subcommittee for allowing me the opportunity to appear before you today. If I may I would like to present my statement.

Mr. FLOOD. Proceed, as you wish.

Mr. PERKINS. Mr. Chairman, it is with great pleasure that I appear before this distinguished subcommittee today. The task which you have before you is indeed a difficult one. In emphasizing the necessity of establishing priorities in Federal spending, President Johnson, in his budget message earlier this year, defined your job. He said: "We cannot do everything we would wish to do, and so we must choose carefully among the many competing demands on our resources."

President Johnson has rightly proposed continued progress to building upon the national commitment to provide a quality education for all Americans. The President did, in his education message in February, in my judgment, correctly pose the problem of priorities in meeting the needs in education. He noted: "Our resources are not unlimited—and never will be. So it is all the more important in assigning priorities that we focus on aid where the need is greatest."

Mr. Chairman, based on the testimony presented to our subcommittees in numerous hearings this year and on my discussions and correspondence with educators and school administrators, I am convinced that we must focus additional aid on education as this is clearly an area which continues to be where need is one of the greatest. Decisions which you will be making within the next few weeks are unquestionably difficult ones. They are also decisions which will have a profound impact on not only our schools today, our colleges and universities, and our research program, but more importantly, your decisions will affect the very future of this Nation, as our future is today in our classrooms.

As the President indicated, we must establish priorities. In doing this, I think you will agree with me that we should rely quite heavily on the views of the American people. In this connection, I should like to call to your attention a scientific study which was undertaken by the Joint Commission on Correctional Rehabilitation. The Commission asked Lou Harris and Associates to conduct a national survey of public opinion about corrections. The survey was made in November of 1967. One of the questions asked the public was: "Where would you most like to see Federal spending increased?" I thought that the

subcommittee would be interested in learning of the results of the survey. Forty-one percent of those interviewed placed as the highest priority increased Federal spending for education. Twenty-one percent placed increased support for programs aimed at reducing juvenile delinquency, a related area. Thirteen percent said support for law enforcement programs should be increased. When first, second, and third choices are combined, 71 percent of those interviewed said they would most like to see Federal spending increased in our educational programs.

I feel it is important to note that these opinions were obtained not in a survey concerning education, nor in one conducted by the Office of Education or some related agency or organization. It seems to me that when we sit down to establish priorities, we must consider very seriously what the public wants. How can meaningful national priorities be established unless they reflect the views of the American people.

Mr. Chairman, last year when I appeared before you, I discussed some of the then pending appropriation requests in terms of the disparity between the statutory authorizations and the appropriation requests. You will recall I mentioned that the Committee on Education and Labor recommends specific dollar authorizations only after the most careful and thorough consideration, and that we do not view our authorization figures as ceilings, but rather as the specification of a minimum figure which we feel is necessary to meet the needs and make the programs work. As I know you realize all too well, there is a considerable disparity again this year between current authorizations and pending requests. More distressing, however—and alarming and possibly damaging—is that certain of the requests are substantially below what was in fact appropriated last year. I should like to discuss just a few of the comparative figures.

The pending request to fund the NDEA title III program of grants to local educational agencies for the acquisition of instructional equipment represents only 14 percent of the amount authorized last year. Of greater concern, however, is the fact that the current request represents an 80-percent reduction in what was appropriated for the program last year.

Only 22 percent of the authorization for title II of the ESEA is being requested. This is a 55-percent reduction in the level of financing last year—in a program which is aimed at alleviating shortages and inadequacies in textbook and other instructional materials. For this program, only $46 million is being requested against $104 million which was appropriated last year.

The appropriation request for title III of the Elementary and Secondary Education Act represents only 37 percent of the authorizations.

The most dramatic example may be seen in connection with the program of assistance for the construction of higher education academic facilities. The $64 million being requested for grants to assist in the construction of undergraduate academic facilities is only 6 percent of the current authorization. Last year, $400 million was appropriated for the program. The Office of Education is requesting $336 million less, an 84-percent reduction, than what was appropriated last year.

The statistics are almost identical for the program of grants for the construction of graduate facilities. Only $8 million is being requested

this year—that is, only 7 percent of the authorization. This also represents an 84-percent reduction in the appropriation for last year.

And finally, Mr. Chairman, we must examine our contemplated effort on behalf of the disadvantaged youth of our Nation. If funds were sufficient to pay authorizations at the full amount, the fiscal year 1969 authorization for title I of the ESEA would be $2.7 billion. However, only $1.2 billion is being requested—this represents only a 52-percent effort on the part of the Federal Government to assist in the provisions of programs and services which are vitally needed.

Mr. Chairman, I know that the final appropriations will not and cannot be at the level of the authorizations. It does seem to me, however, that we can—in fact, we must—reduce these disparities as much as we possibly can. I am sure you know from the testimony of educators and from your correspondence the complications that will result at the local level unless we provide more favorable funding. Perhaps the problem is more dramatically presented in terms of the impact these reductions will have on individual institutions and on local school systems.

I have been advised that in the State of Kentucky, an 80-percent cut in NDEA title III funds would result in a serious detriment to the whole educational program in my State. Schools could have used $600,000 more than their allotment in fiscal year 1968. Over a half million dollars could not be approved that year. An 80-percent cut in that amount might leave too small an amount to justify administration and accounting.

I have been further advised that in Pennsylvania, instead of a cut, the State needs over $1.4 million more in fiscal year 1969, and that in California, more than $12 million over and above the fiscal year 1968 allotment is needed to satisfy requests.

Again, Mr. Chairman, I want to say that I appreciate fully the complexities and enormity of the work before you. I will not, as some might, argue that our educational programs should have a higher priority than our military budget. But I think we must consider one very important fact—the weakening of our colleges and universities and the consequent loss of educated manpower for our great Nation—or the weakening of elementary and secondary schools and the consequent loss of students to unemployment or disruptive activity—should not be among the costs of the war in Vietnam.

As a nation, I am convinced our affluence is sufficient to pay for both education and national defense. And if our priorities are properly ordered, we would meet educational needs, whatever the other demands for a share of the gross national product.

I am sure the war in Vietnam will end in victory, but it will be a shallow victory indeed if our developing colleges remain unaccredited, if the disadvantaged are denied college opportunities, if prospective college teachers are not able to attend graduate school, if young men and women continue to drop out of school because of crowded classrooms and inadequate programs, and if students are not able to find educational programs which prepare them for an occupation.

Mr. PERKINS. That completes my statement, Mr. Chairman. Thank you again for the privilege of appearing before you.

Mr. FLOOD. The pleasure has been ours.

STATEMENT OF HON. AL ULLMAN, A REPRESENTATIVE FROM OREGON

WITNESS

HON. AL ULLMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. FLOOD. We now have with us our friend Al Ullman who has taken time to prepare a statement regarding his views on several education programs. We are pleased to hear your remarks at this time.

Mr. ULLMAN. Thank you, Mr. Chairman. I have a fairly brief statement but one which, I believe, sums up the needs of certain educational programs. If I may I would like to read my statement.

Mr. FLOOD. As you wish.

Mr. ULLMAN. Mr. Chairman, I welcome the opportunity to present this statement today. The Federal programs whose appropriations come under the jurisdiction of this subcommittee are of the greatest importance to the State of Oregon and to my congressional district. The age of science and technology has placed increased emphasis on education, and the financial assistance of the Federal Government has made possible many important innovations in the field of education. Therefore, I am particularly pleased to have this opportunity to express my firm support for the administration's budget request for the broad range of educational appropriations which are before this committee.

In addition, I would like to comment on the interest expressed by a large number of Oregon school administrators, teachers, and parents in several of the President's budget request. They are disturbed by the requested reductions in title II of the Elementary and Secondary Education Act. Under this program, school libraries are striving to achieve a complete informational center for their students, and have proceeded with plans for a gradual development of library materials over a period of years. A reduction in the funding of title II would most certainly curtail these plans and be detrimental to an extremely worthwhile program.

This is a difficult year—the pressure for increased Federal participation in all areas of our economy and, at the same time, the demands for fiscal restraint have weighed heavily upon us. As one who has to help raise the money, I want you to know that I fully understand the burden of you who must decide how it is to be allocated. Yet the continued development of America's educational system ranks high in any determination of national priorities, and fully justifies support for the requests pending before you.

Thank you.

Mr. FLOOD. Thank you, Congressman.

WITNESS

HON. ARNOLD OLSEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MONTANA

Mr. FLOOD. We are pleased now, to have before us Hon. Arnold Olsen of Montana. Congressman Olsen has prepared a rather comprehensive statement supporting full funding of Public Law 874 for 1968 as well as 1969.

Congressman Olsen, we will be pleased to hear your statement.

Mr. OLSEN. Thank you, Mr. Chairman and members of this subcommittee.

Mr. Chairman, I very much appreciate this opportunity to present my views on education appropriations to your subcommittee.

I am very much aware of the pressures this subcommittee and others of the House Appropriations Committee are under these days to not only hold down spending on domestic programs, but to cut back on such spending. I know that the decisions you must make are difficult ones.

There is one area of education appropriations to which I would like to address myself particularly and briefly. It is involved in the urgent supplemental appropriations bill, still in conference, and in the appropriations legislation you are presently considering.

My concern is that insufficient money this year, and in previous years, has been appropriated for aid to federally impacted school under Public Law 874.

Although $416 million was appropriated for fiscal year 1968, only $395,390,000 was allocated to the entire program because of the Bureau of the Budget cutback in funding in December. In the urgent supplemental bill, the House did not add to the funding for impacted aid legislation, but the Senate added approximately $91 million. In conference, it was agreed to raise the appropriation to $416 million, but the Senate refused to accept the compromise, so the bill is still in conference.

The current level of allocation to Montana is $3,228,000. If the amount of $416 million is finally accepted by both the House and the Senate, it will mean an increase of a little over 5 percent or approximately $3,400,000 for my State. If the Senate figure is finally accepted, it will increase the Public Law 874 funding to Montana by about 23 percent, to a total of $3,970,440—an amount which my State badly needs.

Cutbacks in funding for federally impacted schools has a much greater impact, I believe, in a State like Montana than it might for other areas. Our tax base is more limited because of the lack of major industry in the State and the fact that a considerable portion of land in the State is federally owned.

In the Browning public schools in Browning, Mont., this cutback in impacted aid funds has created a major problem. Browning is adjacent to the Blackfoot Indian Reservation, with an enrollment in the

primary school of 80 percent Indian children and 90 percent in the secondary school. Under the present level of allotment, the Browning schools are receiving approximately $446,000. If the $416 million figure for Public Law 874 is finally accepted by the Congress, these schools will receive approximately $540,000, but if the Senate figure is accepted, the amount to the Browning schools will increase to approximately $563,000. For a small school system with such a high proportion of its students coming from families from which no taxes are derived, $117,000—or even $94,000—would make a substantial difference in the quality of education these schools are able to offer their students. A really good education is of particular importance to these chlidren, if they are to be prepared to take their proper place in today's society. Indian children have many handicaps to overcome, and we must not add the further handicap of an inadequate education.

The number of federally connected children in our schools in Montana has frequently fluctuated. The most recent figures I have indicated that there are roughly the same number of B category children as A category children in the schools in Great Falls, Mont. adjacent to Malmstrom Air Force Base. What also disturbs me about the present situation is that unless the Office of Education is able to fund Public Law 874 at a 100-percent level, many servicemen at Malmstrom Air Force Base, returning from Vietnam, may find an inadequate school situation for their children. I do not believe, Mr. Chairman, that we in Congress can justify shortchanging these young men who are fighting for our country. Malmstrom is not in my congressional district, but I am concerned about the quality of our schools and educational opportunities not only in my district, but in the entire State, because lack of educational opportunities anywhere in the State are going to ultimately have an impact on the entire State.

It is my hope that this subcommittee will give vigorous support to appropriations permitting full funding of Public Law 874 both for fiscal year 1968 and future years.

In recent months, many studies have been made of the causes of unrest and violence in our country. Without exception, these studies have indicated that one of the basic causes of such unrest is lack of adequate education, which, in turn, leads to unemployment—lack of communication skills and knowledge with which to get a job.

We have made phenominal strides in education in the last decade, particularly in the last few years. It is ironic that such progress has not kept pace with the growing demands on our educational systems, making necessary the expenditure of vast sums on remedial education and "crash programs" to upgrade verbal skills and train people for jobs.

I believe most sincerely that an important key to the solution of our domestic problems in this area lies in the field of public education and that this is one area we cannot fail to support fully.

I am aware that cuts must be made in our domestic spending as long as we must pursue the Vietnam conflict. But, I am convinced that if we are to continue to grow as a nation, and remain the strong, vital country we have always been, the one place where we cannot economize is in the field of education.

An informed, alert, educated people is the basic strength of our country. Our children are our hope of the future, and the least we can

do for them, I believe, is to insure that they have maximum educational opportunities.

I would add my urging to those, I am sure, of many previous witnesses, that we not only maintain but increase the Federal commitment to the education of our young people.

Thank you, Mr. Chairman.

School Assistance in Federally Affected Areas

WITNESS

HON. CHESTER L. MIZE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. Flood. We will now hear from Congressman Chester Mize of the Kansas delegation. Congressman, I believe you would like to present your views concerning Public Law 874. Please proceed.

Mr. Mize. Thank you, Mr. Chairman.

Mr. Chairman, members of the subcommittee. I'm grateful for this opportunity to come before you in behalf of funds for the federally impacted areas. I am one of those who supports the Senate action in adding funds to the urgent supplemental, now in conference, so that the schools which depend upon these funds can receive 100 percent of the projected entitlement this year.

The 20-percent cutback, now in effect, has caused critical problems in several of the school districts in the Second District of Kansas. Our State is eligible for a 1968 entitlement of $7,726,091, but money appropriated for the 1968 program will fall $1,529,951 short of this amount unless we make up this difference in one of the supplementals. Of the State totals, schools in the Second District are usually allocated some 40 percent of the funds. Such installations as Fort Riley, Fort Leavenworth, the U.S. Army Command and General Staff College and Forbes Air Force Base are responsible for bringing a large number of Federal employees to the district and thus bringing a tremendous burden on the local school districts in the areas of these installations.

In some of these districts, the Public Law 874 funds constitute as much as 50 percent of the school budget. In one of the smaller districts, the 20 percent reduction deprives the schools of some $110,000, and unless the Federal Government provides the full amount of the entitlement, local taxpayers will be forced to make up $115 for each student qualifying for Public Law 874 funds.

Through no fault of this committee, the program has been liberalized to the point where school districts can qualify for these funds although they are not in federally impacted areas as originally spelled out under the program. This has meant that available funds have had to be spread out over a larger number of school districts and many schools which have always depended upon these funds have come up short. This is at a critical time too. The Defense buildup has brought more personel into the various installations and the schools have had more students as a consequence, and have had to get along with reduced budgets because of the cutback in funds.

It is obvious that we will have to reevaluate this entire program. We need to return to the original definition of federally impacted areas and reestablish meaningful criteria so that those school districts which are burdened by the influx of students Federal installations bring to an area can receive payments in lieu of taxes and carry out their educational programs accordingly.

It is up to Congress to amend this program and operate it as it was intended to be operated from the beginning, but until we make the necessary changes, we are obligated to provide the full amount of the funds to those districts called upon to educate the children who are brought into their districts because of activities of the Federal Government.

It has been proposed to fund this program in fiscal 1969 on the same level as in 1968. As we know, this is some $91 million less than needed to pay 100 percent of the entitlement. It would be a mistake, as I see it, to try to hold to these levels and put the schools in the same kind of situation they have experienced this year. I call upon the committee to weigh carefully all of the factors involved and to vote to provide the full entitlement under Public Law 874. Thank you.

Mr. FLOOD. Thank you, Congressman Mize.

FUNDING OF TITLE I OF THE LIBRARY SERVICES AND CONSTRUCTION ACT

WITNESS

HON. JOHN C. WATTS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. FLOOD. At this point we will hear from our colleague, John Watts of Kentucky. He is appearing to present his views on the funding of public library services.

Please proceed, Congressman.

Mr. WATTS. Thank you, Mr. Chairman.

I deeply appreciate this opportunity to express my views and to urge that the members of this committee approve full funds authorized for title I of the Library Services and Construction Act.

I would briefly to call attention to the outstanding benefits this program has brought to the State of Kentucky under the able leadership of our State librarian, Miss Margaret Willis, which, in my opinion, emphasizes why this program should not be curtailed but continued with full funding.

Before fiscal 1957, when the Library Services Act provided $40,000 for Kentucky to start improving rural public libraries, there were almost no public libraries of any consequence in Kentucky. Most were supported with small donations, and run by woman's clubs or other organizations. They had only old donated books for their book stocks.

There were 86 small bookmobiles from the bookmobile project out in the counties. These held only 900 books; a small collection of new books was provided for each by the department of libraries. These books were used so much that they were worn to bits after a short time.

There was no interest in library cooperation. Each "library" struggled by itself to keep its doors open a few hours each week. Bookmobiles were able to give only token service. There was little interest in

reading, because there was little that was new and stimulating available.

The real beginning was made in fiscal 1958 with $137,000, appropriated through the Library Services Act. Twenty counties were organized into four library regions under the supervision of trained State regional librarians. Because of the limited funds available, progress was slow, but carefully selected new books were added to libraries in each county, with a stronger collection of information material in each regional library headquarters. The move ahead had begun.

Since then the following has resulted from LSCA title I (services) funds: 85 counties out of 120 are developing in 19 regions. All are served by State regional library staffs; 104 new, larger bookmobiles, holding 2,000 books, are serving the isolated, the disadvantaged, the physically handicapped, the aging, housewives, farmers, small children and in fact, entire families to the extent of circulating over 5 million books a year. Some are providing story hours, film programs, etc., out in areas where people never saw a book or a film previously.

One much larger bookmobile, holding 4,000 books, is serving impacted areas in Kenton County; 60 counties have passed a local library tax since 1960; 10 counties have been receiving demonstrations.

Almost 1,500,000 new books have been carefully selected, cataloged, processed, and delivered to participating counties.

Records, films, periodicals, and pamphlets have been distributed to each library.

Library and bookmobile service is making a great impact directly on the people of the State. In spite of improved school library collections, children and young people flock to public libraries and bookmobiles. Circulation totals over 10 million for both.

A centralized processing center has been organized at Frankfurt to handle books purchased by the State and local orders.

All libraries in regions have well organized catalogs and book collections for the first time; 420 regional workshops and 12 state-wide workshops have been held in the past 10 years for untrained library personnel.

Mr. Chairman, with all this accomplished, you may ask, "What is still needed?"

Thirty-five counties still have not been helped; they include half the population of the State, or 1,500,000 people. Of these, 10 counties want and need demonstrations now, because they can in no other way stimulate local action for partial local support. A good demonstration costs $5 per capita. There are 275,000 people in these counties with no or almost no library service. The total cost would be $1,375,000.

Seven counties want and need larger bookmobiles to serve disadvantaged impacted urban areas, but these cost $21,000 each. Filled with three complements of books, they cost $53,000 each.

Four counties now qualify for regional library development for the first time. They include 200,000 people. The cost would be $100,000.

Fifteen counties need bookmobiles replacements. The cost would total $135,000.

There is an acute need for 300 trained local librarians as soon as possible. To obtain these over a 10-year period, 30 scholarships of $3,000 each for graduate training is needed. The cost would be $90,000 annually.

The State library is still woefully inadequate. The present $596,000 for the statewide library and bookmobile development program will only continue the development of present county libraries in regions.

Without the full appropriation under title I "Services":

There will be no Federal funds to start new regional programs.

There will be no Federal funds for new, larger bookmobiles.

There will be no Federal funds for new demonstrations.

There will be no Federal funds for bookmobile replacements.

There will be no Federal funds for additional books and materials.

There will be no Federal funds for a scholarship program for training local library specialists.

There will be no Federal funds to expand the present processing center at Frankfort.

There will be no Federal funds to strengthen further the State library.

There will be no Federal funds to aid impacted, urban areas.

There will be no Federal funds to start innovative, outreach programs, which have been found to be most successful in two counties.

In other words, a state of retrogression will exist, because of increased costs for everything.

Good public library service is a right of every citizen of the United States. Far too many have had no taste or experience of this service.

Mr. Chairman, I maintain the story of Kentucky shows how the benefits of the Library Services and Construction Act are cumulative. I am sure other States have experienced equally satisfying achievements, made possible by this act. I, therefore, plead with this committee to vote the necessary funds so as to continue making possible some improvement each year, in order that the goal of good library service may be reached for all within the next 5 to 10 years.

The full appropriation for title I "Services" is the only answer. Thank you.

Mr. FLOOD. Thank you, Congressman Watts.

EQUAL EDUCATION COMPLIANCE ACTIVITIES

WITNESS

HON. JAMIE L. WHITTEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. FLOOD. We now have the privilege and pleasure of hearing from our friend and colleague of many years, the distinguished gentleman from Mississippi, Mr. Whitten.

How do you wish to proceed, Mr. Whitten?

Mr. WHITTEN. Mr. Chairman, I would just like to talk to you briefly if that is satisfactory, and leave it to the committee as far as the permanent record is concerned. I just want to talk to you about what amounts to a common problem which I think may result in losing our freedom in a good country.

I received a letter from one of the county officials in the State of Mississippi this morning in which is situated the town of Marks. This has nothing to do with what I came here to talk about. It is what you have been reading about in connection with the March of Poverty, so-called.

They have gone down there and picked out areas that are outside of town and where the pictures, as they will be presented, will be completely opposite to the facts. This, I think, follows from some of the things we have let happen in our schools. I need not remind this committee—I know everybody on this committee is familiar with the Constitution of the United States and I am not going to burden the record with too much except to say that the Congress or the legislative branch is the first one mentioned as being closest to the people. It is certainly intended to be equal to the executive department and to the courts. The courts are mentioned last.

In recent years the Supreme Court has set itself up as a supreme department. I will have to say that Congress, to some degree, has come along and ratified many actions after the fact, many of the usurpations of power that has been done by the Court. I have talked to you many times in times past about the school problems that we are having in my area as a result of the dictatorial attitude and policies of the U.S. Department of Education. I would say for the record that if you get the act under which the Office of Education was created, you will find that the purposes are intended to be to promote the cause of education throughout the country. In my area they have continued to cut corners, not demanding but withholding needed funds to the point they are dictating the running of schools throughout the area. In several counties they have required the closing of the doors of a first-rate school building and required both races then to crowd into the building that is left. Otherwise, they withhold funds.

Mr. FLOOD. Who do you mean by they?

Mr. WHITTEN. Personnel of the U.S. Department of Education, the Civil Rights Division, and other Federal departments and agencies at their request. They do that by refusing to approve proposals until they come up with one that suits the Department. In several towns in my district they have refused proposals until the school authorities come up and offer to close one school down so all the children will have to go into the other under crowded conditions.

Not only that, but they have required students to go to schools—may I say the tactic is that they just refuse to approve the operations of the school to the point of making grants to the schools unless they come up with a proposal that is satisfactory, and it is never satisfactory until the school in some cases abolishes the use of buildings, others to require students to attend schools over the protest of the parents, and I understand, busing to change a requirement they refrain from imposing in other parts of the country.

Now, to let you know, Mr. Chairman, just how far this group in charge of the Civil Rights Division has gone, years ago the U.S. Department of Agriculture, at the instance of the Congress and under the laws, provided by the Congress, bought up lots of forestry lands throughout my area.

Under the terms of the purchase the Federal Government agreed that 25 percent of the timber sales would go to the counties. I don't recall whether these funds are for roads and schools or not. That act was passed prior to my coming here but, because the U.S. Department of Education said the State was not in compliance, the Forestry Department has withheld funds from counties that were in compliance

even though a part of the compensation for taking the lands was this 25 percent of the land rentals, going back to the county.

Since I have been here, I introduced and got the Congress to pass a law providing that where the Corps of Engineers took land for flood control that the owners have the right to trial by jury; 75 percent of the land rentals went back to the counties for roads and schools. In order to set it up and make it more simple to handle, under the bill which I got the Congress to pass and which is law, the funds of the Federal Government are paid to the State for distribution, but the State has no interest whatever in it. But funds were withheld under that act from counties that were in compliance with their demand because the State, they said, was not in compliance.

I serve on another committee where the Atomic Energy Commission refused to let schools in this country have—allow students to have—the benefit of educational films prepared by the Atomic Energy Commission. They refused to let those films be shown to white or colored or mixed because the U.S. Department of Education said the school is not in compliance.

What I am saying to you is that they are destroying education in the name of something or other which has led to this condition.

I will not burden you with all this information. I know you are familiar with all the acts and perhaps with many of the actions they have taken. I have learned, and we have all learned that to put something in a committee report will not work. I have before me the Senate Report of 1967 where Senator Hill's committee provided as follows:

The committee recommends that no funds herein provided for the Office of Education shall be used for busing of public school students or for any other activities calculated to eliminate racial imbalance in the public schools.

Prohibition of giving money for that purpose or a recommendation in a report is different from the matter of withholding all Federal funds unless they submit a proposal that suits somebody down here in Washington. They just withhold all the funds for all these purposes unless you comply.

I can say with regard to the agricultural lands, I took it up with the Attorney General and I told him that the 25 percent was a part of the consideration in the purchase.

In regard to the Corps or Engineers, I raised the point the State had no financial interest and was merely an agent for the transfer of funds from the Corps of Engineers to the counties for roads and schools.

Now that the school year is about over, I have gotten them to yield in my district but the Attorney General says they haven't yielded over the State.

The Atomic Energy Commission has written up regulations that they hope will get by the Department of Education so that the folks in these areas may have the benefits of educational pictures where they have helped pay their share of the taxes.

I come to you, Mr. Chairman, because if Congress doesn't stand up for something we are just going to be sunk. The Court is entitled to its respect and it is entitled to its review and consideration, but it is only equal to the Congress. The Congress is entitled to take such

action as it sees fit to retain its own stature. That goes for the executive department.

I would hope that the committee would give some consideration to prohibiting any part of the Department of Education from withholding funds as a condition precedent to the granting of funds where they would require busing or the abolishment of schools, or require students to go to schools over the protest of the parent.

Mr. SMITH. Could we do that in this bill?

Mr. WHITTEN. Certainly you could. I would have no trouble in writing the limitation that under no conditions could they make a condition precedent to the grant of funds otherwise available that would call for them to do these three things. There could easily be a limitation on the administrative funds of the Department, or of the Government. I am talking about what is possible.

As I say, I am not insisting that this remain in the record. It makes no difference to me one way or the other, though I am glad to stand by what I say.

They started off with perhaps good intentions, but it has reached a point where these people have become dictatorial. The things we have been seeing, the riots and everything else, traces back to much of this type of thing.

That is about all it is. I could cite chapter and verse or anything else that you want. One step leads to another and I think all of you will agree that we of the Congress were led to believe they would not do what they were doing and still are doing. You won't find any statute that allows them to dictate the operation of local schools by indirection. That is, withholding Federal funds until they come up with a proposal that they approve and they don't approve it unless—as I say, before they will release money they require busing. In other cases they require you to abolish a school and put the children in one school even though the abolished school may be better.

In other cases they issue orders for students to go to a school over the protests of the parents or they will hold up Federal funds. I think it has come to the point where we are going to cut out education.

I submit either of the following suggested paragraphs would carry out what Congress intended.

(The paragraphs follow:)

No part of the funds contained in this act may be used to force busing of students, abolishment of any school, or to force any student attending any secondary school to attend a particular school against the choice of his or her parents or parent.

No part of the funds contained in this act shall be used to force busing of students, the abolishment of any school, or the attendance of students of a particular school as a condition precedent to obtaining Federal funds otherwise available to any State, school district, or school.

Mr. NATCHER. Mr. Chairman, would you yield to me at that point.

Mr. Chairman, as you know, during the hearings last year, when Secretary Gardner appeared before our committee, I asked him certain questions concerning the school situation in the United States and asked him why the directive from the Commissioner of Education was sent only into the 11 Southern States.

Mr. FLOOD. I remember very well that situation.

Mr. NATCHER. I asked him, Mr. Chairman, why this directive was not sent into the other States in the United States, just as a matter of

fairness. You will recall that in answer to my questions he said that in certain of these matters he was unable to answer and if I would agree to it, and with your permission, Mr. Chairman, the next day he would bring back Mr. Libasse to assist him with the answers. The next day he brought Mr. Libasse and we went into detail concerning the enforcement of our existing law in regard to education. The question was asked Mr. Libasse as to whether or not under existing law they had the right to go into any State and to say to any principal or superintendent, "You shall bus students or else your Federal funds will be cut off."

His answer to that question, Mr. Chairman, was: "We have no right under the law to make this demand." That is in the hearings last year.

I understand Mr. Whitten's concern, and I say to you that I too am concerned. They ought to enforce the law as it is on the statute books equally and fairly in all of the States and not go into a number of these school districts in the South and place limitations and restrictions on them that they don't have in other States.

Thank you, Mr. Chairman.

Mr. WHITTEN. Going back to what my colleague just said, in the name of education, you can't afford to close schools where there is a shortage of buildings. You can't justify closing down buildings or making that a condition precedent before they get their share of Federal funds. Mr. Chairman you, as a good lawyer, I know, realize litigation with the Federal Government is long and expensive and the Supreme Court can sit on a case for 15 years.

The point is, we come to the place where the money comes from and that is this committee and this branch of Congress. These things are not tied to Federal court orders. These cases are ones where the executive department holds up money you appropriate until executives receive a proposal that suits them. I have come to where the remedy ought to rest and in my opinion does rest and that is where the money is.

I can cite chapter and verse in great detail.

I have here before me a letter received April 18th, this year, which happens to have been my birthday, from the U.S. State Department of Education and at the insistence of the Department of Education they have gone ahead and closed this fine school in order to stay in compliance to get their share of money, but that is not enough. These are counties where the colored population is not very large. The two counties mentioned are in my district. In order to get their share of our tax money, they have done away with one of the school buildings, but that is not enough. They in turn require now that since some areas of the county are white entirely, they have to go to some other county, somewhere else and hire some colored people to come in and teach so they won't give the image of being a colored or a white school. Otherwise, they will lose the money after they have done the other.

I have here a letter from the son of a doctor; he is a Federal official, or employee, rather. They cut out all this money last November. At the end of this year, the community will be without a school for lack of money; all in the name of education.

Mr. Chairman, to show you how far this reaches, I want to leave in the record a copy of the letter about the march in Marks. This is an eye opener.

Mr. FLOOD. It will be included in the record.

Mr. WHITTEN. Thank you very much, Mr. Chairman.

Mr. FLOOD. Thank you, Mr. Whitten. We are very glad you came back.

Mr. WHITTEN. I urge the committee to take appropriate action because in the final analysis it is our business first.

Mr. FLOOD. Do you want to identify the writer of the letter we are going to place in the record?

Mr. WHITTEN. It is a letter I received today from one of the public officials whom I know personally; a man of very fine character.

Mr. FLOOD. From where?

Mr. WHITTEN. Marks, Miss.; a man of very high character and someone you can believe.

(The letter follows:)

APRIL 30, 1968.

I guess that you have read in the papers about the planned march from Memphis to Marks to pick up 35 wagons and mules and go on to Washington. The news services have picked it up as usual and were in Marks last week making a newsreel to use on television, which CBS had on their news report yesterday, Monday, April 29th and today on the early morning news. They went to a low, undrained place near the city limits where there are a number of Negro homes (owned by the Negroes) and took pictures saying that this was typical of all of Marks and in particular the Negro section. There was no water or sewerage they said, which of course was untrue except that not all of the Negroes are on the water service, by choice and because the lands are so low in others that they cannot have sewerage, but it is all outside of Marks. They then proceed to either bring along their own clothing or borrowed old torn clothing from some of the Negroes and dressed them up in it and stated that this is the way the Negroes in Marks looked. In other words they had the Negroes dress like they thought they should look and then took the pictures.

They also keep printing about how poor and starving the Negroes are around here, when they own 90 percent or more of their homes, a large percent of the farmlands, which they are farming, several businesses, two burial associations, and other businesses. The Riverside Industries works mostly Negroes and cannot get enough to work because they do not want to work. We have three factories which all work Negroes and recently opened another for the handicapped people and all have a high percentage of Negroes working. We have several commercial buildings being built, a contractor is beginning work on street and water construction and other works such as these being done in Marks who cannot get the Negroes to work. Some of the Negroes will work but a good many will not as they receive pay from the welfare and also a large number from the Negro organizations work and are paid by SCLC (Snic), NAACP and others so keep things stirred up. They wrote up about a Negro baby not having any milk and yet they are giving away food stamps to all those who are needy. They had the Negroes move their automobiles back away from their homes and did not take the pictures showing the TV aerials, even in the section they said they were starving.

Of course they did not take a picture of the new $50,000 furnished community center recently constructed in the Negro section of the city, nor did it show the many brick and other homes owned by the Negroes. It said nothing about the number of jobs opened and how they were trying to get Negro workers. They did have the paid agitators, children, and others get in a church and tell what they wanted to hear and put on the film. In other words they filmed the pictures and reel like one would make a movie and put it on a nationwide TV broadcasting system the Columbia Broadcasting System and tell the people that this was what Marks was like and how the Negroes all looked and acted.

We are getting outsiders here now, who tell the Negroes if they don't do something they will burn their houses down and if they will march on Washington the Government is going to give them a house and money to live on the rest of their lives and a lot more like this. They are fooling some of the ones who have lived on farms all their lifes and had to leave because of the wage and hour law that Congress passed, they tell these not to work and the welfare will take care

of them. They have not been able to find mules or a wagon as yet around here to go to Washington as they have been saying in the news, but they might bring a wagon and mules with them. They have been trying for about a week or more to get the Negroes stirred up, but as yet they have had no success, as most of the Negroes have their own homes, work and tend to their businesses.

I thought that I would write you about the facts since they have put what amounts to lies on the broadcasting and television stations across the country. That if you have the chance that you might have some of the facts at hand to let some of the people know that they have not in any way told the true story about the people or the city. They are supposed to leave Memphis Thursday and get here some time this weekend with numbers greater than the population of Marks, we hope that it does not happen, but for some reason they have tried to make Marks a symbol of poverty, which it is not. I believe the people will appreciate it, both white and colored, if the truth is told about the situation. Forgive my typing, as I did it in a hurry without my stenographer to get it in the mail to you. We trust that Congress will not again give them all that they want or ask as the people I believe are a little tired of this continuous marching and riots.

With kindest personal regards, I am,

———.

Mr. WHITTEN. My friends, I seek your help.

SCHOOL ASSISTANCE IN FEDERALLY AFFECTED AREAS AND TITLE II OF THE ELEMENTARY AND SECONDARY EDUCATION ACT

STATEMENT OF HON. HERVEY G. MACHEN

Mr. FLOOD. Congressman Machen had planned to be with us to present his views on some matters connected with the budget for the Office of Education. Unfortunately he was not able to be here as scheduled because of a conflict with other important commitments. He is sending his statements to us and they will be placed in the record at this point.

(The statements follow:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., May 1, 1968.

HON. DANIEL J. FLOOD,
Chairman, House Appropriations Committee,
Subcommittee on Labor and HEW,
The Capitol.

DEAR MR. CHAIRMAN: I regret sincerely that I was unable to appear personally before your committee today to testify on the appropriations levels which the administration has requested for title II of the Elementary and Secondary Education Act and the Federally Impacted Areas program. However, I had a number of previous commitments today which just could not be rescheduled.

Therefore, I would greatly appreciate your inserting the enclosed testimony in the hearings record.

With kindest personal regards, I am

Sincerely yours,

HERVEY G. MACHEN,
Member of Congress.

Mr. Chairman and members of the subcommittee, I represent the Fifth Congressional District of Maryland which is composed of Prince George's and Charles Counties. Since the enactment of Public Law 874 in 1950, these two counties have received over $41 million under this program. Prince George's County entitlements under this program have increased from about $97,000 in 1950 to a projected figure of over $7 million for fiscal year 1969. Charles County entitlements have increased from $87,000 in 1951 to about $600,000 for the 1969 fiscal year.

If the amounts requested by the administration for this program for the 1969 fiscal year are not increased from the requested $395,390,000 level, this would mean a reduction of over $2.2 million in the funds which the county school sys-

tems in my Congressional District receive. Therefore, I feel compelled to present my views on this matter and earnestly request that you increase the appropriations level for this program to a point where the recipient school districts will receive 100 percent of their entitlements under this program for the 1969 fiscal year rather than the 70–75 percent they would receive under the administration budget request. The two counties which I represent rely heavily on the Federal money they receive under this program. For the 1968 fiscal year, Prince George's County is eligible to receive about $6.3 million and Charles County $500,000. For the 1969 fiscal year, it is estimated Prince George's County would be eligible to receive $7 million and Charles County $600,000 based on 100 percent entitlements

It has become increasingly apparent to me that the administration is not taking seriously efforts which we in the Congress are making to cut back nonessential civilian as well as military expenditures. I firmly believe that there is a continuing need for us to make a rational evaluation of all Federal programs and expenditures, and consider appropriations levels in relation to a realistic appraisal of our needs and our ability to meet them. When we say that we want nonessential expeditures cut back, it appears to me that one of the first things that the administration seems to do is pick out one of the best run least complicated programs and cut it back with the reasonable assurance that the Congress will not sit still for such highhanded action and will restore the funds reduction somewhere along the line. I believe that the federally impacted areas program is a classic example.

In his 1965 Budget Message, President Johnson recommended that a thorough study be made of the Public Law 874 and 815 programs. I would, at this point, like to point up some of the conclusions which this report reached as regards the Federal impacted areas program.

First of all, it was determined that financial burdens are in fact created for local school districts by Federal activities of the types covered by this act. Secondly, it was found that it is possible to determine the financial burden each school district bears as a result of these activities. Thus, it is possible to determine the extent to which any Federal payments made under this program compensate, undercompensate or overcompensate recipient school districts. Thirdly, the report stated that the financial burdens created by the establishment of a Federal project are not restricted to their initial impact but present a continuing burden. The report concluded that Federal activities create additional school enrollment while associated Federal properties do not contribute property tax revenues to support these enrollments.

As I am sure you recall, the administration's budget request for fiscal year 1968 operations of the impacted areas program was $461,500,000. We appropriated $416 million for fiscal year 1968 operations of this program because I believe we all felt that, even though the program was necessary, some budgetary reduction was in order on all programs because of the situation faced by the Nation both at home and abroad. We appropriated this amount even though we knew full well that, for the affected school districts to receive 100 percent of their entitlements, we would have had to provide over $486 million for the program. As a result, school districts only got 80 percent of their entitlements.

I believe that the Congress, in cutting back this appropriations request, manifested its desire that it would cut all governmental spending even in much-needed programs such as this one. Then the administration turned around and didn't allow the Office of Education to spend the entire appropriated amount. The amount spent for the 1968 fiscal year is $395,350,000.

Now for the 1969 fiscal year, the administration is submitting to us a budget request for the impacted areas program which represents over $154 million less than the amounts which would be needed to pay the affected school dsitricts 100 percent entitlements.

In view of the results of the administration sponsored report, and considering the great increases which have taken place in the number of children of Federal personnel enrolled in schools in these federally affected school districts, I urge you to increase the administration's budget request to a level where each affected school district will receive 100 percent of its entitlement.

It is of the utmost importance that the Congress appropriate enough money to meet its commitments under the Public Law 874 program. I believe that there is a matter of good faith involved. The affected school districts rely on this Federal money to compensate for the extraordinary burdens caused by excessive Federal activities in such areas. They prepare their annual budgets accordingly.

This program of aid for impacted school districts is a response to excessive costs incurred in areas where school rolls become abnormally high due to military and other Federal concentrations. It brings about an unbearable burden on

the local taxing capacity. It is, in fact, a form of aid to military personnel and their families, made necessary by conditions over which such personnel have no control. Indeed, many of them are away fighting in Vietnam or are committed elsewhere while their children are sent to schools in impacted areas.

Our school districts need the money provided under this program. They need 100 percent entitlements; and I urge the committee to act to increase the appropriations level requested by the administration for this program.

With your permission, I would like to include in the hearings record letters which I have received from school officials and other interested parties on the impacted aid program.

BOARD OF COUNTY COMMISSIONERS OF CHARLES COUNTY,
February 20, 1968.

Hon. HERVEY G. MACHEN,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN MACHEN: The Board of County Commissioners of Charles County is very concerned over the negative results of reducing the impacted school aid to Charles County. The State of Maryland and its subdivisions are in the midst of adjusting to one of the most thorough tax reforms ever attempted by any State, and with all the new problems bearing down on us in 1968, any assistance in the form of fiscal constants is a most welcome sight.

Charles County can ill afford to lose the $141,000 to $169,00 suggested by a 25 to 50 percent reduction of last year's assistance.

The administration's last attempt to cut back aid o impacted areas was defeated on the floor of Congress * * * and, we think, appropriately so. It is our sincerest hope that the impacted aid program will be continued at the present levels at the very least.

Ours is one of the fastest growing counties in the State. Our growth is related, in large measure, to the Washington Metropolitan area. This rapid growth places its greatest strain on the school system.

Our position is quite simple * * * nothing must be done to shortchange the schoolchildren of Charles County. We look forward to your kind assistance in this very important matter.

Very truly yours,

REED W. MCDONAGH,
President.

BOARD OF EDUCATION OF PRINCE GEORGE'S COUNTY,
Upper Marlboro, Md., March 8, 1968.

Hon. HERVEY G. MACHEN,
5th Congressional District,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN MACHEN: Senator Fulbright has offered an amendment in the Senate to increase Public Law 874 appropriations for 1968 by $90,965,000. Of this amount, $4,631,000 would come to the various school jurisdictions in Maryland which benefit from the impacted Federal aid. Our county would receive $1,560,000 or almost one-third of the total amount coming to the State of Maryland.

Should the Senate Appropriations Committee accept the amendment offered by Senator Fulbright and should the Senate approve the amendment, I would hope that you would support this increase in appropriations when the legislation reaches the House of Representatives. Or should the matter go to a conference committee, that you would instruct the House Representatives on the conference committee of your keen interest in this legislation.

Charles County, the other jurisdiction in your congressional district, would receive $102,000.

Actually, our school budget is made on the assumption that the Federal Government will provide 100 percent appropriations of entitlement. We have counted on receiving this $1½ million and would be seriously embarrassed in balancing our budget for the 1967–68 school year if this money should fail to be appropriated.

Your help and support in securing the passage of this supplemental appropriation would be greatly appreciated.

Sincerely yours,

WILLIAM S. SCHMIDT,
County Superintendent.

STATEMENT OF HON. HERVEY G. MACHEN, OF MARYLAND

Mr. Chairman and members of the subcommittee, I represent Prince George's and Charles Counties, Md., adjacent to the Nation's Capital. Elementary and secondary public and private schools in these counties and throughout Maryland and the United States have been participating in the title II Elementary and Secondary Education Act program for some time and have achieved remarkable results. School officials and parents in both counties of my district have expressed their alarm at the administration's proposed 53-percent reduction in funds for the operation of this program during the 1969 fiscal year. I am appearing before you today because I, too, am very concerned about this proposed reduction.

As you all know, the title II program consists of basically two components—acquisition and administration. The acquisition program includes the purchase, lease-purchase, or straight lease of library resources, textbooks, and other instructional materials. It also includes the necessary costs of ordering, processing, and cataloging such materials and delivering them to the initial place at which they are made available for use. Administration includes those executive, supervisory, and management responsibilities vested in the State agency to carry out the State plan.

The money which has been available as a result of the funding of title II of the Elementary and Secondary Act has had a tremendous impact on the quality of education in Maryland. Increases in the number of libraries and in the variety and quality of the materials provided are proving that instruction is greatly enhanced by such outstanding backup materials. I believe it is incumbent upon the Congress to at least continue this program at the level which it operated last year, fiscal year 1968. The administration's budget request for $46 million as compared to the almost $100 million spent on title II operations in 1968 fiscal year is unrealistic. It completely ignores the outstanding success which the title II program has achieved. If the administration budget request is passed, the past achievements of this program will go down as a monument to futility and it will be our fault.

If action is not taken by this committee and by the Congress generally to increase the appropriations level for this program, the maximum allocation that Maryland could expect to receive for its fiscal year 1969 operations would be $603,600 as compared to the fiscal year 1968 level of $1,300,823. In fiscal year 1968, Prince George's County received $199,235 under this program and Charles County got $18,527. There were over 300 public schools receiving title II funds in these counties during the 1968 fiscal year. Under the administration's budget request, Prince George's and Charles Counties would get only $92,445 and $8,597, respectively. I am sure it is obvious why both I and my constituents are very concerned about this possibility.

I am very proud of the operations which Maryland has undertaken with the funds provided under title II of the Elementary and Secondary Education Act. I believe that the tremendous cooperation which both public and private school officials have exhibited can well serve as a model for the Nation. Perhaps the foremost example of this cooperation can be found in the Maryland State Advisory Committee which was appointed by the State superintendent of schools in 1965. This advisory committee helped to formulate the original State plan, suggested procedures for implementing the plan, and then took charge of disseminating information regarding the provisions of the plan. The committee was composed of representatives from private, parochial, and public schools throughout the State.

The program which the State adopted is indicative of the unmet need which title II funds were aimed at meeting. Relative need throughout the State was identified by means of a statewide survey of all public and private school libraries during the fall of 1965 and school library reports which were filed on June 30, 1966.

The results of the survey and the report indicated that the greatest need was among elementary schools having less than 5,000 books in their central library collection, which is the State minimum standard.

Under the title II program in Maryland, funds were made directly available to public school systems. Private schools requested to borrow materials from the State department of education. The schools submitted requests for the desired materials; the requests were checked by the division of library extension staff; and approved requests were sent to a subagency of the department which purchased, processed, and delivered the materials to the private schools. Each piece

of delivered material was stamped, "Property of the Maryland State Department of Education," and was placed in the school on a loan basis with privilege of recall at any time.

One of the great strengths in aiding both public and private school systems was the fact that all private school requests were handled by the State department of education. This removed the burden of responsibility from the local school systems and assured that uniform treatment would be accorded to all private schools while the local school systems could expend their energies on the public schools for which they are directly responsible. The net result of this procedure is to allow each private school to request those types of materials which best fulfill its individual needs. The result is a wide variety of nonprint materials were added to collections which previously had little or none.

The public school systems were allowed to select materials under the existing policies established in their respective districts. There were no specific restrictions set by the State indicating that certain percentages be spend for specific types of materials.

As of June 1967, Prince Georges County had received over 33,000 books and 32,000 filmstrips, recordings, slides, and transparencies under the title II program. Charles County had received 10,000 books and 221 filmstrips, recordings, slides, and transparencies. Since both these counties began participating in the title II program they have received almost $800,000. In addition, the Glenridge Junior High in Prince Georges County received special grants in order that it might serve as a demonstration center of an outstanding instructional materials program. The Charles County Board of Education received a special grant to improve its central collection of files, filmstrips, etc., to the schools in the county.

As yet, the title II program has had a small but clear impact on the improvement of public and private school libraries in schools throughout the State of Maryland and in Prince Georges and Charles Counties particularly. From the statistics available and a knowledge of what individual schools and school systems are doing, it is obvious that title II has made a very real contribution in encouraging the inclusion of all types of instructional materials, particularly nonprint materials, in school libraries. The requirement that teachers be included in the selection of these title II materials has brought about an involvement that was too often lacking before and has helped to create an awareness of the great variety of materials which are available to help improve instruction. The inability of librarians to purchase the materials requested by teachers has in a very real way, pointed up the need to improve the level of support which local school systems and private schools were giving.

The following statistics give a partial picture of the impact of title II materials on the amount of school library resources in use in June of 1967:

Public secondary school collections were increased by 5.2 percent by title II materials.

Public elementary school collections were increased by 7.7 percent by title II materials.

Private elementary school collections were increased by 10.5 percent by title II materials.

Private secondary school collections were increased by 5.1 percent by title II materials.

Private combination school collections were increased by 12.1 percent by title II materials.

I am fully aware that we must set priorities and make a realistic appraisal of our domestic and foreign needs and resources. I certainly will support budgetary reductions in programs in almost any area other than those providing funds for the support of our forces in Vietnam or for education. I believe that education should be left uncut because, if it is not, we have only ourselves to blame later when our false economies come back to haunt us. We owe it to the people of this great Nation to cut governmental expenditures where they can be cut. But we also owe it to them to maintain expenditures in areas where cuts would do irreparable harm. If the operation of the title II program has been nearly as successful throughout the country as it has been in the State of Maryland and in my district, I am sure that no more eloquent testimony could possibly be heard for continuing this program at at least last year's level. Therefore, I urge you to increase the administration's budget request for the title II program.

TITLE II, ELEMENTARY AND SECONDARY EDUCATION ACT

LETTER FROM HON. CLAUDE PEPPER AND STATEMENT OF FLOYD T. CHRISTIAN

Mr. FLOOD. Our good friend Congressman Pepper has spoken to me about a statement he has recently received from his State superintendent of the department of education. He is sending us the statement which we will, of course, place in the record.

(The statement and letters regarding it follow:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., May 10, 1968.

Hon. DANIEL J. FLOOD,
Chairman, House Subcommittee on Labor, Health, Education, and Welfare of the House Appropriations Committee, Washington, D.C.

MY DEAR MR. CHAIRMAN: You will recall that I spoke to you regarding the funding for title II of the Elementary and Secondary Education Act. I have felt that the budget requests for the library and textbook resource program for fiscal year 1969 is a drastic reduction from that previously appropriated by the Congress for the current year. This feeling has also been expressed to me by various public-spirited-minded individuals and the superintendent of the department of education for the State of Florida, the Honorable Floyd T. Christian.

Superintendent Christian, at my suggestion, has prepared a written statement for your committee's consideration relating his views and those of the Department of Education of the State of Florida concerning this drastic reduction in appropriations. I find his statement most informative and respectfully request that they be made a part of the official record of your honorable subcommittee.

I personally feel that this reduction is an unwarranted slashing of a vital educational program, particularly in view of the previous congressional authorizations of up to $167 million for the 1969 fiscal year. I do not believe the need for economy in government justifies such sharp reductions in the investment we are making in the education of the next generation, and I will most certainly do all I can to see that this program is fully funded.

Warmest personal regards, and
Believe me,
Always sincerely,

CLAUDE PEPPER,
Member of Congress.

STATE OF FLORIDA,
DEPARTMENT OF EDUCATION,
Tallahassee, April 26, 1968.

Hon. CLAUDE PEPPER,
House of Representatives,
Congress of the United States,
Washington, D.C.

DEAR CLAUDE: Thank you for your letter of April 19. We are happy that you are going to support the full appropriation for title II of the Elementary and Secondary Education Act.

You were kind enough to invite me to appear in person or to submit a written statement to the House Appropriations Committee. Because of my heavy schedule, I will not be able to appear in person, but I am submitting a statement that I hope you will place in the record.

Thank you for your cooperation, and with kindest personal regards.
Sincerely,

FLOYD T. CHRISTIAN.

STATEMENT BY FLOYD T. CHRISTIAN, STATE SUPERINTENDENT OF PUBLIC INSTRUCTION, IN FAVOR OF FULL FUNDING OF ELEMENTARY AND SECONDARY EDUCATION ACT, TITLE II (PUBLIC LAW 89-10)

To the children and teachers of Florida, the proposed reduction of 53.6 percent in the approporiation for title II of the Elementary and Secondary Act (Public Law 89-10) will be a crippling blow. After 3 years of participation in this unique program, our schools are beginning to approach the threshold of excellence in the school media program. It is our sincere hope that this essential program will be funded at the present rate until more progress has been made in our State toward providing the materials needed for meeting the needs of children and young people of all ability and interest levels.

During the first 3 years of supplementary funding under title II, many schools have been able to make significant progress toward updating collections of printed materials to serve more adequately their curricular needs. In addition, they have for the first time had the opportunity to begin building useful collections of much needed audiovisual materials. As a result, our school librarians have begun to feel they may be able to duplicate some heavily used materials and to provide enough materials for use in both classroom and media center. With more and more emphasis upon individualized instruction, the need increases for materials in great variety and quantity.

Throughout the State, there has been enthusiastic support for and genuine appreciation of this phase of the Elementary and Secondary Act, the only title intended specifically for the acquisition of materials. In almost every county, there has been an increase in local support for instructional materials and a statewide increase of $2,666,486, or 31 percent, since the inception of the program. This substantiates the increasing need for materials in greater variety and quantity in today's classroom. Title II has served as an excellent stimulus for self-improvement.

For the first time, many private schools are setting up budgets for regular support of school library resources. Many persons from private schools have stated that the materials purchased with title II funds furnished the nucleus of their first centralized libraries, and that, with the prospects of continued support from title II, they have bright prospects for providing functional collections of materials in their schools.

Because of the availability of more useful and up-to-date materials, many teachers have been able to tailor their teaching methods more adequately to fit individual needs of students. Also many schools have been able to meet a higher level of accreditation because of the increase in needed materials.

Since the beginning of the ESEA, title II program, 84 new school libraries have been established in Florida, 62 in public schools and 22 in private. Additional pupils served in these new libraries alone are: public, 32,706; private, 5,354, making a total of 40,059. Additional materials in libraries or media centers already existing have made it possible for the needs of increasing numbers of children to be met also.

During the first year of the Elementary and Secondary Act, most school systems in Florida, under title I, made extensive purchases of equipment for using newer media; however, much of the equipment has been utilized to only a limited extent. Nonutilization of this equipment has not been caused by lack of interest or desire on the part of school personnel, but by the lack of materials designed for use on such equipment. There is still a great dearth of materials of this kind. Many schools, having raised their accreditation levels as far as books are concerned, have begun to concentrate upon other forms of educational media requiring equipment for use. The reduction proposed for fiscal year 1969 will in all probability relegate much expensive equipment to the storage room, for without needed materials, this equipment is not usable. There is now enough of such materials available to enable schools to be highly selective in choosing that which best suits their needs, and many schools are just beginning to make real progress toward providing an educationally useful collection of recordings, film loops, transparencies, videotapes, filmstrips, and other media; however, the most recent accreditation report shows that 97 percent of Florida's schools have five books per student—the lowest level of accreditation; that 77 percent have seven books per student—level 2; and that only 35 percent have 10 books per student—level 3. The same report shows that for audiovisual materials, the need is even greater: one filmstrip for every two students; one disc recording for every 3.3 students; and only one tape recording for every 26.5 students. Transparencies were not reported, but there is an equal need for these newer media. If we are

to give more than lipservice to the tenet that individuals learn in different ways and through the use of varied media, then we simply must continue to provide materials in all formats.

With the implementation of the act providing for kindergartens, the schools will be faced with a further shortage of materials, for materials now on hand will have to serve additional children. Especially will the need for audiovisual materials increase.

Title II of the Elementary and Secondary Education Act is the one title which affects all children enrolled in Florida schools both public and nonpublic. It is not aimed at meeting the needs of any one category of users. Let us not fail to continue adequate funding of this important title.

Programs for the Nation's Elderly Poor

STATEMENT OF SENATOR EDWARD M. KENNEDY

Mr. Flood. We now have a statement from the senior Senator from the Commonwealth of Massachusetts, the Honorable Edward M. Kennedy, which we are happy to have for our record at this point.

(The statement follows:)

Mr. Chairman, I appreciate this opportunity to urge this subcommittee to earmark OEO funds for programs to benefit the elderly poor. I am particularly interested in this subject from the standpoint of three of my subcommittee assignments. First, I serve as chairman of the Special Subcommittee on Aging of the Senate Committee on Labor and Public Welfare. Second, it is my privilege to serve as chairman of the Subcommittee on Federal, State, and Community Services of the Senate Special Committee on Aging. And third, I serve as a member of the Subcommittee on Employment, Manpower, and Poverty of the Senate Committee on Labor and Public Welfare, which has jurisdiction over OEO authorizations.

As a member of the latter subcommittee, I have sponsored amendments to the Economic Opportunity Act which have been enacted to express unmistakable congressional intent that adequate funds be administratively allocated to programs for the elderly poor, only to find that programs for this age group have been given a low priority in administrative allocation of funds. An excellent example of this was the authorization in the Economic Opportunity Amendments of 1967 of a new special program, called senior opportunities and services, to identify and meet the needs of older poor persons. When we were successful in including this authorization in the bill, which became Public Law 90–222 on December 23, 1967, it looked like a major victory for our Nation's elderly poor. Not long after that, however, it became apparent that it had been a paper victory only, at least for the time being, as this significant new program was completely bypassed in the administrative allocation of scarce appropriations. And, I am advised that there is no prospect in the foreseeable future that funds will be allocated to it.

Formerly, Mr. Chairman, I was willing to acquiesce in the desire of other Members of Congress that there be no congressional earmarking of OEO funds, in order that there may be maximum administrative flexibility in the allocation of OEO funds. However, now, after having seen the agency repeatedly ignore the congressional intent, clearly expressed in the authorization statute, that programs for the elderly poor be adequately funded, I have reached the conclusion that only by congressional earmarking will there be adequate funding of programs we authorize to benefit the elderly poor. I am, therefore, joining other Members of Congress in urging that your subcommittee specifically allot for programs to benefit our poverty-stricken older compatriots at least $40 million in title II funds together with a proviso that there will be no cutback in the current level of expenditures on behalf of the elderly in all OEO titles.

The question at this point is whether we of the Congress who are elected by the people and who are directly responsible to the people shall do the earmarking or whether we should abdicate this function, which is essentially legislative in character, permitting it to be carried out instead by an agency which is not as directly responsible to the people of the United States. If we follow the latter course, we will have thrown away an opportunity to effectuate congressional intent.

Funding of Special Programs for the Elderly

STATEMENT OF SENATOR HARRISON A. WILLIAMS, JR.

Mr. Flood. We also have a statement from the distinguished Senator from New Jersey, Harrison A. Williams, Jr.

We know of his interest in programs for the elderly and are happy to have his statement for the hearings' record.

(The statement follows:)

Mr. Chairman, I appreciate this opportunity to comment on the pending Office of Economic Opportunity appropriations, and particularly, on the necessity of adequate funding of special programs for the elderly. Twenty-five percent of the Nation's poor—almost 8 million impoverished Americans—were promised positive, realistic assistance in the original antipoverty legislation. Your subcommittee has a chance now to build on that original commitment to the elderly poor.

I propose to your subcommittee that $40 million in title II funds be earmarked for special programs for the elderly poor. Additionally, I urge you to adopt a proviso that there will be no cuts in current levels of spending in any program for the elderly poor, under any OEO title.

This earmarking of funds for the elderly poor is wholly consistent with the basic philosophy behind the war on poverty. When we set out to eradicate poverty among the people, we said then that our work would be concentrated where poverty was the worst. Again and again, Congress and the administration emphasized the need for specialized, concentrated, intensive involvement in the areas where poverty gripped the people the hardest.

As Chairman of the Senate Special Committee on Aging, I have seen and heard the evidence of poverty's impact on the Nation's senior citizens. Our hearings into income levels after retirement, together with our investigations of the housing and health needs of older Americans, have revealed the pressing need for special programs for the elderly poor.

In 1964, when Congress passed the Economic Opportunity Act, we grappled first with the needs of the millions of young people who were caught in poverty's persistent cycle. These desperately poor young men and women and children became the focal point of much of the early war on poverty, and programs after program was funded to meet the needs of poverty's children.

In spite of this emphasis on youth, there was candid congressional recognition of the plight of the Nation's anonymous elderly poor. Antipoverty legislation has stressed the needs of the aging. Last year, the Economic Opportunity Amendments of 1967 outlined several specific programs for the elderly poor—training, community action programs, a senior opportunities and services project—and underscored the urgency of special assistance for America's impoverished senior citizens.

Somehow, in spite of congressional acknowledgement of the need for older persons' programs, these programs have not been undertaken with anything approaching the scope and intensity which they must have if they are to be successful. Priorities have become clouded; programs have languished for lack of creative leadership; and in general, the antipoverty effort has failed to reach the majority of the elderly poor so desperately in need of help.

At present, less than 3 percent of the total OEO funds are finding their way into older persons' programs—this in spite of the fact that a quarter of the Nation's poor are past age 55. Indications are that this meager level of spending for the elderly poor will continue, unless Congress issues a mandate to the Office of Economic Opportunity, directing the full and immediate implementation of special programs for the Nation's impoverished senior citizens.

Mr. Chairman, by earmarking $40 million for older persons' programs, this committee will deliver the kind of mandate that is now required. Congress, through the 1969 appropriations for the Office of Economic Opportunity, has the opportunity—and the responsibility—to make good on the promises we have made to the elderly poor.

FUNDING LEVEL OF LIBRARY RESOURCES (TITLE II, ESEA)

LETTERS OF HON. GEORGE H. FALLON AND THE VERY REVEREND MONSIGNOR WILLIAM C. NEWMAN (ARCHDIOCESE OF BALTIMORE)

Mr. FLOOD. At this point we will include as a part of our record, two letters received from our good friend George Fallon.

(The letters follow:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., April 22, 1968.

Hon. DANIEL J. FLOOD,
Chairman, Subcommittee on Labor and HEW Appropriations,
House Appropriations Committee, Washington, D.C.

DEAR MR. CHAIRMAN: Attached please find a letter from the Very Rev. Msgr. Newman, superintendent of schools, Department of Education, Archdiocese of Baltimore, which I shall appreciate being made a part of the record of the hearings of the Labor HEW appropriation bill of 1969.

I am in complete agreement with the statements in Monsignor Newman's letter and shall greatly appreciate your careful consideration of it and your cooperation in this matter.

Kindest personal regards, I am

Sincerely yours,

GEORGE H. FALLON.

[Enclosure.]

DEPARTMENT OF EDUCATION, ARCHDIOCESE OF BALTIMORE,
OFFICE OF THE SUPERINTENDENT,
Baltimore, Md., April 9, 1968.

Congressman GEORGE H. FALLON,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN FALLON: Title II of the Elementary and Secondary Education Act has undoubtedly been an important agent in the improvement of education. Great benefit has been derived from participation in this program. Many students who had previously been deprived of school library services now enjoy the advantages of a library program which can provide them with the necessary tools for learning.

You no doubt are aware that for the fiscal years 1966, 1967, and 1968 Congress appropriated for this program $100 million, $105 million and $104.5 million respectively. Now despite Congress' authorization of $167 million for title II in fiscal year 1969 the administration is requesting only $46 million. Locally this would mean that less than 75 cents per student would be allocated for school library resources, textbooks, and other instructional material. Such a drastic cutback would so seriously handicap the program that its impact on education would be negligible. It is obvious that under such conditions title II could not accomplish its purpose.

I am keenly aware of the necessity of establishing priorities in such budget matters, and for that purpose I feel that it is incumbent upon me to inform you of my opinion concerning the benefits derived from the Elementary and Secondary Education Act for the children of your constituents. It has been our experience after 3 years of operation that, with the exception of title I, greater benefits have been derived from title II for all school children than from any other title; yet it is only title II which is being drastically cut.

I believe that it will be to the best interest of children who attend school in the State of Maryland that every possible effort be made to see that the appropriation for title II for fiscal year 1969 should be no less than the appropriation for the current year. I appeal to you to do whatever lies in your power to assure that such action will be taken.

Sincerely yours,

WILLIAM C. NEWMAN, *Superintendent of Schools.*

Vocational Education Works Study Program

LETTERS AND STATEMENTS OF JAMES W. COVEY, DIRECTOR, RICE LAKE SCHOOL OF VOCATIONAL, TECHNICAL, AND ADULT EDUCATION, (RICE LAKE, WIS.)

Mr. Flood. Congressman O'Konski has asked that we place in the record a letter he has received from the director of the Rice Lake School of Vocational, Technical, and Adult Education. This we will, of course, be happy to do.

(The letter follows:)

Rice Lake School of Vocational, Technical, and Education,
Rice Lake, Wis., February 15, 1968.

Hon. Alvin O'Konski,
House of Representatives,
Washington, D.C.

Dear Congressman O'Konski: Recently I received a letter regarding the President's recommendations to Congress on a fiscal budget for vocational education. Much to my chagrin, I notice that President Johnson is once more recommending that the work-study funds be omitted from the vocational education budget.

I am sure that you are aware that during this past year, these funds were taken out of the vocational education budget and somehow ended up in the Economic Opportunity Act budget. The end result being that our schools have been on the hook all year trying to establish a permanent, firm, work-study program. All of these uncertainties have certainly led to a confused situation.

The students who receive financial assistance, under the work-study program, really are in financial need. I know that you don't need to be reminded that the citizens of northwestern Wisconsin, which our school serves, in general, have a low annual average income. For your information, during this 1967–68 school year, 47 students, approximately 16 percent of our student body, are receiving assistance under this program with a working budget of $21,400. Without this help, I know a large number of these people would not be advancing their education.

This past year has been rough. In October, we were informed that there might not be work-study funds this year. Our school decided to operate this program on a half time basis during the months of November and December waiting to see what would happen. Finally, in January, when it was felt that our local budget was stretched well beyond its means, it was decided to discontinue the program. Three weeks after this decision was made and the students were informed that we would have to discontinue this program, we were informed that moneys would be available and we had to once more reestablish our program.

Th net effect of this budget juggling is one of confused planning. Our school is unable to prepare a financial aid program for our needy students because the types of money available are limited to loans and work-study only and if you take away the work-study funds, we really have a very meager financial aid program.

In recent years, our school has been involved in all sorts of occupational training programs under various governmental laws. It is my honest opinion that of all of these programs, the work-study funds are the best spent funds which the Federal Government can provide. Under this program, the students earn enough money to gain them an education and, in addition, they have to work for these funds.

This letter is to request your assistance in supporting any efforts which may be made to put the work-study funds back into the vocational education budget.

Sincerely,

James W. Covey,
Director.

STATEMENT OF THE NATIONAL TUBERCULOSIS AND RESPIRATORY DISEASE ASSOCIATION

Mr. FLOOD. I believe that completes the statements and other material that has been sent to us by Members of Congress. However, we have several statements sent to us by national organizations and others that we will now place in the record. The first is a very fine statement from the National Tuberculosis and Respiratory Disease Association that was brought to us yesterday by our friend and their very able Washington representative, Noble Swearingen.

(The statements follow:)

The National Tuberculosis and Respiratory Disease Association wishes to comment on the appropriations requested for several programs of the Public Health Service with which its interests are closely intertwined. The program of the NTRDA and its affiliated associations throughout the States is concerned with control of all respiratory diseases, and, because respiratory conditions are affected by air pollution, with efforts to provide healthful air.

Throughout their long history, tuberculosis and respiratory disease associations have operated on the premise that the combined efforts of government and voluntary agencies offer the most satisfactory approach to providing good healh services. We have welcomed the leadership which the Federal Government has provided in recent years in instituting such major health programs as the regional medical programs, recognizing that the resources of the Federal Government are essential to solving many of the health problems of our complex 20th century society. We would like to discuss certain Federal activities which will influence future services for tuberculosis and other respiratory disease patients.

NEEDS IN CHRONIC RESPIRATORY DISEASE CONTROL

Congressional action

The NTRDA expresses its tremendous gratitude to Congress for recognizing the great needs of chronic respiratory disease patients in their action of last year. The congressional request that projects be initiated in control of emphysema and related diseases in regional medical programs in fiscal 1968 is the most important development of recent years in attempting some solution to this critical disease problem.

The problem of chronic respiratory disease

The tremendous increase in chronic respiratory conditions has been the subject of considerable discussion in recent years. There is abundant documentation that the increase is real and that these diseases constitute a grave medical problem. Emphysema and chronic bronchitis, which frequently coexist, account for extensive illness and high medical care costs. Because they affect the patient's capacity to breathe, they are frightening, exhausting, and often severely disabling conditions.

Emphysema is now the second cause of disability among workers retired prior to age 65, and costs the Federal Government about $90 million annually in social security disability benefits. Emphysema, chronic bronchitis, and asthma together have risen to 10th cause of death in the United States, due primarily to the acceleration of mortality from emphysema. By 1966, emphysema deaths had risen to 20,252 from a total of only 1,204 in 1950.

A task force on chronic bronchitis and emphysema was appointed jointly by the Public Health Service and the NTRDA in 1966 to discuss how the rise in these diseases could be arrested and how more help could be brought to patients. It was on the basis of the recommendations of this group that the NTRDA requested the assistance of Congress in 1967 in providing some impetus within regional medical programs to stimulate programs in chronic respiratory disease.

The resources

In spite of the limited knowledge as to the causes of conditions of pulmonary insufficiency, a considerable amount of alleviation can be offered to patients already ill and their prospects for rehabilitation can be improved with certain kinds of exercises and medical regimen. Optimum handling of patients with emphysema and related respiratory conditions requires not only the provision of medical supervision by competent physicians but also application of nursing and paramedical skills by personnel who are trained in the proper use of diagonstic, therapeutic, and rehabilitative procedures and in evaluation of the patient's physiological response. Mismanagement of the patient's condition can be as serious as neglect.

Findings presented at the 1966 conference were extremely alarming as to the capability of most communities to provide high quality care for patients even at the point where they are acutely and often critically ill. Information available to us indicates that the situation remains critical. Most physicians are not prepared to provide the kind of help whereby patients can maintain themselves in a functioning capacity. This situation is due largely to the lack of adequate preparation of medical students for the proper handling of respiratory disease patients. The curricula of most medical schools do not include sufficient attention to pulmonary diseases because the recognition of the rise in incidence of these diseases is comparatively recent. The number of well-trained paramedical personnel working in the field of chronic respiratory disease, such as inhalation therapists, is also very limited.

The role of RMP's

The area of chronic respiratory disease is a logical extension of activities in regional medical programs as authorized in the enabling legislation because of the interdependence between the respiratory and circulatory systems; serious lung disease adversely affects the heart and serious heart disease adversely affects the lungs. Some regional medical programs have already recognized the need to incorporate chronic respiratory disease projects. A substantial interest in respiratory disease exists throughout the network of regional medical programs and we believe that with involvement of interested community groups, the impetus to provide such projects will be significantly increased. We anticipate that our associations will be able to contribute in various ways to the development of these projects.

Because the purpose of regional medical programs is to improve the medical care delivery system through demonstrations, consultation, and continuing education of the community physicians and other health workers, these programs can be a very influential factor in expanding and improving services for chronic respiratory disease patients. However, the full realization of the potential of regional medical programs will depend on the availability of trained personnel in the various disciplines with which their activities are involved. Unfortunately, the dearth of physicians trained in the specialty of pulmonary disease may seriously impede progress in programs concerned with this area of clinical medicine.

Need for medical and allied manpower

A survey of medical schools done in 1966 by our medical section, the American Thoracic Society, showed that 20 percent of all medical schools had no undergraduate teaching program of any kind in pulmonary disease. Ten medical schools had no full-time faculty member assigned to pulmonary disease teaching and 18 had only one. Over a third of all schools did not assign students to chest clinic patients.

Medical schools find it difficult to improve this situation because of the scarcity of men qualified to teach the specialty of pulmonary disease and the lack of funds to get started. As part of our total program, and with the help of our affiliated associations, the NTRDA and the American Thoracic Society have for many years supported the preparation of doctors in chronic respiratory disease diagnosis and treatment through a program of fellowships and grants. However, to meet the full demand for such people greatly exceeds our resources and we welcome the Federal programs whose purpose is to increase the supply of medical manpower.

Federal manpower programs

Through its grants for graduate clinical training, the National Heart Institute is the principle program in the Federal Government directly concerned with increasing the supply of respiratory diseases specialists. In fiscal 1969, funds will

be requested to support traineeships for 1,195 doctors. Only part of these funds will be used for pulmonary disease training.

The sum requested for 1969 for training grants in the National Heart Institute will train 180 fewer medical specialists than were trained in 1968 and 305 fewer than were trained in 1967. Since the number of physicians receiving grants for pulmonary disease training is only part of the total receiving graduate clinical training grants, it is obvious that with such trends we will not produce the numbers of specialists needed to expand instruction in pulmonary disease and to inspire medical students to devote their careers to this field. Nor will we be able to provide the medical direction for increasing the supply of paramedical personnel so necessary to the care of respiratory disease patients because of technological advances and the limited numbers of physicians.

Expanded services for chronic respiratory disease patients must be anticipated and planned for in Federal manpower programs if we are to meet the enlarged demands generated by regional medical programs and by medical care programs serving the aged, in whom emphysema is most prevalent. Therefore—

1. The NTRDA requests that Congress increase the amount of funds available in the National Heart Institute for training of doctors in pulmonary disease. More funds must be devoted to this program in order to increase the supply of practitioners equipped to give patients with emphysema and related conditions the skilled medical care they need and in order to improve the capabilities of medical schools in pulmonary disease education.

2. The NTRDA records its support for the requested appropriation for fiscal 1969 for the regional medical program in order that this important program can proceed to implement the many plans developed in its initial period of existence. On February 9, 1968, the NTRDA board of directors urged that there be no fiscal restriction on the acceleration of activities in RMP's directed at expanding and improving services for patients with emphysema and other chronic respiratory diseases so that these persons could finally begin to receive the medical help which they so acutely need. We would expect that the amount requested for the RMP budget in 1969 would enable RMP's to at least double the amount of funds to be expended next year on chronic respiratory disease projects as compared with the amount designated by Congress for this purpose in 1968.

Chronic respiratory disease program, PHS

The chronic respiratory disease program of the National Center for Chronic Disease Control of the PHS provides the focus for much of the Federal Government's activities in the control of emphysema, chronic bronchitis and related diseases. These activities have consisted of very important epidemiological studies and demonstrations which are adding to our knowledge about the ways in which these diseases develop, whether certain persons have higher risk of developing them, and what kinds of therapy and rehabilitation are most effective. Such studies are essential to planning effective control programs.

The chronic respiratory disease program was initiated in fiscal 1966. Its budget has been modest from the beginning. For the current year, it approximates $1,600,000 inclusive of about $450,000 devoted to special programs for upgrading medical care of children afflicted with chronic pulmonary disorders, such as cystic fibrosis. Excluding the latter specialized program which was initiated in fiscal 1968, the budget is practically the same as the first appropriation in 1966. For fiscal 1969, the requested appropriation for the program is slightly over $2 million for all activities, including those concerned with pediatric pulmonary disorders, a very modest increase over the previous year.

The NTRDA gives its unqualified support to the administration's requested budget for the chronic respiratory disease program, PHS, for fiscal 1969, believing that this is a minimal amount for developing needed epidemiological knowledge about these diseases whose causation is so poorly understood.

Air pollution

Experience has shown that severe air pollution has a deleterious and often fatal effect on persons already suffering from serious respiratory ailments. Much research is being conducted on the precise role of pollution in the development of disease. It is reasonable to assume that air pollution is a significant factor in the development of many chronic respiratory diseases.

Because the air pollution situation had grown considerably worse, the National Tuberculosis and Respiratory Disease Association appointed a National Air Con-

servation Commission in 1966. Members of this commission are distinguished persons with diverse skills and technical knowledge. The goal of the commission is to further the promotion of control programs at the local, State, and Federal levels, through efforts to make the public more aware of the dangers of pollution.

Although the proposed appropriation for the Division of Air Pollution, PHS, is less than the amount authorized, the NACC welcomes the large increase over the fiscal 1968 appropriation. This increase will be necessary to finance the progress in control activities made possible by the 1967 amendments to the Clean Air Act.

The NTRDA and its National Air Conservation Commission support the proposed budget for air pollution for fiscal 1969.

The National Clearinghouse on Smoking and Health

This agency of the Federal Government has contributed significantly to expanding and improving informational materials on the dangers of cigarette smoking. It has a special role to fulfill in this area since the recent Federal Communications Commission ruling which requires that more time be allowed by the radio and television networks to the subject of smoking and health.

The clearinghouse also works closely with voluntary agencies such as ours to promote programs to discourage young persons from taking up cigarette smoking and to help smokers cease the habit. We believe that the clearinghouse should receive strong support since it represents the only Federal agency with specific responsibilities concerning a problem which is fast becoming one of the major public health issues of the country.

For the first time since it was established, the administration is asking for an increase in the budget for the clearinghouse. The increase is approximately $500,000, a very nominal amount when one considers the extent of the financial resources arrayed on the side of the tobacco industry and the extensive use of these resources to promote only the desirable and beneficial attributes of cigarette smoking.

The NTRDA supports the administration's requested budget for the National Clearinghouse on Smoking and Health, believing that an expansion in its activities is essential in the light of the continuous promotion of cigarette smoking by the tobacco industry.

TUBERCULOSIS

The TB problem

Hearing that tuberculosis deaths have decreased, many do not realize that large numbers of persons continue to develop this chronic, relapsing disease which needs lifetime followup. In 1966, the latest year for which final statistics are available, almost 48,000 persons were reported for the first time to health departments as active cases of tuberculosis. None of these cases should have developed because we know the cause of the disease, how to prevent it and how to treat it effectively. We fear that such facts cannot be given adequate program recognition in State plans under the comprehensive health planning approach, which must consider all health needs in relation to the limited amount of Federal funds being requested and which are below even the authorized levels for 1969.

Our review of tuberculosis control activities of the Federal Government in recent years presents the scope of support needed in the years ahead.

Federal support of TB

A tuberculosis program was first provided in the Public Health Service in 1945. Beginning with that year, formula funds were granted to States to supplement their activities in tuberculosis control. In 1962, project grants also became available and shortly thereafter accounted for the bulk of Federal support of tuberculosis control programs.

Specific drug therapies were developed beginning with the mid-1940's which proved extremely effective in arresting the disease. In 1963, a task force was appointed by the Surgeon General, USPHS, to make recommendations on how activities to reduce the incidence of tuberculosis could be accelerated. The task force recommended substantially increased Federal support of tuberculosis control programs in the States during the next decade, aimed at thorough treatment of the active cases, and supervision of persons at risk of developing disease. Congress recognized the importance of these recommendations and appropriated substantial increases in TB project grants beginning in fiscal 1965.

In the current fiscal year, there has been only minor change in the process of supporting existing tuberculosis projects, because of the need to allow a transitional period during which planning procedures in the States could be developed. It is estimated that approximately $17.5 million in Federal funds will be expended for tuberculosis projects in fiscal 1968, which, although a substantial sum, is below the $25 million recommended for expenditure this year in the task force plan. In addition, approximately $3 million in formula grant funds will be devoted to TB control during the current fiscal year which again is lower than the task force recommendation of $4,200,000. It is estimated that this sum of more than $25 million expended from Federal funds represents at least one-third of the current funds going into support of tuberculosis control activities, a very substantial proportion.

What has been and remains to be accomplished

As of June 1967 over 200,000 TB cases or 65 percent of all cases known to health authorities, were in areas receiving Federal project grants. This means Federal support has been directed at areas where the TB problem is greatest, and that efforts are being exerted to bring maximum supervision to cases, a dramatic improvement over the record of these areas which were previously handicapped by inadequate staff and other resources. This intensification of tuberculosis control in the past few years could not have been possible without expansion of tuberculosis project grants under the competent direction of the staff of the tuberculosis program, PHS, who have devoted many years to evaluation of tuberculosis control and to developing procedures to make then more efficient.

Even so, tuberculosis control is notably deficient. Improved performance requires augmented resources over a long period of time. Many personnel are required to maintain records, to follow persons who are overdue for examination, to arrange clinic visits, to work with patients to obtain maximum cooperation, and to deliver clinic services essential to treatment. Of the various indices of progress in control, practically all show that we have a long way to go.

As of the middle of 1967 the composite record of project areas showed that almost half of all active cases at home had not had an examination within the previous 6 months to show if their sputum was positive for bacilli and if these persons, therefore, were contagious. Only 60 percent were reported to be on drug therapy, the most effective modern treatment for tuberculosis. Making allowances for errors in recording information, these percentages are of a dimension which indicates that great intensification of control is still needed throughout the country. The fact that maximum TB control can be accomplished is illustrated by certain clinics in the city of San Francisco in one of the special project areas receiving Federal assistance. In these clinics, located in areas populated by low-income, ethnic minorities whose health motivation is reputedly low, a combination of innovative methods and adequate financial support has resulted in obtaining a rate of sputum examinations in over 95 percent of all active cases, and an excellent record of adhering to a prescribed drug regimen.

Support needed in the year ahead

For fiscal 1969, the sume recommended by the task force for Federal support of tuberculosis control is again $25 million in project grants and over $4 million in formula funds. This estimate of need does not take into account the inflationary trend of the intervening years since the time of the 1963 report.

Twenty-five million dollars for tuberculosis project grants represents one-fourth of the total sum authorized under section 314(e), Public Health Service Act, for project grants for all health activities in fiscal 1969. Moreover, because the requested appropriation is less than the amount authorized ($89.1 million instead of $95 million) the proportion that $25 million represents of the requested appropriation is even greater.

Increased population, increased expectations for good health care, a larger number of aged persons, and a steady development of new medical knowledge and expensive techniques will mean heavier adn well justified demands for a vari- and expensive techniques will mean heavier and well justified demands for a vari- $14 million below the authorized amount and for project funds which are $6 million below, it is easy to understand our uneasiness about the likelihood of tuberculosis control continuing at the level it has in the past few years.

Tuberculosis remains one of our major public health problems, found most frequently among the enclaves of poverty in our large cities where usually case

finding is inadequate, clinics poorly housed and poorly staffed, and health services underfinanced. Application of known effective techniques to reduce the incidence of tuberculosis should not be allowed to falter now because of inadequate funds, lest we experience the same situation that was demonstrated in veneral disease control when rates increased markedly after overoptimism led to reduction in Federal grants.

The NTRDA requests Congress to appropriate the full amounts authorized for fiscal 1969 for formula and project grants for health services, 314 (d) and (e), in order to allow for as much assistance as possible to States and communities in their programs to provide adequate health services.

We thank you for the opportunity to present our views.

Labor-HEW Appropriations for Programs in Nursing

STATEMENT BY THE AMERICAN NURSES' ASSOCIATION

The American Nurses' Association, the professional organization of graduate nurses, representing over 200,000 members, wishes to record its views on the proposals for appropriations which you are considering. The American Nurses' Association continues to support programs administered by the Department of Health, Education, and Welfare, and the Department of Labor. During the 90th Congress, among the issues the association spoke in favor of were comprehensive planning grants, regional medical programs, support for mental health and mental retardation facilities and staff. Over the years, the association has supported other health and welfare programs.

At this time we will confine our statement to the proposals for financing the health manpower programs, and comment specifically on the funds for the Nurse Training Act.

CONSTRUCTION GRANTS

The authorization for construction for schools of nursing is $25 million. This year the administration is proposing $8 million, one-third of funds authorized. Fifteen projects, already authorized, have not been funded; requests for these projects total $9.4 million. In addition, there are 115 letters of intent to submit construction projects. Since the program began in fiscal 1966, 80 schools have received grants which have provided for 2,700 new first-year places and permitted the maintenance of 12,000 spaces by renovating obsolete facilities or minor expansion. The program review committee on the Nurse Training Act reported that many nursing education programs are located in makeshift quarters, barracks, dormitories, or basement areas that are unsafe and poorly ventilated. Each year of delay in providing funds for buildings constitutes a loss in health manpower since the existing schools cannot expand enrollments. Even if funds were made available this year, the number of nurses could not be expected to increase for at least 5 years, estimating construction time and length of nursing education programs. We urge this committee to seriously consider the need for the full appropriation of $25 million for construction grants.

TRAINEESHIP PROGRAM

Twelve million dollars is authorized for the traineeship program, while only $11 million is proposed. The program review committee estimated that at least $4 million more could be expended; particularly if these funds could be used to assist graduates of diploma programs to secure their baccalaureate degree. The need for faculty, supervisors, and administrators in all types of programs is desperate, There are 1,744 budgeted faculty vacancies. It is not possible to expand enrollments to increase the nurse power, unless there are prepared faculty. Instruction in the clinical centers demands well-qualified supervisors. The quality of nursing practice is determined by the organizational framework in which the student nurse learns to become a competent practitioner. During the years 1967–66, 16,162 nurses were awarded traineeships. Although this program has increased the number of nurses with graduate degrees, the need is still great. At present there are only 42.8 percent of full-time faculty in all nursing programs that have graduate degrees.

SCHOLARSHIP AID

There are over 8,000 nurse graduates of diploma and associate degree programs who are studying for their baccalaureate degrees. In 1966, at least half of these were enrolled on a part-time basis. This practice is uneconomical in time and money. Therefore we recommend that at least the full amount of the authorization of $12 million be proposed so that many of the nurses who are now spending 6 or 7 years securing their degree can enroll full time and be able to enter the active nurse force at a much earlier date. We also urge that the full amount of $7 million for student aid, as authorized in the 1966 Amendments to the Nurse Training Act, be included in the appropriation bill. Education is becoming increasingly expensive, and for the young persons who are entering a 4-year program, the cost to the family can be prohibitive.

RECRUITMENT OF DISADVANTAGED INTO NURSING

The association is cooperating with the division of nursing in developing a project to work with disadvantaged youth to interest them in nursing, and to motivate them to enter the occupation. This program was made possible by the 1966 amendments and the appropriation for fiscal year 1967–68. We believe that this project can furnish future nurse candidates as well as assist the ANA in developing the most successful methods in the art of recruitment. Continuation of this program will be carried out under the institutional support recommended in the Health Manpower Act, H.R. 15757.

RESEARCH

The division of nursing conducts a program of applied and scientific research and supports research fellowships. The budget for this program has remained static for many years, which limits the number of project grants which can be funded. It also limits the number of new fellowships each year, since no new persons can be funded until one of those now studying has completed their program. The budget for fiscal year 1969 does increase the allotments to the following amounts:

Project grants—$3,500,000—an increase of $845,000.
Fellowships—$800,000.
Nurse Scientist Training Grants—$700,000.

The ANA does support these minimal increases, with the expectation that as the demands on the Federal budget ease, the programs can be increased.

CONCLUSION

The members of the association are aware of the need for economy, and the strong pressures to trim the budget, but we believe that any drastic reductions in funds for preparing health manpower would be ill-advised at this time. The need for health manpower in all branches of the armed services to care for our soldiers and veterans, as well as the civilian population, should receive priority.

The American Nurses' Association, the professional organization of over 200,000 graduate nurses, aso wishes to record its support for certain programs of the Department of Labor.

MANPOWER DEVELOPMENT AND TRAINING ACT

During 1967 the American Nurses' Association has worked closely with the Manpower Development and Training Act to develop guidelines for local communities to assist in nurse refresher course training. The project has been coordinated with the program of the Division of Nursing, Bureau of Health Manpower, Department of Health, Education, and Welfare. Coordinators have been employed in 45 States and the District of Columbia, and the American Nurses' Association has received a grant for promotional materials from the Division of Nursing. Although it is premature to evaluate the success of these efforts, we do know that approximately 6,500 nurses have been returned to full-time or part-time employment. Most success has occurred in States or localities where nurse salaries make it economically desirable for nurses with families to return to work. We strongly recommend continued appropriations for this meaningful program.

BUREAU OF LABOR STATISTICS

The Bureau of Labor Statistics has furnished valuable data through the hospital and nursing home salary surveys conducted every 3 years. It is anticipated that the Bureau will now collect data on rate of wage change in nonmanufacturing industries. This data would include hospitals and nursing homes. Coverage of hospitals and nursing homes under the Fair Labor Standards Act and the rate of change of nurse salaries in the past 2 years increases the need for annual wage surveys and the rate of wage change in these industries. This data will be especially important as the investigation of costs of medical care are conducted. We urge that the full amount of the budget be allowed.

WAGE AND HOUR DIVISION

The staff of the Wage and Hour Division is inadequate to inspect all of the facilities which are now covered by the Fair Labor Standards Act, as amended. There is virtually no significant data on the compliance of the hospital and nursing home industries since the enactment of the amendments to the Fair Labor Standards Act in 1966. Until additional staff are available, the effects of the amendments cannot be evaluated.

We realize that the Congress is faced with difficult decisions in the priorities which must be determined in the allocation of available funds. But we do believe that urgent domestic programs must be maintained.

Programs for the Education of Handicapped Children

STATEMENT OF THE COUNCIL FOR EXCEPTIONAL CHILDREN

Mr. Chairman and members of the committee, the Council for Exceptional Children, a professional organization of over 33,000 special educators serving handicapped children and youth, is pleased to submit a statement concerning those aspects of the proposed budget relating to the education of handicapped children. The council commends the chairman and the members of the committee for their long interest and support of programs for handicapped children and youth, and we appreciate this opportunity to address ourselves to some of the problems reflected in this year's budget proposals.

We would like to take this opportunity to laud the Congress and the administration for the propitious manner in which the Bureau for the Education of the Handicapped and the National Advisory Committee on Handicapped Children have been established. All reports from the field are most complimentary as to the manner in which these two bodies have jointly approached and attacked problems of educational opportunity for these children.

PERSONNEL

Over a decade ago with the passage of Public Law 85–926, the Congress of the United States entered into a long-term commitment with the handicapped children of this Nation to guarantee them equality of educational opportunity. Realizing that the basic foundation for adequate programs was well-trained personnel, and that at that time, there were less than 30,000 special educators to serve over 4 million handicapped children, efforts were undertaken to enhance the capabilities of personnel in the field and to provide training for those entering the field. In the last decade, appropriations totaling approximately $100 million have provided over 250 program development grants to colleges and universities to begin programs to train personnel, full-year academic fellowships to over 14,000 students, summer training programs to approximately 6,000 teachers and administrators, and special study institutes to over 12,000 participants (see table I). A side effect of this financial commitment has been the increase of State and other non-Federal funds in this area. The State of Illinois, for example, is preparing over 3,000 special educators on other than Federal funds in addition to the many students receiving Federal assistance.

While this effort has provided the major thrust to swelling our ranks to over 70,000, the need for trained manpower is still acute. It is estimated that over 300,000 teachers and specialists are needed now and 375,000 will be required by 1976. To assist in this venture, the Congress last year passed Public Law 90–247, the Elementary and Secondary Education Act Amendments of 1967, to provide funds to recruit much-needed personnel into the field. The Council for Excep-

tional Children and many State education agencies, while presently engaged in recruitment activities, view these funds as providing the basis for a national effort and campaign to attract high school and college students and other persons into working with handicapped children. Of particular interest to us as a source of manpower are returning Peace Corps workers and military personnel. The Federal effort of providing for recruitment and training will, we hope, assist in narrowing the gap between needed and available qualified personnel.

RESEARCH

Public Law 88–164 provided the second step in congressional commitment to the handicapped child. Following logical procedures, Congress authorized the Office of Education to stimulate and support research and demonstration projects relevant to the education of handicapped children. The Council for Exceptional Children believes very strongly in the principle of building programs on a solid research foundation. We believe it to be the responsibility of all educators to assess and validate their practices. Until 1963, very little had been done to investigate the unique learning characteristics of the handicapped child and the teaching techniques and materials that are necessary to meet these uniquenesses. The moneys appropriated by this committee for research are having a significant effect on special education.

Research without effective means of dissemination is valueless. The Bureau for the Education of the Handicapped has established a national network of 14 Regional Instructional Materials Centers. These centers have three component functions: (a) a service function; (b) a research development activity; and (c) stimulation of materials production activity.

The service function includes: (a) the acquisition of commercial and teacher prepared instructional materials; (b) describing, classifying, and organizing these materials; and (c) the dissemination of materials and information to educators.

The research and development phase includes the evaluation of instructional materials and the development and production of new materials on a pilot basis for experimental trial or demonstration to establish their effectiveness.

The stimulation of production phase includes: (a) contacting the organizations which have the production capacity (sheltered workshops or commercial publishers) and encouraging them to produce materials which have been found to be effective in the research phase; and (b) consulting with producers to assure that ideas which they believe have merit are given consideration.

Mr. Chairman and members of the committee, these centers are providing direct service to local education agencies and their staffs, and we feel are making a major contribution to the field, for it is at this level that we can begin to see the effects of our national efforts on the actual learning of children.

Another means of dissemination that is greatly affecting, not only the field of special education, but the whole field of education, are the Educational Research Information Centers (ERIC for short). ERIC's purpose is to speed the results of educational research and development activities to educators and others interested in educational improvements. The Council for Exceptional Children is pleased to operate the ERIC Clearinghouse for Exceptional Children, one of the 17 clearinghouses that form the basis of the ERIC system. The Clearinghouse for Exceptional Children is funded under the research program administered by the Bureau of Education for the Handicapped whereas the bulk of the funds for the ERIC system come from funds administered through the Bureau of Research, Office of Education.

We would like to address ourselves briefly to some of the benefits that we see coming from the total ERIC system. We will not spend time elaborating on the functions of ERIC, since this information can best be provided by Office of Education representatives.

First, as a national resource, ERIC provides basic services which permit others interested in dissemination to develop special information services suited to the unique needs of our clientele. No State or local educational agency can economically undertake the scope of services being provided by ERIC. For any to try would result in poor service, vast duplication of effort, and tremendous waste of scarce resources. ERIC can do the basic job of collecting and processing documents, announcing and disseminating them effectively and quickly to many groups. These groups can build upon this foundation. An example of this is the Clearinghouse for Exceptional Children which is coordinating closely with the 14

Instructional Material Centers, mentioned previously, to develop a flow of information from a national to a regional to a local level.

Second, reports are not only easily identified, but are also readily available with resultant savings of an unestimable number of man-years. In place of inefficient, laborious, and often wasteful effort in locating needed information, we can now quickly find what we need. Professional staff are freed of clerical tasks and can devote themselves to professional effort. As a result, scarce manpower can be better utilized. Added benefits from the more efficient use of manpower can run into the equivalent of millions of dollars as measured in terms of salary of staff at State and local educational agencies.

Third, the timelag between the reporting of results of research efforts and the general use of these findings is greatly reduced. Instead of waiting for information to percolate through many different levels of education and among many different groups, we can now go directly to the results of the original research.

Fourth, development of new programs and revisions of present programs can be based on the best available current information. Each educator regardless of where he is in the country can have access to all information relevant to the problems in which he is working. We believe that ERIC represents a fine beginning in strengthening communication in education. Its potential though is far from reached. As a nation we could obtain far greater benefits from the billions being invested in education from all sources, including State, local, private, and Federal, if persons responsible for developing new programs had rapid access to current information. We recommend that the ERIC program be as fully funded as possible to enable it to expand and develop efficiently and effectively.

EDUCATIONAL SERVICES

The passage of Title VI of the Elementary and Secondary Education Act of 1965 represented a bold venture on the part of Congress to aid States in their attempts to help over 5 million handicapped children, over half of whom were receiving no special education assistance. The minimal funding of title VI over the past 3 years has brought to fruition complete and comprehensive State plans. These plans reflect the efforts of thousands of educators, lay persons, and parents representing public and private agencies. The plans are a prescription of how each State plans to meet the needs of their handicapped children within the uniqueness of their own State. Mr. Chairman and members of the committee, the Council for Exceptional Children believes that the States have met their responsibility in regard to title VI and are now ready to implement the efforts of the past 3 years and that the 5 million handicapped children of this country are ready to receive an education that will result in their becoming productive citizens instead of wards of society. It is estimated that as contributors to society these children, as adults, would have an annual capacity of over $15 billion. Not only does the failure to provide for these children result in serious hardship on our country, the family and the child, but also on the very fiber of our public schools. This problem is reported well in the report of the National Advisory Commission on Civil Disorders:

"A 1963 survey of Chicago public schools showed that the condition creating the highest amount of dissatisfaction among teachers was the lack of adequate provisions for the treatment of maladjusted, retarded, and disturbed pupils. About 79 percent of elementary school teachers and 67 percent of high school teachers named this item as a key factor. The need for professional support in dealing with the extraordinary problems is seldom, if ever, met."

The $32 million requested by the administration (19.7 percent of an authorization of $162.5 million) falls far short of the necessary amount for States to undertake the steps necessary to effectively implement their plans. It should be noted that under the suggested level of funding, over one-half of the States will receive less than $500,000. A dozen States will receive less than $150,000, and five States only $100,000. Such funding makes the massive attack necessary impossible to achieve (see table II). The $32 million requested by the administration when divided among the 5 million for whom it was intended means that the Federal Government is providing $6.40 to help each handicapped child receive an education. This is a sad commentary on our national commitment.

Public Law 90–247, the Elementary and Secondary Education Act Amendments of 1967, added two new service components to the Bureau for the education of the handicapped and expanded a third. The first of these authorizes the Bureau to create regional resource centers to provide educational evaluation assistance to aid in developing educational strategies for handicapped children.

One major problem of local school agencies, particularly in rural areas, is their inability to hire necessary diagnostic personnel to provide adequate evaluations of the educational needs of handicapped children. Without such evaluations the educational process is severely hampered. This new authority would create several school districts to combine to create a center for pupil evaluation purposes. The second new authority enables the Bureau to provide for the establishment and operation of centers for children who are both deaf and blind. This provision, in the tradition of Gallaudet College and the National Technical Institute for the Deaf, recognizes the concept of a Federal role in meeting the needs of children whose disabilities demand services that are beyond the capabilities of a single State. Public Law 90-247 also expanded the program established under Public Law 85-905 designed to provide films and other educational media for the deaf on an loan basis and research and training on the use of such media to all of the handicapped. We anticipate that this expansion will mean that the numerous benefits that captioned films for the deaf provided for deaf persons over the years will now be available to all of the handicapped with reference to developing educational media.

Mr. Chairman and members of the committee, the Council for Exceptional Children is concerned about the level of funding requested for these three new authorities. While funds were authorized for these programs in 1968, there were no supplemental appropriations made to get them off the ground. We commend Dr. James Gallagher, Associate Commissioner of Education and Director of the Bureau for the Education of the Handicapped, for making it possible for committees to meet to develop plans for the implementation of these new programs. It was our hope that since no funding was provided in fiscal year 1968 that a high level of funding would be provided in fiscal 1969 to make up for the time lost and to make these programs a reality. However, the administration has only asked for $2 million for the regional resource centers (26 percent of the authority), $1 million for the education of deaf-blind children (33.33 percent of the authority), and $4.75 million for educational media (59.3 percent of the authority). We hope this committee will give consideration to increasing funds for these programs, so that these much needed services can be provided.

AID TO STATE SUPPORTED SCHOOLS AND INSTITUTIONS

The condition of our State schools and institutions for the severely handicapped has been one of our Nation's greatest crosses; however increased Federal involvement in the past decade has brought about positive change so that the following recent report by a State legislator is becoming increasingly less common:

"In one building there are 89 retardates warehoused on the ground floor in a large room with a concrete floor and large, out-dated benches. . . . Many have spent every day of their life, since infancy, sitting and staring at the same wall."

One major improvement in the lifespace of these children has been the development of educational programs. During the school year 1966-67, Public Law 89-313 brought educational experiences to nearly 100,000 children, many of whom had never seen a classroom or a teacher before. An example of what Public Law 89-313 is accomplishing is best illustrated by the ease of Hosie, as reported by the National Advisory Committee on the Handicapped:

He was admitted to Woodbridge State School in New Jersey at the age of 12, a victim of celebral palsy. Hosie was unable to dress himself, talk and was hyperactive. Public Law 89-313 funds made it possible to engage a full-time certified teacher for the cottage where Hosie lives with 44 other nonambulatory children. Beginning in September 1966, Hosie attended school 5 days a week. He learned to respond when his name was called by raising his hand and to recognize and place his name-tag on the proper hook of the rollcall board. He learned to hum tunes and began to dress himself, a skill the teacher thought might never be possible when she first saw Hosie. For Hosie and his classmates, Federal resources and State effort have created a chance for change, and he won't be placed in the back wards of a State institution and be forgotten. Although limited by his handicaps, Hosie's future will be brighter; his aspirations raised; his cost to society reduced; and his hope for today kindled.

The Lighthaven State School and Hospital in Luzerne County, Pa., in fiscal year 1967, used a grant of $18,753 to bring to 230 children in that facility the outside world. The staff at the Lighthaven State School and Hospital exposed pupils to meaningful learning experiences so that they would be able to grasp the realities of the modern outside world. Another program at Parson State Hospital

in Kansas employed six teachers, 12 teacher aides, and a supervisor to provide basic language skills, and vocational preparation to 317 trainable retarded children. The total cost of this program was less than $54,000. Public Law 89-313 became the major vehicle for educating handicapped children in state supported schools and institutions. These handicapped children represent a fairly stable population, while the title I deprived population greatly increases each year, thus decreasing the per capita funds available under Public Law 89-313. Realizing the drastic effect of proration on these programs, Congress last year, in Public Law 90-247, guaranteed the full funding of these programs. Without this provision, these programs would have suffered a serious setback. While receiving an average $283 per child in fiscal year 1968, it was estimated that such facilities would receive approximately $160 per child in fiscal year 1969 without "off the top" funding. This would mean a reduction of 44 percent of the funds each facility would receive. Thus, the farsighted commitment of Public Law 90-247 is enabling these facilities to anticipate funding and hire staff during the peak employment seasons of the spring and develop on-going comprehensive programs. We are pleased to report to this committee that, based upon the congressional commitment in Public Law 90-247, State schools and institutions have made major strides in preparing for fiscal year 1969 and that 1969 will be a year of dramatic improvement for these children.

PERSONNEL TRAINING AND RESEARCH ON PHYSICAL EDUCATION AND RECREATION FOR THE HANDICAPPED

Last year the Congress added title V to Public Law 88-164, the Mental Retardation Facilities and Construction Act, to fill a serious gap in programs for the handicapped. Testimony before the Congress pointed out the important role of physical education and recreation in the life of the handicapped and the serious lack of research in this area. We wish to bring to the attention of this committee that no funds have been requested by the administration to begin this program.

SUMMARY

Mr. Chairman and members of the committee, the Council for Exceptional Children realizes the financial demands being placed on the committee in regard to unrest both at home and abroad. Certainly the administration budget requests are a reflection of these demands. However, we urge your consideration of the following aspects of the budget in light of the congressional commitment to provide educational equality of opportunity to the over 5 million handicapped children of this Nation:

1. Full authority of $37.5 million is needed under Public Law 85-926 to provide critically needed personnel qualified to educate handicapped children.

2. The $32 million ($6.40 per child) requested by the administration is not sufficient to initiate the programs requested by the States. The Council for Exceptional Children recommends that substantial increases be provided in the fiscal year 1969 appropriation.

3. The administration failed to provide funds for three new or expanded authorities of the Bureau for the Education of the Handicapped in fiscal year 1968 supplemental appropriations—regional resource centers, centers for children who are deaf and blind, and educational media for the handicapped. Minimal appropriations have been requested for fiscal year 1969. The Council for Exceptional Children urges the committee to consider a higher level for funding for these programs.

4. It is imperative that "off the top" funding of Public Law 89-313 programs in State-supported schools and institutions, established under Public Law 90-247, be maintained to prevent severe cutbacks in these programs.

5. The administration has failed to request funds to initiate the research and personnel training program in physical education and recreation for the handicapped established last year under Public Law 90-170. We suggest that the full authority of $3 million be provided.

Again, we thank the committee for this opportunity to present our views on this most important legislation.

TABLE I.—PROFESSIONAL TRAINING GRANTS AWARDED, DIVISION OF TRAINING PROGRAMS, FISCAL YEARS 1960-67

Area	Number of trainees and fellows, academic year	Number of trainees in summer programs	Number of participants in special study institutes	Number of program development grants
Mentally retarded	6,010	3,125	3,318	70
Deaf	2,733	345	780	4
Speech and hearing	1,537	589	2,030	46
Visually handicapped	708	461	647	9
Emotionally disturbed	1,212	558	926	49
Crippled	881	594	799	18
Other health impared	214	86	2,330	22
General (administrators, supervisors)	176	55	1,331	14
Total	13,471	5,812	12,161	232

TABLE II.—EDUCATIONAL IMPROVEMENT FOR THE HANDICAPPED—GRANTS TO STATES FOR PRESCHOOL AND SCHOOL PROGRAMS

[Fiscal year 1969, estimated allotment]

State and outlying areas	1969 estimate	State and outlying areas	1969 estimate
Total	$32,000,000		
Alabama	625,835	Montana	$123,074
Alaska	100,000	Nebraska	238,330
Arizona	246,330	Nevada	100,000
Arkansas	326,442	New Hampshire	101,861
California	2,627,751	New Jersey	950,020
Colorado	312,637	New Mexico	192,764
Connecticut	404,924	New York	2,555,090
Delaware	100,000	North Carolina	882,477
Florida	806,910	North Dakota	119,627
Georgia	747,948	Ohio	1,665,804
Hawaii	123,871	Oklahoma	402,134
Idaho	128,210	Oregon	305,842
Illinois	1,631,788	Pennsylvania	1,832,576
Indiana	816,741	Rhode Island	139,952
Iowa	474,433	South Carolina	491,900
Kansas	371,178	South Dakota	124,478
Kentucky	558,919	Tennessee	649,428
Louisiana	625,611	Texas	1,752,381
Maine	168,745	Utah	181,509
Maryland	541,276	Vermont	100,000
Massachusetts	822,839	Virginia	723,664
Michigan	1,390,468	Washington	495,366
Minnesota	605,674	West Virginia	344,219
Mississippi	438,055	Wisconsin	685,467
Missouri	703,400	Wyoming	100,000
		District of Columbia	110,033
		Outlying areas	932,039

National Center for Educational Statistics Appropriation

Letter and Statement by the National Association of State Universities and Land-Grant Colleges

National Association of State Universities
and Land-Grant Colleges,
Office of the Executive Director,
Washington, D.C., March 25, 1968.

Hon. Daniel J. Flood,
Chairman, Subcommittee on the Department of Health, Education, and Welfare., Committee on Appropriations, U.S. House of Representatives, Washington, D.C.

Dear Mr. Flood: I enclose herewith a statement on behalf of 12 major national organizations in higher education, which I would appreciate being made a part of the record—and the subject of consideration by your subcommittee—during hearings on the 1969 fiscal appropriations bill for the Department of Health, Education, and Welfare as they relate to the National Center for Educational Statistics, U.S. Office of Education.

The chief executive officers of each of the major organizations listed have endorsed this statement, as they have previously cooperated on several occasions in bringing to the attention of the Secretary of Health, Education, and Welfare and the U.S. Commissioner of Education, their great concern over the lack of availability to educational organizations and institutions and the general public, of statistical material.

The statement speaks for itself in describing the situation. We bring it to the attention of your committee, in the hope that adequate funds may be provided for performing one of the major functions of the U.S. office that has suffered in recent years, and that your committee will indicate its interest in seeing that this particular function is performed.

The educational organizations indicated comprehend, in their membership, a high percentage of all U.S. institutions of higher education, at all levels.

Sincerely,

RUSSELL I. THACKREY, *Executive Director.*

TESTIMONY ON BEHALF OF ASSOCIATION OF AMERICAN COLLEGES, AMERICAN ASSOCIATION FOR HIGHER EDUCATION, AMERICAN ASSOCIATION OF JUNIOR COLLEGES, AMERICAN ASSOCIATION OF STATE COLLEGES AND UNIVERSITIES, ASSOCIATION OF AMERICAN UNIVERSITIES, AMERICAN ASSOCIATION OF UNIVERSITY PROFESSORS, AMERICAN COUNCIL ON EDUCATION, COUNCIL OF GRADUATE SCHOOLS IN THE UNITED STATES, COUNCIL OF PROTESTANT COLLEGES AND UNIVERSITIES, NATIONAL ASSOCIATION OF STATE UNIVERSITIES AND LAND-GRANT COLLEGES, NATIONAL COMMISSION ON ACCREDITING, AND NATIONAL CATHOLIC ASSOCIATION ON PROPOSED INCREASE IN APPROPRIATIONS FOR THE NATIONAL CENTER FOR EDUCATIONAL STATISTICS

The associations which join in submitting testimony on the proposed budget increase for the National Center for Educational Statistics represent all major segments of higher education in our country.

These associations feel that increased support for the NCES is of utmost importance—provided such support is used to bring about an urgently needed improvement in the U.S. Office of Education's ability to perform its basic historical function of gathering and disseminating statistical information about education. Creation of the NCES was expected to be a major step in this direction; however, for a variety of reasons the promise of the NCES has not yet been fulfilled.

In recent years, the need for prompt availability of accurate educational statistics has increased greatly. Currently facts and figures are required by a growing number of users for a variety of purposes. Among these users are Congress, many Federal agencies, the individual institutions, States, and organizations which need appropriate statistical background in trying to plan and carry out the programs and activities needed to meet the rapidly rising demands for higher education in our Nation. Unfortunately, as the need for useful statistical information about education in general, and higher education in particular, has increased, the availability of such information has not kept pace.

In response to our inquiries, we have been told that much of the difficulty encountered by the USOE in meeting its responsibilities in the statistical area has stemmed largely from shortages in staff, inadequate provision for the use of data processing equipment, and delays in the publishing of completed reports. It is our understanding that the proposed $2.7 million increase in the NCES' budget will enable this agency to overcome these problems and provide the Congress, Federal agencies, and our educational institutions with the services they so badly need. It is also our hope that this committee will help impress upon the leading officials of the USOE and the Department of Health, Education, and Welfare the importance of producing timely statistical reports and upon the Government Printing Office the importance of expediting their production.

Publication of certain vital information has been delayed so long as to render it useless and to amount to largely wasted efforts on the part of project participants. Furthermore, the collection and publication of other needed information have in the past few years been suspended, leaving a dangerous void in our educational planning and evaluating mechanisms.

This is a time of constant change in enrollments, salaries, and other costs. Colleges and universities—as well as Congress—must think and plan not only 1, but also 5, 10, or more years ahead if we are to provide the faculties and facilities to meet the unprecendented demand for higher education. When we need current, complete figures and analysis for 1967–68 and reliable projections for the future,

and when our institutions are willing to cooperate by investing substantial amounts of time and effort into completing questionnaires from which this information can be derived, almost all we find available today are figures for 1963 or 1964.

The annual salary survey, for example, whose average figures are heavily relied upon by many institutions and States for comparative purposes in making and justifying budgets and determining trends, has not been published since the 1963–64 data were released. Although questionnaires have been sent out for fall 1966 salaries, these statistics are not yet generally available. Similarly, the recurring financial survey of institutions of higher education, detailing income and expenses, was last published for 1963–64 and is still available only in abbreviated "preliminary" form. Although institutions have responded in detail to requests for later information, their responses have not yet been tabulated and released.

Although there have been some efforts at improvement (this year's fall enrollment report was issued 5 months earlier than last year's, though still not soon enough), delayed or inaccessible information characterized many other vital survey areas. Among them are tuition, room and board charges; residence and migration of college students; college and university facilities; and the annual compilation of statistics of land-grant colleges and universities. The latter represents the oldest series of published statistics of a comparable group of institutions. Institutions are increasingly raising the question of the value of continuing to furnish information which cannot be tabulated and published with reasonable speed.

The USOE's latest publication catalog reveals, further, that the most current available survey of State boards responsible for higher education bears a 1960 date and a booklet on "recent State studies" covers the years 1956–59. These are both areas where rapid changes are taking place with major implications for higher educational planning and yet not current material is generally available with details.

These problems are not new ones and the Congress and institutions of higher education have been extremely patient in awaiting their solution. Back in 1957, an advisory committee appointed to review the U.S. Office of Education's statistical programs expressed concern "with timelags between the release of data and the periods to which they relate." The committee noted that "although the Office of Education maintains a fase schedule on some statistical reports, others are so retarded that the data, when released, are no longer of current application."

Since that time and especially in the past 4 years, this situation has been repeatedly called to the attention of officials of the Department of Health, Education, and Welfare and the U.S. Office of Education. Last fall the problem was brought directly before Secretary Gardner by the heads of 12 major higher education organizations, including the American Council on Education. Within the past few months, The National Association of State Universities and Land-Grant Colleges, the American Association of State Colleges and Universities, the Council of Graduate Schools, and the Association of American Colleges have all adopted formal resolutions, which follow the statement, urging improvement in the USOE's statistical activities. Others are sure to follow.

Slight improvement in the situation has been noticed recently. We understand higher priority in the use of limited computer resources must go to servicing new programs administered by the USOE and the Department of HEW, rather than to statistical services for which there is no source other than USOE. If only to insure the successful functioning of these new programs, the statistical functions of the USOE need support that will result in improvement. A special House Education and Labor Committee subcommittee, headed by Congresswoman Edith Green of Oregon, has recently documented these and related problems in its extensive study of the U.S. Office of Education. The committee noted that the NCES has been substantially handicapped by inadequate access to computer facilities and by insufficient keypunch staff. The report was also critical of the fact that facilities statistics—needed for further consideration of related legislation—were particularly lacking.

Furthermore, USOE efforts are being expended on catching up with older, already outdated studies rather than focusing on the newest, most timely, and most important figures. The current USOE publication schedule, for example, calls for release of a study of 1966–67 student charges in May of 1968, when 1967–68 figures are really needed.

When the National Center for Educational Statistics was established, we looked with enthusiasm upon the effort it represented to streamline and modernize the USOE's often cumbersome and somewhat uncoordinated statistical machinery. With the rising need for educational statistics and the increasingly sophisticated planning activities underway in both government and our institutions, better procedures were needed. We are aware of the broad scope of the NCES' mission and we have been most sympathetic to the problems of the USOE in devising and implementing new methods of statistical collection, tabulation, and dissemination. Our institutions have been patient in waiting for an improvement. We realize that the transition from old to new systems requires a good deal of time and we were willing to suffer temporary inconveniences in order to be able later to take advantage of a fully functioning NCES which would, we were told, provide needed materials more quickly and in greater detail than in the past.

The time for patience is running out, however. Every year the supply of useful published materials diminishes rather than increases. The proposed addition to the NCES' budget will hopefully enable this unit to promptly take some major steps forward and start providing needed educational information to Congress, Federal agencies, the public, our educational institutions and organizations, and to other governmental and planning units. We think this is a wise use of the Nation's resources, despite other pressures on the Federal budget, and hope Congress will encourage the USOE and the NCES to proceed immediately to remedy an increasingly untenable situation by giving top priority to the prompt dissemination of timely data on higher education's growth, development, and future needs.

Funding of Statistical Programs

STATEMENT OF THE FEDERAL STATISTICS USERS' CONFERENCE

This statement is submitted on behalf of the Federal Statistics Users' Conference to express our views on certain items in the budget for statistical programs of the various agencies in the Department of Labor and the Department of Health, Education, and Welfare.

FSUC is an association whose membership is comprised of business firms, labor unions, and nonprofit research groups who have a common interest in obtaining adequate, timely, and reliable information from Federal statistical programs. We regularly evaluate current and proposed statistical programs of the various Federal agencies in the light of certain criteria which we have established, the principal one being that a statistical program should provide data of optimum usefulness at minimum cost.

We have carefully reviewed the proposed programs of the agencies in these Departments and urge the subcommittee's consideration and support of certain of these programs.

DEPARTMENT OF LABOR

Bureau of Labor Statistics

The need for the data which would be produced by the programs proposed by the Bureau of Labor Statistics is not new. The programs will provide data that would fill a serious gap in our economic data base. The information is needed to provide a better understanding of certain segments of the economy and as a guide to assist in the making of important policy decisions. Our organization has regularly supported and urged the development of these programs.

In the area of wages and industrial relations, we support the proposal to inaugurate a semiannual survey of general changes in wage rates and benefits in the nonmanufacturing sector. This sector of the economy has long been neglected and this program is a necessary step that must and should be taken sooner or later. This information would be helpful in economic analysis because it would show (1) the extent to which wage changes create upward pressures on prices, (2) the magnitude and differences in movement of wages in union and nonunion situations, (3) the effects of changes in the statutory minimum wage on wage levels and the availability of workers in lower paid occupations, and (4) the relationships of particular wage changes to other economic developments.

The conference also wishes to express its support for expanded programs designed to provide more adequate measures of price changes. These include:

Extension of the wholesale price index series to 75 additional industries;

Collection of data on transaction prices rather than list or quoted prices for 40 major commodities in wholesale markets; and

Initiation of work on obtaining price data for commodities in U.S. import and export trade.

In the industry sector, the causes, magnitude, and direction of price movements vary significantly. However, industry-sector indexes have been limited to only 52 industries, so there is a real need to expand the coverage to more industries. The additional indexes proposed will provide information on industries for which price data have been almost completely lacking. The expansion will also greatly facilitate analysis of the sources, sequences, and impacts of price changes.

With regard to collection of data on transaction prices, current indexes are based largely on manufacturers' list prices rather than on prices paid by buyers. They do not reflect large-volume discounts or other special concessions. The reporting of actual transaction prices will provide a more precise and realistic index of wholesale prices.

In the light of the persistent balance of payments problem, it is essential that more be known about the international competitive position of the United States. Our competitive position depends largely upon the level and trend of domestic prices for goods that move in international trade relative to those of other industrialized countries. Unfortunately, no comprehensive and systematic body of information on international prices is currently available. The need for more adequate foreign trade price data has been long recognized and has often been pointed out in various hearings before the Subcommittee on Economic Statistics of the Joint Economic Committee, and that Subcommittee has urged that the Government "undertake research on the building of an adequate measure of international competitiveness." This need and data gap was particularly emphasized at a meeting on the U.S. balance of payments sponsored by FSUC on May 3 of this year. The proposed new program is a much needed first step.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

While many of the programs of the agencies within the Department of Health, Education and Welfare are aimed primarily at meeting their own program needs, the information provided is also valuable in relation to other social welfare programs and are found useful by many non-government users.

Some of the programs are parts of continuing series or as supplements to current surveys. After reviewing these programs, we wish only to itemize those programs of certain HEW agencies that we consider priority items and urge the Subcommittee's careful consideration of them.

National Center for Health Statistics:

To initiate a study of family planning and the problems related to population growth and change;

To provide consultive services to State vital statistics agencies and the training of their personnel;

For studies of methodology to obtain data on birth and death rates in geographic areas as small as census tracts; and

To obtain more comprehensive data on health manpower.

Social Security Administration:

To supplement its current medicare survey (CMS) by special studies to provide information on gaps in covered services and to gather information not otherwise available through the regular reporting system;

Continuation of its survey of disabled adults. This is a three-part-survey which collected information from households in 1967 and will cover persons in institutions in 1968; and

Fieldwork on the retirement history survey. This is a longitudinal survey which would follow persons in the 58–62 age group for a period of 10 to 12 years to evaluate the changing needs of those who are retired or about to retire.

CONCLUSION

We appreciate this opportunity to present our views on the budget requests for various statistical programs of certain agencies within the Department of Labor and the Department of Health, Education and Welfare. We are also well aware of the great need for economy in Government in this time of crisis, but

feel that we should not neglect certain priority statistical needs, many of which would aid in providing necessary information to deal with some of the problems we are encountering today.

National Clearinghouse for Smoking and Health

Statement by the National Congress of Parents and Teachers

I am Mrs. Irvin E. Hendryson, of Albuquerque, N. Mex., president of the National Congress of Parents and Teachers. Our organization was founded 71 years ago to promote the welfare of children and youth in the home, school, church, and in the community. Today we have a membership of some 11 million persons in 45,000 local PTA's. We represent each of the 50 States, the District of Columbia, and the Overseas Dependents Schools in the European area.

I would like to present this statement in support of the appropriation for the National Clearinghouse for Smoking and Health. We are hopeful that the full budget request of $2,575,000 will be allowed for this program which so vitally affects the health and well-being of the youth of our Nation.

The National Congress of Parents and Teachers has long been concerned about the health hazard of smoking as it affects young people. In 1963, even before the Surgeon General's Report, and again in 1964, resolutions were passed in our national conventions, calling attention to the harmful effects of cigarette advertisig and urging PTA cooperation in the education of youth about this health problem. In 1966, with financial assistance from the National Clearinghouse for Smoking and Health, we launched a nationwide program to keep seventh- and eighth-grade students from starting to smoke.

Our goal is to create a smokeless generation who will be spared untold illness and possible early death. Our approach is unique, for we have placed heavy focus on a personal, parent-to-parent contact. This not only assures that the message reaches the parents, but underscores the importance of their role as example to their children. I can report, with a great deal of satisfaction, that our program has had a most enthusiastic reception. Between the months of November 1967 and May 1968 more than 4 million brochures with information on the smoking problem were distributed to parents throughout the country. It is a clear indication, I think, of the high degree of interest that exists among parents, many of whom have expressed gratitude that our organization has taken this step.

Our program to reach seventh- and eighth-graders is just one part of a larger national and communitywide campaign being carried on by parents and other concerned citizens. Already we are conscious of results occurring: teachers are working in close collaboration with local health departments, voluntary agencies, and interagency councils to develop communitywide smoking and health education programs; parents are finding out what the schools are doing about this problem and are marshaling resources and support to improve the curriculum in this area.

We are, of course, most anxious that our program be carried to completion. At the same time we are concerned that there be no lag in the research supported by the Clearinghouse, particularly as it relates to children and youth. The body of knowledge that is already developing on youth's attitudes toward smoking, their habits, and their motivations has direct bearing on the success of the PTA and other youth-oriented antismoking programs. The teaching techniques and educational methods that are being developed and tested under Clearinghouse sponsorship will not only stimulate better teaching of smoking education, but also will have application to the entire field of health education.

The recent report of the National Clearinghouse that youngsters are not taking up smoking at the rate they did a decade ago is heartening, but we must not let this information lull us into a sense of complacency. Our hard-won gains will be too easily lost if we let down our guard at this critical time. There are still hundreds of thousands of youngsters who, by taking up smoking in their early teens, do irreparable damage to their health both in the present and in their later years.

Thank you for the opportunity of offering our views.

Reorganization of the Manpower Administration (U.S. Department of Labor)

Letters from several State employment administrators

Texas Employment Commission,
Austin, Tex., April 22, 1968.

Hon. Bob Casey,
Member of Congress, Longworth House Office Building,
Washington, D.C.

Dear Bob: I understand that the Secretary of Labor recently appeared before the House Subcommittee on Appropriations in behalf of the HEW-Labor appropriation for fiscal 1969. I also understand that he arranged to have inserted in the committee record copies of letters from several State employment security administrators which approve or endorse the recent reorganization of the Manpower Administration in the Department of Labor. The committee record would therefore indicate approval of the States but would not indicate that a number of States have strong objections to this reorganization.

In order that the committee record might present both sides of the question, we ask that the attached copies of letters written by State administrators be made a part of the committee report. The writers of these letters have agreed to this use of their letters. It would be greatly appreciated if you can arrange for the inclusion of these documents in the committee report.

Personal regards.

Sincerely,

J. E. Lyles,
Commissioner.

[Attachments.]

Interstate Conference of Employment Security Agencies,
April 10, 1968.

MEMORANDUM

To: State administrators.

From: Jack B. Brown, president,

Subject: Clarification of position taken by ICESA on realinement of functions.

The conference executive committee, at the regular meeting held in Washington in March, requested that I direct a memorandum to the entire conference membership to clarify any misunderstandings that may have developed as to the position and action taken with respect to principal issues considered at the special meeting held in January in New York.

In order to clarify the position taken at the January 4 meeting, the following points should be noted:

(1) There was consensus among the members of the committee to the effect that the realinement of functions in the Manpower Administration, involving the removing of staff services from the Federal Bureau of Employment Security, was of critical concern to the States. Concern was expressed as to the continuing effectiveness of the Federal BES and the coordination of similar staff services of State agencies to those staff services of the Federal BES.

(2) There was consensus among the members of the committee that the assignment of the work incentive program of the amended Social Security Act to the Federal Bureau of work-training programs, in lieu of the Federal BES, was illogical inasmuch as State employment services were to become the presumptive operating field arms of the program for the Department of Labor.

(3) There was consensus among the members of the committee that the realinement within the Manpower Administration and the assignment of the WIN program responsibility were of sufficient concern and interest to the Federal-State employment security system that consultation between the two partners should have been engaged in prior to such decision and directive.

(4) There was consensus among the committee members that prior consultation on program and policy matters of import and mutual concern (such as the above) had been promised and had not been accorded to the States.

On the other hand, there was a narrow majority opinion and formal vote by the committee members to request the Secretary to reconsider these decisions. The vote was: 7 yes, 5 no, 1 abstention.

Based on the points of agreement and the majority vote of the committee members to request reconsideration, it was decided to prepare a position paper on these issues, and I was authorized to forward the position paper by a letter to Secretary Wirtz.

I requested all members of the executive committee who were able to stay in New York until the following morning (primary among them were those remaining for the next day's tri-regional meeting with the Manpower Administrator on these subjects) to return to the meeting room and aid in preparing the position paper. Members of the committee did appear and in one way or another made a contribution to the content of the document.

The position paper as a whole, including the request for the Secretary to reconsider his decision, was cleared subsequently with the executive committee and a vote was recorded on approval of the position paper as representing the opinion prevailing in the executive committee. The vote was: 12 affirmative, 2 negative, 1 not voting.

According, the position paper and transmittal letter were forwarded to Secretary Wirtz, his reply subsequently received, and copies of all such papers were forwarded to the entire membership as issued and received.

It is recommended that for further edification of the membership, as to the deliberations by the executive committee on these subjects, the minutes of the special meeting of January 3, recently transmitted to you, be read.

It is the considered opinion of your executive committee that you will agree the entire membership of the conference was served in this endeavor and that any misunderstandings that may have developed are thereby resolved.

STATE OF MINNESOTA,
DEPARTMENT OF EMPLOYMENT SECURITY,
St. Paul, Minn., January 12, 1968.

HON. WILBUR MILLS,
Chairman, House Ways and Means Committee,
House of Representatives,
Washington, D.C.

DEAR MR. MILLS: I am writing to you because of my great concern over a recent Department of Labor directive assigning to the bureau of work-training programs, the administration of the manpower components authorized by the 1967 amendments to the Social Security Act.

As a relatively new State employment security administrator, with slightly more than 1 year of experience, I am confused by the means the manpower administrator's office has chosen to administer the program. I feel the decision was not based on sound administrative principles and may well be a result of bureaucratic interaction.

I am referring in particular to the Department of Labor directive of December 19, 1967, which assigned the administration of the work incentive program to the bureau of work-training programs. Legislative and conference reports, as well as related material, indicate clearly that the State employment service offices are to be the key in the manpower concept.

The conference report states: "It is the understanding and clear intent of the conferees that the Department of Labor functions in this program will be carried out through the system of State employment security offices."

In the face of that directive, the memorandum of December 19 assigns the responsibility for the program to the bureau of work-training programs. This same memorandum, somewhat paradoxically, implies that the State employment service system has developed significantly increased capacity for administration of the work-training aspects of the manpower program and should be relied upon to the fullest extent. Of course, as you know, the State employment service system is closely linked with the bureau of employment security in the development and operation of employment and manpower programs. I believe that the bureau of employment security through its public employment service is the system that has the resources necessary to adequately develop and administer the various manpower programs. This is imperative if we are to establish a single manpower center concept in local communities.

It is my belief, which I am sure many of my fellow State administrators share, that the State employment service system has developed expertise in dealing with the hard-core unemployed, the disadvantaged and the vocationally deficient and that the responsibility for the new program should be assigned to the State employment service without any intermediate level of supervision and administration by the BWTP.

There is no need to add another directive authority to an already overburdened organization. To do so will only compound the difficulty of achieving the clear channels of communication and supervision for which we are striving so actively.

I was upset and angry after reviewing the program description prepared by the BWTP staff. It presented a number of conflicting statements and theories. For example, the presentation acknowledges that the State employment service system has developed the experience, expertise, organization and staff to operate this program at the State and local levels and therefore should be utilized to the maximum extent possible particularly since both legislative history and intent indicated this was logical operating procedure. The report also directed the new program must rely upon existing manpower agencies and that "duplication of effort must be scrupulously avoided."

Following this series of quotes indicating the logic behind and the need for almost exclusive utilization of the employment service at the local level, the paper specified—in no uncertain terms—that all aspects of the program would be "directly monitored by BWTP staff."

This doesn't make sense to me. Neither does the assignment of responsibility to a bureau which doesn't have the experience, network, or staff to carry out the goals directed by the 90th Congress.

I feel the decision to assign this program to the BWTP should be reconsidered and here are my reasons:

1. The proposed arrangement is so administratively cumbersome as to preclude proper direction, review and procedures.
2. Costs would be increased through duplication of presently operative staff functions.
3. Interjection of another administrative level will weaken the program and will complicate and obstruct communications and lines of authority.
4. It is impossible to administer a program at the local level when responsibility for direction is split. Our local staff must have only one chain of command and one source of direction if it is to operate effectively and without confusion.
5. The expansion of the BWTP staff to allow direct monitoring of these programs is superfluous and contrary to good management principles.
6. When, oh when, Mr. Mills, are the taxpayers to be given consideration—The goal, I believe, is to get the job done and not to satisfy bureaucratic whims.

I have read your statements and the conference report issued by the 90th Congress. I believe you are as concerned as I am about the problems we face in preparing individuals now on the welfare rolls for suitable employment which not only will take them off welfare but will give them added diginity.

For that reason, I have taken this opportunity to express to you my concerns about the direction the program has taken. As one of those who will be responsible for the success of the program, I sincerely hope the assignment of responsibility for this program can be carefully reviewed and reconsidered. I am joined in this hope by others who are genuinely interested in providing meaningful service to the public.

Sincerely yours,

GEORGE J. VAVOULIS,
Commissioner.

STATE OF VERMONT,
DEPARTMENT OF EMPLOYMENT SECURITY,
Montpelier, January 11, 1968.

Re work incentive program, Social Security Act–Title IV.

HON. WILBUR MILLS,
Chairman, House Ways and Means Committee, House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: May I express to you my concern in regard to the decision of the Secretary of Labor to place the responsibility for administering the

above program in the bureau of work training programs, rather than in the Bureau of Employment Security, of the Department of Labor.

Inasmuch as the program, in accordance with congressional intent, will be carried out at the local level to the extent practicable by the employment service offices throughout the country, it is my belief that the program would be conducted with more efficiency and success by the present experienced working partnership of the State employment service agencies and the Bureau of Employment Security.

The State agencies have always had complete confidence in and excellent operational relationships with the BES. It would be my hope that the Secretary might reconsider his decision, with a view toward attaining maximum effectiveness in the program.

Any attention you may be able to give this matter would be deeply appreciated.

Very truly yours,

STELLA B. HACKEL, *Commissioner.*

TEXAS EMPLOYMENT COMMISSION,
Austin, Tex., January 2, 1968.

HON. WILBUR MILLS,
Chairman, House Ways and Means Committee,
Searcy, Ark.

DEAR MR. CHAIRMAN: I understand that Curt Harding of Utah has already talked with you by phone about the manner in which Secretary of Labor Wirtz proposes to handle the community work and training aspects of the work incentive program under title IV of the Social Security Act recently amended by the Congress.

This letter is to simply voice my concern about this same matter. To me this makes no sense to divide the responsibilities for local office program operations into two separate bureaus in Washington. This can only complicate and make more difficult the carrying out of responsibilities at the local office level. It can create competitive situations, i.e., programs financed from the trust fund as opposed to those financed under social security monies under title IV. It also makes little sense to say that the public employment service is the principal operating arm for this program and yet the director of the U.S. Employment Service has no responsibility for it.

All of these situations give rise to the belief that the methods outlined by the Secretary may well jeopardize the success of the program.

Your long-time interest in the employment security program of this Nation is appreciated.

Sincerely,

R. L. COFFMAN, *Administrator.*

EMPLOYMENT SECURITY AGENCY, STATE OF IDAHO,
Boise, Idaho, December 27, 1967.

HON. WILBUR D. MILLS,
Chairman, House Ways and Means Committee,
Searcy, Ark.

DEAR MR. MILLS: I have just received information that Secretary of Labor, W. Willard Wirtz, has announced that all work training functions, including those under title IV of the Social Security Act and Manpower Development and Training Act will be lodged in the Bureau of Work Training Programs under the Manpower Administration in the Department of Labor and that staff functions of the Bureau of Employment Security, including planning and policy, evaluation, research, and special programs will be under the Associate Manpower Administrator.

I am writing to you expressing my concern on two points: (1) This seems to me to be contrary to the intent of Congress concerning the administration of the new work incentive program under title IV of the Social Security Act; and (2) the separation of staff functions from an operating program will so cripple the administration that it cannot possibly function effectively.

While admittedly I do not have full information on the organizational structure that has been announced, it is sufficient to raise serious doubts in my mind

concerning the Federal-State relationship and the ability of the States to meet their responsibilities under such a divided organizational structure. During the years that I have had the pleasure of working with you on employment security legislation I have appreciated your dedication to constructive legislation and sound administrative principles. It is for this reason that I am expressing my concern to you so that on your return to Washington you may take a look at what is happening.

With warm personal regards.

Sincerely,

H. FRED GARRETT,
Executive Director.

VETERANS EMPLOYMENT SERVICE

STATEMENT OF THE VETERANS OF FOREIGN WARS

FEBRUARY 28, 1968.

Hon. DANIEL J. FLOOD,
Chairman, Subcommittee on Labor, Health, Education, and Welfare, Committee on Appropriations, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in reference to the appropriation for operation of the Veterans Employment Service of the Bureau of Employment Security, Department of Labor for fiscal year 1969.

The Veterans of Foreign Wars has long and continuously supported the Veterans Employment Service which has done such a tremendous job down through the years in helping to find jobs for veterans through the 2,000 local employment offices throughout the Nation.

The support of the Veterans of Foreign Wars is found in several resolutions, which were unanimously adopted by the delegates representing 1,400,000 members at our 68th national convention, which was held in New Orleans, La., last August. The resolution directly in point with your hearings in support of the appropriation requested by the administration is identified as No. 160 and is entitled "Adequate funds for Veterans Employment Service" and reads as follows:

Whereas it has long been the policy of the Veterans of Foreign Wars of the United States, to promote a maximum employment for all veterans, particularly disabled veterans; and

Whereas title 38, U.S. Code (Public Law 85-857), as amended, and the Veterans Readjustment Benefits Act of 1966 (the Cold War GI Bill) provide for maximum counseling and placement services for all veterans; and

Whereas the U.S. Department of Labor, through the Bureau of Employment Security, the Veterans Employment Service, and the State employment services placed veterans in approximately 1 million jobs in the calendar year 1966, including 103,000 jobs which were filled by disabled veterans; and

Whereas this workload is being greatly increased as a result of the Veterans' Readjustment Benefits Act of 1966, which makes more than 4 million cold war veterans eligible for specialized employment services through the State employment services of the several States; and

Whereas the number of these veterans is expected to increase at the rate of several hundred thousand per year in the foreseeable future; and

Whereas there will be many thousand additional veterans commonly designated as military retirees added to the number of veterans entering the civilian labor force each year during this decade; and

Whereas many veterans of World War II who are now in the older worker category encounter resistance in their efforts to obtain suitable employment as a result; and

Whereas the disabled veteran finds it more and more difficult to obtain gainful employment, due to both age and disability; and

Whereas the Manpower Development and Training Act of 1962, as amended, which provided for job training and retraining of unemployed persons, including eligible veterans, places additional responsibilities upon the State employment services; and

Whereas all of the above responsibilities demand, and will continue to demand, more time, more manpower, and additional funds for the U.S. Department of Labor, the Bureau of Employment Security, the Veterans' Employment Service and the State employment services of the several States: Now, therefore, be it

Resolved by the 68th National Convention of the Veterans of Foreign Wars of the United States, That we go on record as requesting the Congress to provide adequate funds for the U.S. Department of Labor, the Bureau of Employment Security, the Veterans' Employment Service, and the State employment services to adequately staff the veterans programs and assure that the provisions of title 38, United States Code, as amended, and the Veterans' Readjustment Benefits Act of 1966, are carried out as contemplated by these laws.

Also enclosed are copies of Resolutions Nos. 147 entitled "Preference to Veterans in Referral to Training" and No. 159 entitled "Increase Employment Service Positions," both of which are germane and pertinent to your consideration of this appropriation.

As this subcommittee well knows, the additional duties and responsibilities that have been thrust upon the Veterans' Employment Service are a matter of record. Last year the President called upon the Veterans' Employment Service, in cooperation with local employment offices, to contact each and every veteran upon his discharge from the Armed Forces to make sure that every effort is made to locate him a job.

In his message to Congress of January 30, 1968, the President referred to this program when he stated early information indicated it was achieving good results. The Veterans' Employment Service is helping make this transition period of the veteran back into civilian life a most successful and rewarding one.

The Veterans' Employment Service, however, does not limit its activities to Vietnam veterans. All veterans who are seeking employment are the responsibility of the Veterans' Employment Service. The work of the Veterans' Employment Service and its VER's has become much more onerous during the past several years because of the proliferation of other programs which have ultimately become the responsibility of the local employment office. This has meant that the interviewer in the local employment office who has the responsibility of taking care of veterans (local VER's) who visit that office has found less and less time to devote to veterans.

Consequently, the Veterans of Foreign Wars has noted with some alarm the increasing complaints of our members at the local level, who have found that the local VER's in the local employment office have just not had enough time to adequately do the job so far as veterans are concerned.

It is noted that the budget for the Veterans' Employment Service is about $2 million, a very slight increase over last year. It is further noted that despite the tremendously increased workload contemplated by the Veterans' Employment Service in carrying out its responsibilities to get the returning veteran a job that there are only three additional jobs which are contemplated in this budget. In other words, the Veterans' Employment Service will continue its functional supervision of this vast national program of such intense interest and concern to veterans and their families with only three additonal personnel.

It is assumed, however, that additional positions will be authorized and the money approved for jobs in the State employment offices to man the U.S. Veterans' Administration Assistance Centers which will be established in 20 major U.S. cities within the next year. These are the Centers which were recommended by the President in his message of January 30, 1968 and will be under the supervision of the Veterans' Administration but will have Department of Labor personnel therein to take core of the needs of veterans who are seeking information and assistance respecting programs handled by the Department of Labor.

In summary, the Veterans of Foreign Wars would remind this subcommittee that while the main emphasis today is on the Vietnam veteran, there are still thousands of World War II and Korean veterans who find themselves unemployed or in need of employment, counseling and assistance. The Veterans' Employment Service has responded magnificiently down through the years in helping these veterans, and, as the record shows, hundreds of thousands of veterans have been placed in jobs.

Therefore, the Veterans of Foreign Wars strongly supports the amount of $2 million requested by the administration to operate the Veterans' Employment Service for fiscal year 1969.

Your favorable consideration and recommendation of this appropriation to the full committee and the House will be deeply appreciated by the 1,400,000 members of the Veterans of Foreign Wars of the United States.

Sincerely,

FRANCIS W. STOVER,
Director, National Legislative Service.

[Enclosures.]

RESOLUTION NO. 147—PREFERENCE TO VETERANS IN REFERRAL TO TRAINING

Whereas there are many veterans who have been faced with longtime unemployment or underemployment, and whose employability could be enhanced, and whose opportunities in the field of gainful employment could be enhanced, and through training or retraining in programs carried on under the laws of the United States; and

Whereas trainees under these programs are selected by local offices of the State employment service, affiliated with the U.S. Employment Service; and

Whereas the Congress of the United States, in the Servicemen's Readjustment Act of 1944, specifically stated that it was its intent and purpose that veterans be provided with the maximum of job opportunities in the field of gainful employment; and

Whereas no qualified veteran could be said to be provided with such maximum of job opportunities in the field of gainful employment if he is not given preference in selection for such training opportunities for which he is otherwise qualified or if he is discriminated against in favor of some other class of applicant: Now, therefore, be it

Resolved, by the 68th National Convention of the Veterans of Foreign Wars of the United States, That the Employment Service and the public employment service of the several States continue to follow legal policies of giving preference to veterans from among all otherwise qualified applicants when making referrals to these training and retraining opportunities just as when making referrals to regular job openings.

Adopted at the 68th National Convention of the Veterans of Foreign Wars of the United States held at New Orleans, La., August 20 through 25, 1967.

RESOLUTION NO. 159—INCREASE EMPLOYMENT SERVICE POSITIONS

Whereas the Department of Pennsylvania, Veterans of Foreign Wars by established policy promotes a maximum employment program for all veterans, particularly disabled veterans; and

Whereas the Congress of the United States has accordingly provided under title 38, United States Code (Public Law 85–857) as amended, and the Veterans Readjustment Benefits Act of 1966 (the cold war GI bill), for maximum counseling and placement services for veterans; and

Whereas the Chairman of the President's Committee of Employment of the Handicapped has found evidence that the local veterans employment representatives are delegated as area redevelopment expert, the war on poverty expert, the older worker expert, the youth worker expert, the Peace Corps expert, and the draft rejectee expert to the detriment of the mandated services to veterans; and

Whereas in Pennsylvania the increasing load of 217,780 projected for fiscal year 1967 through 1969 of cold war veterans, plus military retirees, handicapped, and older worker veterans would justify the employment of approximately 106 local office veterans employment representatives in Pennsylvania; and

Whereas the elimination of approximately 37 Veterans Administration contact men in many Pennsylvania communities has shifted the initial point of inquiry for veterans to the local office veterans employment representative; and

Whereas current budgetary funds ares not available to fully staff the local office with the veterans employment representatives needed by the legal mandates: Now, therefore, be it

Resolved, by the 68th National Convention of the Veterans of Foreign Wars of the United States, That we request that adequate funds and/or supplementary budgetary funds be annualized in the Bureau of Employment Security Federal budget to provide the 600 or more local office veterans employment representatives positions needed nationwide, thus providing the number needed in Pennsylvania, and also to provide adequate funds for the Veterans Employment Service of the U.S. Department of Labor to assure that the provisions of title 38 United States Code, as amended, and the Veterans Readjustment Benefits Act of 1966 are carried out as delineated by these laws.

Adopted at the 68th National Convention of the Veterans of Foreign Wars of the United States held at New Orleans, La., August 20 through 25, 1967.

WATER FLUORIDATION

LETTER AND STATEMENT OF ELISE JERALD

PHI BETA KAPPA, ENVIRONMENTAL STUDY GROUP,
CITIZENS RIGHTS COMMITTEE,
New York, N.Y., March 28, 1968.

HON. DANIEL FLOOD,
Chairman, Subcommittee on Health Appropriations,
U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN FLOOD: In behalf of the above organizations, as well as the Ad Hoc Committee on Environmental Contamination, I am offering the following testimony, with important exhibits.

As requested by Congressman Delaney in previous years, we should be grateful for the privilege of having our testimony inserted in the record of the hearings. It contains vital and expertly researched facts, which the public is entitled to know.

With thanks for your cooperation,

Sincerely,

ELISE JERARD,
Coordinator, Ad Hoc Committee on Environment Contamination; Chairman, Citizens' Rights Committee; and Phi Beta Kappa Environmental Study Group.

[*Enclosures.*]

TESTIMONY SUBMITTED TO THE SUBCOMMITTEE ON HEALTH APPROPRIATIONS OF THE HOUSE OF REPRESENTATIVES, U.S. CONGRESS

Since this is preeminently a time for careful use of the taxpayers' dollar, this committee's attention is urgently sought for a number of hard-headed reasons why no congressional appropriation should be allocated for promotion of the fluoridation of citizens' water supplies.

These reasons stem from vital experiences, as well as extensive study by the following organizations: The Ad Hoc Committee on Environmental Contamination, comprising physicians and scientists—some eminent—and leaders of scientific-humanitarian societies, the list of names being appended to this statement; of the Citizens' Rights Committee, which has merged the interests in this issue of 20 organizations, totaling some half a million members; and the autonomous Phi Beta Kappa Environmental Study Group, composed of members of the Phi Beta Kappa—scholars, researchers, and physicians who have earned the key. This group does not speak for the united chapter of the Phi Beta Kappa Society which, to the best of our knowledge, have never engaged in research or action relating to environmental problems.

ABUSES

(1) The taxpayers' money which has been appropriated for promotion of water fluoridation has been repeatedly misused (*a*) for the dissemination of improper publicity—containing misleading, arbitrarily discrediting and sometimes libelous statements in order to repress dissent. A recent flagrant example of such abuse is submitted with this statement as exhibit A; (*b*) for circulation of publications purporting to present a total unslanted situation actually omitting evidence unfavorable not only to the fluoridation policy, but also to the problem of total exposure of citizens to environmental fluorides, of which water fluoridation is only one aspect. It is vital that this committee should consider this total situation and view the water fluoridation issue in perspective.

INCREASED FLUORIDE IN PROCESSED FOODS AND BEVERAGES IS PART OF THE PROBLEM

(2) There is reliable evidence that human ingestion of fluoride has been sharply augmented through consumption of commercial foods and beverages, which increasingly are processed with fluoridated water. A study emanating from the National Research Council of Canada (appended as exhibit B) indicates that amounts established as the maximum permissible range of fluoride ingestion have already been appreciably exceeded. The U.S. Food and Drug Administration has estimated that 2 to 3 milligrams should be the maximum of total ingestion; the Russian expert, Krepkogorsky, has recommended a similar limitation. The research report of the Canadian scientists, Marier and Rose,

however, shows that healthy persons, with indoor occupations, and living in cool climates ingested up to 5 milligrams daily. Persons in warm climates or engaged in heat work or afflicted with the thirst of illness would accordingly ingest even more.

This study calls for monitoring and medical evaluation of this critically important problem. None has been forthcoming in this country.

The issue has, instead, been evaded, while fluoridation of more and more water supplies has been promoted, by high pressure methods. Appropriations for such headlong promotions are not in the public interest; monitoring and unbiased medical evaluation are in order to assure that such dietary fluoride does not present hazard to citizens, including the ill, the old, and those who must consume much water.

FLUORIDE AIR POLLUTION IS ANOTHER PART OF THE PROBLEM

(3) Flouride air pollution is another vital aspect of total fluoride ingestion by citizens, yet this problem is covered with a blanket of silence. Numerous Government pamphlets, indeed, fail to mention fluoride as an air pollutant, although the President's Science Advisory Committee (as demonstrated in exhibit C) has designated fluoride as a "highest priority" environmental contaminant. The Surgeon General, likewise, has recently named fluoride as one of the major pollutants which have been inadequately studied.

More than 50 types of industries rank as important fluoride air polluters. Commercial interests, involved in the fluoride problem and in promotion of sales of fluoride byproducts, as well as mechanical equipment, for fluoridation of water supplies, are in part, responsible for the persistent blackout of honest discussion of this complex issue. The U.S. Public Health Service, however, is equally responsible. As far back as 1948, when the Donora air disaster occurred, involving numerous deaths and illnesses, as well as destruction of crops and property, Chemical & Engineering News carried an on-the-spot report by Philip Sadtler, after thorough investigation, which showed fluoride to be a major culprit. Evidence of chronic and acute fluoride poisoning of human beings, animals, and vegetation was specifically detailed. Thereafter, the Public Health Service, along with Kettering Institute, sponsored by numerous fluoride-involved industries, suppressed the mention of the role of fluorides as a causative factor in this air catastrophe. Recorded litigation due to fluoride damage by these industries is considerable.

The Canadian Broadcasting Corp. recently devoted two hour-long programs to the subject of fluoride air pollution, subsequent to the revelation of an air catastrophe in the area of a phosphate manufacturing plant. An American medical expert on the total fluoride problem appeared on both of these candid programs. By way of contrast, a recent airborne fluoride tragedy in Iowa has been generally ignored by U.S. media. Only in the case of a similar disaster at Garrison, Mont., has our public been informed about airborne fluoride damage, and even then, the New York Times was virtually alone in acknowledging harm to human health—not merely to cattle and crops.

The point is, obviously, that citizens ingesting excessive fluoride through air pollution should not also be required to fluoridate the water used by them for drinking and cooking. Yet even communities exposed to severe industrial fluoride air pollution have been insistently subjected to pressures for water fluoridation. For instance, in The Dallas, Oreg., where children were found to have fluorosed teeth as a result of fluoride contamination by nearby factory, the drinking water was, nevertheless, fluoridated. (Exhibit D pertains to this phase of the problem.)

Airborne fluoride increase in raw foods

Studies, in this country and in several European nations (as suggested in exhibit E) show, also, that plants destined for food, when grown in fluoride-air polluted areas, absorb fluorides, the concentrations being highest in the leafy portions.

Here, then, is another haphazard source of fluoride ingestion, which is consistently ignored by the fluoride proponents, including water fluoridation promoters.

In sum, the lack of monitoring and medical evaluation of fluorides in raw foods, in processed foods and beverages, and airborne fluoride, entering through respiration, adds up to serious neglect of the welfare of American citizens; and makes insistence on fluoridating everybody's water not only superficial but also

irresponsible. The insistence that fluoridation is "controlled" because a certain concentration enters the water is meaningless; the amount of fluoride entering the system of any given individual is uncontrolled.

EVIDENCE OF HAZARD AND HARM

(4) The medical literature contains clear evidence that the recommended dose for water fluoridation is, per se, not universally safe. It is shown by research studies as well as in the clinical practice of physicians that metabolically defective persons, especially those with diseased organs of elimination, the old, who have been generally found to store more fluoride that do younger persons, and individuals allergic to fluoride should not be subjected to enforced ingestion of fluorides through the water supply—especially since fluorides concentrate in cooking and, even more in various types of commercial processing, so that exposure can be more extensive than is ordinarily estimated. (Exhibit F shows that 14 years of experimentation demonstrated that one out of 100 pregnant women and children were made variously ill by fluorides.) This study is honored by pharmaceutical companies and scientists in many parts of the world. Exhibit G, Allergy to Fluorides, refers in the introduction of the study, to more than a hundred proven cases of allergy to fluorides, in minute concentration. Official denials of these facts by fluoridation promoters are disturbing and such attitudes and actions do not warrant supportive appropriations by the Congress. Exhibit H, in a study from an AMA publication, acknowledges the fact that "the problem of retention of fluorides" in the case of kidney disease "is unresolved." (Archives of Internal Medicine, February 1965.) Many urologists prescribe nonfluoridated water for their patients. This constitutes financial hardship for many; and many more could not afford to comply with this prescription. Also, as is rarely realized, persons suffering ill effects from fluoridated water are in jeopardy if they must dine in public places, in fluoridated areas, nor can they know which processed foods and beverages have been prepared with fluoridated water. The Marier-Rose study shows the fluoride content of such items may be multiplied two- to fivefold.

EFFECTS ON THE FETUS ARE INSUFFICIENTLY KNOWN

(5) The Medical Journal of Australia, the Lancet, Acta Scandinavia, and other careful professional publications, have acknowledged that effects of ingested fluoride, in minute amounts frequently consumed, are capable of inhibiting enzymes which steer the life process, and that the effects on the developing fetus are inadequately understood.

Drug News Weekly, October 24, 1966, reporting the FDA ban on prenatal fluoride-containing pharmaceuticals, states that "scientific studies have shown untoward effects from the drug in at least one species of animal, the Agency said. There has been some scientific debate as to whether fluoride might aggravate mental retardation and mongoloidism in offspring."

"The effects of fluoride on the fetus are not precisely known," FDA officials said. (Exhibit H.)

Studies indicating potential problems in this area have been publicized in other countries but bitterly opposed and suppressed by the Dental Division of the U.S. Public Health Service. Thorough investigation of these crucial problems is needed; not appropriation for promotion.

ALTERNATIVES TO WATER FLUORIDATION ARE NUMEROUS, SAFER AND MORE ECONOMICAL

(6) Human exposure to hazards and potential harm from fluorides and water fluoridation is tragically unnecessary, since there are various rational alternatives. Without discussing the benefits of fluorides through the hardening of dental enamel (and no other claimed benefits have been scientifically substantiated) we ask this committee to consider research evidence indicating that:

1. Other minerals in water have been found to contribute to dental benefits, and in the absence of such minerals in the water the benefits of fluoride are questioned.

2. The action of fluoride is considered, by an increasing number of scientists, to occur in the oral cavity.

(Exhibit I.) Experts in the Naval Academy, among others, and scientists of the Universities of Toronto and Alabama, in reports delivered at a dental health conference in the New York Academy of Sciences, February 1966, have recom-

mended that fluoride toothpaste and/or mouthwash should be sufficient for the purpose.

(Exhibits J and K show that, in truth, water fluoridation is a needlessly expensive and wasteful procedure.)

A recent issue of Chemical and Engineering News reveals that fluosilicicacid, extensively used in water fluoridation costs $3 to $5 a ton to produce and sells at about $45. Previously there was no use for this industrial byproduct.

METHODS OF PROMOTION ARE QUESTIONABLE

(7) In addition to release of improper publicity (such as is illustrated in exhibit A) overdetermined promotional efforts on the part of the Dental Division of the Public Health Service, together with the American Dental Association, have resulted in coercion of citizens, misinformation on the facts of fluoridation and suppression of legitimate dissent and research.

(Exhibit L reveals Public Health Service support of a survey in a Wisconsin town—of more children than were enrolled in the schools. Exhibit M reveals extreme improprieties in fluoridation promotion in Detroit. Exhibit N discloses insistence on fluoridating towns which already were naturally fluoridated. There is such a thing as too much zeal, especially at taxpayers' expense.)

Public Health Publication No. 777 and Public Health Service Publication No. 10791 show how many millions of American dollars annually are used for pushing fluoridation abroad, often against the will of able scientists and the public. This type of foreign aid could be eliminated.

RESOLUTION 39 WARNS AGAINST WATER FLUORIDATION

(8) The International Society for Research on Nutrition and Vital Substances, of which Dr. Albert Schweitzer was a founder and first honorary president, and which includes scientists from 76 countries, some outstandingly distinguished, passed Resolution 39 which urges governments to refrain from water fluoridation, because of wide individual variabilities of human beings; because of multiple sources of fluoride ingestion; because fluoride in minute amounts has been found to be capable of poisoning enzymes; because effects on the fetus are not understood; and because thorough long-term tests of individuals, to date, have not been performed. (The resolution is exhibit O.)

The recommended tests over a long period should include as many individuals as possible, each followed through the years, with clinical observations, as well as extensive biological tests. Persons of all ages should participate, as well as individuals in varied states of health and illness, the pregnant, nursing mothers—the whole spectrum.

No such tests have been performed, despite sweeping claims of fluoridation promoters. The above resolution has, accordingly, been attacked repeatedly and in defamatory fashion, by the Dental Division of the U.S. Public Health Service; the contents have been misrepresented, both by omission and distortion and this literature widely disseminated. The fact remains that this resolution is more prudently protective of human beings than the American proponents of environmental fluorides and universal water fluoridation. Resolution 39 was passed by 393 scientists of the society's 400-member council; it was introduced by gifted and long-experienced flourde researchers—Professor Douw-Steyn, chief pharmacologist of South Africa, who has experimented with effects of fluorides on animals and human beings: Professor T. Gordonoff, of the Pharmacology Department at Berne University, an equally thorough researcher; the late Dr. Clive McCay, distinguished nutritionist and fluoride researcher of Cornell University; and Dr. H. M. Sinclair, director of the Cortenay Laboratories, an Oxford researcher who has worked with fluorides for over 3 decades, and who, also, is a doctor of medicine.

For all these reasons we earnestly request that the Subcommittee on Health Appropriations, taking thought for the public interest, refrain from endorsing any further allocation of funds for the purpose of Federal promotion of fluoridation of water supplies.

Respectfully submitted by,

ELISE JERARD,

Coordinator, Ad Hoc Committee on Environmental Contamination, Chairman, Citizen's Rights Committee and Phi Beta Kappa Environmental Study Group.

THE AD HOC COMMITTEE ON ENVIRONMENTAL CONTAMINATION

Dr. Simon Beisler, M.D., Director, Department Urology, Roosevelt Hospital, N.Y.: past president, American Urological Association.
Dr. Fred Squier Dunn, M.D., D.D.S., longtime director, Department Oral Surgery, Lenox Hill Hospital, N.Y.
Dr. Girard Oberrender, M.D., longtime director, Department Otolaryngology, Lenox Hill Hospital, N.Y.
Dr. George C. Andrews, M.D., past president, Dermatological Association, Professor, Columbia-Presbyterian Medical School, N.Y.
Dr. W. C. Hueper, M.D. emeritus, chief environmental cancer, Public Health Service: recipient Rosenthal Medal, Association for Advance, Science: WHO Award, research, cancer and allied diseases.
Dr. Leslie O. Ashton, M.D., pediatrician, longtime chairman, Child Welfare Committee, New York County Medical Society.
Dr. A. J. Blazey, M.D., former legislative chairman, Association American Physicians and Surgeons (20,000 members of the A.M.A.).
Dr. H. M. Sinclair, D. Medical, F.R.C.P., Oxford; Director, Courtenay Labs, Nutritionist.
Dr. Albert Schatz, Ph. D., D.Sc., F.R.S.H., microbiologist, Professor, Washington University, codiscover of streptomycin; dental prize, chelation-proteo lysis theory.
Dr. A. W. Laubengayer, Ph. D., professor chemistry, Cornell University; researcher; chemicals consultant.
Dr. Lawrence MacDaniels, Ph. D., professor botany, Cornell University; conservationist.
Dr. Albert Burgstahler, Ph. D., professor chemistry, University of Kansas, researcher.
Dr. James Patrick, Ph. D., researcher; Lederle Laboratory, will head chemistry department, Mary Baldwin College.
Dr. Ida Rolf, Ph. D., biochemist, formerly Rockefeller Institute, educator.
Dr. Helen MacDonald, Ph. D., biologist.
Professor Percival Goodman, F.A.I.A., Columbia University.
Dr. R. Lindsay Robb, ecologist; professor University of Edinburgh; consultant, F.A.O. & International Soil Association.
Elise Jerard, chairman, Phi Beta Kappa Environmental Study Group.
Dorothea Seeber, executive director, Independent Citizens' Research Foundation.

COMMITTEE NOTE: Eighteen exhibits were attached and have been placed in the Committee's files.

NATIONAL CANCER INSTITUTE APPROPRIATION

STATEMENT BY THE CITIZEN'S COMMITTEE TO CONQUER CANCER, HEART DISEASE AND STROKE

May we first thank the subcommittee and its chairman, Congressman Daniel Flood, for its kindness in affording us the opportunity of presenting our statement?

I wish to direct these remarks to only one of the Institutes—the National Cancer Institute.

The Congress of the United States, in naming you gentlemen on the Subcommittee on Appropriations for Health Agencies, by so doing, has placed upon you a grave burden.

While this responsibility would be serious under any circumstances, it is more weighty today because of the gross inadequacy of the requests made by the President's Bureau of the Budget. May I make three points?

(1) Your committee, in the field of cancer alone, is faced with a budget which in reality is a civilian casualty budget. To adopt it as it now stands is to assure that in the year ahead approximately 100,000 American lives which might otherwise be saved will be fated to an earlier death because of the frugal budget now before this committee.

Among the recommendations made a few years ago by President Johnson's Commission on Cancer, Heart Disease, and Stroke, was a proposal for the creation of a national network of regional health centers.

It has been carefully, and very conservatively estimated that the construction and operation of about 20 regional cancer centers working closely with local hospitals, making available the scientific medical knowledge available today, could reduce our annual deaths from cancer from 300,000 to 200,000. This is a shocking—and exciting—medical prediction, made by responsible leaders in the field of cancer research and treatment.

Will the gentlemen of good will, who as Congressmen serve the people of the United States by prime responsibility for the budget, turn their backs on 100,000 people, and say, in effect, that they are insensitive to the death of 100,000 Americans? It is inconceivable that the conscience of the Congress—if fully aware of the facts—could be cruel to the families of 100,000 Americans and consciously accept a civilian casualty budget, calling for the doom of 100,000 persons!

Yet, this in effect, is the consequence of accepting the meager budget of the President.

No less than $50 million—as a starter—should be added to the budget to make a proper beginning in providing for these regional centers, and thus lay the foundation of preventing an avoidable holocaust.

(2) The appallingly limited budget of less than $190 million should be increased by at least an additional 50 percent. As the budget now stands, more than one-third of the cancer research grants, which can otherwise be approved on grounds of scientific needs, will have to be scuttled for lack of funds!

Furthermore, activities conducted directly by the National Cancer Institute would be drastically curtailed in many areas such as: Aid to special work on lung cancer; cancer of the intestine, uterus, bladder, and prostate; work in the field of immunology; special population studies; viruses and their relation to cancer—to mention but several.

Besides, grants to encourage training in cancer research also suffer severely from this limited budget.

(3) Frightful as the budget is, in the form in which it came from the Bureau of the Budget, even more horrendous is the thought that added cuts may be in prospect, by 10 percent or 20 percent!

It is not possible to even imagine any further decrease in this budget.

Rather than even consider any reduction, the subcommittee is urged to provide a massive increase in Federal funds to health agencies to counter the cigarette smoking propaganda. It is insufficient to rely upon the weight of voluntary health agencies alone. Clear-cut, categoric warnings against cigarette smoking, particularly addressed to the young, should be made possible in massive quantities with the imprimatur of the U.S. Government.

My confidence in the basic patriotism of the Congress, convinces me that an understanding of the facts showing health needs will produce a budget for fiscal 1969 dramatically larger and more adequate than the propossed budget before your committee.

Again, thanks to your subcommittee for the opportunity to present our views.

Funding of Foreign Language Training and Area Programs

Statement of the Ibero-American Studies Program of the University of Wisconsin

Statement Submitted by Earl M. Aldrich, Jr., Acting Director, Language and Area Center for Latin American Studies, University of Wisconsin

I respectfully recommend that the committee support authorization of the necessary funds to continue this act. My reasons for this recommendation are that (a) the act has produced beneficial, indeed impressive, results and (b) the reasons for its original enactment and funding remain urgent and important. Please note that in developing these arguments, I shall refer to NDEA title VI only as it relates to Latin American studies since this is the area I know most intimately.

Since the acedemic year 1959–60, when the first NDEA language and area centers began receiving support, the Government has contributed approximately $3.5 million to encourage the growth of Latin American studies. The Latin American centers receiving NDEA assistance numbered two in 1959–60. With

the addition of new centers in 1961 and 1965, the total reached sixteen.[1] As of this academic year (1967–68), the student enrollment in courses provided by these centers in Latin American language and social science totals over $25,000.

It should be noted that in establishing these centers, the Federal Government chose always to cooperate with universities which previously had been noted for the strength of their Latin American programs or with those which at least had a unique potential for development in that area of specialization.

I shall use the University of Wisconsin as a case in point. Since 1930 the University of Wisconsin has operated a Latin American studies program. Over the years a competent staff has been assembled, an adequate library has been built up, interdisciplinary cooperation has come to be understood, and connections in Latin America have been established. In 1959 an NDEA center for Latin American language and area studies was established at Wisconsin, and since that time the program has been developed dramatically and always with an eye to careful planning. Originally seven departments participated in the program; as of this year, 16 departments are actively cooperating: Agricultural economics, anthropology, art history, business, economics, educational policy studies, geography, history, journalism, law, linguistics, music, political science, Spanish and Portuguese, sociology, and rural sociology. In fact, since receiving Federal support, the program has grown rapidly in every respect: faculty, number and variety of courses, facilities (especially language laboratories and the library), and students. My observation of the other NDEA Latin American centers indicates that they have experienced a similar dramatic growth in their programs as a result of the stimulus provided by NDEA funds.

It is important to emphasize at this point that every dollar of Federal money that supports the centers is matched by university funds. In fact, most of the 16 centers have spent considerably more than the matching requirement. Out of the total amount spent on Latin American studies at these universities, the Federal portion comes to about 15 percent. By no means am I implying that the Federal contribution has been insignificant. On the contrary, these Federal funds, judiciously used, have stimulated the universities to expand their own resources and have provided that financial margin necessary to allow them to enter into training and research activities which would not otherwise have been possible. My colleagues agree unanimously that the matching stipulation is not only just but vital to the very health of such programs since university administrations are thereby in the position of having a stake in their successful development. At the same time, it is our hope that in the future the Federal Government's percentage of contribution to the total Latin American program of the universities involved might increase over the present 15 percent. In fact, such an increase will be imperative if the university responsibilities implied in President Johnson's Punta del Este commitment (to be mentioned in more detail later) are to be met.

Another important aspect of NDEA title VI has been the fellowship support provided for graduate students in Latin Amreican studies. Since 1959 nearly 1,200 of these coveted awards, at a cost of $4.5 million, have been given for advanced study in Latin American language and area courses. These fellowships support only a small fraction of the graduate students who specialize in Latin American studies. However, the NDEA fellowship program has contributed in a vital way not only to the education of some of our most gifted students but to the stimulation of interest among students in general. The program accounts in no small part for the growth in the number of students who have obtained advanced degrees in this field. The following chart dramatically demonstrates this.

Academic year	Number of degrees received	
	M.A.	Ph. D.
1959–60	147	69
1960–61	168	87
1961–62	263	99
1962–63	328	141
1963–64	343	169
1964–65	442	172
1965–66	539	208

[1] New York, 1959; Wisconsin, Madison, 1959; California, Los Angeles, 1961; Columbia, 1961; Florida, 1961; Texas, 1961; Tulane, 1961; Antioch, 1965; Cornell, 1965; Illinois, 1965; Miami, 1965; New Mexico, 1965; Stanford, 1965; Virginia, 1965; Wisconsin, Milwaukee, 1965; and Yale, 1965.

These students have used their training in a variety of professions, including university, junior college, and high school teaching, government service, private industry, and mass communications. A high percentage of the Ph. D. recipients are now teachers and researchers at universities where they are contributing to the development of Latin American programs. I might add that the statistics take on a special meaning when they include graduates who have held a title VI fellowship and have been taught or advised under this act. It is significant that many of these have gone on to make important contributions in Latin American studies.

But if the act has been successful in its avowed purpose of increasing the number of language and area specialists and thereby improving national competence in world affairs, surely the job is not complete. No extraordinary perceptiveness is needed to see that the task of promoting a proper understanding of and cooperation with the 20 Latin American nations is only beginning. Prof. Kalman Silvert best sums up the reasons for our continuing need to accumulate a national pool of competence in language and area teaching and knowledge about Latin America. He states that the recurrent crises of the past 20 years in hemispheric affairs can hardly be expected to diminish, since "no Latin American Republic has as yet passed through the storms of the tag end of traditionalism into the self-sustaining growth of modernism." [2] In other words, just because the indecision, embarrassment, and frustration caused by Guatemala, Cuba, the Nixon episodes, Venezuela, Panama, and the Dominican Republic have been largely forgotten and Latin American news is once again relegated to the back pages of our papers and magazines, it does not follow that we can afford to ignore that area which is, by the very nature of its history, location, size, and population, inextricably bound to our national interests.

To be sure, we have begun to learn something about Latin America in recent years.[3] And hopefully this knowledge will help us overcome some past insufficiencies in our Latin American dealings. But any serious student of the hemisphere recognizes that the progress which has been made also reveals what a complex problem it is to know, understand, and appreciate Latin America. Professor Silvert summarizes the complexity and unfinished dimension of the task clearly and succinctly:

"Now that the Nation urgently needs information and analysis, there is little capital stock of mature, accumulated knowledge of Latin America's special circumstances upon which to draw. I do not mean to imply that there are not brilliant scholars in all disciplines devoting themselves to Latin America; my point is that the number and their experience are as yet short of what is needed to give us reasonably rounded and yet profound analyses of the array of social situations of the several Latin American Republics.

* * * * * * *

"Foreign studies require a special set of skills and techniques in addition to the knowledge of theory and method normally to be expected of the scholar. The social scientist working overseas must learn another language so well that he can understand the subtle nuance; he must know the history of another country as intimately as that of his own in order to be able to feel the meaning of symbols and stereotypes, and he must recognize when his theory is alien and inadequate to what he is finding.

* * * * * * *

"Another great difficulty—one inherent in the nature of the area itself—is that Latin America is not at all an easy theater of research but, on the contrary, is extraordinarily difficult to subdue intellectually. The 20 countries are disparate and growing more unlike each other every day. Worse, they are sufficiently European to look familiar and yet sufficiently special to defy their being forced into the standard categorical boxes of 'Westerness' or 'underdevelopment.'" [4]

To summarize quickly, my two basic arguments for funding NDEA title VI are as follows: (a) On strictly pragmatic grounds alone, the act is proving to be successful in achieving its avowed aims. That is, with the judicious application

[2] Kalman H. Silvert, "The Conflict Society: Reaction and Revolution in Latin America," rev. ed. (New York, American Universities Field Staff, Inc., 1966), p. xi.

[3] A glance at the bibliography published in the Latin American Research Review (University of Texas) will show that a number of impressive scholarly works on Latin America have been published in recent years. Of course, this material does not even begin to compare with that which pertains to Western Europe.

[4] Silvert, op. cit., pp. xi–xii.

of a limited amount of funds, the Federal Government has contributed to the development of sound university programs, which in turn have begun to produce competent language and area specialists and a body of mature, scholarly information. (b) On the other hand, the job has only begun and should not be abandoned after a successful start. The process of strengthening our understanding of and cooperation with the nations of Latin America is difficult and complex.

In closing, I should remind the committee just very briefly of President Johnson's April 13, 1967, remarks at the OAS meeting in Punta del Este, since they have special significance for the future of Latin American studies at institutions of higher learning and since they also have special significance for the amount and nature of possible funding for title VI. I refer specifically to his final statement:

"Finally, I shall urge that funds be provided to help establish Alliance for Progress centers at colleges and universities in the United States. Our partnership must be based on respect for our various cultures and civilizations. And respect is built on knowledge. This new education program will offer new opportunities for students and educators of your countries and mine to work together."

This statement constitutes both a public and an international commitment which is neither offhand nor unpremeditated. It thus seems to imply not only a need for the expansion and intensification of the current teaching and research functions of existing NDEA Latin American language and area centers but the impartation of an international dimension, which the current operations do not have. It seems likely that U.S. universities, which have the resources of highly competent and specialized staffs, library and training facilities, and experience, will be called upon to prepare greatly increased numbers of students, faculty, and research specialists from both halves of the hemisphere, with a view toward increased professional capacity and the ability to undertake joint research functions on the basis of real equality.

The present NDEA langauge and area centers (and perhaps additional ones to be designated later) could logically become the operational framework for the increased activity which President Johnson's speech implies. It follows also that the need for adequate and long-term appropriations for NDEA title VI becomes of paramount importance to the universities which might be called on to bear the responsibility.

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