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HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETY-FIRST CONGRESS

FIRST SESSION

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

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

PART 2

STATEMENT OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

OVERVIEW OF 1970 BUDGET REVISED BUDGET

Printed for the use of the Committee on Appropriations

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U.S. GOVERNMENT PRINTING OFFICE
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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1970

WEDNESDAY, MARCH 12, 1969.

STATEMENT OF THE SECRETARY

WITNESSES

HON. ROBERT H. FINCH, SECRETARY
JOHN G. VENEMAN, UNDER SECRETARY
CREED C. BLACK, ASSISTANT SECRETARY FOR LEGISLATION
LEWIS H. BUTLER, SPECIAL CONSULTANT TO THE SECRETARY
JAMES F. KELLY, ASSISTANT SECRETARY, COMPTROLLER
JAME B. CARDWELL, DEPUTY ASSISTANT SECRETARY, BUDGET

Mr. FLOOD. We will now begin the hearings with the Department of Health, Education, and Welfare. We have the pleasure of having with us the Secretary, the Honorable Robert H. Finch, who will make a presentation.

BIOGRAPHICAL SKETCH OF PRINCIPAL WITNESS

I see here a rather impressive biography which I think we should insert at this point in the record.

(The biography follows:)

HON. ROBERT HUTCHINSON FINCH, SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Robert H. Finch was appointed Secretary of Health, Education, and Welfare by President Richard M. Nixon on Janaury 20, 1969. At the age of 43 he is the youngest member of the President's Cabinet and the youngest of the eight HEW Secretaries ever to serve as head of the Department.

At the time of his appointment, Robert Finch was Lieutenant Governor of California, having been elected in 1966 with the largest vote of any statewide candidate in the Nation, amassing a total vote of 3,834,978, and defeating his opponent by a plurality of 1,256,901 votes.

He credits his success in that campaign in large part to its predominant theme: that the vast resources of the nongovernmental sectors must play a more dynamic role in solving our Nation's problems.

Carrying out this theme during his tenure as Lieutenant Governor, he won widespread recognition as chairman of the California Job Training & Placement Council for developing and coordinating a massive job training program in conjunction with private industry in the State.

In addition, he was chairman of four other commissions including: the Interagency Council for Ocean Resources, the Bicentennial Celebration Commission, the Commission of the Californias, and the Electronic Data Processing Policy Committee.

He also served as a member of the Executive Committee of the Inter-governmental Council on Urban Growth, where he was actively concerned with assisting local governments to meet the problems of urban growth, and was a member

of the State Lands Commission, the Commission on Interstate Cooperation, the Advisory Panel-Teaching of the Bill of Rights, the Toll Bridge Authority, the Governor's Cabinet and the Governor's Council. Added to the duty of presiding over the State senate, Robert Finch had more statutory responsibilities than the second officer of any other state in the union.

In 1967 he was honored by election to the Executive Committee of the National Conference of Lieutenant Governors.

The Secretary has been deeply involved in education at all levels. He has served as a regent of the University of California, a trustee of the California State Colleges and a trustee of Occidental College. He also served on the faculty and was formerly a member of the Advisory Boards of both Palos Verdes College and Marymount College in California.

Robert Finch was born in Tempe, Ariz., on October 9, 1925, the son of Robert L. and Gladys Hutchison Finch. He has been a resident of California for the past 34 years. As a boy he earned the Eagle Scout Award with silver palm and graduated from Inglewood High School, Calif., where he was editor of his school newspaper, lettered in track and football and was elected president of the student body.

Robert Finch received his B.A. degree in political science from Occidental College and earned his law degree at the University of Southern California Law School. Again he was elected president of the student body at both institutions. In 1967 he was awarded an honorary doctor at laws by Occidental College and Lincoln University.

In 1943, at the age of 19, Robert Finch enlisted in the Marines, serving for 2 years. He was recalled to active duty in 1951, during the Korean War and was discharged first lieutenant. Following his return to civilian life, he organized his own law firm Finch, Bell, Duitsman & Margulis in 1953, and later organized and became president of a savings and loan association. He resigned from his law firm upon selection as Secretary of HEW.

Included in a long record of community service are former membership on the Board of Directors of the Centinela Valley YMCA; the statewide Committee of YMCA Youth Government; the Los Angeles District Attorney's Advisory Committee; the Advisory Board of the CORO Foundation; and Little League manager from 1962–65.

He is a member of Legion Lex, Kappa Sigma, Phi Alpha Delta, the California Club, Los Angeles Athletic Club, Commonwealth Club, Jonathan Club and Town Hall.

Secretary Finch is married to the former Carol Crothers and they have four children: Maureen, 18; Kevin, 15; Pricilla, 13; and Cathleen, 10.

BIOGRAPHICAL SKETCHES OF SUPPORTING WITNESSES

Mr. FLOOD. We will also place in the record the biographical sketches of the Under Secretary and the Assistant Secretaries who are here.

(The biographical sketches follow:)

JOHN G. VENEMAN

PERSONAL HISTORY

Age: 43 years old; born October 31, 1925, Modesto, Calif.

Family: Wife, former Nita Baumberger of Modesto, Calif. Three children, Ann, John, Jane. Resides at Modesto, Calif.

Education: Attended local schools. Graduated Modesto High School, 1943.

Higher education in business administration at Arizona State College and University of Texas.

Military service: U.S. Navy officers training program (1944–45).

Occupation: Member, California State Legislature.

GOVERNMENT SERVICE

Member California State Assembly:

Committee on Revenue & Taxation, chairman.
Joint Committee on Medi-Cal Administration (Medicaid), chairman.
Committee on Social Welfare, member.
Committee on Finance and Insurance, member.

Joint Legislative Committee on Public Domain, member.
State Social Welfare Board, member.
Committee on Fish and Game, member (1962–63).
Committee on Agriculture, member (1963–67).
Stanislaus County Board of Supervisors (1958–62):
Chairman, Board of Supervisors (1960).
Chairman, Stanislaus County Highway Advisory Committee (1960).
Stanislaus County Committee for School Organization, member (1957–58).
Empire Union School District, trustee (1957–58).
Stanislaus County Grand Jury, member (1956).

COMMUNITY SERVICE AND AFFILIATIONS

First Presbyterian Church of Modesto, member.
Stanislaus County YMCA, member board of directors.
American Cancer Society—Stanislaus County branch, member (1958–62).
California State Chamber of Commerce and Greater Modesto Chamber of Commerce.
Commonwealth Club of San Francisco.
Empire Lions Club, president (1957).
Modesto Elks.

CIVIC AWARDS

Selected as "Outstanding Assemblyman of 1968" by California Capitol Press Corps.
"Young Man of the Year," Modesto Junior Chamber of Commerce (1960).

CREED C. BLACK

Born in Harlan, Ky., July 15, 1925.

Educated in public schools of Paducah, Ky. Received B.S. in journalism from Medill School of Journalism, Northwestern University, with highest distinction and with honors in political science, 1949; received Chicago Headline Club's annual award to outstanding Medill graduate. Received M.A. in political science from University of Chicago, 1952.

Served 3 years in Army during World War II; Bronze Star and Combat Infantryman's Badge for service with 100th Infantry Division in European Theater.

Began newspaper career in 1942 with Paducah Sun-Democrat as reporter while still in high school. Copy editor on Stars and Stripes (Germany edition) after war. Edited college daily during sophomore year at Northwestern. Copy editor for Chicago Sun-Times and Chicago Herald-American 1949-50. Became editorial writer for Nashville Tennessean in August 1950, executive editor of Savannah Morning News and Savannah Evening Press, July 1, 1959. Vice president and executive editor of Wilmington Morning News and Evening Journal, June 1960 to June 1, 1964. Managing Editor of Chicago Daily News, September 1, 1964; executive editor February 12, 1968, to present.

Married to former Catherine Davis of Paducah, also Northwestern graduate. Three sons. Residence: 141 Kenilworth Avenue, Kenilworth, Ill.

Former president of National Conference of Editorial Writers. Secretary and member of board of directors of the American Society of Newspaper Editors. Vice president, Northwestern Alumni Association. Member of Sigma Delta Chi, Kappa Tau Alpha, American Committee of International Press Institute, Economic Club, Chicago Press Club, Mid-America Club, Kenilworth Club, Indian Hill Club. Member of Kenilworth Union Church.

LEWIS H. BUTLER

Age 41.
Married, Sheana Wohlford Butler.
Three children: Lucy, 13; Lewis, 11; and Serra, 3.
Residence: 44 Commonwealth Avenue, San Francisco, Calif.

Employment

1965 to date: Practicing attorney, firm of Butler and McCloskey, San Francisco, Calif., dealing with environmental problems. Consultant on urban affairs for foundations, employer associations, universities.

1961–64: Peace Corps Director, Malaysia. (Deputy 1961–62). Responsible for the largest medical program and science teaching program in the Peace Corps.
1951–1961: Practicing attorney, firm of Pillsbury, Madison and Sutro, San Francisco, Calif.

Education

1948–51: Stanford University Law School, LL.B. President, Stanford Law Association.
1946–48: Princeton University, A.B., cum laude.
1945–46: Oregon State College (U.S. Navy ROTC).
1944: Massachusetts Institute of Technology (west coast regional scholarship).
1940–1944: St. Ignatius High School, San Francisco. San Francisco public schools.

Military

1945–46: Active duty, U.S. Navy Reserve, Rank: seaman, first class.

Activities

1967 to date: Founder and president, Opportunity Enterprise Corp., San Francisco. Bipartisan, nonprofit corporation formed by leaders in State government and business to test the use of private and community corporations for the delivery of governmental services in ghetto areas.
1965 to date: President and a founding director of Planning and Conservation League, San Francisco. Statewide citizens lobby for legislation to protect the California environment. Member groups include the American Institute of Architects, American Institute of Planners, California Roadside Council.
1966 to date: A founding director and secretary of the Management Council for Bay Area Employment Opportunity, the forerunner of the National Alliance of Business in the San Francisco Bay area.
1958–60: Chairman, California State Bar Committee on Legal Aid.
1954–58: Club director, Booker T. Washington Center, San Francisco.

Board memberships

Rosenberg Foundation, Hunters Point Boys Club, Constitutional Rights Foundation, Arriba Juntos (Spanish-speaking citizens community corporation), and Council for Civic Unity.

Other

Member, Citizens Mediating Committee for San Francisco State College dispute.

Articles

Evaluation of the Role of Peace Corps Volunteers in Education in Africa, 1964–65.

"Peace Corps Staff Overseas," article appearing in The Annals, 1965. (A reprint of this article is distributed to every applicant for a Peace Corps staff position.)

Evaluations of Peace Corps Training at Universities, 1966, 1968.

Mr. FLOOD. Mr. Secretary, I suppose you would like to introduce for the record and to the committee the staff that you have with you.

Secretary FINCH. Yes, Mr. Chairman.

We have the Under Secretary John Veneman; Assistant Secretary for legislation Creed Black; Assistant Secretary, Comptroller James Kelly; and Bruce Cardwell, the Deputy Assistant Secretary, Budget. Mr. Lewis Butler will be here later.

Mr. FLOOD. As you probably gathered, Mr. Secretary, this brother act of Kelly and Cardwell is not unknown to the subcommittee. They are practically covenants running with the land.

I was in California last weekend, in Los Angeles; I had the pleasure of receiving a humanitarian award from the Children's Research Institute. An old friend of ours was there who sat with me in the Appropriations Committee for 20 years, Mr. Sheppard of California, who retired. He suffered from emphysema much of his life, and is 85 now

and quite ill. There was quite a distinguished audience, as I suppose you have heard.

Secretary FINCH. Yes.

Mr. FLOOD. And during the course of the festivities, before and after I made a point of asking them about you, obviously, and it was quite a cross-section, all sorts of people there—I was very pleased to know, and you will be pleased to know, and I think the committee should be, that they all spoke very highly of you. I made a point of inquiring.

Secretary FINCH. Thank you, Mr. Chairman. I am not sure that after I have completed my tenure in this office, I will be able to return to such resounding praise, but it is nice to know I'm starting off with good wishes.

Mr. FLOOD. There is no reasonable doubt about that, I can assure you. Even with us. At this point, it is a very happy family.

You have here an excellent statement. How do you wish to proceed?

Secretary FINCH. I am at your pleasure, Mr. Chairman. In my previous appearances I have tried to highlight what I regard as the important sections of the prepared statement. When we are dealing with as many items as we have here, I am reluctant to take the committee's time with a lengthy reading.

Mr. FLOOD. I rarely take an opposite position. But in view of the extraordinary importance of this shop of yours and under the circumstances of the new administration and your taking over, and since the whole thing is, as you have found out, quite a can of worms, I think we will break our precedent and suggest, if you will, that you read this statement.

Secretary FINCH. Fine.

Mr. FLOOD. I have read it myself and I am sure many of the others have, but I repeat, for the purposes of emphasis under the circumstances perhaps you had better read it, no matter how long it takes. This is no penny ante game you are playing, sir.

Secretary FINCH. I am well aware of that.

GENERAL STATEMENT

Mr. Chairman and members of the committee, it is a privilege to appear before you today to present the 1970 budget for the Department of Health, Education, and Welfare.

As a 6-week veteran in office, I am still new to the detailed scope of my department's responsibilities. But I am not new to the problems that HEW's programs are meant to address. I have a strong personal commitment to the solution of these problems—economically, effectively. So, too, does this administration, and the overwhelming majority of the American people.

This budget, like the scope of HEW's responsibilities, is vast and complex. In order to get a grip on it, I set up a series or review teams—consisting of outside experts, my own appointees, and HEW agency heads and program managers—for as thorough a study as time would allow of the Department's ongoing programs and the budget before us. As a result, we have submitted to the President a number of possible budget amendments to move us more rapidly toward objectives of the highest priority.

I would be happy to appear before you again to discuss the amendments that the President may approve. Today, I want to share with you some broad views concerning the problems we confront—and the Department's resources and potential for resolving them.

MAJOR NATIONAL PROBLEMS

In my judgment the final third of this century will be marked by a growing concern about the quality of life that all Americans may ultimately enjoy—qualitative progress that will depend in part on that which you in the Congress and we in the executive branch put in motion now.

I think one of the lessons that came out of the last election is that there has been a growing erosion of public confidence in our national systems of health, education, and welfare, in how those programs are delivered, and in the extent to which they fail to get to the target area. Certainly it is clear that the average American taxpayer, rightly or wrongly, is convinced that his dollars are not being properly used. This erosion in public confidence is evidenced by—

Dissatisfaction on the part of recipients, the general public, and State and local governments with a welfare system that seems to perpetuate dependency, at an ever-growing and ever-more-costly pace;

Doubt about the capability of our educational system to prepare people for a productive life in a society of ever-greater complexity. Indeed, the whole theory of compensatory education is being challenged;

Concern over the availability of health services, and over their rising costs;

Frustration over the failure of existing systems to serve the poor and the disadvantaged with equity and dignity;

Alienation on the part of young people who sense a widening gap between social problems and effective solutions.

These, of course, are only a few examples of the very urgent problems that demand action. We do not suggest that in the time we have been here we have found any instant solutions. The proposed amendments to this budget will not provide easy answers either.

Final resolutions of these problems will be hard, and long in coming. But I believe we can step up the rate of progress. We can begin at least to move in new directions—to afford the American people a new assurance that we are on the road to effective solutions.

INTERIM STRATEGY

In the broad view, our basic purpose is to fulfill the commitments that have been made by the Federal Government to the American people. Our emphasis will be on—

(1) Efforts to help bring the poor and the disadvantaged into the productive mainstream of American life; and

(2) Programs that mobilize the vast resources of the independent sector—that genuinely and substantially involve private enterprise and voluntary initiative.

More specifically, our interim strategy includes—

(1) Rigorous and prompt evaluation and reevaluation of all existing HEW programs.

(2) Mounting experiments and demonstrations, first as a means of identifying and testing the best courses of action and second, as means of persuading others—the States, local communities, and the private sector—to take over and to drive promising programs on to completion.

(3) Greater emphasis on planning and coordination so that both we and others may know better what we are doing, where we are heading, and why.

(4) Cutting back low priority programs, and unpromising approaches, as soon as such action is indicated.

(5) Strengthening the Department's capability to discharge its responsibilities.

In this broad context, I will now turn to a more detailed discussion of HEW's 1970 budget.

EVALUATION

We have had this enormous investment in health, education, and welfare that has taken a quantum jump in recent years. At least in the brief time I have been in office, I must say the one thing I have found that disturbs me more than anything else is the inability to evaluate ongoing programs. We keep asking for data without success, and we are simply unable to evaluate programs across the board.

I am not at all satisfied with the present procedures for systematically evaluating program effectiveness and this, I think, makes it more difficult to account for our stewardship.

What I am talking about is the need for objective criteria for sorting out good programs from bad. In fiscal 1969, $6 million is available for evaluation. For fiscal 1970, $21 million is requested, mostly for use in the Office of Education.

I might point out, gentlemen, that this is not an in-house evaluation we are talking about. Ninety percent of the figure is contracted out so we get an outside objective analysis of what it is we are trying to do. I feel it is essential that at least this amount be appropriated.

SELECTED EXPERIMENTS AND DEMONSTRATIONS

As I see it, there are three areas in which the need for model building is most acute: the dilemma of the welfare system, the role of the public school in relation to the community, and the organization and delivery of health services. These are critical problems, yet we are doing little to find new approaches and new solutions.

THE WELFARE SYSTEM

Everyone agrees that our welfare system is defective, that it is replete with inadequacies and inequities. But we cannot simply abandon the present system. First, something better must be put in its place, and that is impossible until we can agree on modifications of maximum promise.

Despite the wealth of suggestions and proposed alternatives, there has been almost no practical testing. This year about $1 million is

available in the cooperative research budget of the social and rehabilitation service to begin some limited experimentation. The 1970 budget asks for an additional $3 million to design a few more experiments. I think much more than this will eventually have to be spent to achieve a real breakthrough. But so little is now known that we have no choice but to start slowly and, by developing a limited number of projects, study various combinations of income payments and social services for both adults and children. This is the first step toward reducing perpetual dependency. I think this will be a sound investment and I strongly urge the committee to act favorably on the budget proposal now before you.

As far as we know, there is only one ongoing demonstration project in income maintenance, funded by OEO. This project is located in New Jersey, and is funded at about a million and a half, as I recall.

SCHOOL EXPERIMENTATION

The public school is the foundation of our educational system. It has a key role in preparing the disadvantaged for entrance into the mainstream of American life.

It is becoming apparent that our established school systems are doing neither the job they can do nor the job they ought to be doing. There are problems of curriculum, staffing, community involvement, and the infusion into the classroom of new educational substance and new educational technologies. The need for testing and experimentation is desperate.

What we want to do—and we are not out in any way to try to run schools—is attack these problems through demonstrations and experimental schools.

We think, for example, it is urgent to test various extensions of the concept of a community education center. This concept is by no means limited to the traditional 9-to-3 school. The community school—a nucleus of community action and service—might embrace adult education, vocational and remedial training, recreation and physical fitness programs, and interaction among social groups of diverse values and viewpoints. I think it is extremely interesting, in a few cases, that there have been disorders in so-called ghetto areas, where community schools exist. While whole areas around the schools would be decimated, not even a window would be broken in the school. Because of the proprietary sense many of the disadvantaged have in these schools, they have gone to great pains to protect them.

[An example of how important this would be is where the entire area around the school is involved. This is an explosive matter, as we saw in New York last year, but one we dare not ignore much longer.]

Other crucial areas for testing and measurement are the value of compensatory education, the role of preschool and early childhood development programs—which becomes critical now that Headstart has been assigned to the Department of Health, Education, and Welfare—and the potential for developing more effective teaching programs for the disadvantaged. We must also experiment with new departures in vocational education, a key target in my view, and deal with the special problems of the child who needs to work in order

to support either himself or his family. The range of alternatives to investigate is unlimited.

Our purpose, across the board, will be to identify alternatives and offer options to local school boards and school systems.

The educational research budget does not now contain a request for a diversified program of experimentation with the community school concept. The D.C. Model School, for which there is $5 million in the budget, will yield some useful data, but this is only one approach that needs to be tested. We may propose an amendment to mount such a program or, failing that, consider a restructuring of the pending budget request so that at least a few such projects might be put in motion in 1970.

As many of you know, there are a number of separate districts and at least two schools in the District of Columbia where they have had foundation money to provide this 18-hour-a-day, year-round service. We are anxious to take a critical look at these examples of the kind of school I have been describing.

ORGANIZATION AND DELIVERY OF HEALTH SERVICES

Another problem of critical concern is that many Americans lack adequate health services—not simply because we lack the resources but because of shortfalls in the organization and delivery of health services. It takes many years to plan and construct a new health facility, and it takes even longer to train a new physician. But changes in organization and maximum use of subprofessional personnel—that is, of paramedical technicians—can have a much more immediate effect.

In that connection, we are giving considerable thought to what we might do. We are asking the medical societies, particularly in California, to see what we can do to avoid repeating the mistake made following World War II when we failed to fully utilize a great resource of veteran corpsmen, many of whom came out with a good deal of practical experience in diagnostic and actual care. When and if we can terminate Vietnam, we can pick up many of these people and get them into the health delivery system in some form or another. We have no present recommendation on that, but we are giving considerable thought to it.

The National Center for Health Services Research and Development was established last year to attack this problem. The 1970 budget request for the Center is $45 million, an increase of $3 million over 1969.

I strongly support this request. Since most of the Center's base budget is taken up with continuation costs of projects that predate its establishment, new and more creative research depends on at least this modest increase in appropriations. In addition, I feel that we need to evaluate the existing programs that have been absorbed into this program.

Significant innovation can come only from new money, to make a start toward developing new delivery systems for health services to the urban and rural poor.

BASIC HEALTH AND EDUCATION SYSTEMS

Many of our programs are targeted to special groups within the total population—the poor, the aged, the young, and the disabled.

At the same time, we want to improve those programs that support and strengthen the basic fabric of our society—programs designed to bolster our national systems of health and education. And we must tie the one thrust to the other: both, in my view, are efforts aimed at conserving the Nation's basic human resources.

HEALTH PROGRAMS

The Department's major health programs constitute a broad commitment in the interest of all. From a base of biomedical and mental health research, this comprehensive effort involves the dissemination of the results of that research, State and regional health planning, consumer protection and environmental control programs, and training health personnel to man all these systems.

For the biomedical research programs at the National Institutes of Health, a budget of $1.1 billion is proposed for 1970. This would maintain the substantial investment that the Nation has made in the past.

The aim of the regional medical programs is to bring the latest advances in heart, cancer, and stroke research into everyday medical practice. About 1,000 private medical institutions and 800 State health organizations, including every medical school and hundreds of hospitals, are now participating in this effort. By 1970, 43 regions will have moved from planning into program operations.

The partnership for health program will also reach a critical phase in 1970. By then, comprehensive health planning agencies will be functioning in all 54 U.S. political jurisdictions and thus move effective State health planning closer to realization. For this program, the basic source of funds is bloc grants, funds provided without categorical limitations for use by the States to meet public health needs as they see them. But it is difficult for the States to do much that is creative with present funding levels, little higher than the sum of the categorical programs that the new grants replaced. I hope we can surmount this handicap as quickly as possible.

Another feature of the partnership for health in 1970 will be the continuation, and the acceleration in fact, of a vaccination program against German measles—the rubella program. A request to get it under way in 1969 by means of an appropriation transfer is now pending before this committee. You have already had testimony on it. It is essential to do everything possible to head off the next peak in the rubella cycle, projected for 1970–71. If we are successful, some 40,000 to 50,000 children, otherwise imperiled, will be born free of birth defects. And the implications of those defects I am sure I do not need to stress before this committee.

One of the real successes of recent years has been the program of community mental health centers. Progress in treating mental illness was begun with advances in drug therapy, but the victory will be confirmed by these community centers. By the end of 1970, there will be 275 centers in operation serving nearly 42 million people.

I believe that 1970 will also be a year of significant progress in the effort to control and reduce air pollution. The Clean Air Act requires that air quality control regions be designated covering all our urban population centers. Twenty regions will have been designated by the end of 1969, and another 30 will be designated in 1970. So we would be

about seven-tenths of the way down the road once that milestone has been reached. Once a region is designated, all jurisdictions within it must work together to develop and apply uniform quality control standards. These standards and their implementation must be consistent with general criteria established by the National Air Pollution Control Administration.

Last but by no means least, let me say a few words about the problem of supplying enough manpower to make the Nation's health system run.

Critical shortages exist today. And, because of the long leadtime for training, they will persist for many years to come, even if we take vigorous action now. The situation is worsened by the fact that a number of medical and dental schools are on the edge of bankruptcy. According to one estimate, 20 medical schools and 15 dental schools are in serious financial trouble. Two dental schools did not admit freshman classes last fall. Among other factors, the health manpower shortage is one key to rising medical costs, so any diminution in output of trained personnel will have serious long-range consequences. One potentially hopeful avenue is the maximum utilization of paramedical personnel—advanced planning, as I have already noted, to make sure we make good use of the pool of trained technicians that will be available once the Vietnam conflict subsides.

The 1970 budget requests $219 million for operational support and capital improvements at medical, dental, and related schools, an increase of $75 million over the 1969 approportion.

Of that $75 million increase, $43 million is for construction. I believe this request is an essential investment in our health system.

EDUCATION PROGRAM

The Department's education program represent a crucial investment in America's future. We are seeking to strengthen the entire educational spectrum and, as one key target, to make it more responsive to the needs of the poor and disadvantaged.

ELEMENTARY AND SECONDARY

The principal means for such assistance is the program for educationally deprived children, authorized under title I of the Elementary and Secondary Education Act.

Eligibility of school districts for aid is determined by the number of poor and disadvantaged children they serve. Because its impact will be diluted if it is spread too thin over an entire school system, title I funds should be concentrated on those schools with highest percentages of disadvantaged students. The Office of Education is now attempting to persuade States and school districts to focus funds in this way. In 1970, $1.226 million is budgeted for title I, an increase of $103 million over 1969. The program has stayed more or less level for the past several years while the number of eligible children has increased substantially and inflation has been reducing the amount of educational improvement it can buy.

Additional assistance is provided to elementary and secondary schools through special programs of bilingual education, dropout prevention, and education for the handicapped. These programs are directed toward specific behavorial, cultural, or physical problems that

receive less than adequate attention in general programs of assistance. I support the budget requests for all these programs.

On the side of teacher training, a very creative approach has been the Teacher Corps. By combining the efforts of highly motivated professionals and teacher trainees, this program has had a salutary impact both on the school districts participating in the program and, more broadly, on practical methods of teacher training. The 1970 budget provides funds for 2,400 corps members in active service and for recruitment and initial training of 2,000 new members.

Elementary and secondary teachers also receive training through programs authorized in the Education Professions Development Act. About 45,000 teachers and administrators would receive training with the funds requested in the 1970 budget—nearly half of whom would work with educationally deprived children.

HIGHER EDUCATION

The emphasis of most ongoing student-aid programs is on poor and disadvantaged young people. The talent search program seeks out those with a potential for college training, and informs them of requirements for college entrance and of available types of financial assistance. Upward bound, a program formerly administered by the Office of Economic Opportunity, aims to prepare high school students from poor families for eventual college entrance. Educational opportunity grants, averaging about $550 each per year, are scholarships for students accepted by accredited institutions.

We recognize that $550 is hardly enough, but hopefully it can help the student not to be totally dependent on his own labor and resources so that he can participate as fully as possible in the academic life and other advantages in higher educational institutions.

Direct loans will be more readily available to poor youngsters because of new OE instructions targeting NDEA loans to students from families with incomes below $10,000. Once such students are in college, their chances of success are improved by the work-study program, which helps them earn money during the school year, and also by a new special counseling program to help them resolve academic or personal problems that come up during the course of their education.

Nearly all our programs in higher education are slated for modest increases in the 1970 budget. Talent Search would try to identify 140,000 potential college students, an increase of 25,000. Upward Bound world level off at 26,000 high school students assisted. Educational opportunity grants would be awarded to 308,000 students, an increase of 30,000. Work-study programs would involve about 370,000 students, the same as in 1969 but at higher wage levels. Special services in college, a new program authorized by last year's Higher Education Amendments, would assist 10,000 students. This new program involves college students trying to work with the disadvantaged in a special tutoring program.

COMMUNITY COLLEGES

One of the most exciting, promising, and rapidly growing elements within our higher educational system is the Community College. These 2-year colleges and technical institutes, with ever-increasing emphasis

on technical training, are uniquely suited to fill the growing gap between vocational education and the skills needed by business and industry.

During the last 2 years, there has been a phenomenal growth in their numbers: on the average, a new one opened every week. Today, nearly 2 million students are enrolled in community colleges and technical institutes. By 1970, 2.3 million will be enrolled, about one-third of all undergraduate students nationwide. But we are still far short of meeting total needs. Today, community colleges are to be found in only about 60 percent of our major cities.

We look on these as being a peculiar and unique mechanism because obviously the level of quality education differs from high school to high school. The community colleges have been helpful in these cases where the student is a late bloomer and was not motivated to push himself in high school and prepare for college. In California, where there are 90 of these community colleges, we found that they provided excellent assistance in preparing the student and feeding them into higher educational institutions they would not have other have been able to enter.

But they are not just feeder systems for higher education. They do an excellent job in training teachers and in providing vocational education. I think they offer great promise, for example, in training more of our paramedical people.

The 1970 budget contains funds for 177 construction projects for 2-year colleges, and 550 fellowships for teachers at the Ph. D. level.

These schools also participate to a limited extent in the college work-study program. I do not think this is an adequate level of support, considering their rapid growth rate and their unlimited service potential. If it proves impossible to make a major forward step in fiscal 1970, because of budget restraints. I would certainly hope to see expanded support for community colleges in future budgets.

Because of rapidly expanding enrollments, construction of facilities is a major problem for many institutions. The 1970 budget proposes a program level of $400 million for the construction of various kinds of college facilities, about the same as 1969. This consists of $150 million in construction grants, and $250 million worth of subsidized loans obtained in the private market.

In addition to student aid and construction, program assistance is also offered—principally to developing institutions such as southern Negro colleges and former teachers' colleges struggling to upgrade their quality of education. Projects in this program involve establishing cooperative arrangements wtih more advanced institutions and with private business and industry. The 1970 budget will support 375 such projects, an increase of 25 over 1969.

A number of new assistance programs authorized by the Higher Education Amendments of 1968 would get started with funds requested in the 1970 budget. A beginning would be made toward the more efficient use of college resources through teacher exchanges and the sharing of such facilities as laboratories and computers. A program to upgrade graduate schools would get under way by making awards to three graduate schools with the potential for excellence, to hire additional faculty and diversity course offerings. A small number of grants would also be made to graduate schools to set up professional

training programs in disciplines relevant to the public service, and to award graduate fellowships.

Also appearing as a new program is a request to begin strengthening international studies in American colleges and universities. This program was first authorized by the International Education Act of 1966—with a very large authorization—and extended by the Higher Education Amendments of 1968. It has repeatedly been attacked as a new foreign aid program, but this is simply not the case. It is a domestic program, with the objective of better preparing Americans, of all professions, to take part in international business and commerce, education, and government affairs. We seek an appropriation for this of $2 million, a modest figure.

VOCATIONAL EDUCATION

As I have already suggested in connection with community colleges, one of the highest of educational priorities is to reorient vocational education to current job markets and thus to reduce unemployment among disadvantaged young people, urban and rural. The Vocational Education Amendments of 1968 laid the ground work, and the 1970 budget would make a real start. Forty percent of the basic State formula grant must now be set aside for specific purposes: 15 percent for the disadvantaged, 10 percent for the handicapped, and 15 percent for postsecondary programs. A new program of consumer and homemaking education would enroll 2 million students, at least one-third of whom must be from rural or urban poverty areas. About 98,000 students would be enrolled in a new cooperative education program in which full-time work experience alternates with full-time academic study. We are asking $14 million for this program. The 1970 budget also requests $13 million for more than 100 innovative projects aimed at discovering new ways to upgrade the employability of school dropouts and high school graduates who lack marketable skills.

The budget completely ignores another section of the amendments, however, which authorizes a new program for training the disadvantaged student. The program would target assistance to areas of high unemployment ,and would allow private school children to take part in projects. These special projects would be developed by each State within the context of a comprehensive plan. They would, in my opinion, add significant leverage in reorienting vocational education toward areas of highest priority. In our budget review, we have been seriously considering an amendment to get this program started.

For a closely related program, adult basic education, the 1970 budget would provide funds to train 533,000 adults, an increase of 53,000 over 1969. This program helps adults overcome the handicap of illiteracy and makes it more likely that they will either join the work force or upgrade their present jobs. This program has been augmented substantially by the efforts of civic organizations in many States to seek out the elderly and middle aged who frequently have been ashamed to admit that they were really illiterate. We think that voluntary involvement will make this program more effective in the future.

SPECIAL TARGET GROUPS

Much of the HEW budget is directed toward specific groups. Usually these are labeled "welfare" programs, but, by their very nature,

they cross over into health and education as well. The principal such programs are those directed toward the poor, the aged, the young, and the disabled.

PUBLIC ASSISTANCE

Total cash payments to welfare recipients in 1970 is expected to reach $7 billion, of which $3.7 billion would be provided by the Federal Government and is included in the HEW budget. This represents an increase of $1.1 billion over 1969 in total costs, and $294 million in the Federal appropriation. The increases result from greater numbers of recipients in all categories, except old-age assistance, and in some instances from higher benefits.

Of the total increase in the Federal appropriation, $117 million is in the form of aid to families with dependent children (AFDC). This, in my opinion, is a low estimate.

Even aside from the fact that inadequate statistical projections have led us in recent years to underestimate the total welfare caseload—a point to which I will return—this figure assumes that the AFDC freeze will go into effect on July 1, 1969, as presently scheduled.

This freeze would impose on the States and local juridsictions—and we have consulted with practically every one of the State welfare directors—a nearly intolerable fiscal burden. Although the total number of AFDC recipients is expected to increase by 800,000 in 1970, the number for which Federal matching funds would be available, under the ground rules of the freeze, would decrease by 300,000. Thus, 1.1 million people on the AFDC rolls in 1970 would not be covered by Federal matching payments.

It is estimated that total costs for the program will rise by $810 million in 1970. Under existing formulas, the Federal Government would normally contribute $424 million of this. With the freeze in effect, it is estimated that the Federal Government would contribute only $117 million, and the impact on the States is, of course, obvious to all of us here today.

Because of rising monthly payments, the Federal share would increase, even though the total number of recipients covered by Federal funds would decrease. Thus the States and localities would be required to absorb about $307 million in extra public assistance costs. Given the present condition of State and local finances, it is no accident, that pressure is building, either to postpone the freeze once more, or to do away with it altogether.

We in this administration, are fully aware of the legislative history of the AFDC freeze, and also of the problems it threatens to impose on State and local governments. We will shortly be making our recommendations on this urgent matter to the Ways and Means Committee, and we hope we can work together with you in this area.

WORK INCENTIVES

The legislation imposing the AFDC freeze also authorized the work incentives program (WIN). Its goal, is to reduce the numbers on the welfare rolls, by providing job training for AFDC recipients. Frankly, this program has barely gotten off the ground. Of a projected January 1969 goal of 100,000 enrollees, only 39,000 were in fact, en-

rolled by the end of that month. Fiscal 1970 will be, in effect, the first full year of operation for the WIN program.

In any case, its effect on the welfare rolls will become substantial only in the long haul, because recipients do not lose all their welfare benefits when they become employed. Up to a certain level of income, they remain eligible for at least a partial benefit.

Since we have been in office, we have spent a good deal of time working with the Department of Labor on this program. They provide job training and counseling, while HEW refers welfare recipients for training, and provides day care for their children during the training period, and even after they are employed, if they cannot themselves afford to pay for it.

This part of the program, too, has lagged behind targeted goals. Of the 23,400 projected, only about 13,600 children were receiving day care, as of January 31, 1969.

To work effectively, the WIN program will require a degree of interdepartmental cooperation that has not yet been attained. I can only assure you that I intend to work closely with Secretary Shultz to make sure that the intent of the Congress in setting up this program will be fully implemented.

The budget assumes that 175,000 trainees will be enrolled in the WIN program in 1970. Even though the program is not reaching its planned targets at the present time, we will do everything in our power to reach the goal for 1970. Our success in this area will be in great part dependent on the effectiveness of State departments of employment. There is an uneven performance from State to State, as you know, which we are attempting to resolve through discussions with the Governors and their staffs.

MEDICAID

The medical assistance program authorized by title XIX of the Social Security Act, covers everybody on the welfare rolls, plus those whose income is less than a certain percentage of the maximum welfare benefit.

In fiscal 1970, all 54 States and political jurisdictions will have adopted medicaid programs. There are still 11 now pending.

About 10.2 million people will receive services, an increase of 700,000 over 1969. The total cost of the program will reach $5.8 billion, an increase of $1.2 billion, about 25 percent of which represents rising costs—medical and other. The Federal share has been budgeted at $3.1 billion for 1970, an increase of $661 million.

I have become greatly concerned, let me add, about reports of improper and fraudulent charges being made to the program. A thorough investigation of these charges is being made, and I intend to correct such abuses as we may find. These cases add to public displeasure and we are now spending a good deal of time trying to develop better methods to monitor them.

FAMILY PLANNING

Lack of family planning can mean that the poor stay poor, or get poorer. Dissemination of family planning information and services is, therefore, a key ingredient in any antipoverty program. Our function

is to disseminate family planning information through State and local agencies, and other health and hospital agencies.

The current year is the first, during which any significant program has gotten started. About 850,000 women are expected to receive services, through education and counseling. With the 1970 budget, this number would increase to 1,300,000.

HUNGER AND MALNUTRITION

The presence of malnutrition among the Nation's poor is now an established fact—and a shocking one. The national nutrition survey will continue to yield objective data on the extent of hunger and its effects.

The survey at persent, however, is confined to a relatively small sample of States and localities. This survey was ordered by my predecessor but came in to view after this Congress assembled. I hope it can be broadened so as to develop a detailed and comprehensive picture of malnutrition in the United States. I hope, too, that the survey can be put on a continuing basis so that progress in overcoming hunger can be accurately monitored. In addition, HEW can and should undertake innovative health and educational demonstrations to meet the needs uncovered by the survey. Food alone will not combat many of the medical porblems involved; information and training in good nutritional practice will also be called for. We in HEW have a key role to play in both these areas.

I believe we should have the capabilities to explore new approaches to the problem of hunger—in 1970, if possible, or as soon thereafter as funds can be made available.

THE AGED

HEW's principal programs of assistance to the aged are the retirement and medical insurance programs of the Social Security Administration. Social security beneficiaries whose income is below certain minimum levels are also eligible for old-age public assistance. As social security benefits have increased over the years, the number of old people on public assistance has gradually declined. In addition, the Administration on Aging in the Social and Rehabilitation Service has the responsibility for coordinating all Government programs for the aging and for supporting a selected number of demonstration service programs.

Old-age and survivors insurance is now a firm fixture of American life. Over 90 percent of all workers and their families are insured by the program. In 1970, monthly checks will go to more than 23 million people, including some 3.5 million children under age 18, and the aggregate of benefits will reach $24.6 billion.

We have the question of increased benefits, and of increased minimums under intensive review and in the near future will make specific proposals on both scores.

We estimate that, in 1970, more than 20 million people age 65 and over will be covered by the Federal hospital insurance program. Of these, more than 95 percent will also have chosen to participate in the supplementary medical insurance program. Over 60 million

claims and bills will be processed under the two programs combined.

The enormous administrative job of handling this workload is on the way to being mastered and, although there are still problems, hospital and medical bills are generally being paid promptly and efficiently. I think Mr. Ball deserves a great deal of credit for this. The major problem now facing medicare is that of rising costs, across the board. My predecessor chose to hold supplementary medical insurance premiums at $8 a month (half paid by the Federal Government)—a rate whose adequacy has been called into question by actuarial projections. With respect to one cost factor, the Social Security Administration has issued guidelines and recommendations to insurance carriers to hold down reimbursement rates to physicians. Clearly, our first order of business is to do everything possible to hold medicare costs within reasonable limits.

THE YOUNG

Aside from our educational programs, HEW's efforts with respect to the young concentrate on improving and protecting the health and welfare of newborn and very young children, and curbing the rising rate of juvenile delinquency.

We must begin working to harness the tremendous potential energy of our young people for constructive social purposes. I think we must develop a different kind of approach—not just the traditional White House Conference, which has become a sort of stylized exercise. But today I will confine my remarks to programs in the 1970 budget.

The infant mortality rate has been dropping significantly in recent years, and I believe an important factor in this has been the comprehensive maternity and infant care centers supported by the Social and Rehabilitation Service. Certainly, infant mortality rates have dropped dramatically in the areas where these centers have been operating. In 1970, 54 centers will be in operation, providing services to 190,000 mothers and children. In other child health programs, over 500,000 crippled children and 400,000 poor preschool and school-age children will receive health services.

The child welfare program provides services for the care of homeless, dependent, and neglected children. While no increase in quantity of services is proposed for 1970, an increase in quality should result from involving parents more effectively in child welfare programs, and from training poor people to work as subprofessional aides.

Federal efforts to combat juvenile delinquency took a new direction with the passage of the Juvenile Delinquency Prevention and Control Act of 1968. The heart of the new program is the development of comprehensive community plans for reducing delinquency through prevention and rehabilitation. The first full year of the program will be 1970. The budget would support 47 community projects, plus 17 model projects to develop and demonstrate new techniques in juvenile delinquency control.

THE DISABLED

The Department administers two major programs for the disabled: The disability insurance program of the Social Security Administration, and the vocational rehabilitation program of the Social and Re-

habilitation Service. In addition, we support smaller programs for assisting the mentally retarded and for rehabilitation research and training.

The disability insurance program provides monthly benefits to disabled workers who were in jobs covered by social security. In 1970, we estimate that more than 2.5 million people will receive benefits totaling $2.6 billon. Those covered by this program would share in whatever benefit increase might be adopted for all social security beneficiaries.

The State grant program for vocational rehabilitation services is a time-tested, worthwhile investment. In 1970, 265,000 people will be served, an increase of 35,000 over 1969. On the basis of past experience, these people will earn an extra $35 for each dollar spent on their rehabilitation.

Two new vocational rehabilitation programs are proposed in the 1970 budget. One would begin to provide services to migratory agricultural workers, and the other would serve the socially disadvantaged—that is, people who are incapable of holding a job because they cannot adjust to a work environment. This latter program was authorized by the Vocational Rehabilitation Amendments of 1968 as an open-ended State formula grant program. The budget proposed for 1970, however, contains appropriation language to make it a closed-end project grant program. I firmly support this proposal. I think it would be most unwise at this time to start a new noncontrollable program.

INVOLVING THE PRIVATE AND INDEPENDENT SECTORS

The budget for 1970 proposes a number of important steps to involve the talents and resources of the private and independent sectors in the Department's overall effort—and I could not support such steps more strongly. These sectors, in my view, represent the greatest untapped resource in our society.

For example, our loan programs are gradually being converted to loan guarantees or interest subsidies. Under these arrangements, loans are procured in the private market while the Federal Government either insures the lender against default or pays the difference between a fixed low rate of interest and prevailing market rates.

This approach is based on a student loan program that originated in the private sector several years ago and proved to be highly successful. In 1969, higher education construction loans will take this form if the supplemental, now pending before Congress, is approved. The amendments to Hill-Burton hospital construction program to be submitted later this session will very likely rely on the same approach.

I might comment on some data that we received from the Office of Education this morning on financing student assistance in the 1967–68 calendar. The $1.5 billion, or 71 percent of the total, came from Federal sources. From State government there was $10 million, which is 0.4 percent, and from completely private sources there was $600 million or 28 percent, for a total of $2.2 billion.

Since 1906 the private sector has been conducting a program of cooperative education in which a student alternates full-time study with full-time employment. This program has helped many students financially, in addition to giving them invaluable work experience and help-

ing them to set career objectives. The program, however, has been operating on a more limited scale than desirable.

In the education budget there are two new programs for the expansion of cooperative education, one for college students and one for vocational students.

The Federal Government's involvement would be limited to providing seed money for administrative costs. A school could utilize a grant to start a new program or to expand an existing program into additional curricular areas such as teaching and business administration. All wages earned by the student would be paid by the employer.

I believe that expansion of the cooperative education programs would foster a very healthy working relationship between business and colleges and vocational schools.

These examples are, of course, only a beginning. I feel that if we are going to develop practical and workable techniques for problem solving and be responsive to the local chemistry of each community, we must enlist the vast array of nongovernmental associations in a broad partnership with government at all levels.

We need the fresh ideas and bold experimentation of private innovators. I envision this as a two-way, give-and-take partnership. At times the private sector might do the experimenting with Government acting as a catalyst and disseminating workable results to other communities; at other times we in Government might develop new ideas and, through example and demonstration, give local communities the benefit of our progress. There is a great potential here that we are actively exploring. I have directed one of my assistant secretaries to focus a major part of her effort on mobilizing voluntary sector activity.

CUTBACK OF LOW-PRIORITY PROGRAMS

As I have already suggested, our detailed recommendations in this area will have to await the results of the efforts of my departmental review and reevaluation teams. But we have cut back on some of our so-called low-priority education programs.

The main reduction proposed is in impacted area aid, which would be cut $206 million below the 1969 appropriation of $521 million. This reduction is related to, but not technically dependent on, proposed legislation that would focus such aid on school districts serving children whose parents both live and work on Federal property. These are the families who contribute least to local tax revenues.

In addition, the budget proposes to eliminate special programs for purchasing educational equipment for elementary, secondary, and undergraduate schools. The rationale for this is that equipment should be purchased as a part of other assistance programs and does not require any special program of its own. And also, our indications are that demand for a good deal of this hardware has declined in recent years.

As a result of our budget review, we decided to support these recommendations. With the tight budget we have to live with in 1970, we must make some hard choices if the country is to receive the greatest benefit from what money is available. I realize that all these programs, and particularly impacted area aid, have wide support in Congress. However, I hope that the committee will view these cutback proposals

in the full context of priority programs and budget stringency and, having done so, come to the same conclusions that we did.

STRENGTHENING MANAGEMENT

During my term of office I hope by working with you to make some significant improvements in the Department's management. A number of organizational studies are underway right now and others will get started in the coming months. For the present, I would like to discuss three problems which are immediate and pressing: (1) estimating the cost of public assistance and medicaid; (2) getting adequate staffing for several high-priority programs; and (3) controlling expenditures.

ESTIMATING PUBLIC ASSISTANCE AND MEDICAID

The inability of the Federal Government to make an accurate estimate of public assistance and medicaid costs is notorious. The fact that 1969 supplementals in excess of $600 million had to be requested for these programs indicates how wide of the mark last year's estimates were. Even this represents something of an improvement since the 1968 estimates were off by more than a billion dollars.

The 1970 budget follows the principle of budgeting exactly what the States estimate as their need for Federal matching payments. A canvass of the States was made in December 1968 and what the States estimated was put in the budget, no more, no less. While this procedure highlights State responsibility for these programs, it does not, in and of itself, produce a more accurate estimate. Traditionally, the States have done as poor a job of estimating public assistance and medicaid costs as the Federal Government.

In February, the Social and Rehabilitation Service initiated a survey of 20 States to determine if they had revised their December estimates. Because we are terribly concerned about this we now intend, if we have the resources, to broaden this survey to include all States and jurisdictions.

The results of this survey will be available by the end of March or early April. It is my intention to inform the congressional Appropriations Committees of any revisions which the States might make, as soon as I have the information in hand.

The long-range solution to this problem is to improve estimating methods. A task force made up of State and Federal officials made a thorough study of this problem last year and offered recommendations for standardizing budgeting procedures and statistical estimating so that a more scientific and accurate estimate of trends can be made. I have directed that implementation of these recommendations be accelerated so that the system will be in full operation for the 1971 budget.

STAFFING

Since July 1, 1968, the Department has been operating under the employment limitations of the Revenue and Expenditure Control Act. On duty employment has been declining steadily ever since. The budget estimates that employment will decline by 4,000 during fiscal year 1969.

While these limitations, in some cases, have undoubtedly accelerated the healthy pruning of excess staff, the basic approach to manpower control taken by this law is inherently unsound. It bears no logical relationship to workload or legitimate manpower requirements. All jobs that were vacant on July 1, 1968, were abolished whether they were wasteful or productive. Since July 1, employment levels have been governed primarily by the happenstance of where vacancies occurred.

The damage that the limitations have had on the Department are gradually becoming apparent.

The Social Security Administration, for example, is now forced to use an excessive amount of overtime to keep up with the claims and benefit workload. They are bound to reach a saturation point where backlogs begin to build up and quality of service to the public starts to deteriorate. Since overtime costs 50 percent more than regular time, the artificial restriction on employment is not a very good economy measure for the Social Security Administration, for the Department, or for the Federal Government.

Perhaps the most serious immediate effect of the limitations will be felt on the Department's recruitment effort this spring on college campuses. If there is no relief in sight, the limitations will all but wreck the program. I think it is essential that new blood be brought into the Federal service. But we have not been doing as good a job as we should in this area for some time.

But the Department's program managers will have little choice but to curtail college recruitment if the employment limitations are not lifted.

The 1970 budget was prepared on the assumption that the employment limitations would be removed at the end of 1969.

I would like to call to your attention those staffing increases which, in my opinion, have the highest priority: 75 new jobs for civil rights compliance activities under title VI of the Civil Rights Act of 1964. This increase is necessary if we are to carry out that act's intention, and carry it out nationally.

—New jobs for administering the programs of the Social and Rehabilitation Service and the Office of Education. These increases, which would bring these organizations only slightly above 1968 employment levels, would be used primarily for innovative projects and recently authorized programs.

—2,800 new jobs for the Social Security Administration. These jobs will not be sufficient to prevent overtime from increasing in 1970 but, without them, the overtime problem would become intolerable.

—100 new jobs for medicare and medicaid audits. As I mentioned earlier, I am very concerned about reports of excessive and fraudulent charges being made to these programs. Timely and thorough auditing can help us resolve this situation.

—63 new jobs for field coordination and the Center for Community Planning. These jobs are necessary to strengthen HEW's ability to coordinate its programs in the cities.

EXPENDITURE CONTROLS

The 1969 ceiling on expenditures subject to the Revenue and Expenditure Control Act is very tight. In order to insure that the ceiling

is not exceeded, the Department has instituted an extensive and complex expenditure control system. The system is fully operational and will effectively control expenditures to the budgeted level.

The 1970 estimates of general fund expenditures are based on the assumption that the expenditure control system will remain in effect throughout 1970 even though there will be no legal requirement to do so. The estimates are every bit as tight as in 1969. Until the inflationary pressures are eased in the economy we must do everything we can to keep expenditures as low as possible without impairing essential program objectives.

That is the full gamut, Mr. Chairman.

Mr. FLOOD. You say you are new here, but you have had deep concern over the years for many of the problems you have encountered here, and that you have touched upon in your statement. It reminds me of a line from Kipling. He was Irish, of course. He had a son, you may not know, who was in the Irish Guards in World War I, killed at the Marne, and he wrote, among many of his interesting things, a piece called "The Irish Guard," obviously a tribute to the outfit and his own son. There was one line that always struck me. He begins by saying, "We are not so old in the Army lists but we are not so new at the game. After 150 years we are fighting for France again."

So while you may not be so old in the lists here, you certainly are not so new at the game. You made that very clear.

This is a very impressive and very comprehensive statement.

Secretary FINCH. My staff deserves the credit for the work that has gone into this.

Mr. FLOOD. Yes, I know, but your imprimatur is on it. I read it from "kiver to kiver," which is a high compliment.

Obviously many of the questions that I will ask you have been touched upon in your statement; some of them are induced by the statement, and I will ask them largely for the purpose of emphasis. Many of them are leading questions to which we know the answers, but the record does not, and much of what we do and say must be done for the record.

Secretary FINCH. Yes, sir.

TRANSITION BETWEEN ADMINISTRATIONS

Mr. FLOOD. I never cease to marvel, sitting here as long as many of us have, and more especially in an extremely difficult assignment like you have, how you new fellows coming into town manage to grasp these things so very dramatically and very understandingly. I never cease to marvel no matter what administration it is or where you come from, and you fellows are a good example of that.

Secretary FINCH. If I may, Mr. Chairman, I had some experience with the transition in 1960, but at the direction of President Johnson the transition briefings provided by my predecessor over a several day period were extraordinary.

We also had our own task forces that were set up in all these disciplines and areas and coupled them with the in-house work we did prior to and just after taking office. So we did work at it, but it would not have been possible without the very substantial assistance that our predecessors in the previous administration gave us.

Mr. FLOOD. It is a very gracious statement. Sitting where we do on this side of the table, down through the years we have seen Secretaries and Under Secretaries and Assistant Secretaries and Deputy Assistant Secretaries, and so on and so on, come and go like Greyhound buses. I say that because there are some of us who had very high regard for your predecessor, Mr. Cohen, and have the impression that you have a very large pair of shoes to fill. I imagine you would be the first to embrace that idea.

Secretary FINCH. I would say he is the greatest one-man band I have ever seen in my life.

Mr. FLOOD. Mr. Secretary, this subcommittee will spend the better part of the next 2 months going through the budget for your Department item by item. We will hear testimony from about 90 different program administrators for HEW and their supporting staff, as well as Members of Congress, representatives of private organizations, and other citizens.

We call the others "outside witnesses." We hear them at the end of the normal hearings of the Government witnesses, and they become quite a number, as you may gather. They go sometimes into the hundreds. In recent years there have been more and more of these.

It will help us a great deal here if we can start off these hearings with a very frank and free discussion with you and your top advisers, and I have no doubt that will follow. I hope you will keep in mind that we are very, very much interested in your ideas about how this massive Department should be organized and where you think its $59 billion worth of programs should be heading.

And of course I think you should understand this, and we are very serious about this: We are looking for any help we can get, Mister Secretary, any help we can get. In carrying out the responsibility that has been given to us by Congress in reviewing your budget, we need it.

Don't be bashful, insofar as you are concerned and your staff, in getting in touch with us individually as you see fit—certainly with me. I know that I speak for every member of this subcommittee and certainly for that very excellent staff, headed by that extraordinary fellow, Moyer, the clerk, who has forgotten more about this thing than most of us will ever know. He is a rare breed. We are lucky he is here and so are you.

Naturally we would expect you to call on this, also extraordinary, team of Messrs. Kelly and Cardwell, to assist you at any time in any of these hearings or any of your people who you feel can be helpful in answering some of the more technical questions. We expect the backup people to be told by your chiefs and by you that they can sound off at any time about anything. Even though the bureaucratic principle is never volunteer, just like in the Marine Corps, we consider it a great help.

You probably especially will have to call on Kelly and Cardwell on anything having to do with the Revenue Expenditures and Control Act. You have not been here long enough to catch up with the details of that.

Secretary FINCH. It has come into the rhetoric of our Department with greater and greater frequency, Mr. Chairman.

Mr. FLOOD. All through your statement your touched upon this sector and that sector that you had reviewed, and were prepared to make recommendations, and have made them in at least some instances, but have you completed your review of the budget?

Secretary FINCH. We have completed it. I think that is a fair statement, yes. We have made our departmental estimates and recommendations to Mr. Mayo. That has gone forward and as of——

Mr. FLOOD. Made it to whom?

Secretary FINCH. Mr. Mayo, Director of the Bureau of the Budget. We are advised that they will have their response to it by what time?

Mr. CARDWELL. They indicated toward the end of last week that it would be within 2 or 3 weeks.

Mr. FLOOD. What is going to happen then?

Mr. KELLY. President Nixon is expected to send to the Congress a series of budget amendments that reflect the result of his administration's review.

Mr. FLOOD. It won't be a package, but a series of amendments?

Mr. KELLY. I think it will be a package of formal amendments.

Mr. FLOOD. In the nature of amendments?

Secretary FINCH. To Congress.

Mr. Cardwell. They would be formal amendments transmitted under presidential cover.

Mr. FLOOD. Have you proposed any changes in this to the Budget Bureau?

Secretary FINCH. Yes, sir.

Mr. FLOOD. You touched lightly upon a couple. Suppose you go further. This is where we can use your help.

Secretary FINCH. I think our largest decrease, if you want to begin with that side of it——

Mr. FLOOD. That is exactly where we want to begin.

Secretary FINCH (continuing). Is a reduction in the Public Broadcasting Corp. of $10 million, Mr. Chairman; from 20 to 10.

Mr. FLOOD. This is in the public broadcasting?

Secretary FINCH. Yes, sir. For the reason that——

Mr. FLOOD. There will be sparks flying about that.

Secretary FINCH. Because they have been slow in getting underway. They had $8 million in hand as of the time we went to work on the budget. Five million was a Federal grant, and we felt that an additional $20 million was simply not spendable in an efficient way. This was our judgment.

I just want to add this note: I am keenly interested in the future of public broadcasting. From my own experience in California, I know the potential of this medium to serve the public interest. That potential needs to be developed as quickly as possible to meet a variety of needs—education, community communication, public program information, and other such noncommercial purposes.

I am particularly impressed with its potential, under the leadership of the Corporation for Public Broadcasting, in filling an essential communication need for a variety of Federal programs, many of which fall within the administrative responsibility of HEW. I expect to have Department representatives work closely with CPB and other public

broadcasting officials to plan appropriate uses of public broadcasting in delivering information about Federal services to the American people.

Mr. FLOOD. Then this outfit is not a victim of your realinement of priorities?

Secretary FINCH. No, sir.

Mr. FLOOD. Just weren't in a position to efficiently use the larger amount?

Secretary FINCH. As you know, they have a new chairman and are just getting off the ground.

(Mr. Mahon, chairman of the Committee on Appropriations, entered the room at this point.)

Mr. FLOOD. Mr. Chairman, we have finished a very lengthy and interesting statement by the Secretary. I have just asked him only one or two questions. They were, Has he completed the review of the budget? And, if he has, What changes has he sent to the Budget Bureau? How soon did you say you expect these changes to come to Congress?

Secretary FINCH. We expect to have a package of the so-called Nixon amendments directed to the subcommittee by the 24th of this month, Mr. Chairman. Do you want to amplify that?

Mr. CARDWELL. I would add at the time the Bureau of the Budget gave us that estimate they had not made their presentation to the President. We can't really tell you firmly how long it is going to take for him to complete his deliberation. That was their hope as of about a week ago.

Mr. FLOOD. It is an educated guess.

Do you expect, Mr. Secretary, that the budget request will be increased or reduced in total?

Mr. KELLY. If you were to put it in terms of new budget concepts, the total——

Mr. FLOOD. You put it in your terms. All I want to know is what I asked.

Mr. KELLY. In terms of the new total budget concepts the current estimate is that it will be a reduction. In terms of general fund expenditures, coming before this committee, the estimate is likely to be an increase.

You will recall in the Secretary's statement he referred to the necessity for reconsidering the AFDC freeze which involves about $300 million.

Mr. FLOOD. We have reasonable cause to believe that the Ways and Means Committee are unhappy about your treatment of trust funds in determining the debt limit. Will that effect the increase or reduction here?

Mr. KELLY. This is not associated with that problem. This is a question that the Johnson budget included.

Mr. FLOOD. You are proposing a reduction in expenditures under trust funds?

Mr. KELLY. That is right. The Johnson budget included a proposal for legislation which would increase benefits, and the budget reflects the legislative proposal for the increase in benefits. That legislative proposal is now being reconsidered.

PROPOSED CHANGES IN EMPHASIS

Mr. FLOOD. Mr. Secretary, here is a basic question which everybody not only on this subcommittee but I think everybody in the country is very much interested in. We read a lot about you in columns and have heard you on TV. I talked to your friends and neighbors in California just last Saturday night. Do you expect there will be major changes of emphasis within the budget, major changes of emphasis? If so, where?

Secretary FINCH. In the 1970 budget; no, sir.

I think, given the complexities of the budgetary process which, of course, all of you understand so much better than I do—although I lived with it in California—I think it would be unwise for us to try to come in at this point and make massive changes.

BUDGET PROCESS IN CALIFORNIA

Mr. FLOOD. There is something I have wanted to ask you, or someone who has been in a similar position, about for a long time. For a number of years I have been talking to former legislators from the great State of California, Republicans and Democrats. I have been very unhappy with the Budget Bureau and the budget process ever since I have been here. I have introduced legislation from time to time to take the Bureau of the Budget out of the executive branch and put it in the legislative, where I think it belongs. They tell me that you fellows have done that in California and it is a tremendous success.

Secretary FINCH. I would say—and I will let Mr. Veneman speak, because he was a member of the legislature for years—but I would say that what we have done is set up a check and balance system. We have an outstanding legislative analyst there. His department of finance corresponds to the Bureau of the Budget in the executive branch.

Mr. Post and his staff do an outstanding job of tearing apart the administrative budget that comes in. They are an ongoing, nonpartisan body. I will let Jack develop a little further how they operate, with respect to the legislative function in California.

Mr. FLOOD. What about that? I have heard nothing but good about it from everybody who comes from California.

Mr. VENEMAN. Essentially, what we have in the department of finance, would be the counterpart of BOB. They do the preliminary budget reviews. The agency heads make their budget requests during the late summer; they try to have it out sometime in October, November, December. Then the legislative analyst, through a joint committee of the two houses of the legislature, does a line item review, independent of any legislative staff operation. They have that work completed by the time we go into ways and means hearings.

Mr. FLOOD. How many years were you in the house out there?

Mr. VENEMAN. I was in my eighth year.

Mr. FLOOD. What committees did you serve on?

Mr. VENEMAN. Through the years, I served on social welfare constantly. I was the chairman of the Welfare and Taxation Committee, and a member of the Committee on Social Welfare, the Agricultural Committee, and the Fish and Game Committee.

Mr. FLOOD. You have been around.

Mr. VENEMAN. Yes, sir. My primary interest has been in the fields of health and welfare, and revenue and taxation. There is one additional aspect to the California budget process. There is a joint legislative audit committee on top which members of the house can turn to as the counterpart to the administration's auditor. In other words, there is another check available.

Mr. FLOOD. I understand that you are the only State that has a setup like that?

Mr. VENEMAN. I couldn't answer that with certainty.

Secretary FINCH. I think that California has gone further. A great deal of money was spent on it, and it has worked very well. I think you have to give a lot of credit to Speaker Unruh for putting the things together in the 8 years he has been there.

Mr. VENEMAN. Significantly, it is totally bipartisan. Allen Post has been legislative analyst for a good many years. Nobody in either party questions him.

PRIORITIES IN THE BUDGET

Mr. FLOOD. Which items in the budget have the highest priority in your estimation?

Secretary FINCH. As I testified before in other committees, I would have to say, that an increase for title I in the Elementary and Secondary Education Act is a high priority item. There is no question that many of our school districts, and not just those in the metropolitan areas, have grave, grave problems. For another, as I indicated in the opening part of my statement, we put a very high premium on this evaluation process. We are asking for an increase from $6 to $21 million for evaluation simply because we don't really know what is working, and what is not working. With the present inadequate, uneven information that we receive on these various programs, we can not come back to you with straight answers as to whether they are really producing the results that are intended.

FEDERAL CONTROL OF EDUCATION

Mr. FLOOD. You are fresh from a State capital. You are fresh from the Lieutenant Governor's chair. Are the States and localities worried about Federal control of education?

Secretary FINCH. Under title III we have really, I think, protected the States. In the act that was passed last year, the primary emphasis was placed on the States as opposed to the direct relationship of the Federal Government to school districts.

I think that issue of the Federal Government dominating local districts is largely behind us.

Mr. FLOOD. I am interested to hear that.

Secretary FINCH. I think the experience, limited as it has been, is such that there is a pretty clear recognition of the kinds of problems we have in our school districts. They can not do it alone. The property tax, or other sources of revenue, is inadequate. We have seen bond issue after bond issue defeated.

Mr. FLOOD. That is related to this basic question, in your opinion?

Secretary FINCH. I am saying that I think there is a greater public and professional recognition of the limitation of resources in this

area, and that what you did was a wise decision in anticipation of a crisis.

NONCONTROLLABLE BUDGET INCREASES

Mr. FLOOD. What is the total increase in the budget 1970 over 1969?

Two, how much of it is for so-called mandatory or noncontrollable programs?

Secretary FINCH. The total increase is $7.2 billion in terms of budget authority, and our projected outlays are $5.6 billion. Most of the increase was in the mandated programs.

Mr. FLOOD. What is the total for them?

Secretary FINCH. The total budget authority for them is $10,243 million.

Mr. FLOOD. Will you please at this point in the record list these mandatory or noncontrollable programs for the committee.

Secretary FINCH. Yes, sir.

(The information follows:)

NONCONTROLLABLE PROGRAMS

[Budget authority in millions, excludes proposed legislation]

	1969	1970	Change
Health Services and Mental Health Administration: Retired pay of commissioned officers	$13	$17	+$4
National Institutes of Health:			
Health education loans: Participation sales insufficiencies and interest differential		1	+1
Office of Education:			
Insured student loans:			
Interest payments	62	62	
Defaults		11	+11
Construction loans:			
Interest subsidization		4	+4
Participation sales insufficiencies	5	5	
Permanent appropriations:			
Colleges for agriculture and the mechanic arts	3	3	
Promotion of vocational education, act of Feb. 23, 1917	7	7	
Subtotal, Office of Education	77	92	+15
Social and Rehabilitation Service:			
Grants to States for maintenance payments	3,425	3,719	+294
Grants to States for medical assistance	2,396	3,057	+661
Social services and administration	595	731	+136
Vocational rehabilitation basic grants	346	524	+178
Assistance to refugees in the United States	71	87	+16
Assistance to repatriated U.S. nationals	1	1	
Subtotal, Social and Rehabilitation Service	6,834	8,119	+1,285
Social Security Administration: Federal fund payments to the trust funds	1,691	2,015	+324
Total, Department of Health, Education, and Welfare	8,615	10,243	+1,628

Mr. MICHEL. What is the total figure again?

Secretary FINCH. The total figure for these items is $10,243 million. Its make up, by agency, is: Health services and Mental Health Administration, $17 million; National Institutes of Health, $1 million; Office of Education, $92 million; Social and Rehabilitation Service, $8,119 million; Social Security Administration, $2,015 million, for a total of $10,243 million.

REDUCTIONS IN EDUCATION PROGRAMS

Mr. FLOOD. You are requesting an increase in the budget for every agency in your shop, except the Office of Education. Further than that,

their total budget will actually decrease. Do you agree with that realinement of priorities?

Secretary FINCH. The decreases come, of course, in the Elementary and Secondary Act, in library resources, guidance counseling and testing, equipment, and minor remodeling.

Mr. FLOOD. That is it?

Secretary FINCH. Yes, sir.

Mr. FLOOD. My question was, "Do you agree?" Do you agree, Mr. Secretary, with this realinement, this assignment of priorities? You are the new boss.

Secretary FINCH. We went over these reductions in considerable detail. These seemed to be the areas where there was less need in terms of the existing facilities and existing requirements.

Mr. FLOOD. Do you agree?

Secretary FINCH. Yes, sir.

Mr. KELLY. Mr. Chairman, could I make a point on that? In addition to the decreases that the Secretary talked about, there is another phenomenon in the Office of Education budget which makes the total Federal involvement larger than it appears on the face of the budgetary figures. The use of the guaranteed loan and the interest subsidy feature for the construction of educational facilities and the increased use of the student guaranteed loan program will provide a larger program in these two areas than is apparent.

So the only place where there is actually a cutback is in the equipment and library resources, and in the federally impacted area construction.

In other aspects of construction there is an expansion.

Mr. FLOOD. Do you see why he is indispensable?

Secretary FINCH. I learned that the first day I was on board, Mr. Chairman. Of course, we have increases in some of the other areas. There is a pending supplemental for payment to the Federal City College. And for community colleges——

Mr. FLOOD. I thought you made an excellent statement on that point, the community colleges.

Secretary FINCH (continuing). With what we have seen in California that this is a very, very valuable mechanism.

Mr. FLOOD. My spies tell me that you went too far, too fast in getting mixed up in the humanities.

Secretary FINCH. This is one weakness we would like to avoid building into any Federal legislation that we propose. As I indicated to you in an earlier conversation, they tend to fall too much into what we call the liberal arts syndrome. They tend to ape the older institutions and the State colleges and universities. I think it is important that we build into developing community colleges a greater capacity for vocational and technical training.

Mr. FLOOD. Personally, I am a humanist, but I agree with you that those particular types and kinds of schools, the vocational technical training is of considerable importance.

Secretary FINCH. The other aspect of the education budget, Mr. Chairman, is that we will be coming in or rather have come in with supplemental requests for $4 million for subsidy for educational construction loans and $7 million for the Federal City College. If you want to look at the aggregate, there is that input.

BUDGET PRIORITIES IN EDUCATION

Mr. FLOOD. For the purpose of emphasis let me ask you the same thing just from a different approach.

Within the Office of Education, funds for several programs are either drastically reduced or eliminated altogether. There seems to be a lower priority on facilities and equipment than on scholarships, training grants, and other kinds of assistance to students.

Is that a good thing? Do you agree with those priorities?

Secretary FINCH. I think it is presumptuous for me to make a general observation such as this, but in trying to respond to your question I will say that I think that local boards and State systems have tended in recent years to invest an undue amount of their resources in gadgetry or hardware. What we are trying to reflect in this budget is a greater emphasis on experimentation for school systems. This is the basic concept of the experimental schools. We are shaping the program emphasis on the development of modular programs that can be picked up by other systems to provide a more efficient use of facilities.

EDUCATIONAL EQUIPMENT GRANTS

Mr. FLOOD. There are no funds at all in this budget for grants to schools for equipment under title III of the National Defense Education Act, and none at all for equipment grants to colleges and universities under the Higher Education Act. Did you ever think you would live long enough to see that? Why did that happen?

Secretary FINCH. Mr. Kelly, do you want to respond to that?

Mr. KELLY. Mr. Chairman, no one is suggesting that the equipment should not be supported by Federal funds. The Elementary and Secondary Education Act provides an opportunity for each local school board to determine what its priorities are. They can utilize the funds for the employment of teachers, for the employment of student aides, for some form of assistance to the pupil, or for the purchase of equipment. So since funds for education are limited, the preferred method for expending it is through the Elementary and Secondary Education Act formula, which tends to place the funds in those local school districts that have poor children. This gives the school district the opportunity to make the decision rather than making a categorical Federal decision that funds are available only for the purchase of equipment.

Mr. FLOOD. What about the higher education? You forgot about that. I asked two questions.

Mr. KELLY. This is not as clear-cut a case. There are substantial funds available for the assistance and the operation of higher educational institutions. The attempt here is to make the funds categorical only in terms of their purpose. Such a purpose might be training people for elementary and secondary education. The funds would be available within the framework of this purpose, and the institution would decide what to purchase with the funds, be it equipment or teachers or some other element of cost.

Mr. FLOOD. Mr. Secretary, do you embrace this?

Secretary FINCH. Yes, sir. That was the conclusion of the task force.

Mr. FLOOD. Do you agree?

Secretary FINCH. Yes, sir.

Mr. FLOOD. Members of Congress have been getting a tremendous amount of mail from the vocational education people in our States and in our districts complaining about the inadequate funding of vocational educational programs in the 1970 budget. What in the world are we going to tell them?

Secretary FINCH. Our net increase in vocational education is $31 million. We go from the 1969 figure, $248,216,000, to $279,216,000. I think within the constraints of the budget we are responding to that emphasis and to the concern over vocational education.

Mr. FLOOD. That is a rough question to answer off the top of your head. In view of the circumstances surrounding it, if you wish to embellish that for the record, for the benefit of Members of Congress, I wish you would.

Secretary FINCH. If I would have that opportunity, I would like to do so.

(The information follows:)

FUNDING OF VOCATIONAL EDUCATION PROGRAMS IN 1970

The total fiscal year 1970 request for vocational education programs is $286,377,455, including $7,161,455 under the Smith-Hughes Act permanent appropriation. This represents an increase of $31 million over the 1969 level of $255,377,455. An amount of $237,497,455 for basic grants to States and $15 million for consumer and homemaking education will maintain these programs at approximately the same level as in 1969. The 1968 amendments provide that a minimum of 40 percent of the funds for basic State grants be used for programs for postsecondary education, for the disadvantaged, and for the physically handicapped. However, up to 30 percent of this requirement, which is for postsecondary and disadvantaged programs, may be waived in any State if such set-asides impose hardships or are impractical in their application. Therefore, it is not possible at the present time to determine the overall or specific effects of this provision. However, since the intent of the 1968 amendments is to bring about urgently needed new directions in vocational education, the 1970 budget also includes $33,880,000 for the following: the implementation of the new programs of cooperative education, innovative projects, curriculum development, and planning and evaluation; the creation of both a National Advisory Council and State advisory councils and a transfer of $2 million to the Secretary of Labor for studies and projections of manpower needs. Of the $33.9 million, $27 million would be allotted to the States, resulting in a total of $279.5 million for State plan programs, or $24.1 million higher than the 1969 level.

In order to overcome the problem of late funding, the Department of Health, Education, and Welfare will propose special language for the 1970 continuing resolution which would enable States to begin immediately in July to implement the new programs.

Mr. CARDWELL. Mr. Chairman, if I could volunteer, I think the basic issue as it is viewed by Members of Congress is what happens to the basic grants program as a result of the vocational education amendments of 1968. The basic grants program in the budget remains static at $234 million. Some Congressmen view it as having been cut. The reason they take this position is that the 1968 amendments require that certain activities within the basic grants be set at fixed levels.

In order to meet those levels, they argue that additional money should be added to the basic grants. As the Secretary pointed out, in the aggregate the total budget for vocational education goes up.

Mr. FLOOD. There is something the matter with that.

Mr. CARDWELL. For example, the law now says that at least 25 percent of every dollar in the basic formula grant should go to the dis-

advantaged. If a State is now spending less than 25 cents out of every dollar for the disadvantaged within the formula grant, it may require additional money. They are asking that the basic grant be increased by that increment. That really is the issue.

Mr. FLOOD. I am not sure of the figure but in the State of Pennsylvania there will be an appreciable loss, and I come from the city of Wilkes-Barre, as you know, the coalfields. The school people and the civic leaders, and so on, who are interested in these programs in the rest of the State are afraid that most of this will go to Philadelphia and Pittsburgh. Is that the idea all over the country? First, is it true in Pennsylvania?

If it is true in Pennsylvania, I take it for granted it will be true all over the country.

Secretary FINCH. This is again a question of the State plan being filed. Basic decisions are required of every State executive or the governing board of each State.

Mr. KELLY. Mr. Chairman, I do not think that the State of Pennsylvania will actually receive less money from the 1970 budget than it received in 1969. The problem is that there are on-going programs that were supported in 1969 for which Federal funds will diminish in 1970 in order that those funds can be redirected.

Mr. FLOOD. You think the total will be larger?

Mr. KELLY. I think the total will be larger.

Mr. FLOOD. Some of us are getting a little bored with this big-city psychology around here. Everything you hear, everything you pick up is metropolitan, big city. Not all of us come from those places, you know.

Mr. KELLY. In developing the statement that you asked the Secretary for, there will be one item that we ought to call to your attention. One of the areas of concern on the part of the States and of the Members of Congress is that the appropriation is not likely to be made until the end of the summer. The States will not have a chance adequately to plan for these new provisions. The issue arises as to whether or not there should be advance funding, and whether there should be a supplemental now. It seems a little late to achieve these now, but we are going to need your help to get a provision into the continuing resolution that makes it clear that the Congress is extending the 1969 funds but is implementing the new legislation. This will help the school districts to recognize the terms and conditions on which they are going to spend their funds.

IMPACTED AREA AID

Mr. FLOOD. This budget also proposes to reduce the appropriation for impacted area aid under Public Law 874 by over $200 million.

This committee has tried without success to reduce this appropriation. The most conservative, the most rigid, the most blatant defenders of budget balancing go down in the well of that House without hesitation and lean on that rostrum and just shed tears about this porgram. This is a sacred cow.

The Budget says that legislation will be proposed. Let me quote for you: "Which will more equitably distribute funds to school districts affected by the Federal activity." That is the premise. What about that one, Mr. Secretary?

Secretary FINCH. We have attacked this problem. I recognize that this will be a problem.

Mr. FLOOD. I am sure that you know. Even the elevator operators here know that.

Secretary FINCH. We feel that restructuring the formula is a rational way to go about improving the impact of this program and we think that this program has gotten out of control. We want to make an administration proposal that will ease your burden on the floor.

Mr. FLOOD. You talked about legislation. Has any bill been introduced which would reduce entitlement of this program, if you know?

Secretary FINCH. Not to my knowledge. We are working on some legislative proposals now.

Mr. FLOOD. In that case, no hearings could have been held because there isn't any bill?

Secretary FINCH. Right.

Mr. FLOOD. What are the prospects for presentation of the bill?

Secretary FINCH. Do you have any information on this, Creed?

Mr. BLACK. The legislative proposal which was sent up by the outgoing administration has not been introduced yet. We are waiting for final approval from the Bureau of the Budget on our own recommendation.

Secretary FINCH. All I can say is that we will move as rapidly as we can on this.

Mr. KELLY. The budget request is, of course, based on the prospect that legislation will be introduced to provide for a more equitable distribution of funds. We would even propose to have the same kind of language which you considered last year in the Appropriation Act in order to make a more equitable distribution of the reduced funds.

Mr. FLOOD. Have you found a Member to introduce this bill?

Secretary FINCH. No, sir.

Mr. FLOOD. Suppose there is no such legislation? Suppose it doesn't happen; then what?

Mr. KELLY. That is the point I was suggesting. I think the budget recommendation would still be of a lesser sum. You would then have to make the choice as to whether or not you adopted the kind of language which the committee considered last year, or whether or not you would allow the basic law to operate which would just distribute the smaller amount.

Mr. FLOOD. Won't some school districts be hurt awfully badly by this budget request?

Mr. KELLY. If the proposed legislation is passed, or if language is adopted comparable to that which you considered last year, you avoid reducing those school districts which are made up predominantly of children whose parents live on and as well as work on Federal property. These are the districts in which any substantial setback becomes relatively disastrous.

You will recall last year when you were considering the supplemental funds for this appropriation, there was a whole list of school districts, mostly small ones, which were badly hurt.

Mr. FLOOD. We will recess now until 2 o'clock.

AFTERNOON SESSION

SUPPORT OF MEDICAL RESEARCH

Mr. FLOOD. Mr. Secretary, we are getting a lot of mail from universities and medical schools complaining bitterly about cutbacks in

support of medical research. How much is in this budget for medical research?

Secretary FINCH. I am advised, Mr. Chairman, including the National Library of Medicine and the Office of Director, NIH, the total figure is $1,429,727,000.

Mr. FLOOD. Do you think we are failing to give adequate support to the medical research effort in this country?

Secretary FINCH. Medical research is very important. I don't know that it is possible to do too much in this field. We could never do enough in these areas. We wish we could do more now, but we feel that the budget is responsive to the needs as we now see them.

TRAINING OF HEALTH MANPOWER

Mr. FLOOD. You mentioned at some length in your statement, and we hear too on all sides about the crisis in medical education. You mentioned and we hear that so many medical schools and dental schools and so on are on the verge of closing. You make quite a point of that.

Do you think this constitutes a crisis?

Secretary FINCH. Yes, I do. One problem is in the regional dispersion of where we locate our medical schools, and these large medical complexes. I believe this was the thrust of the Carnegie report under Dr. Kerr. That report of course would have us make many new starts but, given our budgetary constraints, we felt it was more important to try to put the emphasis on existing facilities and on existing programs to increase the supply of trained medical personnel. We do not want to institute some sort of crash program.

Mr. FLOOD. Why should we not be trying to find new ways to meet these medical manpower needs other than just training doctors? You touched on paramedics at some length. Are you exploring the possibility of training medical technicians who could provide many kinds of medical care in less than the long period of time it takes to get an M.D.?

Secretary FINCH. Yes, I personally have had a number of discussions, not only with AMA, but the medical societies in the larger States, with regard to the licensing problem. In some countries there are technical assistants, who are permitted to do a limited amount of diagnostic work under the control of and accountable to a licensed physician.

We think that particularly in the community colleges, we can begin to make a good start. We could build from a base of experience a corpsman might have had in the service, and in as short a period as 2 years begin efficiently and effectively to use these people on a broad scale in our health delivery system.

EFFECT OF REVENUE AND EXPENDITURE CONTROL ACT

Mr. FLOOD. Tell us about the effect of the Revenue and Expenditure Control Act on the Department. How much of the total $6 billion expenditure reduction was taken by HEW?

Secretary FINCH. I will ask Mr. Kelly to comment on that.

Mr. FLOOD. How much of this was made by Congress in acting on the appropriation bill for 1969, and where did the rest of the cuts come from?

Mr. KELLY. Mr. Chairman, the effect on the Department of Health, Education, and Welfare was substantial. The President did not allo-

cate any of the $6 billion cut to the Department of Health, Education, and Welfare, but instead said that the Department would be limited to the predicted expenditures in the 1969 budget.

The impact of this was more substantial than it sounds. A series of events occurred, which established that the expenditure estimate in the 1969 budget was inadequate. The Congress made a series of reductions in the appropriation request, and some changes in the legislative proposal, which had the effect of bringing about expenditure reductions in part, offsetting the underestimations in the budget.

The Congress also gave us additional relief by permitting us to treat $560 million of additional public assistance costs as not chargeable against the limitation in the Revenue and Expenditure Control Act.

We then had to go through every activity in the Department, and reevaluate how much money would be disbursed. We had to create a control system, that assured that no more than this would be disbursed during the fiscal year. The Department had never before endeavored to control expenditures. It had always dealt with the control of obligations and commitments. Expenditure estimates merely flowed from this. We were not overly good estimators.

I do not think there was a bias in favor of underestimating or overestimating, although there was a tendency to overestimate. The Bureau of the Budget was knowledgeable about this, and tended to discount our estimate of expenditures.

We have now created a very elaborate piece of machinery to assure we live within the limitation that was imposed. Every disbursal has to go through a control mechanism which has established monthly limitations for each type of expenditure in the Department. This effort has had some beneficial effects. It has made us more capable of estimating expenditures.

One principal method that we have used to keep us within the limitation, is to avoid having idle cash in grant programs financed through letters of credit.

Some of the grantee communities feel that we have been arbitrary and harsh with them. I think they would have felt we were more arbitrary and more harsh had we been forced to really cut back programs, rather than trying to pick up this idle cash. But it has been serious, and it has been acute.

The expenditures in the 1969 budget which were subject to the act totaled $12.815 billion, and the Congress exempted an additional $651 million from the act. This exemption included the $560 million increase in public assistance programs. We subsequently determined that the public assistance requirements would probably increase by an additional $63 million. The Congress, through its action in reducing the appropriation requests, decreased the budgeted expenditure requirement by $213 million.

We made further expenditure cuts of $38 million in programs approved by the Congress and then devoted all our energies to staying within the resulting ceiling of $13,278,000,000.

EFFECT OF PERSONNEL RESTRICTIONS

Mr. Flood. Suppose you tell us about the effect of the personnel restrictions in the Revenue and Expenditure Control Act.

How many employees in permanent positions did you have as of June 30, 1968? Two, how many do you have now? And how much further will you have to reduce your staff to get down to the June 30,

1966, level required by the Revenue and Expenditure Control Act?

Mr. KELLY. On June 30, 1968, the Department had an employment level of 107,000 employees. The first thing we had to do as a result of the Revenue and Expenditure Control Act was to eliminate about 7,000 authorized positions which were vacant on that day. Some of these were authorized by the Congress in the 1969 Appropriation Act. We then had to proceed on the basis of only filling seven out of 10 vacancies.

The prediction is that we will be down to a level of 102,700 employees by the end of this fiscal year. We are, in fact, at that level now. We have achieved the reduction requirements that were imposed upon us this fiscal year. It has had an adverse effect throughout the Department. We have taken a series of steps to try and minimize that impact.

Mr. FLOOD. Will you meet the June 30, 1966, figure?

Mr. KELLY. This June 30, 1966, figure is not a control figure for each agency or department. It is a Government-wide control figure. Inasmuch as the Post Office Department and much of the Department of Defense were exempted from this requirement of the Revenue and Expenditure Control Act, I think it would be safe to say that it is a figure that will never be achieved. If the legislation remains in effect, the nonexempt agencies will continue to decline at 30 percent of all the jobs that become vacant.

Mr. FLOOD. How are you administering the personnel restriction? How do you decide which positions will be filled and which will be left vacant?

Mr. KELLY. In essence, what was done during the first 3 months of the fiscal year was to limit all of the Department to filling only 50 percent of the positions that became vacant. This allowed us to pick up a reserve of the difference between 50 percent and 70 percent. There are two principal purposes for which that reserve is being used. The first is to maintain adequate staffing levels in the hospitals and direct patient care facilities. We did not want to have an arbitrary reduction in the staff taking care of sick people. We are holding them at the ratio of employee to patient that existed on October 1, 1968.

The second principal use has been to provide some relief to the Social Security Administration which is burdened by a heavy workload.

The Secretary has recently inaugurated a review of manpower utilization in the Department. Organizational requirements have been made of each operating agency to make sure that we are utilizing vacant jobs in the areas of highest concern.

A Department-wide review by the Office of the Secretary is undertaking to examine areas of low priority so that we can shift staff to high-priority areas.

Mr. FLOOD. Mr. Secretary, do you have the impression that President Nixon plans to request the lifting of the employment restrictions?

Secretary FINCH. I have no commitments from the President, Mr. Chairman, but I have certainly been urging it.

Mr. FLOOD. Then you think he should?

Secretary FINCH. Yes, sir.

Mr. FLOOD. Will you place in the record a table showing for each appropriation item that covers personnel the employment at beginning of the fiscal year 1969, the employment as of December 31, the anticipated employment on June 30, and the number of positions and average employment included in the budget for 1970?

(The information follows:)

EMPLOYMENT IN FISCAL YEARS 1969 AND 1970

Appropriation/account	Full-time permanent employment			Budgeted employment, fiscal year 1970		
	July 1, 1968, actual	Dec. 31, 1968, actual	June 30, 1969, anticipated	Permanent positions	Full-time equivalent of other positions	Average employment
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE						
Food and drug control	4,374	4,110	4,123	4,370	75	4,280
Air pollution control	1,070	1,017	1,034	1,203	78	1,205
Environmental control	2,098	2,040	2,000	2,098	102	2,135
Salaries and expenses, Office of the Administrator	325	253	370	387	10	384
Revolving fund for certification and other services—Food and drug control	245	240	240	247	----------	240
Advances and reimbursements	236	223	236	243	32	268
Total, Consumer Protection and Environmental Health Service	8,348	7,883	8,003	8,548	297	8,512
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION						
Mental health	2,364	2,260	2,329	2,591	432	2,937
St. Elizabeths Hospital	3,849	3,730	3,800	3,925	37	3,816
Health services research and development	181	189	216	238	23	250
Comprehensive health planning and services	644	582	620	658	884	1,517
Regional medical programs	812	750	748	783	70	827
Communicable diseases	2,454	2,311	2,300	2,374	275	2,575
Hospital construction	244	243	241	258	3	251
Patient care and special health services	6,357	6,136	6,303	6,664	140	6,558
National health statistics	460	428	447	488	13	479
Salaries and expenses, Office of the Administrator	585	550	570	596	2	578
Indian health services	6,113	5,857	6,128	6,459	95	6,320
Indian health facilities	0	0	0	0	212	212
Emergency health	207	199	201	208	9	202
Operation of commissaries, narcotic hospitals	6	6	4	3	0	3
Service and supply fund	117	114	117	151	4	141
Working capital fund, narcotic hospital	31	31	31	22	1	22
Advances and reimbursements	592	479	536	587	42	601
Health Services and Mental Health Administration trust funds	2	1	2	3	2	5
Allocations and allotments from other agencies	393	390	366	441	3	422
Total, Health Services and Mental Health Administration	25,411	24,256	24,959	26,449	2,247	27,716
NATIONAL INSTITUTES OF HEALTH						
Biologics standards	291	273	270	285	5	280
National Cancer Institute	1,446	1,386	1,370	1,427	35	1,409
National Heart Institute	589	587	581	620	30	626
National Institute of Dental Research	298	295	290	306	14	309
National Institute of Arthritis and Metabolic Diseases	614	611	610	647	38	623

National Institute of Neurological Diseases and Stroke	665	672	662	690	45	713
National Institute of Allergy and Infectious Diseases	705	692	692	737	10	720
National Institute of General Medical Sciences	206	195	195	202	6	202
National Institute of Child Health and Human Development	397	403	397	475	16	456
National Eye Institute	61	61	61	78	6	76
Environmental health sciences	169	170	188	229	9	220
General research and services	255	249	249	260	11	263
John E. Fogarty International Center for Advanced Study in the Health Sciences	51	44	50	58	3	57
Health manpower	451	419	423	459	42	483
Dental health	243	237	234	243	20	258
National Library of Medicine	470	473	458	492	21	491
Salaries and expenses, Office of the Director	466	441	447	467	15	467
NIH management fund	3,762	3,614	3,618	3,778	145	3,807
Services and supply fund	719	672	673	700	1	676
Advances and reimbursement	75	75	75	77	5	71
Total, National Institutes of Health	11,933	11,569	11,543	12,230	477	12,207
OFFICE OF EDUCATION						
Salaries and expenses	2,315	2,189	2,160	2,410	280	2,567
Higher education	299	285	287	331	9	325
School assistance in federally affected areas	70	69	64	64	2	64
Civil rights education	81	71	83	121	4	113
Advances and reimbursements	52	46	45	47	----	47
Allocations and allotments from other agencies	219	199	209	227	13	209
Total, Office of Education	3,036	2,859	2,848	3,200	308	3,325
SOCIAL AND REHABILITATION SERVICE						
Salaries and expenses	1,700	1,617	1,656	1,768	62	1,778
Assistance to refugees in the United States	115	108	117	177	10	172
Advances and reimbursements	25	24	25	15	----	15
Allocations and allotments from other agencies	50	51	49	----	----	----
Child welfare	----	----	----	----	21	21
Development of programs for the aging	----	----	----	----	7	7
Juvenile delinquency prevention and control	----	----	----	----	12	12
Total, Social and Rehabilitation Service	1,890	1,800	1,847	1,960	112	2,005
SOCIAL SECURITY ADMINISTRATION						
Limitation on salaries and expenses (trust fund)	52,459	50,834	49,526	53,941	936	51,936
Advances and reimbursements	188	199	200	202	----	216
Operating fund, Bureau of Federal Credit Unions	483	442	480	500	12	497
Consumer credit training	----	----	----	12	1	8
Total, Social Security Administration	53,130	51,475	50,206	54,655	949	52,657

EMPLOYMENT IN FISCAL YEAR 1969 AND 1970—Continued

Appropriation/account	Full-time permanent employment			Budgeted employment, fiscal year 1970		
	July 1, 1968, actual	Dec. 31, 1968, actual	June 30, 1969, anticipated	Permanent positions	Full-time equivalent of other positions	Average employment
SPECIAL INSTITUTIONS						
National Technical Institute for the Deaf: Salaries and expenses	2	2	2	2		2
Model Secondary School for the Deaf: Salaries and expenses	2	2	2	2		2
Total, special institutions	4	4	4	4		4
DEPARTMENTAL MANAGEMENT						
Salaries and expenses, Office of the Secretary	280	269	279	344	24	341
Salaries and expenses, Office of Community and Field Services	789	749	771	946	17	889
Salaries and expenses, Office of the Comptroller	634	616	615	796	10	734
Salaries and expenses, Office of Administration	402	374	392	434	4	416
Surplus property utilization	94	93	98	101		98
Salaries and expenses, Office of the General Counsel	258	247	255	273		262
Working capital fund	663	629	643	669	6	653
Advances and reimbursements	114	97	118	108	42	147
Total, departmental management	3,234	3,074	3,171	3,671	103	3,540
Grand total, Department of Health, Education, and Welfare	106,986	102,920	102,581	110,717	4,493	109,966

UNOBLIGATED BALANCES

Mr. FLOOD. Mr. Secretary, the chairman of the full Committee on Appropriations has asked us to make a careful review of unobligated carryover funds this year with a view to identifying possibl rescissions. Will you have prepared for the record a list showing each case where the budget predicts that unobligated funds will be carried over from the fiscal year 1969 to 1970 with the amount of carryover, and an explanation of why the funds are carried over and why they are needed in fiscal year 1970?

Mr. KELLY. We will do so for the record. We do not have it now. (The information follows:)

ANALYSIS OF UNOBLIGATED CARRYOVER BALANCES

[In thousands of dollars]

Appropriation	Balance at end of 1969	Balance at end of 1970	Explanation
Consumer Protection and Environmental Health Service:			
Air pollution control	$1,000	.....	Represents a programed carryover of sec. 104 contract funds to be obligated in 1970.
Buildings and facilities	8,571	$2,439	Carryover represents compliance with obligation ceilings of $22,075,000 in 1969 and $10,309,000 in 1970 as established in the President's budget.
Total, CPEHS	9,571	2,439	
Health Services and Mental Health Administration:			
Community mental health resource support.	10,000	.....	Represents prior year approval of projects to be obligated in subsequent years. Carryover is in pliance with obligation ceiling established in the President's budget.
Hospital construction	213,760	203,500	Carryover is result of normal lag between approval of construction projects and subsequent year obligations.
Buildings and facilities	6,850	3,975	Represents compliance with obligation ceiling of $10,326,000 in 1969 and $7,928,000 established in President's budget.
Total, HSMHA	230,610	207,475	
National Institutes of Health:			
Health manpower	1,000	.....	Programed carryover of nurse scholarship funds to be obligated in fiscal year 1970.
Construction of health education, research, and library facilities	22,900	.....	Funds appropriated for construction of teaching facilities for the health professions. Carryover represents amount placed in reserve in compliance with obligation ceiling.
National Library of Medicine	700	.....	Consistent with 2-year availability, 1969 grant funds are programed for obligation in early 1970.
Building and facilities	9,505	501	Represents compliance with obligation ceiling of $14,795,000 in 1969 and $6,674,000 in 1970 established in President's budget.
Health professions education fund	3,223	2,134	Carryover represents undisbursed balance of revolving fund to be obligated in subsequent years.
Nurse training fund	3,341	690	
Total, NIH	40,669	3,325	
Office of Education:			
Higher education	47,287	.....	Funds appropriated for interest payments and advances to States for the establishment of guarantee programs. Carryover due to (1) fewer number of loans and (2) insufficient time for States to match advances.
Research and training	585	.....	Carryover due to intended review of proposed construction projects.
Student loan fund	3,420	.....	Funds appropriated to meet loan defaults. Carryover is the result of unexpected decrease in student loan defaults.
Total, OE	51,292	.....	

ANALYSIS OF UNOBLIGATED BALANCES—Continued

[In thousands of dollars]

Appropriation	Balance at end of 1969	Balance at end of 1970	Explanation
Social and Rehabilitation Service: Mental retardation.	6,969	1,469	Funds appropriated for construction of university-affiliated facilities. Carryover represents amount in excess of estimated construction costs. Balance is not enough to support construction of an entire project.
Social Security Administration:			
Federal old-age and survivors insurance trust fund.	28,749,280	34,196,591	Surplus is programed as contingency against unexpected occurences, such as recessions. Since payments weighted toward lower incomes, recent rise in wage levels has produced larger surpluses.
Federal disability insurance trust fund.	3,741,411	4,897,335	
Federal hospital insurance trust fund.	2,327,634	2,751,016	
Federal supplementary medical insurance trust fund.	466,190	523,355	Premiums are designed to cover accrued costs; carryover is result of lag between incurrence and payments of these accruals.
Total, SSA	35,284,515	42,368,297	
Special institutions:			
National Technical Institute for the Deaf, salaries and expenses.	1,224	.....	Funds appropriated for construction of facilities. Carryover due to delay in start of construction projects.
Model Secondary School for the Deaf, construction.	620	.....	
Model Secondary School for the Deaf, salaries and expenses.	70	.....	Funds appropriated for development of curriculum and feasibility programs.
Gallaudet College, construction	180	209	1969 carryover due to delay in construction of dormitory facilities. 1970 funds appropriated for utility and dormitory planning. It is estimated that planning will continue into fiscal year 1971.
Total, SP	2,094	209	
Total, Department of Health, Education, and Welfare.	35,625,720	42,583,214	

OBLIGATED BUT UNEXPENDED BALANCES

Mr. Flood. Also, please give us the same information for each case where the budget shows an unobligated carryover balance at the end of fiscal year 1970, and then please also give us a statement showing the total amount of obligated but unexpended funds for the Department as a whole at the end of fiscal years 1968, 1969, and 1970, together, of course, with an explanation of the major elements making up these obligated but unexpended balances.

(The information follows:)

Obligated Balances at End of Year

Each fiscal year, funds available in an appropriation or trust fund are obligated to support the various activities for which their use is authorized. An obligation represents a legal commitment on the part of the Government to pay for services or work performed, goods ordered, or such support of individuals as may be legally authorized or requested. Actual payment, or expenditure, of obligated funds normally does not occur at the time of obligation. Full payment of obligations may be made shortly after obligation or may be made, in increments, over the course of 1 or more years. The rate at which funds are expended generally depends upon the nature and purpose of the activity for which they were obligated.

Due to these circumstances, obligated balances exist at the end of the fiscal year in most appropriations and trust fund accounts. These balances represent the amount of funds obligated prior to the end of the fiscal year against which payments, or expenditures, have not been made. Expenditures from these obligated balances will occur in subsequent fiscal years.

The size of an end-of-year obligated balance in an appropriation or trust fund will normally vary from year to year. The size of the balance is governed by a variety of factors, including variations in the amounts obligated from year to year, changes in the size or nature of activities being supported, and the time at which obligations are made during the year.

OBLIGATED BALANCES END OF YEAR

[In thousands of dollars]

Appropriation	1968	1969	1970
Consumer Protection and Environmental Health Service:			
Food and drug control	$10,631	$11,384	$14,672
Air pollution control	41,892	61,719	80,554
Environmental control	22,537	26,924	31,812
Buildings and facilities	154	10,441	18,466
Office of Administrator (salaries and expenses)	6,128	5,542	1,955
Total	81,342	116,010	147,459
Health Services and Mental Health Administration:			
Mental health	382,292	464,521	509,586
St. Elizabeths Hospital	1,795	2,672	2,901
Health services research and development	43,986	50,335	40,333
Regional medical program	51,373	98,460	122,622
Communicable diseases	25,214	18,861	12,758
Hospital construction	540,739	581,704	569,917
Patient care and special health services	4,893	7,819	10,219
National health statistics	1,468	1,475	1,796
Retired pay of commissioned officers	3,444	4,773	6,193
Buildings and facilities	489	2,617	3,227
Indian health services	11,789	16,792	19,573
Indian health facilities	18,304	18,646	14,704
Emergency health	3,031	1,854	2,088
Total	1,088,817	1,270,529	1,315,917
National Institutes of Health:			
Biologics standards	2,725	3,044	3,975
National Cancer Institute	111,398	132,859	138,666
National Institute of Dental Research	19,695	23,635	25,411
National Institute of Arthritis and Metabolic Diseases	72,609	91,608	97,877
National Institute of Neurological Diseases and Stroke	69,677	89,652	82,508
National Institute of Allergy and Infectious Diseases	54,334	62,651	71,144
National Institute of General Medical Sciences	108,580	132,378	133,383
National Institute of Child Health and Human Development	41,920	54,116	61,232
Eye Institute			13,613
Environmental health sciences	13,907	15,893	16,986
General research and services	49,556	62,318	63,645
John E. Fogarty International Center for Advanced Study in Health Sciences		705	1,640
Health manpower	107,047	204,541	284,098
Dental health		5,806	9,019
Construction of health educational research and library facilities	511,381	556,534	539,939
National Library of Medicine	22,070	21,338	20,815
Buildings and facilities	7,555	24,493	7,914
Office of the Director (salaries and expenses)			755
Scientific activities overseas	18,833	23,964	23,926
Total	1,211,386	1,505,535	1,596,546
Office of Education:			
Elementary and secondary education	660,551	740,029	820,193
School assistance in federally affected areas	160,563	334,800	193,947
Educations professions development		136,610	79,170
Teacher Corps	1,222	2,663	9,520
Higher education	1,473,428	1,372,494	1,322,190
Vocational education	173,999	183,522	207,249
Libraries and community services	67,138	101,213	96,980
Education for the handicapped	46,444	66,528	81,362
Research and training	68,449	114,859	102,998
Education in foreign languages and world affairs	15,750	17,050	21,458
Research and training (special foreign currency program)	542	781	2,757
Salaries and expenses	6,976	8,133	9,393
Civil rights education	9,784	9,823	12,373
Defense educational activities	68,101	43,933	24,178
Arts and humanities educational activities	639	239	39
Promotion of Vocational Education Act, Feb. 23, 1917	4,690	4,883	4,883
Total	2,758,276	3,137,560	2,988,690

OBLIGATED BALANCES END OF YEAR—Continued

[In thousands of dollars]

Appropriation	1968	1969	1970
Social and Rehabilitation Service:			
Grants to States for maintenance payments	565,903	840,000	840,084
Work incentives	10,000	37,415	38,790
Grants to States for medical assistance	576,981	650,000	792,025
Social services and administration	131,754	163,373	165,093
Assistance for repatriated U.S. nationals	155	162	181
Grants for rehabilitation services and facilities	60,276	62,456	117,279
Mental retardation		25,386	42,133
Maternal and child health	79,901	98,981	113,309
Child welfare			12,565
Development of programs for the aging	13,249	17,316	19,130
Juvenile delinquency prevention and control	1,545	2,907	8,054
Rehabilitation research and training	32,395	37,136	40,341
Cooperative research or demonstration projects	3,560	4,490	8,040
Research and training (special foreign currency)	7,163	8,746	8,984
Salaries and expenses	1,913	2,132	2,302
Assistance to refugees in the United States	8,031	10,631	14,613
Total	1,492,826	1,961,107	2,22?,923
Social Security Administration trust funds:			
Federal old-age and survivors insurance trust fund	22,634	30,493	43,678
Federal disability insurance trust fund	10,646	12,891	16,390
Federal hospital insurance trust fund	9,589	6,711	9,346
Federal supplementary medical insurance trust fund	11,600	12,520	19,381
Total	54,469	62,615	88,795
Special Institutions:			
National Technical Institute for the Deaf (salaries and expenses)	172	95	320
National Technical Institute for the Deaf (construction)			14,395
Model Secondary School for the Deaf (salaries and expenses)	5	27	109
Model Secondary School for the Deaf (construction)		14	472
Gallaudet College (salaries and expenses)	241	377	342
Gallaudet College (construction)	771	855	600
Howard University (salaries and expenses)	852	1,495	1,925
Howard University (construction)	1,477	5,452	25,222
Freedman's Hospital (salaries and expenses)	917	1,339	1,248
Total	4,435	9,654	44,633
Departmental management:			
Office of the Secretary (salaries and expenses)	1,402	960	696
Office of Community and Field Services (salaries and expenses)	316	330	1,207
Office of the Comptroller (salaries and expenses)	466	841	1,082
Office of Administration (salaries and expenses)	186	254	510
Surplus property utilization	93	123	142
Total	2,463	2,508	3,637
Total, Department of Health, Education, and Welfare	6,694,014	8,065,518	8,408,600

FUNDS AVAILABLE FOR RESCISSION

Mr. FLOOD. I direct your attention to table G–9 on page 90 of Special Analysis G in the President's budget. There you will see it shows $153 million of unobligated funds for higher education facility loans as available for rescission. What would be the effect if these funds were in fact rescinded?

Secretary FINCH. This relates to discussions we have had within the Department about the relative merits of direct loans versus guaranteed loans. I think this gives strength to the argument we made about granting the guaranteed loans as opposed to the direct loans.

Mr. FLOOD. What would be the effect if the rescission was executed?

Secretary FINCH. I think it would be very bad.

Mr. KELLY. One of the things we did in connection with meeting the requirements of the Revenue and Expenditure Control Act was to decrease the amount of direct loans we have made. Witnesses have

appeared before you asking for supplemental funds to initiate the interest subsidy program for facilities.

Mr. FLOOD. And there will be more witnesses.

Mr. KELLY. Yes. But we plan to produce the same level of construction through the interest subsidy mechanism. Therefore, the elimination of the funds available for direct loans would not decrease the level of the program but would only change the method.

Mr. SMITH. Is that $153 million all loans?

Mr. FLOOD. This is all loan money and marked for rescission. Not marked for rescission, available for rescission.

Secretary FINCH. Susceptible.

Mr. FLOOD. In view of the requirements of the Revenue and Expenditure Control Act, I assume that the executive branch is also reviewing all accounts with the thought in mind of identifying possible rescission.

Secretary FINCH. Yes.

Mr. FLOOD. In general, or specifically if you have specifics and care to divulge them, what possibilities do you see for HEW across the board?

Mr. KELLY. They are very limited, Mr. Chairman, and let me tell you why. What we have done in both fiscal year 1969 and fiscal year 1970 is reduce the requests for construction accounts and use up the carry-forward balances. Rather than proposing those for rescission and continuing at the same appropriation levels, we have proposed to decrease appropriation levels and utilize carry-forward balances to maintain the level of the programs.

We can give you some others, but they would be small sums of money. The large sums of money have all been used to decrease appropriations.

REORGANIZATION PLANS—HEADSTART

Mr. FLOOD. What plans do you have for the reorganization of this great Department or any of its parts, Mr. Secretary?

Secretary FINCH. I have in mind living with the present "organizational structure" for a period of time before any drastic rewiring. We are confronted with at least Headstart, as I indicated earlier——

Mr. FLOOD. Have you decided where to put Headstart?

Secretary FINCH. No, sir.

I will give you my own tentative conclusion and I give you this in anticipation of a report that will be filed with me either today or tomorrow by an in-house group headed by Mr. Charles Schultz. We had meetings Friday and Saturday on this problem.

Mr. FLOOD. I heard about that, but I did not hear the answer yet.

Secretary FINCH. I have not seen the full report, but I was told verbally by Mr. Schultz that the strong feeling of this group—which included educators, parents of Headstart children, and people in welfare and other disciplines involved—was that it should retain its own integrity. It should not be put under the Office of Education in a line position and it should not go into the present Children's Bureau.

The net effect of the report, again as I say without having read it in full, or without its formal presentation to me, is that either Headstart should be an independent autonomous agency reporting directly to the Office of the Secretary, or retain its integrity and report through the

Office of Education and not be a part of the line responsibility in the Office of Education.

Mr. FLOOD. How are you going to do that?

Secretary FINCH. It would simply be an office reporting to the Commissioner of Education.

Mr. FLOOD. Or?

Secretary FINCH. Or reporting directly to the Office of the Secretary.

Mr. FLOOD. Which one do you like?

Secretary FINCH. I want to talk to Dr. Allen about it. I know he has some thoughts in connection with the general reorganization of the Office of Education.

Mr. FLOOD. Forget about Dr. Allen. What are your visceral sensations?

Secretary FINCH. I would choose neither the Children's Bureau nor line responsibility in the Office of Education. I think either of these alternatives would badly cripple the program. The program has some very unique features about it, not the least of which is voluntary and parental involvement. I think it needs to retain high visibility.

Mr. FLOOD. If you had to decide now, where would you put it?

Secretary FINCH. I would lean toward having it report directly to my office. And we may build from there, Mr. Chairman, depending on what other programs presently in the Office of Economic Opportunity might be moved from there into an Office of Children's Development.

MATERNAL AND CHILD HEALTH PROGRAMS

Mr. FLOOD. Quite a number of Secretaries who sat in that chair have thought about and talked to us about taking the health programs out of the Children's Bureau, and consolidating them with the Public Health Service activities. Do you have any plans in connection with that?

Secretary FINCH. No. We have had some discussion with the Surgeon General about that, but I have not arrived at any firm conclusions at this time.

If this other concept has any validity, and we want to discuss that with you and your staff as well, and there were created a kind of child development office, I would be more inclined to pull them from Children's Bureau and put them into that kind of an office rather than move them into the Public Health Service.

DECENTRALIZATION TO REGIONAL OFFICES

Mr. FLOOD. What are your opinions with regard to the extent to which the Department's administrative personnel should be decentralized? Some people are very strong for decentralization to the regional offices, and others think they are kinks in the pipe. Where do you stand on this issue?

Secretary FINCH. After 5½ weeks exposure, I made two determinations.

One is, I am going to get the regional officers in for 2 days away from telephones——

Mr. FLOOD. I am in favor of that. That is a good idea.

Secretary FINCH. I have had two field visits to regional offices and I might say there was a considerable disparity between the two offices in terms of what I regarded as level of performance. I will not identify the offices. But I have talked to several of the others on the telephone and it appears that there is an uneven quality of leadership in the regional offices.

So I have to give you an honest answer and say that my tendency would be to give them the maximum possible opportunity and to beef them up. Particularly in those programs where we receive State plans, we need a closer liaison with State governments.

I would like to give them as much authority as it is possible to give them, and I hope we can upgrade the quality of personnel in these offices.

SIZE OF THE DEPARTMENT

Mr. FLOOD. A lot of people, including one former Secretary, have recommended that your Department be split into three separate and distinct departments. What is your opinion? Do you think the Department is too large to operate efficiently?

Secretary FINCH. I suppose the greatest constraint we have in that area, Mr. Chairman, has been a traditional wish of the President that his Cabinet not be increased, for the Cabinet room is already too small. If you look in a comparative way at other governments around the world, there is every justification for having three separate departments for this department that I head.

Mr. FLOOD. What do you think?

Secretary FINCH. I think that the kinds of qualitative problems we have today require an interdisciplinary approach. This may sound like a cliché, but I do think we have a great seamless web here. I believe that it is manageable, and I think it would be ill-advised to break up the Department into three separate departments.

LEGISLATIVE PLANS

Mr. FLOOD. Do you have any legislative proposals, any white-haired children you want to trot out here?

Secretary FINCH. In connection with reorganization, sir?

Mr. FLOOD. Anything.

Do you have any areas in which you think legislation would be not only desirable but advisable?

Secretary FINCH. Yes. We think, for example, in the community college area, all we really have done so far is just pull together various pieces of existing legislation. I think we are going to have to come up with a comprehensive program that will really induce the local communities to pull themselves together.

Mr. FLOOD. You are not going to drop it in the hopper tomorrow morning when we are not looking?

Secretary FINCH. No, sir.

I think our big problem right now, as I said at the outset, is that we really have to assimilate a massive amount of legislation that has been passed in recent years. We must find out what works and what does not, and rationalize that which we have on the books already.

Mr. FLOOD. You are not going to have the House passing an appropriation bill and then, when we wake up the next morning, find out something funny happened on the way to the forum, before we get to the Senate?

Secretary FINCH. The first instinct of anybody in a position like this is to preserve his options, but I can guarantee you that will not happen.

CHANGES IN WELFARE SYSTEM

Mr. FLOOD. Public assistance accounts for a very large share of your budget, $7.5 billion. Are you getting used to the way we toss around billions here? Did you in California?

Secretary FINCH. It is the way we used to toss around thousands in the State government of California.

Mr. FLOOD. For welfare and medical assistance payments, the Federal share is fixed by law. We do not control those payments through the appropriation process. However, we do have to make an annual appropriation to cover the costs and the higher they are, the less money there is for other things.

Welfare costs have been going up everywhere. We hear criticism of the welfare system—and you went into it at some length in your statement—from every side. Not only from the taxpayers——

Secretary FINCH. The recipients, also.

Mr. FLOOD. Yes, the people who are supposed to benefit, the recipients.

Do you have some ideas on this?

Secretary FINCH. As I indicated earlier, we have a study going on right now that developed from the meeting I had with most of the 50 State welfare directors. We are trying to build in every administrative control that we can. We have these experimental programs that we want to test to see whether they are the kind of radical departure we might be able to recommend to other States.

Mr. FLOOD. You have been quoted as favoring raising the minimum monthly payment to $40. If the answer is yes, of course the next question from me will be how much would it cost.

Secretary FINCH. This was a recommendation of the so-called Nathan task force. It was an attempt not to raise the minimum, but to mediate, if you will, the disparity between what some of the less affluent States pay—which is something less than $10—and what some of the more affluent States pay as a minimum—up in the area of $80. We would have to be careful to build into any proposal assurances on the part of the affluent and the less affluent States that they would not just walk away from their own full share of the responsibility. From the more affluent we would want some idea of how they might use the resources that would become available to them.

It is clear that inequities in welfare have a profound impact upon where people go, and why they go and where they move. We cannot allow the disparity to go on forever.

And the figure, to answer your question specifically, was costed out at $1.4 billion.

I am not going to go as far as some Governors, who said we ought to have HEW pick up the whole thing.

Mr. FLOOD. A lot of Governors.

Secretary FINCH. Yes, a lot of Governors. I think each level of government ought to share this great ecstasy and agony of taxing and dividing responsibilities at each level—county, State, and Federal—in these sensitive areas.

I certainly do not think HEW ought to become the "Department of Dole." We ought to share, as in the classic, orthodox Federal concept, with the other units of government. Otherwise they are going to lose their capability, and we will still have to rely on their delivery systems.

Mr. FLOOD. What do you think of what are sometimes referred to as the more radical proposals, such as the negative income tax, or the family allowance system?

Secretary FINCH. We have study groups working on both of those. I must say that I have a visceral instinct against them, but at this point have not closed my mind to such possibilities. We want to have experimental projects to study.

I am just giving you my top-of-the-head opinion.

Mr. FLOOD. Any horizon for this study or is it going to go on and on?

Secretary FINCH. No, I think we will be able to lock it into a definite time frame if we get the money we are requesting in the budget.

Mr. FLOOD. Within the rule of reason?

Secretary FINCH. Yes, sir.

INCOME MAINTENANCE EXPERIMENTS

Mr. FLOOD. Is the Department experimenting with any new methods of income maintenance? I understand that the Social Security Act gives you authority to do that.

Secretary FINCH. I think Mr. Kelly would know more about it.

Mr. FLOOD. You have authority under the Social Security Act?

Mr. KELLY. We have authority under the Social Security Act. A group has been put together, consisting of people from the Social and Rehabilitation Service, the Social Security Administration, and the Office of the Secretary. They are now trying to design two relatively small projects that would identify a research approach to examining the various alternatives that are being offered.

The OEO study in New Jersey that the Secretary alluded to in his opening statement, is entirely related to families with an employed male head but which are still in poverty.

We are endeavoring to develop two counterpart research projects that will deal with the female-headed family, which is a principal problem of public assistance.

NEW METHOD OF DETERMINING ELIGIBILITY OF WELFARE APPLICANTS

Mr. FLOOD. Now the news media are giving a lot of attention to the fact that the Department is requiring the States to accept a simple declaration by the applicant, in place of investigation, to determine eligibility. Is that not pretty dangerous business?

Will that not blow up the welfare rolls even higher than they are? Has it been done any place, and if it has, what is the record or experience?

Secretary FINCH. Mr. Chairman, my predecessor promulgated a regulation with respect to asking states to respond to this proposal. This has been attempted, for example, in New York City. Mayor Lindsay has said that it saved considerable administrative costs, although others have expressed doubts about the adequacy of the test sample. In one or two States I know that it has simplified the workload.

Mr. FLOOD. Has it blown up the caseload?

Secretary FINCH. There has not been an appreciable or unexpected jump in the caseload.

As far as I am concerned, the jury is still out on this approach. This is included in the 50-States review we are making now. We want information as to where it has been tested——

Mr. FLOOD. I want to find out how you feel. I know the jury is out on it.

Secretary FINCH. I think it is worth digging into a lot further. There is, of course the classic social worker's objection that he is not able to service his clients properly. I think it is worth examining further, and I do not yet have enough data on which to give you a solid answer.

RISING COST OF MEDICAL CARE

Mr. FLOOD. You talked about one of the most serious problems facing the country, this almost unbelievable rise in the cost of medical care.

I was in the hospital myself for 6 weeks in July and August. I was in the hospital 6 weeks and it cost me $6,000, $1,000 a week.

That thing has a very substantial impact on the HEW budget, not to mention an ordinary bloke like me who has to go to a hospital or even a doctor's office.

What can we do and what should we do?

Secretary FINCH. As I said in my opening statement, the whole field of welfare and rising medical costs are two of the greatest problems we have to face. We think we have to approach the medical cost problem in a variety of ways.

If we develop a better system in our neighborhood health clinics, we can detect disease earlier and avoid the catastrophic effects of a sudden emergency or disability.

I would hate to see us go to a set fee schedule. If my information is correct, hospital costs have risen at a faster rate than physician's fees. Seventy percent of cost is for labor, and this is a part of the whole inflationary problem.

Mr. FLOOD. And Congress raised the minimum wage law.

Secretary FINCH. The figures we have show that nurses and other supporting personnel are still about 30 percent below comparable professions, despite recent increases they have had.

ALLEGED ABUSES OF MEDICAID AND MEDICARE

Mr. FLOOD. The costs in your Department are further increased by what appears to be actual fraud on the part of some doctors. I have in my hand here, an excerpt from the Washington Star of November 1968. The heading is "Cohen Fears Abuses in California Medicaid."

I am sure you know just as much or more about that than Mr. Cohen does.

For the purposes of the record I will insert that.
(The article follows:)

[From the Washington Star, Nov. 9, 1968]

COHEN FEARS ABUSES IN CALIFORNIA MEDICAID

Wilbur E. Cohen, Secretary of the Department of Health, Education, and Welfare, is "deeply concerned" about abuses of the Medi-Cal program in California—that State's version of medicaid—and says that funds may have been similarly misused in other States.

At a news briefing yesterday, Cohen said a thorough investigation is being made and that he and a 21-man advisory committee on medicaid have been meeting frequently to map recommendations for reform. He plans to submit the recommendations to Congress, he said, before the advent of the Republican administration next year.

In California the State justice department has turned up what it says is evidence that health professionals have cheated Medi-Cal of $6 to $8 million a year. But the Department acknowledged that it will be hard to make the charges stick because the State office of health care services and the private intermediaries administering the program have created so much red tape.

The intermediaries are the insurance organizations that deal with billing and with payments to health service vendors for both medicaid and medicare. While acknowledging that they have faced "monumental problems," Cohen said "there have been some notible cases in which the fiscal intermediaries have not panned out as well as expected."

During the weeks he remains in office, Cohen said, he and HEW will complete a comparative analysis of the performance of all the private fiscal intermediaries participating in medicare and medicaid. "There may have to be some changes in the law which provide for a more competitive situation than there is now," he said.

Asked what this meant, Cohen said that he thought fiscal intermediaries "should have more responsibility in carrying out certain elements of Federal policy" and that this might well entail more Government surveillance.

Responding to other questions, he said he was considering a proposal whereby enforcement of civil rights legislation in Government health and education programs might be shifted from HEW to the Department of Justice and repeated previous statements that he would urge Congress to expand medicare to cover the costs of health care for the disabled of any age and out-of-hospital prescription drugs.

Cohen said he felt that prospects for expansion of medicare were favorable because the Democrats retain control of Congress.

Discussing his own future, he added that he plans to return to the University of Michigan to teach "HEW" (health, education and welfare).

Mr. FLOOD. I have here as well the Albuquerque Tribune, January 17, 1969. The headline is "Welfare Fees to New Mexico Doctors and Dentists as High as $90,000," and there the Tribune staff writer, James Boyer prints this story with names and amounts and so on.

I think at this point, if there is no objection, I will insert that in the record. You can comment about that later.

(The article follows:)

[From the Albuquerque Tribune, Jan. 17, 1969]

WELFARE FEES TO NEW MEXICO DOCTORS, DENTISTS AS HIGH AS $90,000

(By Jim Boyer)

SANTA FE.—An Albuquerque dentist was paid $96,378 and another was paid $94,790 in 1968 for treating welfare patients, it was disclosed today.

The figures were released by John Jasper, state director of the Health and Welfare Department.

According to the list, Dr. Jose A. Garcia, 110 Edith SE., was paid $96,378, and Dr. Robert C. Greiner, 1010 Bridge SW., was paid $94,790.

Those were the top payments among dentists, physicians, and osteopaths.

Top payment to an osteopath went to Dr. B. Morgan Wolleson, 1010 Bridge SW., of $66,209, according to the list.

Dr. Irby B. Ballenger, 726 First National Bank Building, Albuquerque, was the top M.D. on the list. He received $57,607 in payments for treating welfare patients last year, Jasper's list showed.

Another osteopath, Dr. J. W. Price, was listed at the same Bridge SW., address as Osteopathic Dr. Wolleson and Dentist Dr. Greiner. Welfare payments to Dr. Price amounted to $49,568. Also at the same address was listed another dentist, Dr. James F. Gleason, with fees of $17,735.

About $500,000 in professional medical fees were paid to clinics and medical centers that in turn paid the doctors.

Among these listed by Jasper were $272,945 to Lovelace Clinic in 1968, up from $151,758 in 1967, and $147,244 to Bernalillo County Medical Center, up from $26,962 in 1967.

Ambulance and taxi firms were paid varying amounts for hauling welfare patients. The Checker Yellow Cab Co. of Albuquerque was listed as hauling 4,876 welfare patients in 1968 for which it collected payments of $31,061.

Gold Cross Ambulance Service of Albuquerque was paid $19,500, top figure among ambulance services, the list showed.

The figures were detailed in a breakdown of $15,118,903 made in payments to physicians, osteopaths, dentists, chiropractors, nursing homes, hospitals, and doctor groups as released by Jasper.

This was a hefty increase over the same figures for 1967, which totaled $9,221,000.

These are paid from title 19 funds, which are two-thirds Federal and one-third State. They include medicaid funds.

Among the dentists, Dr. Jerome H. Noskin, 200 Oak NE., who resigned recently from the State welfare board so that he could continue treating welfare patients, was paid $38,528 in 1968 for treating such patients, according to the list.

Dr. Noskin figured in a controversy last year when it was disclosed he had been paid over $20,000 for treating welfare patients while serving on the welfare board during 1967.

This year, on the list were payments of $17,489 to Dr. Martin D. Goodwin, of Clovis, a medical doctor. Dr. Goodwin is chairman of the State welfare board.

Among other hefty amounts reported in Jasper's list among State dentists were:

Dr. James N. Bayless, Los Alamos, $54,108; Dr. Alfonso F. Sandoval, 5721 Fourth NW., $49,303; Dr. Abe A. Gonzales, 809 Tijeras NW., $42,744; Dr. Eligio Contreras, 5509 Central NW., $41,660.

Dr. Alfred L. Lopez, 9 Medical Arts Square NE., $34,511; Dr. Paul Franco, 809 Tijeras NW., $32,053.

Dr. Robert J. Henry, Las Vegas, $33,263 and Dr. Michael G. Redman, Fairview, $30,231.

Dr. John Bates, Santa Fe, $17,090; Dr. William J. Cote, Belen, $15,439; Dr. Robert Cunningham, 500 Central SE., $15,231; Dr. C. M. Eiffert, Roswell, $29,644; Dr. Joseph Francis, Santa Fe, $27,482; Dr. E. L. Garcia, Taos, $20,525.

Dr. Billie J. Harris, Carlsbad, $21,402; Dr. Dale Harris, Carlsbad, $14,637; Dr. Dwane F. Johnson 1528 Five Points Road SW., $31,183; Dr. Max M. Sanchez, 1501 Central NW., $15,993; Dr. George A. Segura, Santa Fe, $20,330; Dr. Robert T. Smith, Roswell, $23,072; Dr. Joseph H. Tubb, Espanola, $31,989; and Dr. M. N. Waters, Clovis, $15,866.

Those were the dentists listed whose welfare payments totaled more than $15,000.

Among the top payments to osteopathic physicians were listed the following:

Dr. Sanford H. Kinne, 1517 Fourth St. NW., $52,509; Dr. Lynn Hooker, 1632 Rio Bravo SW., $51,539; Dr. G. H. Roberts, 1586 Bridge SW., $49,030.

Dr. Laszo G. Zold, Las Vegas, $18,350; Dr. Louis Zucal, Santa Fe, $16,058; Dr. H. R. Ansey, Las Vegas, $44,639; Dr. L. D. Barbour, $25,252; and Dr. L. J. Barbour, $39,031, both of Roswell; Dr. Jennie M. Bigsby, 4614 Central SW., $39,429; Dr. G. E. Darrow, 1317 Tijeras NW., $20,581; Dr. B. J. Davis, 1138 University NE., $27,160; Dr. T. M. Willoughby, 1128 University NE., $23,279;

Dr. J. F. Dawson, 3911 Fourth NW., $40,394; Dr. J. A. Dominguez, Taos, $22,044; Dr. K. J. Eberhard, 4401 Fourth NW., $43,768; Dr. F. J. Fellman, 4401 Fourth NW., $21,113; Dr. James E. Franklin, 2511 Rio Grande NW., $19,690;

Dr. M. M. Hitchcock, Roswell, $18,748; Dr. S. M. Howard, 1801 Lomas NW., $35,678; Dr. E. E. Johnson, Espanola, $16,347; Dr. Lawrence Leyba, 5509 Central

NW., $24,861; Dr. A. W. Llewelyn, Belen, $23,946; Dr. Peter J. Marquez, 624 Lomas, NW., $23,703;

Dr. W. O. Reynolds, 3737 Eubank NE., $17,368; Dr. Robert Steider, 1128 University NE., $15,289, and Dr. F. E. Toland, Portales, $15,972.

Among top payments to medical doctors were listed the following: Dr. Leonard Akes, Fairview, $45,082; Dr. John D. Gundzik, Santa Fe, $31,309; Dr. Robert E. Cutler, Espanola, $29,904; and Dr. John A. Gjive, Embudo, $24,695.

A "Dr. Sol Brown" of Albuquerque was listed twice. The list reported Dr. Sol Brown at 412 Cromwell SE., received $19,195, and Dr. Sol Brown at 3906 Fourth NW., got $7,465.

Other medical doctors on the list reported as receiving $15,000 or more during 1968 in welfare fees:

Dr. R. P. Beaudette, Raton, $15,706; Dr. D. L. Bell, Hobbs, $15.507; Dr. C. M. Bovard, 17 Encino Medical Plaza NE., $22,800; Dr. Thomas Brandes, Santa Fe, $20,408; Dr. John B. Blough, Las Vegas, $15,949; Dr. Robert R. Castillo, Encino Medical Plaza NE., $15,656;

Dr. William O. Edward, 4200 Silver SE., $15,394; Dr. A. T. Gordon, Tucumcari, $21,606; Dr. James J. Lehman, 7000 Cutler NE., $20,871; Dr. Paul Mackel, Santa Fe, $15,442; Dr. John A. Most, Carlsbad, $15,296; Dr. G. S. Rubin, 7000 Cutler NE., $27,952; Dr. Orhan Mehmet Sansoy, Las Vegas, $23,090; Dr. L. Seidenberg, 1420 Carlisle NE., $20,102, and Dr. Samuel Ziegler, Espanola, $24,899.

Dr. Garcia, who was listed as receiving $96,378 for treating welfare dental patients, said he didn't know how much he had received last year or what percentage of his business was welfare patients.

"Those payments came to my office but they represent fees to two other dentists, Dr. Paul Franco, and Dr. Robert Cunningham and myself," he said. "I also employ two oral hygienists."

The list also included a Dr. Paul Franco, with an address of 809 Tijeras NW., listed as receiving $32,053 last year. Dr. Robert Cunningham, listed at 500 Central SE., was listed as receiving $15,231 in welfare fees last year.

Dr. Garcia said that because of his location at 110 Edith NE., he does have a high number of welfare patients. He runs a dental clinic which has been serving residents in the neighborhood for 18 years.

Dr. Greiner denied that he had received $94,790 in payments for treating welfare patients last year. Instead, he said he received $50,000 during 1968 in such fees, but that this covered 2 years' payments.

"I made $25,000 in 1968 and a like amount in 1967," he said. He said confusion had resulted from the fact that 2 years' fees had been paid to him during 1968.

"I do not know where such a report came from," he said, concerning the $94,790 report. "It is totally unfounded."

He said his situation is different from that of most dentists since 90 percent of his patients are welfare cases. "If we didn't take them, we wouldn't have any practice," he added.

The release of the figures drew an immediate blast from State Senator William Sego, Albuquerque Republican, who declared:

"Give this program 10 years and the doctors and the dentists are going to be on the Federal payroll. England passed this same thing years ago and the doctors abused the program so badly they all ended up on the public payroll."

Gov. David Cargo told The Tribune that the State has "no control over the services."

He said "the Federal Government sets the qualifications and the door was opened for these services and we had no way of estimating how many people were going to take advantage of this."

The State health and social services board met this morning to discuss the department's financial difficulties and other questions.

The board recently ordered a 25 percent cutback in fees paid to doctors, dentists and other professional people. This action came after the board learned that the department's expenditures were running about 125 percent more this fiscal year than at the same time last year in some areas.

Without the cutbacks, the total deficit for the medical assistance program would pass $3 million by the end of the fiscal year ending June 30, said Jasper.

The board is expected to take action to cut welfare assistance grants five to 10 percent for various groups beginning in March.

Dr. Wolleson was listed as having been paid $66,209 last year by the welfare department.

"And they still owe me $25,000 on top of that," he declared.

Dr. Wolleson, who said "Money isn't important" and that he has been "successful because I've ignored it," asked this question:

"What right do the newspapers have to publish this (the welfare payments) in the paper?"

When told that taxpayers have a right to know where their money goes, Dr. Wolleson said:

"I pay considerable taxes, too. The welfare will probably pay my taxes this year. You'd better be careful. I run a completely ethical practice and if you make any intimation or suggestion that it isn't you're in trouble.

Several million dollars was listed as going to various hospitals, private and public, to cover all types of medical services.

Among the larger amounts were the following:

Bataan Memorial Methodist Hospital, $242,759; Bernalillo County Medical Center, $772,390; Doctors Hospital, $129,809; Osteopathic Hospital, $309,527; St. Joseph Hospital, $253,956; Espanola Hospital, Espanola, $222,048; Memorial Hosnital, Las Cruces, $125,629; Memorial Osteopathic Hospital, Roswell, $106,127; St. Mary's Hospital, Roswell, $118,761.

Presbyterian Hospital in Albuquerque was listed as receiving $2,628.

About 150 out of State hospitals and clinics got New Mexico medical care fees during 1968. Among them were:

National Jewish Hospital, Denver, $24,606; Los Angeles County Hospital, Los Angeles, $2,046; Baylor University Medical Center, Dallas, $2,269; El Paso Orthopedic Service, El Paso, $9,370; University of Colorado Medical Center, Denver, $40,660.

About 400 payments were made to various individuals outside of New Mexico to cover medical treatment and medical services expenses. Among them:

Ernesto Santoscoy, Canutillo, Tex., $23,680; W. W. Schuessler, El Paso, $8,631; J. A. Rodriquez, Canutillo, Tex., $7,648; W. A. Jones, El Paso, $5,101; Glenn E. Furr, El Paso, $11,713.

Other ambulance firms listed as receiving large amounts included Gold Cross Ambulance of Roswell, $3,452; Albuquerque Ambulance Co., with $14,694.

Among institutions and doctor groups receiving fees were listed:

Grants City Medical Clinic, $38,634; Anesthesia Associates, of Albuquerque, $30,255; Doctors Forbis et al., 1025 Medical Arts NE, in Albuquerque, $27,896; Mora Valley Medical Unit, Cleveland, was paid $14,163; Drs. Seligman et al., 801 Encino Place, NE, $14,560; Dr. B. L. and H. B. McClintock, Clovis, $20,348.

Richard Dillbeck, manager of the combined Yellow Cab-Checker Cab Co., said his firm picks up welfare patients on calls from welfare caseworkers.

Dr. J. F. Dawson, an osteopath at 3911 Fourth NW, said he plans to continue seeing welfare patients. He was unable to give a definite figure of his receipts from welfare fees in 1968 but estimated it at about $30,000. The list shows Dr. Dawson as receiving $40,394 in fees.

He said he will continue to bill welfare treatments at his usual rate and expects the welfare department to cut them by 25 percent in accord with its cutback.

Mrs. J. W. Price, who assists her osteopath husband, refused to confirm or deny the $49,000 in fees listed for her husband. She said that whatever he made he certainly worked like a dog for it.

Dr. Duane F. Johnson of 1528 Five Points SW, a dentist, said he also intended to continue treating welfare patients.

Mr. FLOOD. I have in my hand a Washington Post excerpt of January 18, 1969, page 2. This headline is "Big Doctor Fees in Medicare Cited." This is by Eve Edstrom, whom I suppose you know, a Washington Post staff writer. We will insert that in the record.

(The article follows:)

[From the Washington Post, Jan. 18, 1969]

BIG DOCTOR FEES IN MEDICARE CITED

(By Eve Edstrom)

One Florida doctor received more than $250,000 in medicare payments during the first 18 months of the program to help the aged pay their medical bills.

Other general practitioners received medicare reimbursements ranging from $177,000 to $199,500.

The validity of these payments, made to Florida and New Jersey doctors between July 1, 1966, and December 31, 1967, is now under investigation.

This is revealed in a medicare report submitted to Congress yesterday by outgoing Health, Education, and Welfare Secretary Wilbur J. Cohen.

His 74-page narrative focuses sharply on unprecedented rate of increase in medical-care prices since medicare began. His recommendations include special methods of surveillance over billings by doctors whose charges appear significantly higher than normal.

Just how high these charges can be is found in appendix D, exhibit 6, of the 51 pages of appendixes to Cohen's report.

A special study, limited to payments made in only a few States, showed that 47 doctors received annual medicare payments of $50,000 or more.

Of the 47 doctors, 18 had their payments handled by Blue Shield of Florida. One of the 18 received $191,000 annually or $286,500 for the 18-month period covered by the study. Two other Florida doctors received $198,000 and $180,000 during the period.

Thirteen of the 47 payments have been investigated and determined "proper." Among the 13 is a payment of $196,500 to a Georgia surgeon. The other 34 cases are still being investigated, including the 18 Florida doctors and two New Jersey practitioners who received $199,500 and $177,000.

On other medicare matters, cost estimates of several changes that Cohen is recommending to Congress were made public for the first time yesterday.

The first full-year cost of extending medicare to the disabled was estimated at $2 billion. Coverage of certain drugs under medicare would cost another $600 million.

These recommendations plus others, such as combining medical and hospital benefits under one medicare plan, would mean that employers and employees might have to pay an additional combined payroll tax rate of 1.6 percent on the present $7,800 earnings base.

However, the cost could be shifted to general revenue financing or the tax rate could be held down by increasing the taxable earnings base.

Mr. FLOOD. And I have before me a Washington Daily News excerpt, Tuesday, February 18, 1969. The headline here is "Medicare, Medicaid and Costs." I quote:

"A general practitioner in Florida was paid $191,000 in medicare fees alone in a single year.

"Two Albuquerque dentists were paid $96,378 and $94,700 each in medicaid funds. Two Florida doctors running a nursing home were paid $133,000 and $118,000 in medicare fees. A Georgia"—there must be something about the climate—"surgeon collected $131,000 from medicare," and so on almost ad infinitum. We will insert that in the record and we would like to hear your comments.

(The article follows:)

[From the Washington Daily News, Feb. 18, 1969]

MEDICARE, MEDICAID, AND COSTS

In New Mexico a legislative investigation has turned up some incredible doctor and dental fees under medicaid—the State-Federal program which provides medical care for the needy.

Several weeks ago the Federal Health, Education, and Welfare Department revealed similarly unbelievable fees being paid under the medicare program—ad adjunct of the social security program which is strictly Federal.

A general practicioner in Florida was paid $191,000 in medicare fees alone in a single year. Two Albuquerque dentists were paid $96,378 and $94,700 each in medicaid funds. Two Florida doctors running a nursing home were paid $133,000 and $118,000 in medicare fees. A Georgia surgeon collected $131,000 from medicare.

Altogether, the Social Security Administration found 47 doctors who got upward of $50,000 each from Medicare.

Nobody knows how many have collected similar amounts from medicaid, but the cost of this program in New Mexico alone was $15.1 million last year, and

35 or 36 States in the union have bigger populations than New Mexico. So do your own guessing.

What has been going on in New Mexico under medicaid probably has been going on, in varying degrees, in all other States. And in medicare.

In New Mexico, for a time, the medicaid office even was spending $12,000 a month to pay the taxi fares for patients going to doctors and dentists.

The New Mexico director of medicaid said he expects his costs to hit $17 million next year and predicted the costs would jump to $50 million (in that State alone) by 1975 when, as the law now stands, the program will be expanded.

It seems amazing that any doctor (or dentist) would have the time to treat adequately as many patients as those high fees sums indicate. Last year the average net income of doctors in the United States was around $35,000—which suggests a rough comparison.

In addition to this question, there is another:

If the costs keep soaring, as the New Mexico medicaid director forecasts, where is the money coming from? Will there be enough? Or is the whole system in danger of bogging down because of excessive demands on the taxpayers?

Before the change in administrations last month, the HEW Department had recommended that all welfare (and medicaid) applicants be taken on the rolls without investigation, simply on their own word that they were in need.

Since then, a Government advisory commission has rejected this scheme.

Before the Government gets much deeper in this situation, a thorough fact-finding ought to be in order—leading to better rules and a better understanding in Congress of what it has started, where the prorgam is going, and how it will be paid for. Otherwise, the whole project could wind up in a shambles, with the people who need these services the most the first to be hurt.

Mr. FLOOD. This is important enough that it might be well for you to prepare a general statement on it for the record.

Secretary FINCH. We would be happy to do so.

(The statement follows:)

MEDICARE PROGRAM

GENERAL STATEMENT

The potential for abuse of the medicare program comes from the sheer magnitude of this program which affects many millions of beneficiaries, involves the services of thousands of doctors and medical care institutions, and depends upon over 130 intermediaries and carriers to make proper benefit payments and otherwise assist in the efficient and economical administration of the program. Some of the abuse potential is implicit in methods of reimbursement which relate the reasonable charge reimbursable for doctors' services to customary and prevailing charges in a locality and for institutional services to the "reasonable cost" of providing those services. These concepts, reasonable charges and reasonable costs, no matter how carefully or precisely defined, leave room for variation, flexibility and, therefore, possible misuse. But much of the potential for abuse lies in the fact that medicare was deliberately designed in such a way as not to impose arbitrary controls on a patient's access to services or arbitrary limits on doctors' determinations of what are necessary services. Program reimbursement is geared to actual fees and actual costs for necessary services rendered.

To a large measure, we must rely upon the integrity of the people who provide services to our beneficiaries. No amount of policing, however ingeniously conceived or unrelentingly executed, is a substitute. We have no reason to believe that generally this reliance has been misplaced, for the actual amount of program abuse, although widely publicized, has been slight compared to the enormous potential which exists.

Even the relatively small amount of abuse to which the program has been subject, however, causes us much concern and has resulted in intensification of activities designed to detect and discourage abuse. Provision for assuring effective measures for identifying and resolving cases of program abuse is included in the organizational and administrative structure established for the health insurance program. While the development and disposition of questionable or fraudulent activities is ultimately the joint responsibility of the Social Security Administration and its carriers and intermediaries, responsibility for the actual detection of such questionable activities rests, in the first instance, with the

intermediaries and carriers. Their claims processing activity places them in a position to identify cases of possible overuse or misuse of program benefits, overpayments, duplicate billings for services, or fraudulent billing for services not actually provided. Following specific instructions issued by the Social Security Administration, carriers have developed charge data which enable them to readily identify individual physicians and others whose bills in a given period significantly exceed what would normally be expected in ordinary practices. Other claims screening procedures permit carriers to identify physician-patient contacts which appear abnormally frequent for a given diagnosis or therapeutic procedure, possible unreasonable charges by physicians for services they purchase and rebill to patients, and significant changes in charging patterns. Through such mechanisms, carriers are able to identify questionable cases and conduct preliminary investigations to determine whether the situation appears to be such as to warrant referral to State or local medical societies for discipilinary action or is one in which deliberate fraud seems to be involved. In addition, we have recently changed the social security regulations dealing with the disclosure of official records and information to specifically permit the referral to these organizations of information concerning unethical practices or unprofessional conduct on the part of practitioners in providing services to beneficiaries.

In carrying out its overall responsibilities for administration of the health insurance program, the Social Security Administration has continuously sought to improve the mechanisms used by intermediaries and carriers in making payment determinations and in handling questionable or fraudulent charge situations. It has modified its reporting system to assure that each potential violation is reported immediately upon discovery. Claims processing policies and procedures are regularly reviewed and evaluated, and changes are made which seem likely to improve the process.

Since overutilization of services is one of the most costly abuses possible under the program, this has been an area in which we and the carriers and intermediaries have been giving particular attention. The utilization safeguards established by carriers and intermediaries are regularly reviewed to determine their effectiveness in detecting cases of overutilization and onsite visits are made to acquire data on utilization review mechanisms employed by these organizations. One of the more interesting and promising projects in the area of utilization review is now underway in California where three of the State's foundations for medical care are under subcontract with California Blue Shield to review medicare claims in San Joaquin, Kern, and Fresno Counties. This is in addition to their similar undertakings with the State on title XIX claims. These foundations are arms of the county medical societies organized to provide health insurance coverage in a fee-for-service setting. Eighty-five to 95 percent of the doctors in these counties are members of the foundations; they are self-policing and operate on the basic premise that one of the most effective controls on charges is the elimination of unnecessary utilization of services. Reports thus far are encouraging; in the counties where these foundations are reviewing medicare claims, both charges and utilization have been reduced.

CASES INVOLVING SUSPECTED FRAUD

In cases of suspected fraud, the Social Security Administration becomes directly involved through its investigative staff. Since the beginning of the program, over 700 cases of suspected fraud have been identified and investigated. This figure refers only to those cases in which there was an allegation or other indication of intent to defraud. It does not include the many overpayment recovery actions taken by intermediaries and carriers or situations of unethical practices or overutilization which are handled directly with providers, physicians, and State and local medical societies.

In about 300 of the 700 cases, further investigation disclosed that there was insufficient evidence of intent to defraud to justify a full investigation leading to recommendation of prosecution. Often, simple clerical error or misunderstanding was all that was involved. Such cases were closed, and actions taken to recover overpayments. The remaining cases are under continued active investigation.

Cases in which the evidence seems clearly to indicate an intent to defraud are referred to the Department of Justice where final responsibility rests for determining whether criminal action should be taken. As of early April, six medicare cases were pending with the Justice Department awaiting decision as to whether the individuals involved will be prosecuted. Five other cases are at the final

level of review within the Department of Health, Education, and Welfare. There are, in addition, 20 cases in which investigations so far indicate a strong likelihood of intent of defraud. Should further investigation reinforce current indications, these cases too will be referred to the Justice Department for prosecution.

Representatives of the Social Security Administration recently met with officials of the Justice Department to review the referral process and to insure timely handling of our referrals. The Justice Department gave renewed assurance of its willingness to move ahead in processing these cases.

NEWSPAPER ARTICLES REFERRING TO PHYSICIANS WHOSE BILLINGS APPEARED SIGNIFICANTLY HIGHER THAN NORMAL

The Social Security Administration compiles listings of physicians, by code number, whose billings appear significantly higher than normal. Information regarding the first such listing was included in appendix D of the second annual report on the medicare program and has been referred to in various newspaper articles. Specific cases to be reviewed are then sent to the medicare carriers for their identification of the physician and for review.

It should be noted that the amounts shown represented gross income without reflection of costs incurred by the physician in maintaining his practice. As it turned out, a substantial number (about 50 percent) of the physicians on the listing who had initially been identified by the carriers as solo practitioners were later identified as actually receiving payment on behalf of one or more associates, a group, or clinic. Many of the physicians on the listing are reported by the carriers to be respectable, highly qualified specialists with extensive practices in urology, ophthalmology, internal medicine, or general surgery (areas in which one would expect a high incidence of utilization by aged patients) with charges falling within acceptable ranges. While the carriers accepted the payments for some of these physicians as reasonable, we have asked them for further review of many of the cases and requested them to flag future claims from many of the physicians for special bill review.

In contacts with the carriers, the Administration found that many of them have built into their systems a method of maintaining a running control of total amounts being paid to physicians. In fact, through the technique of using gross payments as a control, some carriers had already identified some of these same physicians, and had instituted special and/or continuing reviews of claims to assure that payments were being made properly. In some few cases, the carrier had already instituted fraud development or had reported the physicians' practices to the local medical society.

We are also working closely with the Senate Finance Committee in its investigation of the costs of medical care and have made arrangements, at their request, to prepare additional tabulations which may serve as a basis for identifying other cases which warrant investigations.

MEDICAID PROGRAM

Medicaid is a State-operated program authorized by the Social Security Act to provide needed medical assistance to the poor. As with all public assistance programs authorized by the Social Security Act, the Federal responsibility is for general program guidance to the States. Due to the nature of medicaid payments to a provider of service such as a practitioner or hospital or nursuing facility which may accumulate during any year identifiable accounts may be large. That any account is large is not of itself an indication of abuse or fraud as many required services may have been provided for usual fees.

We are deeply concerned over abuse of the use of medicaid funds. Any abuse or outright fraud tends to eventually deny adequate provisions for needs of those making legitimate use of public funds. Consequently we will continue to act within our authorization to prevent and punish fraud in all of our program areas including medicaid.

A recent meeting with representation of the Justice Department developed agreement that sufficient statutory authority existed for Justice Department intervention in alleged medicaid fraud cases. To assist State and Federal prosecution and to deter future fraud we are developing, for States to use on provider forms, a statement to the effect that unlawful use of the funds would be subject to State and Federal penalties. We are also acting to obtain

compliance from those States which have not yet established methods and procedures to safeguard against unnecessary utilization of health care and services.

In fiscal year 1968 six States referred providers of health services to law enforcement officials for alleged fraud. In many instances recovery of medicaid money was made and charges dropped. In some instances prosecution is still pending. Only four cases have been completed with the defendant sentenced.

We believe that use of the proposed language on vendor forms will both aid prosecution and tend to deter abuse.

Mr. FLOOD. We would like you, also, to comment on this problem now.

Secretary FINCH. First of all, we have asked for some additional audit personnel, but that is not enough. We have laid some further burdens on the intermediaries with respect to how they police the claims.

In particular, I can speak with some personal knowledge on the California situation.

We made the bad mistake in my opinion of moving too fast with what we developed back in 1966, what we called MediCal, even though we were not mandated to come through with a full priced-out program until 1975.

Mr. FLOOD. New York had a lot of trouble, did they not?

Secretary FINCH. They did not go as far as we did.

Mr. FLOOD. I thought it the other way around.

Secretary FINCH. No. When they saw the trouble we were getting into, they managed to roll back a little bit. Without getting into it fully, the point is that the program has been badly abused by certain doctors. There are certain people in any profession who will abuse these programs. It took us a while to structure our peer group in California so that they really moved in and operated. They have done a very good job, in my opinion. I know of decertifications where the peer group volunteers caught their colleagues abusing the program, abusing the "usual and customary" fee system.

One example of abuses that flow out of this is that too often these programs are hospital oriented and keep patients in the hospital for too long. We have built up the extended care facilities in California. They are cheaper, and could save a great deal of money if we can get the patients out of full hospital care and into more limited care.

In California we were giving some thought in terms of State laws. What we have to be concerned about is the extent to which these doctors are allowed to create proprietary hospitals and then to march by in the morning on the way to the main hospital and check the foot of each bed.

Mr. FLOOD. These are crooks, these are thieves, these are fakers, criminals; what are you going to do about it?

Secretary FINCH. In those cases?

Mr. FLOOD. Just say oops, sorry?

Secretary FINCH. No, sir.

In California, in cases where this sort of thing was uncovered, the offender was decertified.

Mr. FLOOD. What does that mean?

Secretary FINCH. It means they are no longer allowed to handle any of the recipients.

Mr. FLOOD. Now isn't that a shame. Is that all?

Secretary FINCH. It is up to each medical society whether they want to go any further than that. We cannot tell a professional group what to do beyond that.

Mr. KELLY. There are some cases in which the investigation has led to a conclusion that there was fraud against the Government. These cases are being referred to the Justice Department. There have been about 700 cases that have at least been initiated as fraud against the Government.

Mr. FLOOD. We can be assured that where there is fraud these fakers will be handled like any other criminal?

Mr. KELLY. It is difficult to say.

Mr. FLOOD. Sure. It is a tough problem, but for the Department of Justice. As far as you are concerned, you refer them and then it is up to Justice?

Mr. KELLY. Right.

Mr. FLOOD. We can be assured of that as far as you are concerned. Are we?

Secretary FINCH. I am sorry.

Mr. FLOOD. Are we assured referrals will be made to Justice as they are found?

Secretary FINCH. Yes, sir; and if we can get additional audit personnel maybe the referrals will be made faster.

Mr. FLOOD. This seems to be your day for bad problems. You asked for it, nobody put a gun at your head and said you have to be Secretary of HEW. Or am I wrong?

Secretary FINCH. No, sir; you are exactly right. I asked for it.

STUDENT DISORDERS

Mr. FLOOD. Another very grave national problem in your area of direct interest is the many serious disorders among the student bodies of our institutions of higher learning. What proposals do you have to make about that?

Secretary FINCH. As you know, there was a provision in the appropriation act last year. In my opinion it has not been adequately noted at many institutions. The provision says, in effect, that any student convicted of a misdemeanor or felony will have his grant automatically terminated. This provision has not had a chance to really operate too fully yet.

What we will do is notify all of the schools and require them to put this into their catalogs. Obviously the enforcement has to remain with the institution. And they handle the great majority of disbursals of these funds themselves.

We are now having the regional offices notify the institutions that the termination of grants will be made in those cases where there have been convictions.

The second area—under Amendments to the Higher Education Act—is where the institution itself, upon the violation of a campus regulation, can with due process, institute proceedings against a student. If they find that the student has violated the campus regulation and disrupted the educational process, they certify that to us, and they can terminate or we will terminate the grant to the individual student. We are asking, in material that is being prepared now, that the individual campuses advise us what due process procedures they have. We want to know if they are notifying the student that his grant is not a right but is conditional, and what other steps they are taking to police themselves.

It is a very sensitive problem and obviously a problem of major concern to the American taxpayer. But I think that what we need to do is to insure that the student is fully aware of the sanctions that accompany these grants. We will have to put the primary reliance on the local institution, the board of trustees, and the administration to carry this out.

Of course there is another aspect to this that is very sensitive, at least in California. There we have a master plan for higher education which says we take the top third of our students, our best high school students, for the State colleges and we take——

Mr. FLOOD. That sort of laid an egg, did it not?

Secretary FINCH. We take the top——

Mr. FLOOD. You did not hear what I said.

Secretary FINCH. I will respond to that in a moment.

Mr. FLOOD. You were not part of that?

Secretary FINCH. No, sir; this was before my time.

We take the top eighth and admit them to the University of California. As a result, most of them come from higher income families. So we find that it is not necessarily the needy ones who are seeking these grants, and who are on the barricades, but those who are from very affluent families.

So I think we should recognize that these new provisions of law may be helpful in some areas, but we cannot assume this is the panacea. We still have to look to the governing boards and administrations to really grapple with this problem.

Mr. FLOOD. Did you ever meet Father Hesburgh of Notre Dame?

Secretary FINCH. Yes, sir.

Mr. FLOOD. He served with me on the Board of Visitors for Annapolis. I was on it because I am on Defense Subcommittee on Appropriations. So I called him on the phone and asked him about it.

I have here Father Hesburg's statement of February 16, 1969, on this subject, addressed to "Dear Notre Dame Faculty and Students."

I will insert this at this point in the record.

(The letter follows:)

UNIVERSITY OF NOTRE DAME,
Notre Dame, Ind., February 17, 1969.

DEAR NOTRE DAME FACULTY AND STUDENTS: This letter has been on my mind for weeks. It is both time and overtime that it be written. I have outlined the core of it to the Student Life Council, have discussed the text with the chairman of the Board of Trustees, the Vice Presidents Council, all the deans of the university, and the chairmen of the Faculty Senate and the Student Life Council. This letter does not relate directly to what happened here last weekend, although those events made it seem even more necessary to get this letter written. I have tried to write calmly, in the wee hours of the morning, when at last there is quiet and pause for reflection.

My hope is that these ideas will have deep personal resonance in our own community, although the central problem they address exists everywhere in the university world today and, by instant communication, feeds upon itself. It is not enough to label it the alienation of youth from our society. God knows there is enough and more than enough in our often nonglorious civilization to be alienated from, be you young, middle-aged, or old.

The central problem to me is what we do about it and in what manner, if we are interested in healing rather than destroying our world. Youth, especially has much to offer—idealism, generosity, dedication, and service. The last thing a shaken society needs is more shaking. The last thing a noisy, turbulent, and disintegrating community needs is more noise, turbulence, and disintegration. Understanding and analysis of social ills cannot be conducted in a boiler factory.

Compassion has a quiet way of service. Complicated social mechanisms, out-of-joint, are not adjusted with sledge hammers.

The university cannot cure all our ills today, but it can make a valiant beginning by bringing all its intellectual and moral powers to bear upon them: all the idealism and generosity of its young people, all the wisdom and intelligence of its oldsters, all the expertise and competence of those who are in their middle years. But it must do all this as a university does, within its proper style and capability, no longer an ivory tower, but not the Red Cross, either.

Now to the heart of my message. You recall my letter of November 25, 1968. It was written after an incident, or happening, if you will. It seemed best to me at the time not to waste time in personal recriminations or heavy-handed discipline, but to profit from the occasion to invite this whole university community, especially its central councils of faculty, administration, and students, to declare themselves and to state their convictions regarding protests that were peaceful and those that threatened the life of the community by disrupting the normal operations of the university and infringing upon the rights of others.

I now have statements from the Academic Council, the Faculty Senate, the Student Life Council, some college councils, the Alumni Board, and a whole spate of letters from individual faculty members and a few students. Some of these are enclosed in this letter. In general, the reaction was practically unanimous that this community recognizes the validity of protest in our day—sometimes even the necessity—regarding the current burning issues of our society: war and peace, especially Vietnam; civil rights, especially of minority groups; the stance of the university vis-a-vis moral issues of great public concern; the operation of the university as university. There was also practical unanimity that the university could not continue to exist as an open society, dedicated to the discussion of all issues of importance, if protests were of such a nature that the normal operations of the university were in any way impeded, or if the rights of any member of this community were abrogated, peacefully or nonpeacefully. I believe that I now have a clear mandate from this university community to see that: (1) our lines of communication between all segments of the community are kept as open as possible, with all legitimate means of communicating dissent assured, expanded, and protected; (2) civility and rationality are maintained as the most reasonable means of dissent within the academic community; and (3) violation of other's rights or obstruction of the life of the university are outlawed as illegitimate means of dissent in this kind of open society. Violence was especially deplored as a violation of everything that the university community stands for.

Now comes my duty of stating, clearly and unequivocally, what happens if. I'll try to make it as simple as possible to avoid misunderstanding by anyone. May I begin by saying that all of this is hypothetical and I personally hope it never happens here at Notre Dame. But, if it does, anyone or any group that substitutes force for rational persuasion, be it violent or nonviolent, will be given 15 minutes of meditation to cease and desist. They will be told that they are, by their actions, going counter to the overwhelming conviction of this community as to what is proper here. If they do not within that time period cease and desist, they will be asked for their identity cards. Those who produce these will be suspended from this community as not understanding what this community is. Those who do not have or will not produce identity cards will be assumed not to be members of the community and will be charged with trepassing and disturbing the peace on private property and treated accordingly by the law. The judgment regarding the impeding of normal university operations or the violation of the rights of other members of the community will be made by the dean of students. Recourse for certification of this fact for students so accused is to the tripartite disciplinary board established by the Student Life Council. Faculty members have recourse to the procedures outlined in the faculty manual. Judgment of the matter will be delivered within 5 days following the fact, for justice deferred is justice denied to all concerned.

After notification of suspension, or trespass in the case of noncommunity members, if there is not then within 5 minutes a movement to cease and desist, students will be notified of expulsion from this community and the law will deal with them as nonstudents.

Lest there be any possible misunderstanding, it should be noted that law enforcement in this procedure is not directed at students. They receive academic sanctions in the second instance of recalcitrance and, only after three clear opportunities to remain in student status, if they still insist on resisting the will

of the community, are they then expelled and become nonstudents to be treated as other nonstudents, or outsiders.

There seems to be a current myth that university members are not responsible to the law, and that somehow the law is the enemy, particularly those whom society has constituted to uphold and enforce the law. I would like to insist here that all of us are responsible to the duly constituted laws of this university community and to all of the laws of the land. There is no other guarantee of civilization versus the jungle or mob rule, here or elsewhere.

If someone invades your home, do you dialog with him or call the law? Without the law, the university is a sitting duck for any small group from outside or inside that wishes to destroy it, to incapacitate it, to terrorize it at whim. The argument goes—or has gone—invoke the law and you lose the university community. My only response is that without the law you may well lose the university—and beyond that—the larger society that supports it and that is most deeply wounded when law is no longer respected, bringing an end of everyone's most cherished rights.

I have studied at some length the new politics of confrontation. The rhythm is simple: (1) find a cause, any cause, silly or not; (2) in the name of the cause, get a few determined people to abuse the rights and privileges of the community so as to force a confrontation at any cost of boorishness or incivility; (3) once this has occurred, justified or not, orderly or not, yell police brutality—if it does not happen, provoke it by foul language, physical abuse, whatever, and then count on a larger measure of sympathy from the up-to-now apathetic or passive members of the community. Then call for amnesty, the head of the president on a platter, the complete submission to any and all demands. One beleaguered president has said that these people want to be martyrs thrown to toothless lions. He added, "Who wants to dialog when they are going for the jugular vein?"

So it has gone, and it is generally well orchestrated. Again, my only question: must it be so? Must universities be subjected, willy-nilly, to such intimidation and victimization whatever their good will in the matter? Somewhere a stand must be made.

I only ask that when the stand is made necessary by those who would destroy the community and all its basic yearning for great and calm educational opportunity, let them carry the blame and the penalty. No one wants the forces of law on this or any other campus, but if some necessitate it, as a last and dismal alternative to anarchy and mob tyranny, let them shoulder the blame instead of receiving the sympathy of a community they would hold at bay. The only alternative I can imagine is turning the majority of the community loose on them, and then you have two mobs. I know of no one who would opt for this alternative—always lurking in the wings. We can have a thousand resolutions as to what kind of a society we want, but when lawlessness is afoot, and all authority is flouted, faculty, administration, and student, then we invoke the normal societal forces of law or we allow the university to die beneath our hapless and hopeless gaze. I have no intention of presiding over such a spectacle: too many people have given too much of themselves and their lives to this university to let this happen here. Without being melodramatic, if this conviction makes this my last will and testament to Notre Dame, so be it.

May I now say in all sincerity that I never want to see any student expelled from this community because, in many ways, this is always an educative failure. Even so, I must likewise be committed to the survival of the university community as one of man's best hopes in these troubled times. I know of no other way of insuring both ends than to say of every member of this community, faculty and students, that we are all ready and prepared and anxious to respond to every intellectual and moral concern in the world today, in every way proper to the university. At the same time, we cannot allow a small minority to impose their will on the majority who have spoken regarding the university's style of life; we cannot allow a few to substitute force of any kind for persuasion to accept their personal idea of what is right or proper. We only insist on the rights of all, minority and majority, the climate of civility and rationality, and preponderant moral abhorence of violence or inhuman forms of persuasion that violate our style of life and the nature of the university. It is, unfortunately, possible to cut oneself off from this community, even though the vast majority of our members would regret seeing it happen. However, should this occur, the community as a whole has indicated that it will vote and stand for the maintenance of this community's deepest

values, since this is the price we all pay for the survival of the university community in the face of anyone and everyone who would destroy or denature it today, for whatever purposes.

May I now confess that since last November I have been bombarded mightily by the hawks and the doves—almost equally. I have resisted both and continue to recognize the right to protest—through every legitimate channel—and to resist as well those who would unthinkingly trifle with the survival of the university as one of the few open societies left to mankind today. There is no divine assurance that the university will survive as we have known and cherished it—but we do commit ourselves to make the effort and count on this community, in this place, to uphold the efforts that you have inspired by your clear expression of community concern. Thanks to all who have declared themselves, even to those who have slightly disagreed, but are substantially concerned as well.

As long as the great majority of this community is concerned and involved in maintaining what it believes deeply to be its identity and commitment, no force within it, however, determined or organized, can really destroy it. If any community as a whole does not believe this, or is not committed to it, it does not deserve to survive and it probably will not. I hope we will. To this, I commit myself with the presumption that the great majority of you are with me in this concern and commitment.

I truly believe that we are about to witness a revulsion on the part of legislatures, State and National, benefactors, parents, alumni, and the general public for much that is happening in higher education today. If I read the signs of the times correctly, this may well lead to a suppression of the liberty and autonomy that are the lifeblood of a university community. It may well lead to a rebirth of fascism, unless we ourselves are ready to take a stand for what is right for us. History is not consoling in this regard. We rule ourselves or others rule us, in a way that destroys the university as we have known and loved it.

Devotedly yours in Notre Dame,

Rev. THEODORE M. HESBURGH, C.S.C.,
President.

The academic council at its meeting of November 26, 1968, endorsed the following statement:

"Peaceful protest is legitimate and in the view of some at times necessary; protest that infringes on the rights of other members of the community or obstructs the normal function of the university is cause for separating from the community those who indulge in such action."

Note: This statement was not released following the meeting so as not to prejudice the discussions yet to take place by the student life council and the faculty senate. The academic council reserves the right to discuss the matter further following the statements from the other bodies.

The student life council at its meeting of December 2, 1968, endorsed the following statement:

"We hold that without the corollary of an 'open listeners' policy, that is, without a guarantee that any member of the university community can exercise his right to hear or to consult with other members or authorized visitors to the campus, then the 'open speakers' policy of the university becomes a mockery. This realization means that when a portion of the community dissents with the views of other members, or authorized visitors, or dissents with the policies of the institutions which they represent, then this dissent must be expressed in a manner that does not abridge the freedom of those members or visitors to carry out their authorized activities on the campus. This principle demands in particular that dissenters refrain from sustained 'heckling' of a speaker, and that they refrain from actions which forcibly obstruct the authorized activity or render the conditions under which such activity can be carried out repugnant to common human sensibilities. To violate these limitations on the expression of dissent is to engage in totalitarian tactics which are alien to a university. We reiterate the provisions of the Notre Dame student manual which specify that such actions shall make the violator subject to disciplinary action as provided for in said manual, and we urge other segments of the university community to be equally frank in their disavowal of these violations of the free nature of the university community."

The faculty senate at its meeting of December 3, 1968, endorsed the following statement:

"Resolved, that the position of this university in the mainstream of our time and society provides certain occasions for a wide variety of persons to be present

on our campus for a multitude of purposes. It is entirely out of keeping with the position and purposes of the university for such persons to be impeded or forcibly interfered with in pursuing their lawful concerns. To participate in such obstructive tactics is a serious disciplinary offense. We recognize that there are appropriate provisions of the student manual pertaining to this matter, and we urge the vigorous implementation of these provisions through normal judicial procedures."

The engineering college council at its meeting of December 5, 1968, endorsed the following statement:

"Recognizing the danger to the university community posed by disruptive activity, we pledge our full support to President Father Hesburgh in whatever action he deems necessary to prevent or to deal with such activity including action to discipline promptly any member of the university community who may be involved in such activity either directly or by incitement."

The science college council, on December 9, 1968, authorized a subcommittee to draft a resolution which follows:

"Within an active academic community, there will be a difference of opinion on major issues that may be brought to its attention. The very nature of the community and the exercise of its functions demand that this be so.

"However, resort to violence, physical harassment, obstruction, or any action which infringes on the right of others, or impedes in any way the function of the university is never an acceptable tactic for expression of viewpoints. Such behavior is intolerable in an academic community."

At a special meeting on December 3, 1968, the faculty of the College of Business Administration passed unanimously the following resolution:

"There are apparently at least three significances to the CIA–Dow demonstrations, all of which are important to the life of the university community:

"1. The two-way freedom-street concept which you have recognized so well in your letter, and the tyranny that results when any group attempts to impose personal convictions on others;

2. The need for a community policy to prevent a recurrence of tyrannical action—one which incorporates penalties for students and/or faculty who involve themselves beyond the acceptable rights of peaceful protest."

Both (1) and (2) above have been spoken of well in your letter. We suggest that a third significance of last Wednesday's actions might be corrected promptly:

3. The need for an official apology to CIA (Dow probably needs none because the protest met was within the bounds of acceptability and respectability). Further, we feel that CIA should be extended an invitation to return soon to campus and be given a guarantee of safety to conduct interviews with interested students."

The faculty members of the law school have generally approved and are preparing a statement supporting the President's letter of November 25, 1968.

Excerpts of a letter received February 12, 1969, from Mr. Leonard Skoglund, president of the alumni board, regarding the board's discussion at their meeting of January 23, 1969:

"While most alumni concur with your philosophy that young people today be permitted, perhaps even encouraged to demonstrate their concern with the burning issues of our time, they cannot and will not support tactics which inhibit or disrupt the freedoms of others * * *. The board was chagrined to learn that some administrative personnel were (by their own admission) uncertain as to the measures to be taken in the face of disruptive tactics. Although uninvited, we responded to your appeal to the community for support in dealing with such activities in the future. We also understand that you have now secured the backing requested from the academic council, the faculty senate, and the student life council, and that the university now has in hand a firm policy regarding demonstrations, and responsive procedures in reaction to disruptive activities. We urge you to clearly publicize consequences which shall be faced by all who violate the established policy, and to prosecute to the limit any outsiders identified as participants. We feel that unless such measures and procedures are clearly defined and executed, the future of this university stands in jeopardy."

Mr. FLOOD. What do you think about that statement?

Secretary FINCH. I thought it was a very good statement.

HOWARD UNIVERSITY

Mr. FLOOD. What are you doing about these problems at Howard University? That is your pigeon.

Secretary FINCH. I have not yet been able to address myself to that problem directly. I am on the governing board. I believe.

Mr. KELLY. The Secretary is represented on the governing board, Mr. Chairman, but to use your phrase, I don't really think it is the Secretary's pigeon. We have tried very hard in connection with Howard University and Gallaudet College to recognize that they are private institutions of higher learning. They draw a significant portion of their support from the Federal Government in much the same way a State institution does at the Sate level.

Mr. FLOOD. Significant support is quite an understatement.

Mr. KELLY. It is support which corresponds in almost every way to the support which the State gives to a State institution. About two-thirds of the cost of education and research comes from Federal funds. The cost of auxiliary enterprises, and room and board is borne by the students.

Mr. FLOOD. Since the Federal Government is here in Washington and has this relationship with Howard University, should the Federal Government take the initiative in dealing with disorders there?

If so, what would it do?

Secretary FINCH. As I understand it—and again I simply have not had a chance with the other problems that I have had to get into that specific problem—the President of the United States is Chairman of the Board. I will talk to the President and see what he wants to do about it.

Mr. FLOOD. Will you let us know?

Secretary FINCH. Yes, sir.

Mr. FLOOD. A lot of people are asking about that.

Secretary FINCH. I know.

Mr. FLOOD. Howard University is right here on our doorstep.

Secretary FINCH. It has great visibility. This is, after all, the Federal City, and what tone is taken here cannot help but be reflected across the country.

MALNUTRITION

Mr. FLOOD. Secretary Cohen recommended that the Congress enact legislation declaring eradication of malnutrition to be a national responsibility and giving appropriate officials in the executive branch the authority and the responsibility to carry out this mandate.

Do you agree with that?

What is HEW doing now about that? What is the Department of Agriculture, the Office of Economic Opportunity, doing about that?

It is getting a lot of attention in the news media.

Secretary FINCH. We will give you a substantial statement on this.

Mr. FLOOD. Give us a paragraph now to see how you feeel about it.

Secretary FINCH. First of all, there is a great deal we don't know about malnutrition. Some people are getting plenty of food to eat, but perhaps not the right things to eat. The findings in this first preliminary report, from the surveys held in Texas, Louisiana, and Kentucky, were not so much the lack of food but rather that it was undernutrition. They were getting the wrong kinds of foods. That is why we expanded from this limited study to a national study. Another agency that has been working with this, Department of Agriculture, is to make sure that under the food stamp program there is a nutritional input. There

was not a nutritional balance before, and they have revised the components of the lunch programs and the other programs so that there is——

Mr. FLOOD. Plus free allocations?

Secretary FINCH. Yes, sir.

Mr. FLOOD. Do you need any new law? What new legislation, if any, is needed? What authority is lacking to enable you, the executive branch, to do a good job on this problem? Develop that later on.

Secretary FINCH. Yes.

(The information follows:)

MALNUTRITION AND HUNGER

The administration is currently examining the responses it might take to the problem of hunger and malnutrition in the United States. While this review is not yet complete, the Department of Health, Education, and Welfare is certain to be deeply involved in any actions to be taken.

Secretary Finch has already directed agencies of his Department to expand and accelerate their efforts to determine the causes and extent of malnutrition in this country. Specific actions directed by the Secretary include:

Expansion of the National Nutrition Survey to cover more States, improved analyses of data obtained, and followup on cases found to require immediate medical attention.

Procurement and evaluation of data on the relationships among malnutrition in the pregnant mother, malnutrition in the infant, prematurity, infant deaths, and mental retardation.

A departmentwide review to determine the most effective preventive and remedial actions in dealing with malnutrition and its consequences.

A review of responsibilities among the various agencies of Government, counterpart State agencies, and county agencies and officials to determine how the joint means of attacking the problem of hunger and malnutrition can be improved.

ABSORPTION OF OEO PROGRAMS

Mr. FLOOD. Speaking of OEO, we saw you when you were on Meet the Press recently. Mr. Spivak asked you, as he always asks, very pointedly, "Secretary Finch, everyone expects that there are going to be changes in HEW. Are there going to be any major changes?"

You replied, "Well, just having to absorb probably many of the programs that are in OEO will require structural changes." Aside from Headstart, what OEO programs do you have in mind as structural changes? You are learning the language fast.

Secretary FINCH. The other ones that have been discussed range from legal services, which I think would be a ghastly error, to Upward Bound, Follow Through, Neighborhood Health Centers, and Community Action programs. I want to make it clear at this point that——

Mr. FLOOD. We will take a short recess to answer that rollcall.

(A short recess was taken.)

Mr. FLOOD. Did you complete your answer?

Secretary FINCH. I think so.

I should add that under the President's declaration with respect to lodging the Job Corps with Labor, and Headstart with HEW, he made a very precise indication that there should be evaluation programs down the line, including the ones that I mentioned. It is not yet completely settled as to what might be delegated to HEW. There will be an ongoing study by the Urban Council.

PROVISIONS OF LEGAL SERVICES TO WELFARE CLIENTS

Mr. FLOOD. I have before me, Mr. Secretary, a letter addressed to the chairman of the full committee, Mr. Mahon, by the distinguished lady from Oregon, Mrs. Green. This deals with regulations requiring State welfare agencies to provide clients with legal services, if such clients request them.

Also it deals with the challenges which might be made to decisions, and Mr. Cohen referred to this, pointing out when the agency is required to provide legal services. I will put the letter into the record and ask you to respond to it.

Secretary FINCH. This is a very complicated subject.

(The information follows:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., March 6, 1969.

Hon. GEORGE H. MAHON,
Chairman, Appropriations Committee,
Rayburn Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: Enclosed is a copy of a letter from Andrew F. Juras, administrator of the Oregon State Public Welfare Commission.

It seems to me that in this letter Mr. Juras makes a very valid point in regard to the regulations sent out by Secretary Cohen 2 days before the new administration took office. Mr. Juras refers to the regulation which states that the State welfare agency must provide a welfare client with legal services if such client requests it. The second regulation referred to is the requirement that the welfare agency must continue the payments for a period of 60 days if the client requests a hearing on the decision. Mr. Juras states (and I think rightfully so) that any recipient whose grant is reduced or closed would be encouraged to challenge the decision and ask for a hearing and thus be assured of the continuation of his grant for at least 2 more months. He also points out that when the agency is required to provide legal services the results would be to convert each administrative hearing into an adversary proceeding. He also points out that these two requirements would cost the State a great deal of money at a time when the State desperately needs it to increase the standards of assistance to all recipients.

Would you please advise me if you think that this was the congressional intent when this law was passed by the Congress.

Sincerely,

EDITH GREEN.

STATE PUBLIC WELFARE COMMISSION,
Salem, Oreg., January 6, 1969.

Miss MARY SWITZER,
Administrator, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D.C.

DEAR MISS SWITZER: I want to express the strong protest of our agency against both of the proposed requirements filed in the Federal Register regarding fair hearings in public welfare.

The requirement that assistance be continued in certain cases to persons who have requested a hearing until a final decision is made on their hearing is so unclear that its effect is difficult to estimate. The limiting phrases used to describe the types of hearings affected are "involving an issue of fact, or of judgment relating to the individual case."

If a claimant has only to dispute the facts on which a grant reduction or closing is based in order to receive 60 days' additional assistance, then every recipient whose grant is reduced or closed will be well advised to request a hearing and assure continuation of his grant for 2 more months. We agree that there are circumstances where it is appropriate not to reduce or terminate a grant until the hearing issue has been decided. We have continued assistance in a number of such cases over the past 10 years in the absence of any Federal requirement to do so. We believe, however, that the proposed wording which

defines the types of situations covered is so loose that it will fail to limit the instances. If so, the result would be to increase greatly the number of hearings requested, the administrative cost of conducting them, and the assistance expenditures on these cases.

We protest the requirement that the agency provide for legal representation in the hearing of any claimant who requests it, for several reasons. First, I have strong conviction that recipients will be the losers in the long run by converting administrative hearings into an adversary proceeding. I expressed an opinion on this subject quite fully to you at the meeting of State administrators last July. If claimants generally are represented by attorneys, then the agency must be, also. Hearings will then become a battle of wits in which legal technicalities will assume more importance than justice for the claimant. We are proud of the fact that now a claimant can simply, and often eloquently, state his complaint in a hearing without concern for rules of evidence or other formalities and often receive a favorable decision. We also protest the cost of having to purchase this legal service for recipients when we do not have sufficient funds even to provide an adequate food allowance. We further object to your provision that we may pay legal aid staffs to represent claimants in the hearing process. They have been providing this service free but surely will begin to charge when your Department makes such an offer.

Both of these requirements, if put into effect as proposed, would cost the State of Oregon a good deal of money. This is money our staff begrudges at a time when we desperately need it to provide increased standards of assistance for all recipients. Our 1969 legislature will be hard pressed to fund our program adequately without increased costs represented by these very debatable changes.

Sincerely yours,

ANDREW F. JURAS, *Administrator.*

DEPARTMENT'S COMMENTS ON MRS. GREEN'S LETTER

The regulation requires that the State's plans must provide that the services of lawyers will be made available to welfare applicants and recipients who desire them in fair hearings. The States are not required to pay to the extent that adequate services are available without cost to the State agency.

The State's plans must also provide that if a fair hearing is requested because of termination or reduction of assistance, the payments must be continued during the period of appeal through the end of the month in which the hearing decision is made.

The effective date that these provisions must be a part of the State plans is October 1, 1969. This regulation is presently being reviewed and reevaluated.

USE OF FEDERAL FUNDS TO SUBSTITUTE FOR STATE FUNDS

Mr. FLOOD. I have also before me a letter from Mr. Allen Short, of the sixth senatorial district, Sacramento, San Joaquin County, in California. This deals with the use of Federal funds by State governments to substitute for State funds. I am sure that, under the circumstances, you would like to see this and reply to this.

Secretary FINCH. Yes, sir. I used to preside over that body, but since Mr. Veneman had Senator Short as his senator we will let him prepare the response.

(The information follows:)

CALIFORNIA LEGISLATURE, SENATE,
December 11, 1968.

DR. SHERMAN KIEFFER,
Associate Director, National Institute for Mental Health, Chevy Chase, Md.

DEAR DR. KIEFFER: This will confirm my conversation with you on my recent visit to Washington. I am sorry we were not able to get together personally to go over this, as I feel that it is most important that some Federal action be

taken. As I indicated to you, the department of mental hygiene budget for the mentally ill has increased from $98,700,000 in the 1963–64 fiscal year to an estimated $114,225,000 in the 1968–69 fiscal year. Federal subventions, including social security, medicare, and so forth, have increased from $15,500,000 in the 1963–64 fiscal year to $44,100,000 in the 1968–69 fiscal year. During this 5-year period the subventions have actually resulted in a reduction in the State mental health budget. Five years ago the subventions represented a little more than 15 percent of the total budget and now they represent close to 35 percent of the budget.

Despite this large infusion of Federal funds, the care and treatment of the mentally ill has not improved. As a matter of fact, a recent survey by the California Medical Association of our State mental hospitals keeps referring to the term "custodial care" and mentions staff shortages in each of the State hospitals.

I was astounded to learn that Federal aid is being provided for the patients in our State hospitals with no apparent guidelines for proper care and treatment. The Federal funds are simpy deposited in the State general fund and are actually being used to reduce the State's participation in the care of the mentally ill. In one State hospital, the CMA report mentioned that only emergency dental care was provided. This meant extractions, no maintenance or preventive care. The California Commission on Staffing Standards in our State mental hospitals reported an overall 35-percent staff deficiency. Had there been Federal guidelines tied to the funds provided by the Government, I am sure there would have been no staff reductions and the treatment programs would have been such to provide much beter care and treatment than is in evidence now.

I am enclosing for your information a copy of the CMA report as well as a copy of the staffing standards report. This certainly should give your agency food for thought. Certainly consideration must be given to insuring that any Federal funds provided must insure the highest type care in keeping with good medical practice.

Cordially yours,

ALAN SHORT.

RESPONSE TO LETTER FROM SENATOR ALAN SHORT OF THE CALIFORNIA STATE SENATE

Senator Short's letter raises two specific problems:

1. The large-scale infusion of Federal funds through the medicare and medicaid programs has not been accompanied by guidelines for the proper care and treatment of the mentally ill.
2. Federal funds appear to be replacing instead of supplementing State efforts to care for the mentally ill in California.

The Social Security Administration, in its medicare program, does have requirements for the maintenance of a certain standard of care. The conditions of participation for psychiatric hospitals contain special sections to provide assurance that the program will pay only for active treatment rendered to medicare beneficiaries. The conditions require that in order for a psychiatric institution to participate, it must be accredited by the Joint Commission on Accreditation of Hospitals (or a distinct part of a nonaccredited hospital must meet equivalent standards), that its clinical records be sufficient so that a determination can be made of the degree and intensity of treatment furnished to beneficiaries, and that it have sufficient staff for carrying out an active treatment program.

The State health departments are required to make biannual inspections of all accredited psychiatric hospitals participating in the medicare program. If the hospitals have insufficient staff or if the medical records do not reflect active treatment, the health department will arrange that such conditions be remedied. The Social Security Administration's Division of State Operations carries out random sample program reviews to determine whether the States and the institutions are complying with the Federal regulations. These surveys are conducted by medical personnel.

The requirements on clinical records stress the psychiatric components of the record, including history of findings and treatment rendered for the psychiatric

condition for which the patient is hospitalized. The special staff requirements are designed to assure that the hospital staff is adequate in number and qualifications to carry out an active program of treatment for individuals furnished services in the institution.

In a similar vein, the legislation for medicaid which made it possible to make public assistance payments for patients in mental hospitals (Public Law 89-97 sec. 1902) describes a number of conditions as requirements for this program.

All State mental hospitals in California are accredited by the Joint Commission on Accreditation of Hospitals, and are certified to participate in medicare. As a result, these institutions also meet the requirements for participation in the medicaid program.

A State implementing the provisions for the aged mentally ill under the medical assistance program (medicaid) must meet the following Federal requirements regarding proper care and treatment of recipient patients.

Provisions to assure a plan of treatment and care that serves the best interest of each individual patient; that is, maintains the patient at, or restores him to, the greatest possible degree of health and independent functioning, including:

(1) Initial and periodic review of his medical, psychiatric, and social needs;

(2) Appropriate medical treatment by the institution;

(3) Periodic joint determination of his need for continued treatment in the institution, and for alternate care arrangements; and

(4) Provision of social services.

To assure that the Federal requirements are being met all States are required by the State plans to establish review procedures for assuring that Federal regulations are being complied with. The regional office staff of the Social and Rehabilitation Service makes periodic visits to all States to determine that these State reviews are satisfactory. These visits often include examinations of the conditions of State mental hospitals.

Turning to the second issue, the medicare provisions of the Social Security Act do not establish any legal basis for maintenance of fiscal effort. Reimbursement is made to providers for reasonable costs of care. California is one of the States that has done an exemplary job of revising its fiscal records and cost accounting systems in order to satisfy medicare requirements by determining actual costs of care. Funds received by the State as medicare payments can be used in any way the State plans. In some States, all funds received for reimbursement go to the general treasury but may later be reappropriated for program purposes. If a State hospital does not have adequate funds to maintain quality care, it may lose certification as a provider of service under the medicare program. Experience indicates that hospitals usually need additional clinical and administrative staff in order to meet the requirements of medicare.

Under medicaid, the State of California receives 50-percent Federal matching for payment of the "reasonable" cost of care provided to aged individuals in mental institutions. Medicaid reimbursements, or vendor payments, go either to the agency providing the service or to the general fund, depending on State law. Some States have been able to work out arrangements whereby the additional funds are made available for staff in the mental hospitals or for additional community mental health staff. Data available to the Department of Health, Education, and Welfare indicates that the maintenance of State effort is being met by the State of California.

In considering possible amendments to the 1970 budget, the Department has given serious consideration to the issues raised by Senator Short as they relate to the medicaid program.

(Short recess taken.)

SOCIAL REPORT

Mr. FLOOD. This you can answer later.

Another of Secretary Cohen's recommendations before he left office, "I strongly recommend the continued allocation of staff resources in the executive branch to prepare a comprehensive social report to the Nation with emphasis on the development of social indicators which will measure social change and be useful in establishing social goals."

What do you think about this?

(The information follows:)

STATEMENT FROM THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

I have not had an opportunity to examine in detail the question of the development of social indicators and the preparation of a comprehensive social report. I am familiar with what the Department of Health, Education, and Welfare has done. I believe that it was a useful effort and it clearly revealed the complexity of the problem. It showed also that the scope of the problem is far beyond the fields of health, education, and welfare. For this reason I want to discuss the question with others in the administration before I reach a position on this matter.

Mr. FLOOD. What would be the mechanics of preparing such a report? Who would do it? How would they do it? How long would it take? How much would it cost?

Secretary FINCH. Yes, sir.

(The information follows:)

STATEMENT FROM THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

If a decision were made to prepare a comprehensive social report, it could be done in several ways. I think perhaps the two best alternatives would be (1) establish a Commission in the Executive Office of the President or (2) assign the job to one of the departments with assistance from all other agencies of the Government. Based on previous HEW experience we estimate it would require 2 years of effort on the part of a staff of 20 to 25 professionals with extensive support by consultants.

ADVISORY COMMITTEES

Mr. FLOOD. Since you have been in office, have you found how many advisory groups, such as committees and councils and study sections, et cetera, et cetera, are set up to advise and assist the Department in connection with its many programs? Would you have prepared for the record a list of all such groups that you have?

Secretary FINCH. Yes, sir.

Mr. FLOOD. Plus those new ones proposed in the budget, with just a sentence or two, to describe the function of each and indicate the number of people serving on each and the estimated amount that each such group will cost the Department in 1969 and 1970.

(The information follows:)

April 29, 1969

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Agency Summary	FY 1969 Number of Groups	FY 1969 Gross Membership *	FY 1969 Cost	FY 1970 Number of Groups	FY 1970 Gross Membership*	FY 1970 Cost
Consumer Protection and Environmental Health Service....	48	499	$551,866	60	618	$662,966
Health Services and Mental Health Administration.....	69	935	1,340,570	72	960	1,355,210
National Institutes of Health.....	196	2,188	3,838,937	202	2,252	3,688,059
Subtotal, health agencies.....	313	3,622	5,731,373	334	3,830	5,706,235
Office of Education.....	21	274	363,000	23	323	652,900
Social and Rehabilitation Service.	40	1,227	335,082	41	1,225	479,792
Social Security Administration....	5	78	157,835	5	78	196,560
Office of the Secretary.....	7	107	506,000	4	58	190,000
Total, Department of Health, Education, and Welfare.....	386	5,308	7,093,290	407	5,514	7,225,487

* Some individuals serve on more than one group.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Food and Drug Control				
Anti-infective Agents Advisory Committee	Advises on the efficacy and safety of drugs employed in the field of infectious diseases, and informs of the advances, changing concepts, and trends in the therapy of infectious diseases.	9	$ 5,480	$ 5,480
Biometric and Epidemiological Methodology Advisory Committee	Advises on extramural and intramural research in the area of epidemiological and biometric methodology.	8	7,200	7,200
Cardiovascular and Renal Disorders Advisory Committee	Advises on the safety and efficacy of drugs employed in the field of cardiovascular and renal disorders and informs of current advances, changing concepts, and trends in the field of cardiovascular and renal disorders.	9	5,480	5,480
Dental Advisory Committee	Advises on the efficacy and safety of drugs employed in the field of dentistry and informs of current advances, changing concepts, and trends in the field of dentistry.	9	5,480	5,480

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Food and Drug Control (cont.)				
Dermatology Advisory Committee	Advises on the efficacy and safety of drugs employed in the field of dermatology and informs of the current advances, changing concepts, and trends in the field of dermatology.	6	$ 5,480	$ 5,480
Drug Experience Advisory	Advises on the methods, results, and import of the collection and dissemination of adverse drug experience within and outside the Bureau of Medicine, FDA, and informs of the current advances, and trends in the general area of drug experience.	11	5,480	5,480
Drug Nomenclature Advisory Committee	Advises on the selection of simple and useful official names for drugs meeting the criteria of the 1962 Drug Amendments.	3	1,500	1,500
Endocrinology and Metabolism Advisory Committee	Advises on the efficacy and safety of drugs employed in the field of endocrine and metabolic disorders and informs of current advances, changing concepts, and trends in the field of endocrine and metabolic disorders.	9	5,480	5,480

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Food and Drug Control (cont.)				
Food Standards Committee	Provides advice in areas where the development of food standards would aid State and Federal regulatory officials in administering their consumer protection programs; advises on the specific need for new standards and/or amendments; advises on published proposals to establish food standards regulations; and provides liaison between FDA and State regulatory officials on matters pertaining to food standards.	7	$ 7,164	$ 7,164
Hematology Advisory Committee	Advises and furnishes expert medical advice and recommendations on the safety and efficacy of drugs used in fields of hematology and related fields, and advises on trends and the development of new protocols.	4	4,500	4,500
Medical Advisory Board	Advises on the policies, methods, and procedures for executing responsibilities of the Food and Drug Administration as they relate to safety and efficacy of drugs and safety of therapeutic devices; recommends and makes suggestions on the development of new programs and changes in existing programs in medicine giving attention to the total program.	8	10,314	10,314

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Food and Drug Control (cont.)				
National Advisory Food and Drug Council	Advises on the attitudes, interests, and values existing in groups such as consumers, industry, general public and the scientific community; trends concerning advances and development of new products, recommends and makes suggestions on existing and new programs.	17	$ 15,228	$ 15,228
Neuropharmacology Advisory Committee	Advises on the safety and efficacy of drugs employed in the field of neuropharmacology and related fields, and informs of the current advances, changing concepts, and trends in this field.	9	5,480	5,480
Obstetrics and Gynecology Advisory Committee	Advises on the trends in advances in obstetrics, gynecology, and related medical specialities; development of new protocols and changes in existing protocols; advises and makes recommendations relative to the safety and efficacy of specific drugs, etc., in the practice of obstetrics and gynecology.	14	10,820	10,820
Oncology Advisory Committee	Advises on the efficacy and safety of drugs used in the field of oncology and informs of the current advances, changing concepts, and trends in the field of oncology.	9	5,480	5,480

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Food and Drug Control (cont.)				
Ophthalmology and Otorhinolaryngology Advisory Committee	Advises on the efficacy and safety of drugs used in the practice of ophthalmology and otorhinolaryngology and advises on the current advances, changing concepts, and trends in these fields.	9	$ 5,480	$ 5,480
Protocols for Safety Evaluation Advisory Committee	Reviews protocols now used in making safety evaluations for pesticide residues, food additives, antibiotics, new drugs, and investigational new drugs. Advises in the development of new protocols and changes in existing protocols utilizing safety evaluations in the support of changes.	12	33,540	33,540
Joint FDA-PHS Psychotomimetic Agents Advisory Committee	Recommends action to be taken on notices of claimed investigational exemption for new drugs involving psychotomimetic agents, and the eligibility of sponsors and validity of projects for their investigation. Assists in developing guidelines for studies justified on the basis of evaluation of the present knowledge of LSD and agents.	10	9,800	9,800

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Food and Drug Control (cont.)				
Radioactive Pharmaceuticals Advisory Committee	Advises on the efficacy and safety of radioactive pharmaceuticals and informs of the current advances, changing concepts, and trends in the field of radioactive pharmaceuticals.	9	$ 5,480	$ 5,480
Research in the Biological and Physical Sciences	Advises on the trends and advances in biological and physical sciences that relate to foods, drugs, and cosmetics; attitudes, interests, concerns, and values extant in the scientific community.	8	12,180	12,180
Respiratory and Anesthetic Drugs Advisory Committee	Advises on the safety and efficacy of drugs employed in the field of anesthesiology and related areas.	9	7,160	7,160
National Advisory Food and Drug Council	Advises and consults on national policies, programs, and planning; to review applications for grants-in-aid relating to research and training projects and recommends approval of those projects which merit support.	12	--	10,000
Safety of Pesticide Residures in Foods Advisory Committee	Reviews the proposal to establish tolerances for DDT, DDD, and DDE in milk and dairy products and advises on the adequacy of the supporting scientific data to support the positions taken; reviews questions involving pesticide residues in foods and advises on steps to protect the public health.	10	14,940	14,940

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Food and Drug Control (cont.)				
U.S. Board of Tea Experts	Prepares and submits to the Secretary, DHEW, standard samples of tea. Advises on standards of quality, purity, and fitness of tea for consumption.	7	$ 700	$ 700
Teratogenic Effect of Certain Drugs Advisory Committee	Advises on the policies, methods, and procedures for carrying out the statutory mission of the FDA in assuring consumers of safe and efficacious drugs such as meclizine, cyclizine, and related groups.	8	9,360	9,360
Veterinary Medicine Advisory Committee	Advises on the policies, methods, and procedures for executing responsibilities of FDA as related to the safety and efficacy of drugs used in veterinary practice and safety, cleanliness, and integrity of animal foods. Recommends and suggests on the development of new programs and changes in existing programs relative to veterinary medicine and animal nutrition and various aspects of total program.	7	10,260	10,260

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE (cont.)				
Air Pollution Control				
President's Air Quality Advisory Board	The Board advises and consults on policy relating to the activities and functions of the Secretary under the Air Quality Act of 1967 and makes recommendations as it deems necessary to the President.	15	$ 15,000	$ 15,000
National Air Quality Criteria Advisory Committee	Reviews air quality criteria on specific pollutants; recommends to the Secretary the publication of criteria documents including the preparation and revision of a basic document on air quality criteria.	15	27,000	27,000
National Air Pollution Manpower Development Advisory Committee	Reviews air pollution training grant and fellowship applications, training contract proposals; advises on the status of air pollution training to determine areas and institutions in which air pollution training should be initiated, expanded, or curtailed.	12	40,000	40,000
National Fuel Additives Advisory Committee	Reviews technical aspects of fuel additives and their registration, recommends policies for registration and consideration of fuel additives.	9	5,000	5,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Air Pollution Control (cont.)				
National Air Pollution Control Agency Development Advisory Committee	Reviews and advises the Secretary on policies and procedures relating to grants for the planning, developing, establishing, improving, or maintaining regional air quality control programs.	7	$ 5,000	$ 5,000
Air Pollution Research Grants Advisory Committee	This is the initial review group responsible for scientific and technical review and recommendations as to merit of air pollution research and development grant applications, contract proposals. Advises on status of air pollution research and development to determine where research and development should be initiated, expanded, or curtailed.	15	33,000	33,000
National Air Pollution Control Techniques Advisory Committee	Reviews air quality control techniques and recommends to the Secretary as to the publication of air quality control documents including data on the latest technology and economic feasibility of alternative methods of prevention and control of air contamination including cost-effectiveness analyses.	12	14,000	14,000
Air Pollution Chemistry and Physics Advisory Committee	Advises on chemical, physical, and instrumental research and development activities directed toward the improvement of air quality.	10	—	4,500

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Air Pollution Control (cont.)				
Meteorology Advisory Committee	Advises on research and development activities in air pollution meteorology.	10	$ --	$ 4,500
Motor Vehicle Research and Development Advisory Committee	Advises on national research and development activities in the control of air pollutants from all vehicular sources; i.e., on-road vehicles, off-road vehicles, aircraft, railroad, and ship.	7	--	3,450
Organic Solvents Advisory Committee	Advises on amounts and types of solvents used nationally and regionally; general techniques for assessing organic solvent contributions to air pollution in an area; research underway and additional studies needed and advisability and feasibility of national criteria for solvent use and regulation as a guide to control agencies and industry.	10	--	4,500
Air Pollution Process Control Engineering Advisory Committee	Advises on engineering research and development activities directed toward the control of air pollutants from stationary sources (i.e., industrial, commercial, and domestic processes).	15	--	10,000
Air Pollution Economic Advisory Committee	Assists in the development and implementation of economic models for the study of impact of alternate air pollution control methods both technical and social.	12	--	12,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Air Pollution Control (cont.)				
National Air Pollution Research and Development Advisory Committee	Reviews and advises on the allocation of research and development resources and provides final review of research grant applications and recommends support.	15	$ --	$ 15,000
Pulp Industry Liaison Committee	Reviews the scope of the systems engineering study of the air pollution problems relating to pulp industry; provide data inputs from industrial sources; participates in periodic contrat progress reviews, and evaluates the final study report.	12	3,000	3,000
Iron and Steel Industry Liaison Committee	Reviews the scope of systems engineering study of air pollution problems relating to iron and steel industry; provides data inputs from industrial sources; participates in periodic contract progress reviews; and evaluates the final study.	11	10,000	10,000
Primary Smelter Industry Liaison Committee	Reviews the scope of systems engineering study of air pollution problems relating to the primary smelter industry.	15	10,000	10,000
Incinerator Industrial Liaison Committee	To develop guides to good practice for federal facilities.	4	--	2,400

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Air Pollution Control (cont.)				
Lead Liaison Committee	To exchange information on the progress being made in lead research to assist in special problems that may arise.	6	$ --	$ 3,100
Coal Liaison Advisory Committee	Reviews, recommends, and provides guidelines for the development of a project concerned with reduction of sulphur.	7	--	3,450
Bio-Medical Effects Advisory Committee	Members will review and provide advice on in-house and contract research projects and proposals, and provide technical and administrative consultation.	4	--	2,400
Environmental Control				
National Advisory Urban and Industrial Health Council	Advises on pertinent programs necessary to meet major problems and responsibilities. Reviews research and training grant applications and recommends approval of projects which merit support.	12	15,500	--
Injury Control Advisory Committee	Advises and consults with Administrator, CPE, regarding development and operation of the Injury Control Program.	15	7,800	7,800

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Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Environmental Control (cont.)				
Occupational Health Advisory Committee	Makes recommendations to the Administrator on policies, objectives, and needs in occupational health field.	13	$ 2,500	$ 2,500
Engineering and Urban Health Sciences Study Section	Reviews grant applications and makes recommendations to National Advisory Council.	16	30,000	30,000
Environmental Biology and Chemistry Study Section	Reviews grant applications and makes recommendations to National Advisory Council.	14	30,000	30,000
Safety and Occupational Health Study Section	Reviews grant applications and makes recommendations to National Advisory Council.	12	25,000	25,000
National Advisory Radiological Health	Advises and consults on national policies, programs and planning; reviews applications for grants-in-aid relating to research and training projects and recommends approval of those projects which merit support.	12	12,700	--
X-Ray Image Production and related Facilities Advisory Committee	Advises and consults in formulation of policy in development and improvement of physical qualities of existing medical x-ray units, as well as the techniques and judgment with which these units are used.	12	8,000	8,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Environmental Control (cont.)				
Radiological Health Sciences Training Advisory Committee	Provides advice concerning grant support for training radiation health specialists, technicians, and others specialized personnel in the field of radiological health. Recommends grants that merit support. Advises on overall training and manpower development program.	8	$ 11,900	$ 11,900
Radiological Health Study Section	Reviews research grant applications pertaining to individual and public health effect of radiation on humans as a result of exposure to environmental radio-activity, including discharges from nuclear facilities, medical and dental x-rays, etc. Recommends grants that merit support.	12	20,000	20,000
Environmental Radiation Exposure Advisory Committee	Advises on the formulation of policy in development of improving national programs of radiological surveillance. Provides guidance to assist staff in development of programs needed to estimate public exposure from environmental radioactivity.	10	8,000	8,000
Radiation Bio-Effects and Epidemiology Advisory Committee	Advises and consults on the total research program concerned with laboratory and epidemiology effects of radiation.	12	5,000	5,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE				
Environmental Control (cont.)				
Collaborative Radiological Health Laboratory Advisory Committee	Reviews research plans and progress and makes recommendations concerning scientific merit and priorities in specific work areas of research in the Collaborative Radiological Health Laboratory and provides advice to staff members as appropriate.	7	$ 4,000	$ 4,000
Technical Electronic Product Radiation Safety Standards Committee	To advise and recommend on electronic product radiation safety standards as required by Public Law 90-602, Radiation Control for Health and Safety Act of 1968.	15	--	34,000
Nuclear Radiology Advisory Committee	Advises in the formulation of policy for development of coordinated approach to improve materials, techniques, and facilities in medical applications of radioactive materials, including the practice of nuclear radiology.	8	--	--
X-Ray Image Analysis and Systems Development Advisory Committee	Advises on the research and development program and the application of results in interpreting x-ray images (including the use of computers) for analysis, as well as related storage and retrieval problems.	12	--	--
National Advisory Environmental Control Council	Advises and consults on national policies, programs, and planning; reviews applications for grants-in-aid relating to research and training projects and recommends approval of those projects which merit support.	16	--	30,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health				
National Advisory Mental Health Council	Reviews applications for grants-in-aid relating to research, training, and instruction in the field of psychiatric disorders, and recommends to the Administrator, Health Services and Mental Health Administration, approval of those projects which merit support. Collects information as to studies being carried on in the United States and abroad relating to psychiatric disorders and makes such information available to interested individuals and organizations. Makes recommendations to the Administrator, Health Services and Mental Health Administration, with respect to the acceptance of conditional gifts pursuant to section 501 of the Public Health Service Act.	12	$ 15,000	$ 15,000
Citizens Advisory Committee to the National Center for Mental Health Services, Training and Research	Advises the Director, National Institute of Mental Health, on mental health services and programs within the Center for Area D, and for the District of Columbia; assists in the development of new programs as well as in the assessment of existing efforts.	15	1,000	3,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Psychotomimetic Agents Joint FDA-NIMH Advisory Committee	Recommends to the Commissioner, Food and Drug Administration, action to be taken on motices of claimed investigational exemption for new drugs involving "mind" affecting agents, such as LSD and the eligibility of sponsors and validity of projects for their investigations. Recommends to the Director of National Institute of Mental Health, action to be taken on requests for supplies of these agents. Develops guidelines as to studies that may be justified on the basis of a thorough evaluation of the state of present knowledge of LSD and similar agents.	11	$ 10,000	$ 10,000
Board of Scientific Counselors	Advises the National Institute of Mental Health on matters of general policy, as they relate to the Mental Health Intramural Research Program.	6	4,000	4,000
National Institute of Mental Health Communications Advisory Committee	Advises and makes recommendations to the Director, National Institute of Mental Health, on matters of general policy concerning the fields of mental health scientific and public information, communications, and public health education.	15	2,000	2,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Clinical Program-Project Research Review Committee	Reviews grant applications for support of mental health clinical research centers and interrelated multidisciplinary projects with a common focus. Makes recommendations to the Division of Extramural Research Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	10	$ 20,000	$ 20,000
Clinical Projects Research Review Committee	Reviews applications for research grants involving the causation of mental illness, diagnosis and treatment (except by drugs). Makes recommendations to the Division of Extramural Research Programs, National Institute of Mental Health, and the NAtional Advisory Mental Health Council.	15	25,000	25,000
Clinical Psycho-pharmacology Research Review Committee	Reviews research grant applications in the area of clinical drug evaluation, collaborative studies comparing treatments and special studies designed to improve research methodology or to gain clinical research information. Makes recommendations to the Division of Extramural Research Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	20,000	20,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Epidemiologic Studies Review Committee	Reviews all grant applications in the area of psychiatric epidemiology, including those concerned with basic and applied research, demonstrations, training fellowships, and conferences. Makes recommendations on applications to the Division of Extramural Research Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	$ 20,000	$ 20,000
Experimental Psychology Research Review Committee	Reviews applications for research grants in experimental, comparative, and physiological psychology. Makes recommendations on grant applications to the Division of Extramural Research Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	20,000	20,000
Juvenile Problems Research Review Committee	Reviews applications for applied research grants in such project areas as children and youth problems, school and college mental health. Makes recommendations to the Division of Extramural Research Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	20,000	20,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Mental Health Extramural Research Advisory Committee	Advises the Division of Extramural Research Programs on the status and future needs of the research field in clinical, applied, behavioral sciences and psychopharmacological research.	16	$ 6,000	$ 6,000
Mental Health Services Research Review Committee	Reviews applications for applied research grants in project areas such as staff services, treatment programs, mental health facilities, and mental health services to special populations. Makes recommendations on applications to the Division of Extramural Research Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	20,000	20,000
Mental Health Small Grant Committee	Reviews applications for research grants limited to one year and to a maximum of $5,000 for direct costs, and makes recommendations on these applications to the Division of Extramural Research Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	25,000	25,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Neuropsychology Research Review Committee	Reviews applications for research grants in the field of brain and behavior and related problems in psychophysiology (relation of behavior to the central nervous system). Makes recommendations to the Division of Extramural Research Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	$ 20,000	$ 20,000
Personality and Cognition Research Review Committee	Reviews applications for research grants in the areas of personality, human motivations, and cognitive processes. Makes recommendations to the Division of Extramural Research Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	20,000	20,000
Preclinical Psychopharmacology Research Review Committee	Reviews applications for research grants in areas including the synthesis of potential new drugs, biochemical and neurophysiological, and animal behavioral studies of the mechanisms of action of behavior affecting drugs as well as proposals relevant to the development of better drug screening methods and to understanding the side effects and toxic effects of these drugs. Makes recommendations on grant applications to the Division of Extramural Research Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	25,000	25,000

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Social Problems Research Review Committee	Reviews applications for applied research grants for studies, dealing with mental health aspects of social problems, social systems, administration of mental health services, mental retardation, and aging. Makes recommendations to the Division of Extramural Research Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	$ 20,000	$ 20,000
Social Sciences Research Review Committee	Reviews applications for research grants in the social sciences areas relevant to mental health, including sociological, anthropological, and social psychological research. Makes recommendations to the Division of Extramural Research Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	20,000	20,000
Biological Sciences Training Review Committee	Reviews applications from universities and training centers for grants to train research personnel in the biological sciences for research careers in the mental health field. Makes recommendations to the Division of Manpower and Training Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	8	30,000	30,000

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Clinical and Personality Sciences Fellowship Review Committee	Reviews research fellowship applications from individuals with Ph.D.'s and Ph.D. candidates who propose to broaden tehir research capabilities in clinical and personality services. Makes recommendations to the Division of Manpower and Training Programs, National Institute of Mental Health.	10	$ 15,000	$ 15,000
Continuing Education Training Review Committee	Reviews applications for training grants in continuing education and makes recommendations on applications to the Division of Manpower and Training Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	15	30,000	30,000
Cultural Anthropology Fellowship Review Committee	Reviews applications for research fellowships and corollary field research training grants in cultural anthropology, language behavior, and physical anthropology. Makes recommendations on research fellowship and field research training grant applications to the Division of Manpower and Training Programs, National Institute of Mental Health.	12	15,000	15,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Experimental and Special Training Review Committee	Reviews applications from training centers for grants for mental health related projects for development of methods of training; evaluation of teaching and training methods; development of special training programs in problem areas; expansion and improvement of mental health content of the curriculum for all students in schools of public health; and training activities such as conferences, institutes, workshops, demonstrations, and surveys. Recommends to the Division of Manpower and Training Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	10	$ 30,000	$ 30,000
Mental Health Manpower and Training Advisory Committee	Advises the Division of Manpower and Training Programs on the status and future needs of mental health manpower and training.	12	4,000	4,000
Nurse Training Review Committee	Reviews applications from teaching institutions for training grants in undergraduate and graduate psychiatric nursing. Makes recommendations to the Division of Manpower and Training Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	9	30,000	30,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Psychiatry Training Review Committee	Reviews training grant applications in psychiatry, general practitioners programs, undergraduate and graduate training programs. Makes recommendations to the Division of Manpower and Training Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	10	$ 36,000	$ 36,000
Psychological Sciences Fellowship Review Committee	Reviews research fellowship applications from individuals with Ph.D's and Ph.D..candidates who propose to broaden or enhance their research capabilities in the area of psychological sciences. Makes recommendations on research fellowship applications to the Division of Manpower and Training Programs, National Institute of Mental Health.	10	15,000	15,000
Psychology Training Review Committee	Reviews applications from teaching institutions for training grants in clinical, school, and other science-profession areas of psychology. Makes recommendations to the Division of Manpower and Training Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	9	30,000	30,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Research Scientist Development Review Committee	Reviews applications for support of additional training or experience of behavioral scientists to develop their full capacities for research careers. Makes recommendations on these proposals to the Division of Manpower and Training Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	$ 30,000	$ 30,000
Social Sciences Training Review Committee	Reviews applications for training grants from universities and training centers to train research personnel in the social sciences for research careers in the mental health field, and to train mental health specialists in the research techniques and methods of the social sciences. Makes recommendations to the Division of Manpower and Training Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	8	30,000	30,000
Social Work Training Review Committee	Reviews applications for social work grants in graduate training (mental health and related special areas), career teachers, student research stipends, senior stipends, educational standards, and selected undergraduate pilot projects. Makes recommendations to the Division of Manpower and Training Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	8	30,000	30,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Hospital Improvement Program Committee	Reviews applications for hospital improvement grants which focus on inpatient programs in State mental hospitals. Makes recommendations to the Division of Mental Health Services Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	$ 20,000	$ 20,000
Hospital Staff Development Committee	Reviews applications for grants-in-aid from State mental hospitals requesting support for development of personnel in mental health services. Makes recommendations to the Division of Mental Health Service Programs, National Institute of Mental Health, and the National Advisory Mental Health Council.	12	30,000	30,000
Mental Health Service Programs Advisory Committee	Adivses, consults with, and makes recommendations to the Division of mental Health Service Programs on matters of general policy concerning the planning, development, and evaluation of comprehensive mental health service programs and related problems.	12	3,000	7,000

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Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Advisory Committee on Alcoholism	Advises and makes recommendations to the Chief, National Center for Prevention and Control of Alcoholism, and through him, to the Director, National Institute of Mental Health, on matters of general policy concerning research, training, service, and control programs in the field of alcoholism and related problems.	12	$ 20,000	$ 20,000
Alcoholism and Alcohol-Problems Review Committee	Reviews all grant applications in the area of alcoholism. Makes recommendations to the Division of Special Mental Health Programs, National Institute of Mental Health, and to the National Advisory Mental Health Council.	15	20,000	20,000
Crime and Delinquency Review Committee	Reviews applications for basic and applied research, training, and fellowship grants pertaining to problems and issues relating to delinquency, crime, correction, law and mental health, and individual violent behavior. The Committee makes its recommendations on applications to the Division of Special Mental Health Programs and to the National Advisory Mental Health Council.	12	30,000	30,000

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Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Metropolitan Mental Health Problems Review Committee	Reviews all basic and applied research, training, and fellowship applications assigned to the Center for the Study of Metropolitan Problems. The range of the proposals includes two major areas: (a) contemporary social issues including racism, group identity, mass violence, alienation and conformity, crowding and the process of urbanization; (b) social planning and urban ecology, e.g., the relationship between the physical environment and behavior, problems and prospects of technology, planning and community structure and development. The committee makes its recommendations to the Division of Special Mental Health Programs and to the National Advisory Mental Health Council.	12	$ 20,000	$ 20,000
Special Mental Health Programs Advisory Committee	Provides advice on program planning and implementation to the Director of the Division of Special Mental Health Programs and, through him, to the Director, National Institute of Mental Health.	12	1,000	15,000
Suicide Prevention Advisory Committee	Advises and makes recommendations to the Director, National Institute of Mental Health, on matters of general policy concerning research, training, and service programs in the field of suicide and suicide prevention.	10	25,000	25,000

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Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Mental Health (cont.)				
Suicide Prevention Review Committee	Reviews all grant applications in the area of suicide and suicide prevention, including basic and applied research, demonstration, training, fellowship, and conference type proposals. Makes recommendations to the Division of Special Mental Health Programs, National Institute of Mental Health, and to the National Advisory Mental Health Council.	15	$ 20,000	$ 20,000
Narcotic Addiction and Drug Abuse Review Committee	Reviews applications for narcotic addiction and drug abuse. Makes recommendations to the Center for Studies of Narcotic and Drug Abuse, Division of Narcotic Addiction and Drug Abuse, National Institute of Mental Health, and the National Advisory Mental Health Council.	15	20,000	20,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (cont.)				
Health Services Research and Development				
Federal Hospital Council	Advises the Administrator, Health Services and Mental Health Administration, on matters relating to the administration of hospital and medical facilities survey and construction program. Consults with the Administrator, Health Services and Mental Health Administration, with respect to grants-in-aid for projects in research, experiments, or demonstrations relating to the development, utilization, and coordination of hospital services, facilities, and resources. Considers appeals from States whose State Plan (or modification) has been disapproved by the Administrator, Health Services and Mental Health Administration. Approves regulations for the administration of Hospital and Medical Facilities Survey and Construction Act prior to promulgation by the Administrator, Health Services and Mental Health Administration, and the Secretary.	12	$ 11,100	$ 12,900

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Health Services Research and Development (cont.)				
National Advisory Health Services Council	Advises the Administrator, Health Services and Mental Health Administration, on the needs and requirements for research and development designed to increase the effectiveness and efficiency of medical care and health services in all communities, the development of policies and programs of the Administration responsive to such needs and requirements; methods and means of stimulating a Nationwide program of health services research and development concerned with increasing the availability and effectiveness of health services; stabilizing costs of providing and financing health services; new methods of training; development and utilization of health care personnel; and the methods of increasing resources for training of health services research and development personnel. Reviews applications for grants-in-aid to support research and research training in health services and related areas, and recommends to the Administrator, Health Services and Mental Health Administration, the approval of those projects which merit support.	14	$ 8,750	$ 12,650

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Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Health Services Research and Development (cont.)				
Health Care Systems Study Section	Reviews research grant applications concerned with systems analysis, operations research, and computer sciences in community health services, hospital medicine, and patient care, and makes recommendations to the appropriate National Advisory Council.	12	$ 22,500	$ 27,900
Health Services Demonstration Grants Review Committee	Reviews research, experimental, and demonstration grant applications relating to the development, utilization, quality, organization, and financing of services, facilities and resources of hospital facilities for long-term care, and other medical facilities in accordance with guidelines established by the Federal Hospital Council and makes recommendations to the Council.	20	40,650	44,000
Health Services Research Study Section	Reviews research grant applications relating to the delivery and acceptance of health services, and makes recommendations to the appropriate National Advisory Council. Surveys the status of research activities in health services and recommends to the Public Health Service the areas in need of emphasis and attention, and the appropriate mechanisms to alleviate them.	20	36,550	39,500

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Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Health Services Research and Development (cont.)				
Health Services Research Training Committee	Reviews research training grant applications relating to programs administered by the National Center for Health Services Research and Development and makes recommendations to the National Advisory Health Services Council. Makes initial review of research fellowship applications and surveys the status of training in this area in order to determine which research training activities should be initiated, expanded, or curtailed.	15	$ 14,300	$ 19,700
Comprehensive Health Planning and Services				
Comprehensive Health Planning Training and Studies Review Committee	Reviews applications and recommends to the Director, Community Health Service, projects to develop more effective comprehensive health planning through graduate training programs.	10	37,000	37,000
Regional Health Advisory Committees	Advises Regional Health Directors in their functions as program managers on matters relating to health activities of the Public Health Service in their respective regions and on matters relating to the Comprehensive Health Planning and Public Health Service Amendments of 1966 (P.L. 89-749) and the Partnership for Health Amendments of 1967 (P.L. 90-174); reviews applications for grants and assists in the review of State policy, plans, and applications submitted under the provisions of this Act.	118	81,620	91,410

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Comprehensive Health Planning and Services (cont.)				
Migrant Health Project Review Committee	Evaluates applications for migrant health project grants relating to family health service clinics and to improve health conditions for domestic migratory farm workers.	14	$ 13,550	$ 15,800
Regional Medical Programs				
National Advisory Council on Regional Medical Programs	Advises and assists the Administrator, Health Services and Mental Health Administration, in the preparation of regulations for, and as to policy matters arising with respect to, the administration of this program. Reviews applications for grants and recommends to the Administrator, Health Services and Mental Health Administration, the approval of those applications which merit support.	16	26,000	26,000
Regional Medical Programs Review Committee	Reviews grant applications and forwards recommendations to the National Advisory Council on Regional Medical Programs.	20	24,000	24,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Regional Medical Programs (cont.)				
Cancer Control Program Advisory Committee	Reviews applications for Cancer Control Training Grants, and advises the Director, Regional Medical Programs Service, on means of developing, executing, and evaluating community cancer prevention and control research applications.	14	$ 3,200	$ 4,300
Epilepsies Advisory Committee; Services and Service Training Subcommittee	Provides assistance to the Chief, Neurological and Sensory Disease Control Program in evaluation overall present and future needs relative to the epilepsies, including the training of sufficient health manpower to carry out these services; and recommends means by which deficiencies can be alleviated.	9	3,000	3,000
Communicable Diseases				
National Advisory Communicable Disease Council	Advises and consults with the Administrator, Health Services and Mental Health Administration, on matters relating to prevention and control of communicable diseases and related fields and provides advice on national policies, programs, and planning. Reviews applications for research grants-in-aid relating to research in the communicable diseases and related fields, and recommends to the Administrator, Health Services and Mental Health Administration, approval of those projects which merit support.	12	7,000	12,600

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Communicable Diseases (cont.)				
Communicable Disease Control Study Section	Reviews research grant applications relating to the development of methodology and technology for the diagnosis and control of communicable diseases and makes recommendations to the appropriate National Advisory Council. Surveys the status of research in this field and recommends the areas in which activities should be initiated, expanded, or curtailed.	12	$ 11,500	$ 16,400
Immunization Practices Advisory Committee	Provides advice to the National Communicable Disease Center regarding the most appropriate application of antigens and related agents for effective disease control. Reviews and reports regularly on immunization practices and recommends improvements in the national program.	7	8,700	8,150
Medical Laboratory Services Advisory Committee	Evaluates the approaches of the Laboratory Improvement Program and recommends revisions or additions; advises on various laboratory matters and proposed regulations.	12	11,500	11,400
Pesticides and Alternatives Study Section	Reviews research grant applications relating to pesticides and vector control, and makes recommendations to the appropriate National Advisory Council. Advises on research activities which should be initiated, expanded, or curtailed.	9	7,000	8,300

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Communicable Diseases (cont.)				
Rabies Advisory Committee	Advises the Epidemiology Program, Veterinary Public Health Section, on methods of implementing the rabies control program.	12	$ --	$ 4,200
Tuberculosis Con rol Advisory Committee	Consults with and advises the Tuberculosis Branch, on policies and programs in tuberculosis control.	8	1,150	2,300
Venereal Disease Control	Advises the Venereal Disease Branch, on methods of implementing its program in assisting States activities in the field of venereal disease control.	12	1,600	2,100
Hospital Construction				
Architectural and Engineering Technical Advisory Committee on Procedures and Regulations	Provides technical architectural and engineering advice on procedures and regulations concerning the programs administered by the Health Facilities Planning and Construction Service.	6	--	6,700

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (cont.)				
National Health Statistics				
National Committee on Vital and Health Statistics	Advises the Director, National Center for Health Statistics, on the formulation of United States policy regarding the development of vital and health statistics for national and international use. Cooperates with similar committees in other countries in the study of mutual problems by subcommittees appointed to deal with specific questions, or by other organizations cooperating voluntarily with the Committee.	10	$ 3,000	$ 5,100
National Committee on Vital and Health Statistics; Health Resources and Services Subcommittee	Identifies, through the National Committee on Vital and Health Statistics, needed information on health resources and services on a regional and national basis and recommends continuing and special studies, including those on quality and effectiveness of health care and methods to be used in conducting these studies.	7	--	1,800
National Committee on Vital and Health Statistics; Physicians' Practice and Ambulatory Clinic Care Subcommittee	Identifies, through the National Committee on Vital and Health Statistics, the need for improvement in organization for the delivery of medical care and for specific types of statistical information on medical care rendered in private practice and ambulatory patient clinics.	7	--	1,600

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
National Health Statistics (cont.)				
National Committee on Vital and Health Statistics; Population Dynamics Subcommittee	Recommends through the National Committee on Vital and Health Statistics types of studies needed in the field of population dynamics and the specific types of data needed to develop such studies, with suggestions as to how such data might best be collected.	7	$ 1,300	$ --
National Committee on Vital and Health Statistics' Vital Statistics System Revision Subcommittee	Recommends through the National Committee on Vital and Health Statistics needed revisions in the method of operation of the vital statistics system in the light of technological developments in data collection and processing equipment and procedures, and by reexamination of the roles of the Federal, State and local governments in the collection of vital records and compilation of vital statistics.	8	800	2,500
Public Health Conference on Records and Statistics-Standing Committee	Advises and recommends to the Director, Office of State Services, National Center for Health Statistics, those problems suitable for investigation by technical study groups and topics for agenda of the biennial meetings of the Public Health Conference on Records and Statistics.	12	4,600	6,400

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (cont.)				
Indian Health Services				
Indian Health Advisory Committee	Advises the Director, Indian Health Service, on health matters and related welfare problems, current and proposed regulations and policies that concern the Indian health program.	9	$ 4,500	$ 4,500
Emergency Health				
Emergency Health Preparedness Advisory Committee	Advises and makes recommendations on the plans and preparedness programs in the provision of emergency health services for civilian casualties with respect to all conditions of national emergency, and local disaster.	19	8,700	9,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Arthritis and Metabolic Diseases				
National Advisory Arthritis and Metabolic Diseases Council	Reviews and recommends action on research grants, training grants and fellowships programs and applications.	11	$ 10,000	$ 10,000
Board of Scientific Councelors	Advises Director of Intramural Research on Laboratory and Clinical Research Programs.	5	1,700	1,700
Artificial Kidney/Chronic Uremia Primary Contract Review Group	Review and evaluation of research contract proposals.	13	7,300	7,300
Artificial Kidney/Chronic Uremia Members of NIAMD Contract Review Committee	Participates with Institute Committee in review and final approval of AK/CU research contract proposals.	5	2,700	2,700
Arthritis and Metabolic Diseases Research Career Program Committee	Performs initial review and evaluation of Research Career Development Awards and unusual training grants, including Clinical Investigation Training Grants.	6	5,900	5,900
Arthritis Training Grants Committee	Performs initial review and evaluation (including site visits) of training grants.	8	7,900	7,900
Dermatology Training Grants Committee	Performs initial review and evaluation (including site visits) of training grants.	5	4,900	4,900
Diabetes and Metabolic Training Grants Committee	Performs initial review and evaluation (including site visits) of training grants.	10	9,800	9,800

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Arthritis and Metabolic Diseases (cont.)				
Gastroenterology and Nutrition Training Grants Committee	Performs initial review and evaluation (including site visits) of training grants.	12	$ 11,800	$ 11,800
Hematology Training Grants Committee	Performs initial review and evaluation (including site visits) of training grants.	6	5,900	5,900
Orthopedics Training Committee	Performs initial review and evaluation (including site visits) of training grants.	6	5,900	5,900
Renal Disease and Urology Training Grants Committee	Performs initial review and evaluation (including site visits) of training grants.	8	7,900	7,900
Division of Biologics Standards				
Board of Scientific Counselors	Provides advice to the Division of Biologics Standards on matters of general policy in relation to the mounting of a research program.	6	3,000	3,000
National Cancer Institute				
National Advisory Cancer Council	Reviews applications for grants-in-aid relating to research and training projects in the field of cancer, and recommends approval of those projects which merit support.	12	21,410	21,410

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Cancer Institute (cont.)				
Board of Scientific Counselors	Provides advice to the National Cancer Institute on matters of general policy, particularly from a long-range viewpoint, as they relate to the intramural research program.	6	$ 4,110	$ 4,110
Cancer Clinical Investigation Review Committee	Provides scientific merit review of applications in the collaborative clinical trials area and reports findings and recommendations to the National Advisory Cancer Council.	13	32,058	32,058
Cancer Research Center Review Committee	Reviews applications for support of planning studies, clinical and specialized research centers, program project grants, and core grants related to the cancer problem.	15	17,270	17,270
Cancer Special Program Advisory Committee	Provides scientific and technical review of applications and makes recommendations to the Director, National Cancer Institute and the National Advisory Cancer Council regarding grant-supported programs.	12	13,563	13,563
Chemotherapy Advisory Committee	Provides the Scientific Director for Chemotherapy, National Cancer Institute, with scientific advise on the progress of chemotherapy program.	12	18,084	18,084

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Cancer Institute (cont.)				
Clinical Cancer Training Committee (Dental)	Provides scientific and technical review of and makes recommendations to the National Advisory Cancer Council on matters pertaining to clinical cancer training in dental schools.	15	$ 17,262	$ 17,262
Clinical Cancer Training Committee (General)	Provides scientific and technical review of and makes recommendations to the National Advisory Cancer Council on matters pertaining to clinical cancer training in medical schools and hospitals.	20	23,427	23,427
Etiology Program Advisory Committee	Provides a continuing resource for advice and consultation on scientific aspects of various topics within the overall etiology area program.	8	6,065	6,065
Cancer Research Training Committee	Provides scientific and technical review of and recommends to the National Advisory Cancer Council on matters pertaining to cancer research and training	15	--	17,300
Medical Care and Medical Economics Advisory Committee	Advises the Director, National Cancer Institute, on activities of the Third National Cancer Survey relating to medical economics, medical care costs and the delivery of medical care.	8	--	8,130
Epidemiology Advisory Committee	Advises the Director, National Cancer Institute, on activities of the Third National Cancer Survey relating to cancer demography and epidemiology and incidence, prevalence and survival data.	7	--	3,630

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH (cont.)				
National Heart Institute				
National Advisory Heart Council	To review programs of the National Heart Institute, to advise, consult and make recommendations, pursuant to Section 414, PL 655, "National Heart Act."	12	$ 15,000	$ 15,000
Cardiopulmonary Disease Advisory Committee	Provides advice to the National Heart Council and through the Council to the National Heart Institute; identifies research and training opportunities, and evaluates current and future program needs in the cardiopulmonary disease area.	7	4,200	4,200
Heart Program Project Committee	Reviews applications for grants in support of programs of multi-disciplinary medical research.	16	50,000	50,000
Heart Special Projects Committee	Reviews applications for support of studies of special program interest to the Institute, especially cooperative studies.	12	30,000	30,000
Training Committee A	Conducts the scientific review of research training applications and career development awards.	11	32,000	35,000
Training Committee B	Conducts the scientific review of clinical research training applications.	9	30,000	30,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Heart Institute (cont.)				
Board of Scientific Counselors, Office of Director of Intramural Research	Provides advice to the National Heart Institute on matters of general policy as they relate to the intramural research program.	5	$ 2,500	$ 2,800
Artificial Heart-Myocardial Infarction Program Advisory Committee	Provides advice to the National Heart Institute on major policy and program issues related to a program of artificial heart development and a program to reduce the mortality and morbidity from myocardial infarction.	9	4,500	5,000
Thrombosis Advisory Committee	Serves as the National Heart Institute focal point for programming in the area of thrombosis and provides advice to the National Heart Institute on long-range research goals, identifying the objectives necessary to attain these goals.	9	2,000	2,000
Erythropoietin Committee	Reviews problems of production and distribution of the presently limited supply of erythropoietin.	3	1,500	1,500
National Blood Resource Program Advisory Committee	Advises the National Heart Institute on the implementation, direction, and sequence of the research and development programs. Provides secondary review of all program-related contract proposals.	6	3,000	3,200
Epidemiology and Biometry Advisory Committee	To advise the Institute regarding population based studies.	8	3,400	3,400

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH (cont.)				
National Institute of Dental Research				
National Advisory Dental Research Council	Reviews applications for grants-in-aid relating to research and training projects in the field of dental and oral diseases and conditions, and recommends to the Director, National Institutes of Health, approval of those projects which merit support.	12	$ 15,000	$ 15,000
Board of Scientific Counselors	Provides advice to the National Institute of Dental Research on matters of general policy, particularly from a long-range viewpoint, as they relate to the intramural research program.	6	3,000	3,000
Dental Program-Project Committee	Reviews applications for support of broad interdisciplinary programs of dental and oral research and makes recommendations to the National Advisory Dental Research Council. Advises the National Institute of Dental Research on long-range planning and broad program objectives of dental and oral research.	14	44,000	44,000
Dental Research Institutes and Special Programs Advisory Committee	Provides advice and makes recommendations to the Director, National Institute of Dental Research, and the National Advisory Dental Research Council on general policy and procedure as related to special programs, particularly dental research institutes. Considers and reviews long-range planning and broad program objectives and evaluates progress of ongoing programs.	10	6,000	6,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Dental Research (cont.)				
Dental Training Committee	Reviews applications for training grants and research career development awards and makes recommendations to the National Advisory Dental Research Council. Reviews regular fellowship applications and advises the National Institute of Dental Research on matters of graduate training.	12	$ 30,000	$ 30,000
National Institute of Neurological Diseases and Stroke				
National Advisory Neurological Diseases and Stroke Council	Reviews applications for grants-in-aid relating to research and training projects in the field of neurological diseases and blindness, and recommends to the Surgeon General the approval of those projects which merit support. Consults with and advises the Surgeon General on matters relating to neurological diseases and blindness.	12	21,800	22,400
Board of Scientific Counselors, National Institute of Neurological Diseases and Stroke	Provides advice to the National Institute of Neurological Diseases and Stroke on matters of general policy, particularly from a long-range viewpoint, as they relate to the intramural research program.	6	3,900	4,506

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Neurological Diseases and Stroke (cont.)				
Neurology Program-Project A Committee	Reviews applications for support of broad programs of medical research and makes recommendations to the National Advisory Neurological Diseases and Stroke Council.	18	$ 46,500	$ 50,000
Neurology Program-Project B Committee	Reviews applications for support of broad programs of medical research and makes recommendations to the National Advisory Neurological Diseases and Stroke Council.	12	31,150	35,000
Neurological Science Research Training A Committee	Reviews applications for training grants and career development awards and makes recommendations to the National Advisory Neurological Diseases and Stroke Council. Also reviews special and post-doctoral fellowship applications.	17	39,000	42,000
Neurological Science Research Training B Committee	Reviews applications for training grants and career development awards and makes recommendations to the National Advisory Neurological Diseases and Stroke Council. Also reviews special and post-doctoral fellowship applications.	16	32,500	35,500

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Neurological Diseases and Stroke (cont.)				
Vision Research Training Committee	Reviews applications for training grants and career development awards in the field of vision research and makes recommendations to the National Advisory Neurological Diseases and Stroke Council. Also reviews special and post-doctoral fellowship applications.	12	$ 33,000	$ 36,000
Epilepsies Advisory Committee Research and Training Subcommittee	Provides assistance to the National Institute of Neurological Diseases and Stroke in evaluating the overall existing research program relative to the epilepsies, in recommending means by which the deficiencies in this program can be obviated, and in the mounting of new clinical and basic research efforts.	9	11,700	12,168
Communicative Disorder Research Training Committee	Reviews applications for training grants and career development awards in the area of communicative sciences and makes recommendations to the National Advisory Neurological Diseases and Stroke Council. Also reviews special post-doctoral fellowship applications.	10	20,250	22,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Neurological Diseases and Stroke (cont.)				
National Advisory Neurological Diseases and Stroke Council	Provides advice and makes recommendations to the Director, National Institute of Neurological Diseases and Stroke, and to the Council in respect to the further development of the Institute's program in impaired vision and blindness.	8	$ 7,800	$ 8,112
Neurological Diseases and Stroke Science Information Program Advisory Committee	Advises Director on needs and progress of Institute's science information program and on technical merit of research contract proposals in support of this activity.	12	11,700	12,168
Evaluation of Clinical Therapy Advisory Committee	Provides advice to the National Institute of Neurological Diseases and Stroke on the development of needed research programs in clinical therapy and drug evaluation at the patient level.	7	5,700	5,928
Perinatal Research Committee	Provides technical advice and assists in the technical merit review of contract proposals from the collaborating institutions and in relation to other facets of the study.	7	15,925	16,562

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH (cont.)				
National Institute of Allergy and Infectious Diseases				
National Advisory Allergy and Infectious Diseases Council	Reviews applications for grants-in-aid relating to research and training projects in the fields of allergy and infectious diseases, and recommends to the Surgeon General the approval of those projects which merit support. Makes recommendations to the Surgeon General on matters relating to programs and activities in the areas of allergy and infectious diseases.	17	$ 6,900	$ 7,500
Allergy and Infectious Diseases Training Grant Committee	Reviews training grant and research career development award applications for grants-in-aid relating to the fields of allergy and infectious diseases and makes recommendations to the National Advisory Allergy and Infectious Diseases Council.	12	50,000	50,000
Arbovirus Committee	Advises the Director, National Institute of Allergy and Infectious Diseases, with respect to the Institute's program to provide research reagents for the full spectrum of arthropod-borne viral agents which have significance in biomedical research. Reviews contract proposals and recommends awards to accomplish above objectives.	7	900	1,000

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Allergy and Infectious Diseases (cont.)				
Board of Scientific Counselors, National Institute of Allergy and Infectious Diseases	Provides advice to the National Institute of Allergy and Infectious Diseases on matters of general policy, particularly from a long-range viewpoint, as they relate to the intramural research program.	6	$ 2,200	$ 2,500
Cholera Advisory Committee	Advises on all phases of National Institutes of Health activities related to cholera, including technical review of contracts, and provides consultative assistance as required to those having program responsibility in direct National Institutes of Health operations related to cholera.	11	4,900	5,300
Research Reagents Committee	Advises the Director, National Institute of Allergy and Infectious Diseases, with respect to the development of the Institute's assigned responsibility for research reagents with specific objectives to establish criteria for classification of an agent in the recognized virus groups (adeno, picorna, myxoviruses and others); to insure production and testing of standard reagents, both prototype seed material and corresponding antisera, and related immunologic materials; to review results of reagent testing and recommend release as reference reagent; to evaluate and standardize methods for identification and classification; and to provide continuity for the above activities. Reviews contract proposals and recommends awards to accomplish these objectives.	7	4,300	4,700

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Allergy and Infectious Diseases (cont.)				
Transplantation and Immunology Committee	Advises the Director, National Institute of Allergy and Infectious Diseases, with respect to the Institute's program for developing and coordinating methods, procedures, and resources to enhance research in transplantation and immunology and on methods of evaluating and monitoring the resutls. Funds are awarded through regular contract procedures and contracts are administered by the Institute's Collaborative Program. Reviews contract proposals in these areas.	9	$ 10,200	$ 11,000
Vaccine Development Committee	Advises and assists the Director, National Institute of Allergy and Infectious Diseases, in determinign methods for definition and control of acute respiratory, rubella, and other infectious diseases and the coordination of these activities between the participating industry, university, and Federal research groups; and on the operation and organization of the Vaccine Development Program. Reviews applications for contract support of research and development projects designed to provide or test prototype vaccines or provide essential resources; monitors program projects and evaluates results.	11	7,300	8,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Allergy and Infectious Diseases (cont.)				
International Centers Committee	Advises the Director, National Institutes of Health, through the Director, Office of International Research, on policies and procedures (including applications) and program evaluation and development for the International Centers for Medical Research and Training Program. Makes recommendations to the International Research Advisory Committee.	7	$ 22,000	$ 24,000
National Institute of General Medical Sciences				
National Advisory General Medical Sciences Council	Reviews applications for grants-in-aid relating to research and training projects in basic medical and behavioral sciences, the methods of sciences, and broad multidisciplinary programs and studies. Recommends to the Surgeon General the approval of those projects which merit support.	14	9,915	9,915
Anatomical Sciences Training Committee	Reviews research training grant applications in the anatomical sciences and makes recommendations to the National Advisory General Medical Sciences Council.	11	8,980	8,980

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of General Medical Sciences (cont.)				
Anesthesiology Training Committee	Reviews research training grant applications, clinical training grant applications, and research career development awards in anesthesiology and makes recommendations to the National Advisory General Medical Sciences Council.	12	$ 16,495	$ 16,495
Automation in the Medical Laboratory Sciences Review Committee	Reviews program project applications and contract proposals for basic and applied research studies and development work designed to further the automation of clinical laboratories.	10	24,980	24,980
Behavioral Sciences Training Committee	Reviews research training grant applications in the behavioral sciences and makes recommendations to the National Advisory General Medical Sciences Council.	13	26,331	26,331
Biochemistry Training Committee	Reviews research training grant applications in biochemistry and related areas of chemistry and biology and makes recommendations to the National Advisory General Medical Sciences Council.	8	23,599	23,599

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of General Medical Sciences (cont.)				
Biophysical Sciences Training Committee	Reviews research training grant applications in the biophysical sciences and makes recommendations to the National Advisory General Medical Sciences Council.	8	16,925	$ 16,925
Engineering in Biology and Medicine Training Committee	Reviews research training grant applications in the area of engineering in biology and medicine and makes recommendations to the National Advisory General Medical Sciences Council.	10	26,489	26,489
Epidemiology and Biometry Training Committee	Reviews research training grant applications in the areas of epidemiology and biometry and makes recommendations to the National Advisory General Medical Sciences Council.	6	15,783	15,783
General Medical Research Program Project Committee	Reviews research program-project grant applications for support of large-scale diverse research programs directed to broad objectives and generally involving a number of different scientific disciplines.	13	113,642	113,642
Genetics Training Committee	Reviews research training grant applications in the genetics area and makes recommendations to the National Advisory General Medical Sciences Council.	11	9,776	9,776

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of General Medical Sciences (cont.)				
Medical Scientist Training Committee	Reviews institutionally-based research training grant applications which seek to provide combined scientific and medical training needed for many areas of medical research and makes recommendations to the National Advisory General Medical Sciences Council.	13	$ 15,201	$ 15,201
Microbiology Training Committee	Reviews research training grant applications in the area of microbiology and makes recommendations to the National Advisory General Medical Sciences Council.	12	17,388	17,388
Nutritional Sciences Training Committee	Reviews research training grant applications in the nutritional sciences area and makes recommendations to the National Advisory General Medical Sciences Council.	8	9,064	9,064
Pathology Training Committee	Reviews research training grant applications in the field of pathology and the clinical laboratory sciences and makes recommendations to the National Advisory General Medical Sciences Council.	12	25,306	25,306

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of General Medical Sciences (cont.)				
Pharmacology and Toxicology Training Committee	Reviews research training grant applications in the areas of pharmacology, toxicology, clinical pharmacology and medicinal chemistry and makes recommendations to the National Advisory General Medical Sciences Council.	13	$ 44,708	$ 44,708
Pharmacology/Toxicology Review Committee	Reviews research program-project and research center applications in pharmacology/toxicology and makes recommendations to the National Advisory General Medical Sciences Council.	14	16,923	16,923
Physiology Training Committee	Reviews research training grant applications in the physiological sciences and makes recommendations concerning scientific merit to the National Advisory General Medical Sciences Council.	9	17,574	17,574
Radiology Training Committee	Reviews research training grant applications in the area of radiology and makes recommendations to the National Advisory General Medical Sciences Council.	9	20,410	20,410

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of General Medical Sciences (cont.)				
Research Career Award Committee	Reviews applications for research career development awards which will foster the development of young scientists with outstanding research potential for careers of independent research in the sciences related to health.	18	$ 27,449	$ 27,449
Surgery Training Committee	Reviews research training grant applications in the surgical area and makes recommendations to the National Advisory General Medical Sciences Council.	14	16,816	16,816
Allergy and Immunology Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	14	20,000	20,000
Applied Physiology Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	8	10,000	10,000
Arthritis and Metabolic Diseases Program-Project Committee	Reviews applications for grants-in-aid. Surveys the status of research.	10	56,000	56,000
Bacteriology and Mycology Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	16	24,000	24,000
Biochemistry Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	14	24,000	24,000
Biomedical Communications Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	11	18,000	18,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function		Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH					
National Institute of General Medical Sciences (cont.)					
Biophysics and Biophysical Chemistry A Study Section	Reviews applications for grants-in-aid. the status of research.	Surveys	9	$ 14,000	$ 14,000
Biophysics and Biophysical Chemistry B Study Section	Reviews applications for grants-in-aid. the status of research.	Surveys	9	12,000	12,000
Cardiovascular A Study Section	Reviews applications for grants-in-aid. the status of research.	Surveys	12	29,000	29,000
Cardiovascular B Study Section	Reviews applications for grants-in-aid. the status of research.	Surveys	14	19,000	19,000
Cell Biology Study Section	Reviews applications for grants-in-aid. the status of research.	Surveys	16	25,000	25,000
Child Health and Human Development Program-Project Committee	Reviews applications for grants-in-aid. the status of research.	Surveys	12	90,000	90,000
Communicative Sciences Study Section	Reviews applications for grants-in-aid. the status of research.	Surveys	16	23,000	23,000
Computer Research Study Section	Reviews applications for grants-in-aid. the status of research.	Surveys	13	53,000	53,000
Dental Study Section	Reviews applications for grants-in-aid. the status of research.	Surveys	17	24,000	24,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function		Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH					
National Institute of General Medical Sciences (cont.)					
Developmental Behavioral Sciences Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	11	$ 24,000	$ 24,000
Endocrinology Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	17	52,000	52,000
Epidemiology and Disease Control Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	14	19,000	19,000
Experimental Psychology Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	12	22,000	22,000
General Medicine A Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	19	45,000	45,000
General Medicine B Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	15	33,000	33,000
Genetics Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	14	25,000	25,000
Hematology Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	16	30,000	30,000
History of the Life Sciences Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	12	10,000	10,000
Human Embryology and Development Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	15	33,000	33,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function		Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH					
National Institute of General Medical Sciences (cont.)					
Immunobiology Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	14	$ 19,000	$ 19,000
Medicinal Chemistry A Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	13	28,000	28,000
Medicinal Chemistry B Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	15	17,000	17,000
Metabolism Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	15	22,000	22,000
Microbial Chemistry Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	13	15,000	15,000
Molecular Biology Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	15	25,000	25,000
Neurology A Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	15	35,000	35,000
Neurology B Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	15	41,000	41,000
Nutrition Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	15	18,000	18,000
Pathology A Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	15	19,000	19,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of General Medical Sciences (cont.)				
Pathology B Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	17	$ 46,000	$ 46,000
Pharmacology A Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	17	23,000	23,000
Pharmacology B Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	13	22,000	22,000
Physiological Chemistry Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	14	29,000	29,000
Physiology Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	16	29,000	29,000
Radiation Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	16	37,000	37,000
Reproductive Biology Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	14	29,000	29,000
Surgery A Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	13	15,000	15,000
Surgery B Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	13	20,000	20,000
Toxicology Study Section	Reviews applications for grants-in-aid. Surveys the status of research.	14	24,000	24,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function		Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH					
National Institute of General Medical Sciences (cont.)					
Tropical Medicine and Parasitology Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	14	$ 29,000	$ 29,000
Virology and Rickettsiology Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	16	24,000	24,000
Visual Sciences Study Section	Reviews applications for grants-in-aid.	Surveys the status of research.	16	20,000	20,000
National Institute of Child Health and Human Development					
National Advisory Child Health and Human Development Council	Reviews applications for grants-in-aid relating to research and training projects in the fields of child health and human development, and recommends to the Director, National Institutes of Health, the approval of those projects which merit support. Consults with and advises the Director, National Institutes of Health, on matters relating to child health and human development.		16	25,000	25,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Child Health and Human Development				
Aging Training Review Committee	Reviews applications for training grants and research career development awards in the field of aging and forwards recommendations to the National Advisory Child Health and Human Development Council. Also provides final review of post-doctoral and special fellowship applications	10	$ 14,000	$ 14,000
Board of Scientific Counselors, National Institute of Child Health and Human Development	Provides advice to the National Institute of Child Health and Human Development on matters of general policy, particularly from a long-range viewpoint, as they relate to the intramural research program.	5	1,000	5,000
Growth and Development Training Review Committee	Reviews applications for training grants and research career development awards in the field of growth and development and forwards recommendations to the National Advisory Child Health and Human Development Council. Also provides final review of post-doctoral and special fellowship applications which have received prior scientific merit review by the fellowship committees in the Career Development Review Branch of the Division of Research Grants, National Institutes of Health. Surveys the status of training in this field to determine and recommend to the National Institutes of Health areas in which training activities should be modified, initiated or expanded.	13	18,000	18,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Child Health and Human Development (cont.)				
Population Research Committee	Advises the Director, National Institute of Child Health and Human Development, on scientific matters concerning research in contraception, particularly oral contraceptives, reproductive biology, and the social and psychological aspects of family planning.	11	$ 4,000	$ 4,000
Reproduction and Perinatal Biology Training Review Committee	Reviews applications for training grants and research career development awards in the field of reproduction and forwards recommendations to the National Advisory Child Health and Human Development Council. Also provides final review of post-doctoral and speical fellowship applications which have received prior scientific merit review by the fellowship committees in the Career Development Review Branch of the Division of Research Grants, National Institutes of Health. Surveys the status of training in this field to determine and recommend to the National Institutes of Health areas in which training activities should be modified, initiated, of expanded.	13	18,000	18,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Child Health and Human Development (cont.)				
Mental Retardation Research and Training Committee	Reviews applications for center grants, program project grants and training grants in the field of mental retardation and forwards recommendations to the National Advisory Child Health and Human Development Council.	8	$ 11,000	$ 11,000
National Institute of Environmental Health Services				
Environmental Health Sciences Advisory Committee	Reviews applications for grants-in-aid relating to research and research training projects in the environmental health sciences, and recommends to the Director, National Institutes of Health, approval of those projects which merit support.	12	23,000	24,000
Environmental Sciences Training Committee	Conducts scientific review of applications for research training grants in environmental health sciences and makes recommendations to the Environmental Health Sciences Advisory Committee.	12	20,000	20,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH (cont.)				
John E. Fogarty International Center for Advanced Study in the Health Sciences				
International Advisory Committee	Consult with and advise the Director on matters relating to the establishment, development, and management of facilities and programs of the Center as well as problems of renovation and construction of the building which will house the Fogarty International Center.	7	$ 1,000	$ 1,000
International Fellowship Review Committee	Responsible for the scientific review and evaluation of applications for international postdoctoral fellowships.	13	5,000	5,000
General Research and Services				
National Advisory Research Resources Council	Reviews, advises, and makes recommendations concerning the Animal Resources, General Clinical Research Centers, and Special Research Resources programs. Reviews applications for grants-in-aid relating to research and training in these programs, and recommends to the Director, National Institutes of Health, the approval of those applications which merit support. Reviews, advises, and makes recommendations relating to the development and operation of the program of biomedical and health sciences communication assigned to the Division of Research Resources.	12	13,000	13,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
General Research and Services (cont.)				
National Advisory Council on Health Research Facilities	Advises and assists the Director, National Institutes of Health, in the preparation of general regulations with respect to policy matters arising in the administration of this program. Reviews applications for grants-in-aid relating to the construction and/or equipping of health research facilities, and recommends to the Director, National Institutes of Health, the approval of those applications which merit support.	12	$ 13,000	$ 13,000
Primate Research Centers Advisory Committee	Reviews applications for primate research centers and makes recommendations to the National Advisory Research Resources Council; also reviews primate resource and primate research applications. Advises the Director, Division of Research Resources, on program development of the primate research centers and administrative policies pertaining thereto.	10	19,000	22,000
Animal Resources Advisory Committee	Reviews applications for support of laboratory animal resources training programs, and other relevant program activities, and makes recommendations to the National Advisory Research Resources Council. Reviews similar grants for the Division of Research Grants upon request. Advises the Director, Division of Research Resources, on matters pertaining to development of scientific programs, facilities, and laboratory animal resources.	10	19,000	23,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
General Research and Services (cont.)				
Health Research Facilities Scientific Review Committee	Reviews applications for health research facilities construction grants and makes recommendations to the National Advisory Council on Health Research Facilities.	18	$131,000	$100,000
Health Sciences Advancement Award Review Committee	Reviews the scientific and institutional program merit of applicant graduate institutions, and the broad-scale health research and research training programs which are part of the development plans; reviews applications and makes recommendations to the National Advisory Health Council; and advises generally with respect to the total aspects of the program.	16	14,000	14,000
General Research Support Scientific Advisory and Review Committee	Reviews applications for General research support; provides advice on policy issues; and makes recommendations to the National Advisory Health Council.	11	28,000	30,000
Chemical/Biological Information-Handling Review Committee	Reviews contract proposals in specific research and development efforts in the area of handling chemical/biological information. Advises the Director, Division of Research Facilities and Resources, on both the scientific merit and the general program relevance of individual proposals.	10	5,000	5,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
General Research and Services (cont.)				
General Clinical Research Centers Committee	Reviews applications for general clinical research center grants, and evaluates the research productivity of ongoing centers. Surveys, as scientific leaders, the status of clinical research in their fields to determine areas in which research activities should be modified, initiated, or expanded. Makes recommendations to the National Advisory Research Resources Council.	18	$ 48,000	$ 48,000
Health Manpower				
National Advisory Health Manpower Council	Provides advice to the Surgeon General on policies and programs necessary to meet the nation's health manpower problems.	15	18,000	18,000
National Advisory Council on Education for Health Professions	Advises the Surgeon General on regulations and policy matters. Reviews research grants for which there is no national primary review committee and provides secondary review for various programs.	17	24,000	24,000
Construction of Schools of Medicine Review Committee	Provides primary review of construction grant applications.	12	13,000	13,000
Optometry Review Committee	Provides primary review of construction grants and special improvement applications.	5	5,000	5,000
Construction of Schools of Pharmacy Review Committee	Provides primary review of construction grants.	10	9,000	9,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
Health Manpower (cont.)				
Podiatry Review Committee	Provides primary review of construction grants and special improvement applications.	5	5,000	5,000
Construction of Schools of Veterinary Medicine Review Committee	Provides primary review of construction grants.	7	6,000	6,000
Construction of Schools of Public Health Review Committee	Provides primary review of construction grants.			
Construction of Teaching Facilities for Allied Health Professions Review Committee	Provides primary review of construction, replacement and rehabilitation of teaching facilities grants.	8	8,000	8,000
Medicine and Osteopathy Special Improvement Grants Review Committee	Provides primary review of special improvement grants.	18	16,000	16,000
Dental Health Research and Education Review Committee	Provides primary review of research grant, research training grant, and research fellowship applications related to dental health.	14	15,000	15,000
Dental Productivity Advisory Committee	Evaluates progress of Dental Clinical Development Center (Louisville, Ky.) "Dentist Productivity Study."	10	3,500	3,500

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
Health Manpower (cont.)				
Dental Student Training Advisory Committee	Provides primary review of Dental Auxiliary Utilization Training program grant applications.	5	$ 5,000	$ 5,000
Dental Education Review Committee	Provides primary review of construction grant and special education improvement grant applications.	12	13,000	13,000
National Advisory Council on Nurse Training	Advises the Surgeon General in regulations and policy matters. Provides secondary review for various programs.	16	19,000	19,000
Construction of Nurse Training Facilities Review Committee	Provides primary review of construction grant applications.	12	13,000	13,000
Nurse Scientist Graduate Training Committee	Provides primary review of research training grant and research fellowship applications related to nursing.	10	11,000	11,000
Nurse Training Act Project Grants Review Committee	Provides primary review of nurse training improvement project grant applications.	9	9,000	9,000
Professional Nurse Traineeship Short-Term Training Review Committee	Provides primary review of professional nurse traineeship program short-term training grant applications.	7	7,000	7,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
Health Manpower (cont.)				
Research in Nursing and Patient Care Review Committee	Provides primary review of grant applications for research in nursing in patient care.	12	$ 13,000	$ 13,000
National Advisory Allied Health Professions Council	Undertakes substantial review, study and deliberation upon current and future national problems and opportunities which are selected by the Surgeon General for consultation and advice. Reviews applications for allied health professions research and training project grants and traineeships.	16	23,000	23,000
National Advisory Public Health Training Council	Advises and assists the Surgeon General in appraising the effectiveness of the traineeship and project grants programs in meeting the needs for trained public health personnel and strengthening or expanding graduate or specialized public health institution training including the development of program standards and policies.	12	14,000	14,000
Allied Health Professions Review Committee	Provides primary review of special educational improvement grants, new method grants, and traineeship grant applications related to allied health manpower.	12	13,000	13,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
Health Manpower (cont.)				
Public Health Review Committee	Provides primary review of applications for project grants for graduate public health training, except in the specific areas of Environmental health and preventive medicine and dentistry, and for traineeships for professional public health training except general traineeships, which are reviewed by Division staff, and in the specific areas of environmental health and preventive medicine and dentistry.	12	$ 13,000	$ 13,000
Environmental Health Review Committee	Provides primary review of applications for project grants for graduate public health training in environmental health and environmental health training grants.	12	13,000	13,000
National Advisory Council on Medical, Dental, Optometric, and Pidiatric Education	Advises the Surgeon General on regulations and policy matters and provides secondary review of various programs.	12	10,000	--
National Advisory Council on Health Professions Educational Assistance	Advises the Surgeon General on regulations and policy matters and provides secondary review of various programs.	14	--	20,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
Health Manpower (cont.)				
Preventive Medicine and Dentistry Review Committee	Provides primary review of applications for project grants for graduate public health training in preventive medicine and dentistry and for apprenticeships and residencies in preventive medicine and dentistry.	12	$ 13,000	$ 13,000
National Library of Medicine				
Board of Regents	Advises, consults with, and makes recommendations to the Surgeon General on important matters of policy in regard to the Library, including such matters as the acquisition of materials for the Library, the scope, content and organization of the Library's services, and the rules under which its materials, publications, facilities, and services shall be made available to various kinds of users.	10	10,800	10,800
Facilities and Resources Committee	Reviews applications and makes recommendations to the National Libraries Assistance Advisory Board as may be required for the medical library resources, regional medical library, and medical library construction grant programs. Advises, consults with, and makes recommendations to the Director, National Library of Medicine, with respect to these programs.	15	10,000	15,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Library of Medicine (cont.)				
Manpower and Training Committee	Provides merit review of applications for grants to support training in the fields, disciplines, and skills of the health information specialties. Advises, consults with, and makes recommendations to the Director, National Library of Medicine, concerning areas in which activities should be initiated, expanded, or curtailed.	9	$ 4,900	$ 7,350
Board of Regents Advisory Council for Extramural Programs	Reviews applications for grants-in-aid relating to research and training projects in library-based programs in health communication. Advises, consults with, and makes recommendations to the Surgeon General on important matters concerned with the planning and development of extramural support of programs in library-related biomedical information and communication systems. Meets in conjunction with the Board of Regents. Same members as the Board.	10	--	--
National Medical Libraries Assistance Advisory Board	Advises and assists the Surgeon General in the preparation of general regulations with respect to policy matters arising in the administration of the Medical Library Assistance Act. Considers applications for construction grants under the Act and recommends to the Surgeon General the approval of applications the amount which should be granted. Meets in conjunction with the Board of Regents. Same members as the Board.	10	--	--

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH (cont.)				
Salaries and Expenses, Office of the Director				
Advisory Committee to the Director, National Institutes of Health	Advises the Director, National Institutes of Health, on matters relating to the broad scientific, technological, academic, managerial, and socio-economic setting in which the continuing development of the biomedical sciences must take place, and also advises concerning their implications for policy, program development, resource allocation and administration of the National Institutes of Health, Provides a framework for overall review and evaluation of specific or general aspects of National Institutes of Health activities not encompassable within or appropriate for individual Institutes and Divisions.	13	$ 11,000	$ 11,000
National Institute of Health Management Fund				
Anatomy and Pathology Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	8	6,000	6,000
Behavioral Sciences Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	8	6,000	6,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Health Management Fund (cont.)				
Biochemistry and Molecular Biology Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	8	$ 5,000	$ 5,000
Biochemistry and Nutrition Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	7	6,000	6,000
Biomedical Engineering Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	6	3,000	3,000
Biophysics and Biophysical Chemistry Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	6	5,000	5,000
Clinical Research Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	8	4,000	4,000
General Biology and Genetics Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	8	10,000	10,000
Medicinal and Organic Chemistry A Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	6	5,000	5,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
National Institute of Health Management Fund (cont.)				
Medicinal and Organic Chemistry B Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	5	$ 5,000	$ 5,000
Microbiology Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	8	9,000	9,000
Pharmacology and Endocrinology Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	8	6,000	6,000
Physiology Fellowships Review Committee	Reviews fellowship grant applications for research training. Provides technical advice on training and manpower needs.	6	6,000	6,000
Proposed for 1970				
National Institute of General Medical Sciences				
Genetic Chemistry Advisory Committee	To identify the needs and present limitations of the overall genetic chemistry area, and identify specific long- and short-range objectives.	8	--	24,980

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
NATIONAL INSTITUTES OF HEALTH				
Proposed in 1970 (cont.)				
National Eye Institute				
National Advisory Eye Council	Reviews applications for grants-in-aid relating to research and training projects in the field of neurological diseases and blindness, and recommends to the Surgeon General the approval of those projects which merit support. Consults with and advises the Surgeon General on matters related to blindness and eye disorders.	12	$ --	$ 22,400
Vision Research Training Committee	Reviews applications for training grants and career development awards in the field of vision and makes recommendations to the National Advisory Eye Council. Also reviews special and post-doctoral fellowship applications.	12	--	36,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
OFFICE OF EDUCATION				
Salaries and Expenses				
Advisory Committee on Accreditation and Institutional Eligibility	Policy is reviewed relating to the recognition and designation of accrediting agencies wishing to be designated as nationally recognized accrediting agencies. The formulation of all current and future policy relating to matters of institutional eligibility is reviewed.	12	$ 12,600	$ 12,600
National Advisory Committee on Adult Basic Education	This Committee reviews regulations, coordinates programs, and reviews policies pertaining to adult education activities and services.	7	5,000	5,000
Advisory Council on College Library Resources	Criteria are established in making supplemental grants to higher education institutions for the purpose of acquiring library materials as well as special purpose grants relating to national or regional need.	8	2,900	2,900
Advisory Council on Developing Institutions	This Council identifies those developing institutions which can best fulfill the purposes of the program and establish guidelines regarding applicants.	14	3,200	3,200
National Advisory Committee on Educational Laboratory	General policy recommendations are provided on the Educational Laboratory Program, including Research and Development Centers.	15	9,500	9,500

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
OFFICE OF EDUCATION				
Salaries and Expenses (cont.)				
National Advisory Committee on Handicapped Children	This Committee reviews the administration, operation and effectiveness of programs relating to handicapped children and makes subsequent recommendations.	12	$ 18,200	$ 20,000
Advisory Council for the National Defense Graduate Program	This Council advises in policy matters related specifically to the administration of the National Defense Graduate Fellowship Program such as criteria, geographical basis, and fellowship utilization.	12	2,500	--
Commission on Instructional Technology	Investigations and evaluations of all instructional technology and media are conducted.	9	1,500	2,000
Advisory Committee on Library Research and Training Projects	This Committee advises on policies regarding research and demonstration projects relating to improvements of both libraries and librarianship training.	9	6,300	6,300
Advisory Committee on Mexican-American Affairs	This Committee provides a focus on the bi-lingual and bi-cultural problems of Mexican-American families.	15	30,000	30,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
OFFICE OF EDUCATION				
Salaries and Expenses (cont.)				
Advisory Committee on the Publication of Copyrighted Materials	Assistance is given in allotting copyrights and licensing to commercial interests for the production and dissemination of Office materials, and help as to if, when and how these materials should be released for public consumption.	7	$ 2,000	$ 2,000
Research Advisory Council	The Council reviews all Office research plans, programs and procedures, suggest fields for special emphasis and advises on program changes.	15	9,000	9,000
National Advisory Council on the Education of Disadvantaged Children	Review is given to the administration, operation, and effectiveness of financial aid to local educational agencies for the education of low-income children.	12	30,500	30,000
National Advisory Council on Education Professions Development	The operation of all Federal programs for training educational personnel is reviewed. The programs aim for quality and quantity of teachers.	15	96,400	100,000
Advisory Committee for the Evaluation of Training in Vocational Schools	This Committee assists in determining the eligibility of institutions to participate in the vocational student loan guaranteed program, as well as prescribes criteria to accredit certain schools for insurable loans to students.	11	7,400	7,400

DPEARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
OFFICE OF EDUCATION				
Salaries and Expenses (cont.)				
National Advisory Committee for the Exchange of Teachers	This Committee provides recommendations on aspects and problems relating to the exchange of teachers with other countries.	20	$ 2,000	$ 2,000
National Advisory Council on Extension and Continuing Education	This Council prepares regulations for programs offering extension or continuing education activities or services and reviews reports and recommends on the effectiveness of these programs.	36	8,600	8,600
Advisory Committee on Guidance and Counseling	Surveys in the field of guidance and counseling are reviewed and priorities are determined. Policies on guidance are examined for consistency at the Federal, State and local level.	12	9,600	9,600
Advisory Council on State Departments of Education	This Council reviews the grants program that assists States in strengthening their educational agencies as well as reviewing grants that establish and improve programs to meet the educational needs of the States.	12	20,000	20,000
National Advisory Council on Supplementary Centers and Services	The administration of and regulations for supplementary centers are reviewed. Programs are evaluated and the results and recommendations are made known.	12	78,600	110,000
Advisory Committee on the Education of Bilingual Children	The Council advises in the preparation of general regulations resulting in the administration of this program, including the development of criteria for application approval.	9	7,200	25,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
OFFICE OF EDUCATION (cont.)				
Proposed for 1970				
Expansion and Improvement of Vocational Education				
National Advisory Council on Vocational Education	The administration, regulations and operation of vocational education programs are reviewed. The effectiveness of these programs is evaluated and distributed.	21	$ --	$200,000
Salaries and Expenses				
Advisory Council on Graduate Education	The Council advises on matters of general policy which arise in administering programs relating to graduate education.	19	--	12,300
Advisory Council on Financial Aid to Students	This Council advises on general policy matters relating to programs of financial assistance to students. The effectiveness of those programs is evaluated.	21	--	25,500

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses				
Child Welfare Training Grants Advisory Group	To review all applications for training grants, including traineeships and short-term grants, submitted to the Child Welfare Training grants program and to make recommendations regarding approval or disapproval of applications to the Chief, Children's Bureau.	9	$ 4,500	$ 4,500
Child Welfare Research and Demonstration Grants Advisory Group	To review all applications for research and demonstration grants submitted to the Child Welfare Research and Demonstration grants program and to make recommendations regarding approval or disapproval of applications to the Chief, Children's Bureau.	9	9,000	9,000
Children's Bureau Maternity and Newborn Advisory Committee	To advise on maternity care policies, especially in relation to high-risk patients; the scope of services, program standards, and professional relationships.	12	1,300	1,300
Children's Bureau Technical Committee on Clinical Programs for Mentally Retarded Children	To advise on policies related to mental retardation programs for children, including scope of services, program standards, and professional relationships.	18	2,000	2,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
Maternal and Child Health and Crippled Children's Services Research Grants Advisory Group	To review all applications for research grants submitted to the Maternal and Child Health and Crippled Children's Research Grants program and to make recommendations regarding approval or disapproval of applications to the Chief, Children's Bureau.	10	$ 10,000	$ 10,000
National Advisors to the Journal CHILDREN	This group provides advice and assistance to the Bureau on the content, quality, presentation, and direction for CHILDREN, an interdisciplinary bimonthly journal for the professions serving children.	15	900	900
Pediatric Advisory Committee	This committee provides consultation and review on Children's Bureau publications for parents.	4	500	500
Medical Assistance Advisory Council	The Medical Assistance Advisory Council was established to advise the Secretary on matters of general policy in the administration of title XIX (including relationship of this title to title XVIII) and making recommendations for improvements in such administration.	21	97,200	95,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
National Advisory Council on Nursing Home Administration	National Advisory Council on Nursing Home Administration was created for the purpose of advising the Secretary and the States in carrying out the provisions of Sec. 1908, "State Programs for Licensing of Administrators of Nursing Homes."	9	$ 79,000	$105,000
Advisory Committee on Older Americans	Advises the Secretary concerning national policies and programs to improve the status and well-being of older people.	15	6,300	14,000
Title IV Technical Review Committee	Reviews and makes recommendations concerning applications for grants submitted to the Administration on Aging under Title IV of the Older Americans Act; also makes recommendations for program development.	9	4,800	6,600
Title V Technical Review Committee	Reviews and makes recommendations concerning projects submitted to the Administration on Aging under Title V of the Older Americans Act.	6	3,500	5,400
Inter-Council Committee on Construction of University-Affiliated Facilities of the Mentally Retarded	Reviews applications and project grants for the university-affiliated facilities construction program authorized under Title I, Part B, P.L. 88-164.	6	--	5,500

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
Medical Advisory Committee	To assist in the planning of long-range medical programs and policies related to the current and expanding State-Federal rehabilitation program; promote liaison with various medical groups throughout the country and interpret the objectives of the Vocational Rehabilitation Administration.	14	$ 5,732	$ 5,732
Medical Education Advisory Committee	Reviews application for awards to be made to medical schools to establish, expand, or improve teaching of rehabilitation throughout the basic undergraduate curriculum. Provides advice on policies governing support of training in the field of medicine. Makes recommendations concerning guiding principles for continuing development of conduct of the teaching program.	8	3,017	3,017
Mental Retardation Project Review Committee	Reviews applications for project grants for the hospital improvement and hospital in-service training program authorized under Section 303, Public Health Service Act, as amended, and, on request, reviews health services project grants auhtorized under Section 14(e) of the Public Health Service Act, as amended.	10	14,379	14,379

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
National Policy and Performance Council	A Statutory Council which advises on policies and criteria to be used in making grants for projects to provide training services to handicapped individuals in public or other non-profit workshops and rehabilitation facilities.	13	$ 8,284	$ 8,284
Nursing Advisory Committee	Provides consultation and advice regarding training needs in the field of nursing; evaluates applications for training grants; recommends priorities for support and policies governing administration of training grants.	3	1,094	1,094
Occupational Therapy Advisory Committee	Provides advice on training needs in the field of occupational therapy; makes recommendations on types of grants to be made; evaluates applications for training grants; and makes recommendations on priorities and amounts of grants in the field of occupational therapy.	4	1,517	1,517
Physical Therapy Advisory Committee	Provides consultation on training needs in the field of physical therapy; recommends kinds of grants to be made; evaluates applications for training grants; recommends priorities for support and amount of grants.	4	1,734	1,734

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
Prosthetics and Orthotics Education Advisory Committee	Provides advice on administration of training grants in the field of prosthetics-orthotics education; identifies training needs and advises on priorities for support; evaluates applications for grants and makes recommendations regarding amounts to be awarded.	3	$ 1,940	$ 1,940
Psychology Advisory Committee	Provides advice on administration of training grants in the field of psychology, identifies training needs and advises on priorities for support; evaluates applications for grants and makes recommendations regarding amounts to be awarded.	3	850	850
Recreation Advisory Committee	Provides consultation and advice regarding training needs in the field of recreation for the ill and disabled; evaluates applications for training grants; recommends priorities for support and policies governing administration of training grants.	3	946	946

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
Rehabilitation Counseling Advisory Committee	Provides consultation on training needs in the fields of rehabilitation counseling and psychology; advises on purpose and direction of training grants; evaluates applications for training grants, determining priorities for support and making recommendations as to the amount of the grant.	8	$ 2,877	$ 2,877
Rehabilitation Workshop Administration Advisory Committee	Provides consultation and advice regarding training needs in the field of rehabilitation workshop administration; evaluates applications for training grants; recommends priorities for support and policies governing administration of training grants.	4	2,800	2,800
Social Work Advisory Committee	Provides advice on administration of training grants in the field of social work; identifies training needs and advises on priorities for support; evaluated applications for grants and makes recommendations regarding amounts to be awarded.	6	4,258	4,258

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
Speech Pathology and Audiology Advisory Committee	Provides advice on administration of training grants in the field of Speech Pathology and Audiology; identifies training needs and advises on priorities for support; evaluates applications for grants and makes recommendations regarding amounts to be awarded.	5	$ 4,056	$ 4,056
Advisory Panel to Cooperative Research and Demonstration Grants Program	To review all applications for research grants submitted to the Cooperative Research and Demonstration Grants Program and to make recommendations regarding approval of applications to the Assistant Administrator, Research, Demonstrations, and Training, Social and Rehabilitation Service, and to the Commissioner, Social Security Administration.	13	5,883	5,900

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
General Research Study Section	This study section will have the responsibility for the technical and scientific review of applications for research grants in the areas of community organization, workshops, emerging patterns of service, OASI, operations research with State agencies, relations with labor and other projects not clearly falling in the area of sensory, medical or psycho-social research. The primary functions of the members will be: (1) to review applications for research grants and demonstrations and make recommendations to the National Advisory Council on Vocational Rehabilitation; and (2) survey, as scientific and administrative leaders, the status of research in their fields to determine areas in which research should be initiated or expanded.	8	$ 6,669	$ 7,500
Medical Research Study Section	This study section will have the responsibility for the technical and scientific review of applications for research grants in the area of medicine and related fields. The primary functions will be: (1) to review applications for Research Grants and Demonstrations and make necessary recommendations to the National Advisory Council on Vocational Rehabilitation; and (2) survey, as scientific leaders, the status of research in their fields to determine areas in which research should be initiated or expanded.	11	6,788	6,800

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
Medical Sub-Committee (Ad Hoc)	Provides consultation on new and continuation applications for Medical Research and Training Centers, and makes recommendations for action on each application to the National Advisory Council on Vocational Rehabilitation.	5	$ 809	$ 1,200
National Advisory Council on Correctional Manpower and Training	Reviews applications for grants covering research and studies into personnel practices, training needs and resources in the field of correctional rehabilitation and submits recommendations to the Chairman.	14	3,536	--
National Advisory Council on Vocational Rehabilitation	To review applications for grants and special projects which show promise of making valuable contributions to the vocational rehabilitation of the physically and mentally handicapped individuals.	14	7,736	11,600
Medicaid Research Advisory Consultants, ORDT Research Staff Observers	The purpose of this group is to serve as consultants on health behavior and health services research under the Directed Research Program of the Social and Rehabilitation Service for the purpose of reviewing and evaluating the development of Medicaid studies contracted with the University of Pittsburgh and Columbia University and for making recommendations to the Deputy Administrator of the Social and Rehabilitation Service regarding the merit and execution of the studies.	14	--	--

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
National AFDC Advisory Committee	Reviews research design, contract specifications, and proposals on National AFDC Study. Evaluates final report in draft and final copy.	5	$ --	$ --
National Citizens Advisory Committee on Vocational Rehabilitation	To make a comprehensive study of the current vocational rehabilitation program and of the Nation's vocational rehabilitation needs and to formulate goals for the program and make specific recommendations for arriving at those goals. The committee's study has been completed and a final report submitted to the Secretary, Department of Health, Education, and Welfare, and the Administrator, Social and Rehabilitation Service, on August 15, 1968. The committee is now being called upon to implement the report. Work should be completed on the conference by June 1969.	16	--	--
Non-Medical Sub-Committee (Ad Hoc)	Provides consultation on new and continuation applications for Non-Medical Research and Training Centers, and makes recommendations for action on each application to the National Advisory Council on Vocational Rehabilitation.	6	--	--

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
Psycho-Social Study Section	This study section will have the responsibility for the technical and scientific review of applications for research grants in the areas mentioned above. The primary functions of the members of the study section will be: (1) to review applications for research and demonstration grants and make recommendations to the National Advisory Council on Vocational Rehabilitation; and (2) survey, as scientific leaders, the status of research in the fields to determine areas in which research should be initiated or expanded.	9	$ 6,954	$ 7,000
Research Fellowship Board	The Committee has the responsibility for technical and scientific review of applications for fellowship grants in the areas of rehabilitation research. As scientific leaders, the Committee members review the status of fellowship research in rehabilitation and determine how and in what locations more fellowship applications might be stimulated. They also participate in evaluation of follow-up on fellowship recipients after termination of the grant. In addition, the Committee has the responsibility for reviewing and making recommendations to this office on research training applications which relate to the development of research training in order to expand the pool of investigators researching the rehabilitation problems of heart disease, cancer, and stroke.	6	--	6,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
Sensory Study Section	This study section will have the responsibility for the technical and scientific review of applications for research grants in the areas mentioned above. The primary functions of this group will be to review applications for research grants and demonstrations and survey, as scientific leaders, the status of research in their field to determine areas in which research should be initiated or expanded.	12	$ 8,140	$ 8,200
Technical Advisory Committee for an Exploratory and Pilot Study for Task Analysis of Social Welfare Jobs	Reviews proposals, makes recommendations for selection of contractor, and provides technical consultation to the project.	7	1,275	7,600
Technical Advisory Committee for an Exploratory and Pilot Study of Factors of Costs in Social Work Education	Reviews proposals, makes recommendations for selection of a contractor, and provides technical consultation to the project.	6	—	—

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Salaries and Expenses (cont.)				
Advisory Committee on Applications for Grants under Section 707 of the Social Security Act	Provides consultation on training needs in the field of social work; evaluates applications for grants, recommending priorities for support and amount of grants.	9	$ 4,808	$ 4,808
Juvenile Delinquency Prevention and Control				
National Advisory Committee on Juvenile Delinquency	To advise the Administrator on matters pertaining to general policy and program direction relating to the implementation of P.L. 90-445, the Juvenile Delinquency Prevention and Control Act of 1968.	18	3,500	20,000
Technical Advisory Committee for Title I Programs (Planning, Rehabilitation and Prevention)	To provide technical expertise and guidance in the review of programs and projects which are submitted for funding under P.L. 90-445.	11	2,500	30,000
Technical Advisory Committee for Title II Programs (Training)	To provide technical expertise and guidance in the review of programs and projects which are submitted for funding under P.L. 90-445.	10	2,000	25,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL AND REHABILITATION SERVICE				
Juvenile Delinquency Prevention and Control (cont.)				
Technical Advisory Committee for Title III Programs (Improved Techniques and Practices and Technical Assistance)	To provide technical expertise and guidance in the review of programs and projects which are submitted for funding under P.L. 90-445.	10	$ 2,000	$ 25,000
State Expense				
Council of State Administrators of Vocational Rehabilitation	Provides a forum to enable State Administrators to study, deliberate, and act upon matters affecting the vocational rehabilitation of handicapped persons; and to provide a resource for the formulation and expression of collective views on all issues affecting provision of rehabilitation services.	3	--	--

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL SECURITY ADMINISTRATION				
Salaries and Expenses				
Advisory Council on Social Security	Reviews the status of the Federal Old Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund in relation to the long-term commitments of the old age, survivors, disability, and health insurance programs; and reviews the scope of coverage, the adequacy of benefits, and all other aspects of these programs.	13	$ 5,175	$ 43,900
Health Insurance Benefits Advisory Council	Advises the Secretary on matters of general policy and the formulation of regulations in the administration of the health insurance program; studies the utilization of services, and recommends desirable changes in the way such services are utilized.	19	77,800	77,800
Advisory Panel on Incentive Reimbursement Experimentation	Advises the Secretary on alternative methods of reimbursement under Medicare which would provide incentives to keep costs down while maintaining quality of care.	20	66,000	66,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
SOCIAL SECURITY ADMINISTRATION				
Salaries and Expenses (cont.)				
Advisory Committee on Research Development	Gives advice on the overall development of the Administration's research and statistics program and its relation to research interests and activities in the broad social science community.	10	$ 6,860	$ 6,860
Medical Advisory	Advises the Administration on disability insurance policies and procedures as they affect physicians or the practice of medicine.	16	2,000	2,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
OFFICE OF THE SECRETARY				
Salaries and Expenses, Office of the Comptroller				
Advisory Committee on Grants Administration	Provides advice and counsel to the Assistant Secretary, Comptroller on administrative, fiscal, and audit aspects of grants administration.	10	$ 15,000	$ 18,000
P.L. 87-258				
National Advisory Committee on Education of the Deaf	Advises and assists the Secretary in the carrying out of existing and formulating of new or modified programs with respect to education of the deaf.	12	100,000	100,000
Salaries and Expenses, Community and Field Services				
President's Committee on Mental Retardation	Provides advice and assistance to the President in the area of mental retardation.	24	45,000	48,000
Office of the Secretary				
National Advisory Committee on Alcoholism	Consults with and advises the Secretary on matters of long-range policy as it relates to alcoholism and related programs.	18	125,000	--

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Advisory Groups

Name of Advisory Group	Function	Size	Cost FY 1969	Cost FY 1970
OFFICE OF THE SECRETARY				
Office of the Secretary (cont.)				
Secretary's Advisory Committee on Health Protection and Disease Prevention	Consults with and advises the Secretary on role of Government in prevention of illness and in planning of major expansion of effort to reduce incidence of disease.	22	$124,000	$ --
Task Force on Prescription Drugs	To make a comprehensive study of the problems of including the costs of prescription drugs in Medicare and related health care programs and evaluates the advantages of including the use of "generic equivalent" drugs to said problems.	9	90,000	--
National Advisory Health Council	Consults with and advises the Surgeon General on matters relating to health activities and functions of the Public Health Service, including advice on national health policies, programs and planning in marshalling the necessary efforts and resources to meet major problems and challenges. Reviews applications for grants-in-aid relating to research and research training projects, including those for the General Research Support Program, and recommends to the Surgeon General the approval of those projects which merit support.	12	7,000	24,000

HEW PAYROLL SYSTEM

Mr. FLOOD. Finally, Mr. Secretary, how is Mr. Kelly's payroll computer doing these days? Is it behaving pretty well?

Secretary FINCH. He doesn't give me a daily progress report, Mr. Chairman. We will let him work that one up.

Mr. FLOOD. How is it working?

Mr. KELLY. There are three basic points I would like to make:

One. The recently released audit findings pertained to fiscal year 1965. The report did include an identification that in July of 1968, errors of the same kind were being made but not of the same magnitude. I don't think we are out of the woods. We still have errors in the system. We are obtaining an entirely new computer system which will be a great improvement over what we now have.

The Secretary has directed me to accelerate this and we are now starting to utilize some contractual assistance to bring the new payroll system into being at an early date.

MODEL CITIES PROGRAM

Mr. FLOOD. Mr. Secretary, can you describe how you are participating in the model cities program? What mechanisms have been set up to channel HEW grants into the model cities? Are model cities given any preference or priority over other places in the competition for grant funds? What is the dollar level of HEW funds which will go into model cities in fiscal year 1969 and fiscal year 1970?

(The information follows:)

HEW PARTICIPATION IN THE MODEL CITIES PROGRAM

For the last 2 years, HEW has worked with the Department of Housing and Urban Development and other Federal, State, and local organizations to help communities develop their plans for model city demonstrations. HEW headquarters and regional staff worked with HUD to review model city planning grant applications received from 270 communities. HEW, along with other agencies, participated in HUD's selection of the 150 recipients of model city planning grants.

ESTIMATED FUNDING

The estimated share of the HEW budget going to the model cities is as follows:

[Obligations in millions]

	1969	1970
Number of participating model neighborhoods	75	150
Estimated portion of formula grants going to the model neighborhoods:		
Medicaid	$94	$183
Other health	62	102
Education	65	106
Maintenance payments [1]	142	236
Social services	10	23
Subtotal	373	650
Estimated portion of project grants available for projects in model neighborhoods:		
Health	28	70
Education	18	53
Social services	19	43
Subtotal	65	165
Total, estimated obligations	438	815

[1] Excludes social security benefits.

The estimated share of formula grants would be going to the model neighborhoods regardless of the model cities program. However, one important purpose of the program is to help cities use these funds more efficiently through comprehensive planning and coordination with other programs in a manner which is responsive to neighborhood needs and priorities.

The estimated share of project grants is the result of a conscious effort to focus funds subject to administrative discretion on the model neighborhoods. In November 1968, former Secretary Cohen identified $65 million as being reserved for model neighborhood demonstrations and outlined a process intended to help city demonstration agencies develop first year action plans based upon realistic levels of HEW funding. The fund reservation was the result of a Departmentwide review of project grant programs to determine which could be used to help the residents of the model cities and also further the general objectives for which the funds were authorized and appropriated. The estimate for 1970 assumes continuation of the projects begun in 1969 and the extension of the reserve system to channel funds for the initiation of new projects. The amount shown in the table for new project ($100 million) is a very tentative figure even on the assumption that all of the Department's budget requests are approved. The actual determination of a specific amount for new projects is contingent upon a Departmentwide review similar to the review which was conducted in 1969.

Mr. FLOOD. Mr. Michel.

Mr. MICHEL. Thank you, Mr. Chairman.

Mr. Secretary, as I recall, you were one of the last Cabinet members to leave your former position to assume your duties in the Cabinet. In so doing, you have been on board for an even shorter period of time than some of your contemporaries in the Cabinet. While you have given due credit to members of your staff for their assistance in preparation of your statement, it is quite obvious it has a good deal of your hand in it and it is a most comprehensive one. We commend you for it.

REVIEW OF THE BUDGET BY THE NEW ADMINISTRATION

Here we are today, March 12, in practically the last quarter of fiscal year 1969, which is the Johnson budget year. There is very little opportunity in this last quarter for you to be doing anything in your shop to reorient any of the expenditures that take place in the last quarter of this fiscal year 1969. You are here testifying on a fiscal year 1970 budget that begins July 1 of 1969 and runs through June 30, 1970.

You mentioned that there is to be a reworking of this 1970 budget and that there will be some recommendations coming up to us in a reasonable period of time. Even with that revision that is currently underway, is it possible in this comparatively short period of time to go deeper; can it be done in depth to any significant degree?

Secretary FINCH. I don't think it is immodest to say, on the basis of the conversations that I have had with my colleagues in the Cabinet—and I would defer to outstanding career people like Mr. Cardwell and Mr. Kelly—that with the quality of people we got on those task forces, we went about as deep as it is possible to go.

Obviously we could not tamper with the ongoing programs, the mandated programs. But I think we made about as thorough a scrutiny in that time as it was possible to make. We went about as far as we could go. I would appreciate Mr. Kelly speaking to that point because he has been through these transitions before. I may be presumptuous in my remarks.

Mr. KELLY. I don't think so, Mr. Michel. I think what occurred was an identification of the problems facing the Nation; the extent to which existing programs were addressed to these problems, and the extent to which they can be reoriented.

I think, on the other hand, that the point which you were developing is certainly a truism. Although you can bring about a redirection to start you on another course, the change that you can expect to bring about quickly is not so great. It can start a redirection. You can identify some targets, but the change that you can make during that time is a modest change.

Mr. MICHEL. Go ahead.

Mr. CARDWELL. I served as a subordinate member of one of the task forces and I can tell you that the task force didn't miss, I believe, a national problem or issue. They went into a lot of detail and examined the budget. Every program was examined. All of the supplementals were examined. The question of extension legislation was examined. The legislative program and its relationship to budget was examined. It was a very, very thorough review. Then you have to move to Mr. Kelly's point. The capacity the new administration will have to identify all of the issues and problems, to shift into significant budget changes overnight—that should be your basic question, a tough one.

Mr. MICHEL. Putting it another way, Mr. Secretary: How long will it be before we will see clearly a Nixon or a Finch imprint on the Department of Health, Education, and Welfare insofar as program priorities and expenditures are concerned?

Secretary FINCH. Without regard to labels, I would hope would see in the evolution of the budget that we have already started for next fiscal year some dramatic changes, particularly in the welfare field and in the health delivery system.

Mr. MICHEL. We will get some indication of these when this is revised; or will we?

Secretary FINCH. I think that you will find some benchmarks but we won't have the whole roadmap by a long shot.

DEPARTMENT EMPLOYEES SUPPORT OF THE BUDGET

Mr. MICHEL. Incidentally, have you issued any instructions to the people in your shop to support the figures which you personally are supporting in behalf of the 1970 budget?

Secretary FINCH. We have.

Mr. KELLY. Yes. At the moment it is a very troublesome problem, Mr. Michel. We are up here testifying on the budget that was submitted by President Johnson. President Nixon has under consideration modifications of it. It has not been fully laid out before you.

Secretary FINCH. We have not gotten all the modifications, by any means. That is one of our problems.

Mr. MICHEL. Maybe it would better be said by me that you ought to be particularly put on notice that it is not beyond the realm of possibility that there are people in your shop who are, as a matter of fact, talking in no unmistakable terms about increased figures, even over and above those which are included in the so-called Johnson budget.

Eventually we will want to be hearing only one voice in your shop, although everybody is entitled to a right of dissent. By the same token, if you are to have a smooth working operation, the horses have to remain hitched.

Secretary FINCH. I am well aware of that problem. It is not unique to this administration. It is one that we are really trying to come to grips with.

FUNDS REQUESTED FOR PROGRAM EVALUATION

Mr. MICHEL. On page 4 of your testimony you mention evaluation, and in fiscal year 1969 $6 million was available for it. In 1970, $21 million is being requested. How do you arrive at that figure? What was the input that said it should be $21 million instead of $18 million, something less or more than that?

Secretary FINCH. Will you answer that, Mr. Kelly.

Mr. KELLY. The principal area was in education. The total is $21 million of which $14,300,000 is related to the educational program; $9,300,000 in elementary and secondary, and $1 million in higher education, $1 million in vocational education, $3 million in research and training.

The task forces recommended support of these figures and they recommended that the extension legislation in elementary and secondary contain a provision that 1 percent of the funds there would be available for evaluation.

Mr. CARDWELL. One of the first things the task force examined was existing legislation to determine whether there were specific authorizations for evaluation and how the budget dealt with those authorizations. We do have a number of programs where there are specific authorizations built in for evaluation. In others we do not.

Mr. MICHEL. I am sure that you appreciate that it is a sizable increase we are talking about. Secondly, we are always wary, I guess, on this committee, of these reevaluations and reevaluating the reevaluation. This can run into some trouble unless you have some good material to sink your teeth into and say this is what is actually required to do the kind of job that has to be done.

I am not saying it does not have to be done because I think it is like our defaulting on our responsibility of legislative oversight for ourselves. We fall down on that.

Mr. KELLY. These can be relatively expensive. A new program is really just a hypothesis to solve something. There has to be built into the program some kind of mechanism to find out whether it works. To build that in, somebody has to design a way of collecting data so that it can be eventually evaluated. Most of the data collection systems that have surrounded programs like elementary and secondary education provide operational statistics. They are not the kinds of data that are designed to tell, let us say, a professional researcher whether or not you are achieving your objectives. They might tell how many students got helped in your county, where they are, and what kind of help they got. The questions as to whether or not in the end these students profited from this undertaking, and what benefit they received from it, go unanswered. A large amount of effort is required to design this kind of data collection. The analysis of the data is a very expensive process also. Yet you would think that it would be something that we would have been doing all along.

Secretary FINCH. I have not computed what percentage of our overall budget goes for evaluation, but private enterprise spends anywhere from 6 to 10 percent for evaluation and research. I think this underscores how flabby we have been in this area.

NEED FOR ADDITIONAL FUNDS RATHER THAN REDIRECTION

Mr. MICHEL. On page 8, and I think page 9, you make mention that significant innovation can come only from new money to make a start toward developing new delivery systems for health systems for urban and rural poor.

On page 9 you say it is difficult for the States to do much that is creative with present funding levels. Then I have to ask the question: Is it all just a question of money? Isn't there some element here of redirection or reorientation?

Secretary FINCH. Unquestionably so, Congressman.

Mr. MICHEL. Unfortunately, we get the response so often, on this committee, "But if we only had the money; the only thing that bars us is that you fellows have been so miserly with appropriations."

Then those who come before us as innovators with a responsibility for doing new things, throw up their hands and say, "Because we didn't get everything we wanted, it is not our responsibility any more. The Appropriations Committee shafted us so now it is the committee's responsibility."

Secretary FINCH. Of course, as you know, in our industrial States it is pretty clear that with all the demands on their resources we cannot look to them for much in the way of help. We talk a great deal about how we might draw upon nongovernmental resources a good deal more. This is really a pivotal point as far as we are concerned.

CLOSING OF MEDICAL AND DENTAL SCHOOLS

Mr. MICHEL. On page 11, the item of $219 million for operational support and capital improvements, medical, dental, and related schools, you are asking for an increase of $75 million over the 1969 appropriation. If this increase is not granted, would there, to your knowledge, be any danger of any of these additional institutions folding as has happened with a few institutions in the past several years?

Secretary FINCH. As we indicated in the paragraph above, we have information that there are a number of them very close to the brink. That is why, despite several reports, including the Carnegie Foundation report, we have weighted these figures heavily on the operational side. We provided $219 million for operational support, $75 million of which is for construction. Of the increase of $75 million, a little over half this, $43 million, is also for construction. We think we have to keep these institutions alive, as well as expanding existing plants or making new starts.

Mr. KELLY. Another way of looking at the same thing is what these figures provide. There are now 840 spaces in the first-year medical schools. This would bring it up to 1,016, or an increase of 176. After you have taken care of the schools that are in trouble, that have a fear of losing enrollment, then you can then begin to make resources go to expand the number of people that can be entered in medical school. The cost per new student decreases as you increase these funds once you have made the initial distribution.

Mr. MICHEL. If we were not caught in the switches as we are moneywise, and you were free or felt free without any kind of wraps to request more money if it could be utilized, do you have any idea of

what figures we would have here instead of a $75 million increase. What could be utilized properly and orderly in this same general area that you just addressed yourself to?

Secretary FINCH. My recollection—subject to correction—was that the Carnegie report stated that you would about have to double the figure just to increase enrollment in existing medical schools over the roughly 100-graduates-per-year level that they seem to be trapped at now. I am talking about practically every major medical school in the country.

Then there is another massive figure in terms of new starts that they thought should be made on a geographical basis. I don't have that figure at hand.

Mr. MICHEL. Could you supply that for the record?

Secretary FINCH. Yes, sir.

(The information follows:)

The 1970 budget estimate for operational support and capital improvements for medical, dental, and related schools is $219 million, an increase of $75 million over the $144 million appropriated for fiscal year 1969. About 70 percent of both the 1969 budget aid the 1970 request is directed to the support of medical schools. Thus the 1969 base for medical school support is approximately $100 million.

The Carnegie Commission on Higher Education has recently proposed a level of Federal funding for academic year 1970–71 of $300 million for comparable medical education programs (excluding student aid). This would also be appropriate for fiscal year 1970. The report states that these estimates are needed for facilities to provide spaces for about 75 percent more medical students by 1976–77.

If the Commission's estimate of $300 million for medical education alone is correct and if it were adopted, the increase for 1970 over 1969 for medical education would be approximately $200 million in contrast to the $53 million increase included in the budget for medical schools. By extension, if the dental and the other health related schools increased at the same rate as medical education as proposed by the Carnegie Commission, an additional $88 million would be required.

Consequently the total increase in 1970, based on these assumptions, would be $288 million for medical, dental, and related schools rather than $75 million as currently requested in the 1970 budget.

CONCENTRATION OF EDUCATION FUNDS ON DISADVANTAGED STUDENTS

Mr. MICHEL. On page 12, in the area of elementary and secondary education you state, Mr. Secretary, the title I funds should be concentrated on those schools with highest percentages of disadvantaged students. And you go on to say that the Office of Education is now attempting to persuade States and school districts to focus funds in this way.

Would it be your considered judgment that under the formula currently in the statute it gives the States too much leeway?

Secretary FINCH. Obviously when you are dealing with figures that are 9 years old, you are dealing with a fairly unrealistic set of figures. We did, as you know, supply additional data on the numbers of children on welfare, but very few States are using that. Various proposals have been made. A 5-year census, for example, could help us to perform in a more responsive and more realistic way. I want to make it clear that we are talking about taking care of disadvantaged students wherever they may live. We are not simply talking about ghetto areas, but rural and other areas as well.

Mr. KELLY. I think the problem here is with the formula that is in the law. Money is getting to the right school districts. But some school districts tend to spread the funds over the entire district rather than concentrate funds in those individual schools that have a very high proportion of disadvantaged. They are allowing it to go to schools that have a small proportion of disadvantaged. Thus, you are not always getting a high degree of concentration in the poor schools.

Mr. MICHEL. Would it be the pressure upon the local school board in a given community that would dictate that policy?

Secretary FINCH. And the State.

Mr. KELLY. And the State.

Secretary FINCH. That coupled with the State approval process. It is up to the individual board or superintendent to settle those differences.

Mr. MICHEL. I will have to agree with you, this is certainly a problem area.

When we are so strapped as we are to do what has to be done, I have always pretty much been an advocate of the rifle approach rather than the shotgun approach. There are some communities, and we have some at home, that frankly ought not to be benefiting nearly to the extent that they are and thereby depriving some more critical target areas of funds that they ought to have. So at least the mere mention of it suggests that some thought is being given to getting the most for our money and targeting in on the more critical areas.

TEACHER CORPS

I see that on the Teacher Corps in the 1970 budget we would have practically a doubling of the program, would we not?

Secretary FINCH. Yes, sir. The request is 50 percent greater than last year.

Mr. MICHEL. You would expect to have 2,400 members in active service and recruit and bring in 2,000 new ones?

Secretary FINCH. Right.

We are finding, in district after district across the country, that we are just not getting teachers meeting the quality requirements for the different levels of licensing. We feel that the current 20 and 30 percent vacancies in teaching loads is an area of desperate concern.

Mr. MICHEL. How about the applications for the Teacher Corps; have you had a significant increase in those who have applied for the program in the past year, over a year ago?

Secretary FINCH. We have to get those figures.

Mr. KELLY. To the best of my knowledge and belief, the supply of available volunteers has been greater than we can possibly fund.

Mr. MICHEL. So that to me suggests there is at least a continuing and growing interest in people getting into the teaching profession to be targeted into some of these areas, but they don't do it without the extra premium and stimulent of what we give them through the Teacher Corps?

Secretary FINCH. Yes, sir.

Again, another source we might be able to tap would be the men returning from the Vietnam war. I have already discussed utilizing a number of them for health delivery services. But if we could also bring these people, and particularly members of the minority groups

who have had some exposure to the educational process and the scientific disciplines into schools where there is a high percentage of students from broken households, it would be very beneficial. This could be very helpful.

Mr. MICHEL. If it is all right, I will ask one more question and then I will run for the rollcall and come back.

EDUCATION OF EXCEPTIONAL CHILDREN

With all of this attention being directed to the poor and disadvantaged young people, the talent search program, upward bound, and you name them, we are not going to lose sight in the Office of Education, are we, of what we ought to be doing to promote and enlarge the programs that have a good start in some areas, not nearly as much as it ought to be, for the exceptional child, those who have the ability and capability for learning faster and can be acclerated in classes to achieve more in a shorter span of time?

In my home community of Peoria we have an exceptional program in this regard, for the elementary and secondary grades. A great many children have been beneficiaries of this program, and it has done marvelous things for them. Taking languages in the fifth grade for example and enabling them to enter high school in the third year level in German or French. Accelerated classes in math, physics and practically all subjects for those who can keep up and have a special gift or ability. It is a wonderful program.

I hope we will not lose sight of our obligation to encourage the exceptional child as well as the disadvantaged.

Secretary FINCH. There is no question about that. I think this is one area where the local districts themselves have really tried to build up these programs. Of course under the Elementary and Secondary Education Act we are given a particular clientele to serve, and we have to work within those constraints. But I agree with you.

Mr. MICHEL. I appreciate that.

Secretary FINCH. This is something we have to work a lot harder on.

Mr. FLOOD. Mr. Natcher?

Mr. NATCHER. Mr. Secretary, I want to join my chairman in thanking you for an excellent statement and for your appearance before our committee at this time. The same also applies to your Under Secretary, Mr. Veneman, and your Assistant Secretaries, Mr. Black and Mr. Butler.

You of course well know that 94 percent of the money in your bill goes out in grants, and that is a large percentage of the amount involved.

Mr. Chairman, with your permission at this point I would like to go off the record a moment.

Mr. FLOOD. Off the record.

(Off the record.)

Mr. NATCHER. Mr. Secretary, as our chairman pointed out, one of the main concerns we have had on this committee in regard to health services pertains to the rising hospital costs that we are confronted with here in this country, and I believe that some who appear before our committee say it will now go to an average of $100 a day, which places a lot of people in a position where they cannot afford to be sick.

I was glad to hear you say to the committee, Mr. Secretary, that this is an important matter and one that is receiving serious consideration at this time.

DISSATISFACTION WITH WELFARE SYSTEM

You point out further the dissatisfaction on the part of the recipient, the general public, the State and local governments in regard to the welfare system. You are not for a guaranteed annual income, are you, Mr. Secretary?

Secretary FINCH. No, sir.

Mr. NATCHER. I join with you in that, Mr. Secretary, and I am glad to hear you say it.

What complaint do you receive mainly, just briefly, in regard to the dissatisfaction of the recipient as far as general welfare is concerned?

What complaints do you hear other than the amount is not high enough?

Secretary FINCH. We hear a number of complaints about what people regard as indignities to which they are subjected, the endless forms they have to fill out. This is why many of them feel strongly about a simplified declaration. They regard the process as degrading.

Other complaints include the peculiar requirements of various States where there are unrealistic categories for food, furniture, or clothes. These tend to be unrealistic in terms of varying costs of different commodities.

What others?

Mr. KELLY. I think that one of the things I have heard a number of times is that people who have been trained as social workers and want to be of assistance to the poor spend their time engaged in the administration of public assistance programs. Frequently you hear the statement that the second-most unpopular person in the ghettos of this country is the social worker.

One of the reasons why some public welfare administrators are arguing for a separation of the administration of financial assistance from the administration of social service is so that the social service person can be a person that the welfare recipient will turn to for aid and assistance, rather than looking upon him as some kind of an investigator. I think that this "investigator" concept has led to a high degree of dissatisfaction.

Secretary FINCH. I think that in a clear case where a person is obviously blind or handicapped, we have gone too far in terms of the paperwork that is required in the regulations. In less clear-cut cases, such as AFDC, we want to do some further study.

Mr. FLOOD. Will the gentleman yield?

Mr. NATCHER. Yes.

Mr. FLOOD. We have had this problem in the early days of the program—the very elite girls' school graduate in a Cadillac convertible and a mink coat, being a social worker in the ghetto telling a mother how to raise 11 children. That is the kind of problem very much heard in the early days.

I think you are away from that now; are you not?

Secretary FINCH. I think w have passed that stage. They generally cannot afford that kind of a car or coat. But the symbol is still there, Mr. Chairman.

There are a lot of people locked into a social welfare approach that really is not relevant any more.

HIGHER EDUCATION FOR INTERNATIONAL UNDERSTANDING

Mr. NATCHER. Mr. Secretary, you stated to the committee that you are very much in favor of the item in the bill that would fund the item "Higher Education for International Understanding." Mr. Secretary, I know they have informed you that this is an item that has been before this subcommittee in two regular bills and one supplemental during the past few years.

Why are you so strong for this, Mr. Secretary?

Secretary FINCH. I tried to point out that this is an area where we really do need to prepare our students better, in combination with other programs of understanding, particularly in the business field, education, and in government. This will give us the flexibility, even with the modest $2 million we are seeking, to make use of a lot of other existing programs that do not seem to be doing the job now.

Mr. NATCHER. Mr. Secretary, when we first had this item up, I was inclined to be against it and I decided I would talk with some of my friends in the field of education, some right able people, to see how they felt about it, and in the main they informed me, Mr. Secretary, that this was something that would cost the Government ultimately about $500 million. You know the basic legislation as I recall carries it up to $90 million, an then on up to $120 million. Is that not right?

Secretary FINCH. The first authorization was in that magnitude, yes, sir.

Mr. NATCHER. And these people, Mr. Secretary, I have talked with seemed to think this is a program that, if funded, would be a matter of subsidizing colleges and universities and in the long run the program would not justify the amounts entailed down through the years.

As I explained to you a few minutes ago, it has been before this committee on a number of occasions and the committee refused to go along with it. You mention in your statement about foreign aid, Mr. Secretary. No one on this committee believes this is part of the foreign aid program.

Secretary FINCH. No, sir.

Mr. NATCHER. We do not believe that at all.

Do you know how that started? Dr. Paul Miller was in here and the question was asked of Mr. Miller, "Dr. Miller, what difference is this from foreign aid?", that is where that got started.

But, Mr. Secretary, nobody on this committee believes that. It is just a matter of funding a program that will require a lot of money that we did not believe was justified.

Secretary FINCH. There are a great many programs that are going on right now. I am acquainted with some because I was a regent of the University of California and a trustee of the State colleges. A great many programs are going on in some private schools and we are unable even to monitor those programs.

In my opinion, we need to do more than just catalog the existing efforts of student interchange sponsored by institutions of higher education. For example, we ought to know a lot more about people who are receiving their medical training abroad and who may or may not return here to practice. I do not conceive of this as a kind of program where we would be subsidizing students.

We are really trying to monitor what is being done now, by public and private education. We want to have a better grasp of what is being done. This is my view about it. I do not know what other legislative background there may be here.

Mr. NATCHER. It would be perfectly agreeable to the committee, to turn to Mr. Kelly. He has been batting this ball a long time and he now comes to bat again.

Mr. KELLY. I do think, Mr. Natcher, that there are a number of very prominent educators in this country, who are very enthusiastic about this program.

As you know, they had a meeting in Williamsburg, for the purpose of developing the concept of the program. It was certainly their conclusion and their recommendation to the then Secretary and to the Congress, that there exists the opportunity in this country to instill into the educational curriculum at every level, a greater awareness of the impact of our actions, and our domestic policies, on the world that we live in.

It is a field in which curriculums have been developed and programs have been drawn in such a way, as to give the American student a beneficial element of awareness and exposure. You do not have to subsidize the operation of every educational program, to achieve this, but you do have to have an outside stimulus, to get this built into educational programs.

And a number of prominent educators are really fighting for the Federal Government, to get involved in this. It seems to me that it is an element that is worthy of consideration. These men really feel that there is a missing element in our higher education and that with national leadership, you could overcome it.

I think this is the message Dr. Paul Miller tried to persuade you with.

Mr. NATCHER. Mr. Kelly, ultimately what would the program cost the Federal Government? Do you have any idea?

Mr. KELLY. I do not.

Mr. NATCHER. How would you be able to leave out any college or university in this country, once this program is funded and gets under way? How would you be able to set the standards to eliminate any State, Mr. Secretary?

Secretary FINCH. My view, is, that we do not even know at this point, what the overseas programs in our major universities are accomplishing. Their overseas facilities are not even inventoried. Without making any long-range commitment, I would just like to find out, what our strengths and weaknesses are, in the existing programs that have been supported by various State and private universities; what they have achieved, and what they failed to achieve; and how many students are involved. And as far as I know, you cannot get that information from any other source.

It seems to me, that some money is in order just to find out if what we have at hand is justified. I would not want to get us locked into an ongoing program, that would involve us with every major institution in the country, because we do not know whether these programs are working well or not. I know we have some serious reservations.

The University of California has some nine campuses abroad. There are some real problems with some of those campuses. We ought to take a national view of what has been done in this area. Some of it is pretty exciting, some of it is pretty bad.

Mr. SMITH. On that point, I think, one of the difficulties has been they have not been able to tell us exactly what they would use the money for if they had it.

One head of the program, explained a program which he said they want to inaugurate. I went to Maxwell School, and I know, they did what he described about 20 years ago. He had a completely different idea of the program than some other people had. We have not been told definitely what would be done with the program if they had it funded.

Secretary FINCH. If we may, Congressman, in the interest of time, let us try to come back with a responsive statement about this, and insert it in the record.

Mr. SMITH. I think we considered appropriating $300,000 for development of a specific program proposal.

Mr. KELLY. It was never funded.

Mr. MICHEL. Will you yield, Mr. Natcher?

Mr. NATCHER. Yes.

Mr. MICHEL. While we are on the same subject, I would have to underscore the last point that Mr. Smith made, that we really have not had any witness come testify and make the case of precisely what it is going to go for. It is very easy to get a group of the most sophisticated and highly educated educators we have in the country, in support of this kind of program, if it means travel abroad or assignment abroad, not only for themselves, but some of their students. Our oldest boy is going to Yale, and next year, he can go to Europe and spend that year there, except he wants to be back here, playing basketball.

At Stanford they have a junior-year-abroad program. It seems to me there are a sufficient number of institutions of higher learning here that on their own have been able to do that kind of thing. If we want to go around and subsidize all of the other universities to do something like that, I don't think we can afford it. If our institutions of higher learning have not been able to develop the kind of studies that ought to be taught for more international understanding, then it seems to me that the educators themselves have fallen down on the job, and I cannot see in this academic area where the Federal Government has the responsibility to subsidize that kind of teaching. The case just has not really been made.

I have to speak from this side of the table and give you that point because, as the chairman says, we all feel that way except for him.

Secretary FINCH. Speaking only for myself, I am not prepared to argue whether programs for students or teachers should be subsidized. But I would like to have us go as far as possible in evaluating what these programs have achieved. I suspect we might find that we have been too provincial in our approach. They tend to be in New England

or on the west coast and there is not enough intermix. At least we would find out some things. That is as far as I would like to take this now.

I would like to come back with a broader statement, if I might.

Mr. NATCHER. At the time Dr. Miller appeared before the committee, we asked about the amount involved in the program and he pointed out to the committee that the authorization legislation started at $1 million, and then I believe it stepped up to 40 and then up to 90 million, and again, Mr. Secretary, you would not have any idea as to ultimately what this type of a program would cost; would you?

Secretary FINCH. No, sir; I would not know until such time as we can take a look at the existing programs in both public and private institutions. I am speaking for myself again, and do not want to reflect a departmental position because I have not yet had a chance to review the full history. I simply want to evaluate what is going on now. I do not want to get into the position of committing ourselves to subsidizing students or instiutions to any degree until I have evaluated the effectiveness of these ongoing programs that are not funded by the Federal Government.

Mr. NATCHER. Thank you, Mr. Secretary.

Mr. FLOOD. We will adjourn until 10 o'clock tomorrow morning, Mr. Secretary.

Secretary FINCH. We will be here, Mr. Chairman.

THURSDAY MARCH 13, 1969.

Mr. NATCHER. The committee will come to order.

Mr. Michel.

EDUCATIONAL PROGRAMS FOR EXCEPTIONAL CHILDREN

Mr. MICHEL. Mr. Secretary, there was one point I wanted to clear up with respect to the views I expressed relative to the climate for encouraging our youngsters who have the ability and an inclination to be accelerated in their classes. In my home community we have a very fine ongoing program of this kind that has been in existence for a long time, and we are finding from those disadvantaged and ghetto areas that we are getting candidates up through the system to accelerate. It is not only one of those programs that would on its face be aimed at an affluent society but rather there are opportunities for those who come from these very areas that are target areas, they are sought out for accelerated training and are doing a marvelous job.

At home, I think there is just one parochial school and one or two other public schools that actually have the facility for providing this type of training.

Secretary FINCH. Do any of the programs that you are talking about involve classes where they allow mobility between age groups and grades?

Mr. MICHEL. So far as I know they do. Probably not to as grand a scale as some that I have heard talked about because they are generally pretty much in the slotted category of sixth, seventh, eighth graders, but nevertheless in the same school it is all up and down the age scale.

AFDC FREEZE

Mr. Secretary, going back to your statement on page 19 where you address yourself to the AFDC freeze that would impose on the State and local jurisdictions, in your words "a nearly intolerable burden," the figures which you cite here are very telling ones. There is no question but that when we enacted this legislation we realized there were going to be some problems.

What we were trying to do was, maybe in our feeble way, to make some effort to turn this thing around. If this, along with the work incentive program, is not the right way, what the devil is our answer to this problem of ever-growing welfare rolls, particularly in the area of aid to dependent children?

Secretary FINCH. I wish that I had the answer, Congressman. I am convinced that the freeze is not the answer because what it does is throw those additional legitimate cases onto the States, and the States are obviously overburdened. So the additional funds come out of education and other critical services. It will probably take some wholly new approach to overcome this problem, and we have not yet found it.

As I said in my earlier testimony, this problem and the problem of controlling rising medical care costs are the most critical problem areas we now have in the Department. There have been three study groups, the latest of which is being headed by Secretary Flemming. He is working on this problem now and I don't know what the result will be. We hope that——

Mr. MICHEL. Is there actually a task force in being or will there be a task force?

Secretary FINCH. The one directed by Secretary Flemming is mandated to go into the whole problem of Social Security, and it is in being. It has a broad enough charter that it can look at the welfare problem as a whole. We have asked for an interim report to coincide with an in-house welfare task force we also have working. We hope this will be available in 60 or 90 days.

I may be optimistic about that. His formal report on Social Security as requested by Congress is not due until 1970.

LAG IN WORK INCENTIVES PROGRAM

Mr. MICHEL. In the following page and closely associated with this whole problem, you make mention of the January 1969 goal of 100,000 enrollees in the WIN program and that only 39,000 are apparently actually enrolled. How do you account for the fact that in this case only 39 percent of the goal has been reached?

Secretary FINCH. This may be an oversimplification, but I think that there is not always a good relationship between the State employment agencies and the State welfare agencies. And we, of course, have to rely on these State systems and subsystems. I am afraid that employers do not have a great deal of confidence in State departments of employment and that the interface we need between the welfare and employment people in the States is not always there. This is what has come up in my conversations with the Secretary of Labor. Of course, the program is fundamentally Labor's responsibility, although we do the funding.

I am not trying to throw blame on someone else, but, as I say again, we have to count on the local people and I am not satisfied. I think that is where the slippage has been, and that is what we have to try to correct.

Mr. MICHEL. In day care for children again the targeted goals have woefully missed their mark when you mention 23,400 being the goal but only about 13,600 children actually receiving day care as of January 31, 1969.

In this area alone what was actually budgeted in money and if we fall short of the mark of achieving what we proposed with the money appropriated, what happens?

Secretary FINCH. Before Mr. Kelly responds to that——

Mr. MICHEL. May I follow on that same subject by saying, on the following page of your testimony you say the budget assumes that 175,000 trainees will be enrolled in the WIN program in 1970. That would seem to be a very high goal in view of the record of achieving goals this year.

Secretary FINCH. That is why we stated the problem the way we did. We were not trying to obfuscate it at all. We are pointing out that it has not worked too well and that we have a very high level, a major target to try to reach. I will say this in defense of the day care program. There has been, I think, a very short time in which to implement the program. One of the possibilities—and I mention it only as a possibility—that we need to look at is to bring into the day-care concept a good deal more parental involvement. This might result in a restructuring of both the organization and program of day care.

In my opinion the day care program has a great deal more potential than does the WIN program. That is my opinion only. I will let Mr. Kelly speak to the dollars.

Mr. MICHEL. Would you? Obviously, I am particularly interested here with certain goals having been projected and coming before this committee asking for funds sufficient to meet that goal of which you are falling short.

FUNDING OF WORK INCENTIVES PROGRAM IN 1969

My first question is, what happens to the unexpended funds?

Then particularly with an increase in that goal for the following year, the natural inclination for us is to say, "Gad, you are not anywhere near achieving that 1969 goal. Maybe we better cut the requested funds back proportionately."

What do you say to that?

Mr. CARDWELL. That is a very good question. We have been working during the last several weeks with the Department of Labor to try to reach some understanding with them as to their plans for the rest of this fiscal year and all of the next fiscal year. We wanted to be certain that we could tell you that we will be able to use the money as originally planned.

First of all, the program is divided into two parts: $95 million of the $117 million available this year was earmarked for the Department of Labor. As of this time they have committed about $60 million of that $95 million. We have asked them to present to HEW a plan

for the remainder of this year which would obligate the remaining $35 million.

One of the problems that they have run into is that 16 States lack the authority to operate the program through the local employment agencies in the States. The plan that we have asked them to give us would recognize that and would enlarge the programs in those States that do have the authority. We pick up those 16 States for the first time next year. In other words, we would shift money that was originally set aside for those 16 States to the remaining States this year and then bring the 16 States into the program in 1970.

Labor believes that they can develop a plan which will obligate the full $95 million available this year. To do this——

Mr. MICHEL. This year?

Mr. CARDWELL. This fiscal year, 1969, between now and June 30.

They would do this by entering into 12-month agreements with the States. The 12-month training period would cross the fiscal year. In other words, the agreement would be a 12-month agreement beginning sometime between now and June 30 and end sometime in the succeeding fiscal year. Thereafter, all agreements with State agencies would be on a 12-month basis starting at the time of the agreement and ending 12 months thereafter.

When we get this plan we will be glad to furnish it to you. We hope that it will be what they say it is going to be.

Secretary FINCH. The problems here are similar to the problems that Labor and Agriculture are having in taking over the Job Corps. That has not been worked out completely yet either.

FUNDING PROCEDURES

Mr. MICHEL. Is this a normal procedure in this contracting business?

Secretary FINCH. Yes, sir. It is.

Mr. MICHEL. Running during different fiscal years?

Secretary FINCH. At first there was a variety of time periods covered by the agreements. Some would run from the point of agreement to June 30th; some ran for only 3 or 4 months, some ran for more than 12 months. We have asked them to develop a uniform plan which would do two things: to set up the training slots, which is the most important objective, and to make maximum effective use of the money. We have to see that this plan blends into the 1970 budget and also would permit reaching the goals set for the program in 1970.

My suggestion is that you give us an opportunity to receive this from Labor and we will then furnish it to you.

Mr. KELLY. This procedure is similar to the way we have handled research grant programs in NIH. It has been more understandable there where we are doing 12 months of research out of the fiscal year funds but don't have to start it within the fiscal year. This corresponds to that plan.

Mr. MICHEL. The more mixing there is, the more it tends to confuse us here.

Secretary FINCH. It also confuses the recipients.

Mr. MICHEL. I want to make sure it is not done by design for that express purpose of keeping us off balance so we don't know for sure.

Mr. CARDWELL. Our objective is to have the program run smoothly

and not have an on-again-off-again financial arrangement. That is what we have had up to this time.

The other answer to your question deals with day care. That is financed under a different arrangement. Day care comes under the Social Security Act concept of reimbursing the States for their expenditures. We cannot fund that in advance. We have not yet worked out any arrangement under which the State welfare agencies could plan a 12-month program in advance. We have asked the Children's Bureau to give us a 2-year plan for day-care activities. It will of necessity have to be based on the States' own forecasts of their capacity to provide day care, and their estimates of how many potential WIN trainees have children requiring day care.

There are some signs they may have overestimated the numbers of such children, and I cannot tell you right now how that is going to work out. I think by the time we have the Labor plans we can give you the day-care plans too.

INCREASE IN MEDICAID COSTS

Mr. MICHEL. In your discussion of medicaid, I think last year I asked in the hearings for a chart.

Secretary FINCH. We have some material on this, Congressman, that might be responsive to your question.

Mr. MICHEL. As I recall, last year somewhere in the hearings—and I regret I don't have that page before me—we had a table showing the increases in the number participating and the costs.

Have we made this a part of the record?

Mr. CARDWELL. No, sir.

Mr. MICHEL. Why don't we, Mr. Chairman, have this particular table inserted in the record at this point?

Mr. NATCHER. Without objection, it is so ordered.

(The table follows:)

MEDICAID

[In millions]

	1969	1970	Change
People on welfare:			
Recipients	5.9	6.3	+0.4
Federal dollars	$1,196	$1,402	+$206
Total dollars	$2,003	$2,645	+$642
People not on welfare:			
Recipients	3.6	3.9	+.3
Federal dollars	$1,115	$1,538	+$423
Total dollars	$2,421	$2,902	+$481
Total:			
Recipients	9.5	10.2	+.7
Federal dollars	$2,311	$2,940	+629
Total dollars	$4,424	$5,547	+$1,123
Jurisdictions participating	47	54	+7

FAMILY PLANNING

Mr. MICHEL. In family planning, what is the dollar figure for 1969 and for 1970?

Mr. CARDWELL. The figure for the Department as a whole in 1969 is about $47 million. In 1970 it will be $68.7 million. Of the amount in 1969, about $18 million is in maternal and child health programs.

Of this about $3.5 million is in the form of State formula grants. We did make an analysis of the total impact of the Department's programs in the area of family planning and it adds up in 1970 to $68.7 million. I think that I have a table I could give you on that.

Mr. Michel. How many States are participating in that formula grant program?

Mr. Cardwell. I am not certain. I think in one way or another most States could be identified as participating.

Mr. Michel. Supply something on that for the record.

Mr. Cardwell. Yes, sir.

(The information follows:)

The maternal and child health program provides grants to States to extend and improve their services for the promotion of the health of mothers and children. Broad discretion is allowed the States in the use of these funds. Expenditures for family planning services by the separate States are not available. However, it has been determined that 38 States, Puerto Rico, Guam, and the Virgin Islands provided family planning services last year, and the States have reported that over 350,000 women received services in the programs in fiscal year 1968. The estimated funding for family planning services in this formula grant program for fiscal year 1969 and 1970 is $3,500,000.

NUTRITION SURVEY

Mr. Michel. On this matter of hunger and malnutrition, you say that the survey at present is confined to a relatively small sample of States and localities.

Who is conducting this survey for the Department?

Mr. Kelly. Health Services and Mental Health Administration.

Secretary Finch. That covered, as I recall, Texas, Louisiana, Kentucky, New York, and Michigan. The basic survey was ordered by my predecessor.

Mr. Kelly. Dr. Schaefer is the one directing the study. He is the one that recently testified before the Senate on the preliminary findings.

Mr. Michel. Are these solely in-house people doing this? Any contracting on the outside?

Mr. Cardwell. There is some contracting on the outside; yes, sir.

Mr. Casey. Would the gentleman yield?

Mr. Michel. Yes.

Mr. Casey. Aren't the State health departments very much involved?

Mr. Cardwell. Yes, sir. They are doing some of the work for Dr. Schaefer under contractual arrangements.

Mr. Casey. They are doing some of the actual survey work on the ground, door to door?

Secretary Finch. Yes, sir.

Then Congress asked us to expand the survey to all 50 States. Within the limits of our present resources, we are expanding the survey now.

Mr. Michel. If there is any special contracting out to do this, would you give me an indication for the record with whom that is?

Mr. Kelly. Yes, sir.

(The information follows:)

There are now 10 States included in the first phase of the National Nutrition Survey. The basic protocol has been developed by the nutrition program with the assistance of several organizations within HEW and other Government agencies, such as the USDA and OEO.

The State surveys are carried out by a direct contract with the State health department or with another agency selected by the State health department. In six of the 10 States in the first phase of the survey—Kentucky, Michigan, California, West Virginia, New York, and South Carolina—the contractual arrangements are with the health department or a related research foundation. In the remaining four States, the work is being done by universities selected by the State health departments. They are, as follows: Texas, University of Texas Medical School; Louisiana, Tulane University; Washington, University of Washington; Massachusetts, Harvard School of Public Health.

The staff of the nutrition program monitors these projects and provides necessary technical consultation, but, as far as possible, the basic staff is drawn from within the State.

The same pattern of contractual arrangements with the State health departments or their designees will be continued when additional States are brought into the survey.

Mr. MICHEL. We have become a little skeptical of some of these surveys made in a very cursory fashion for a variety of findings. Some are pretty shocking when you know how the information is gathered and what distortions, as a matter of fact, there are to some of the material that has actually been presented as an everyday happening and occurrence.

Mr. KELLY. Let us provide you with the design of the nutrition survey.

Mr. MICHEL. If it is a problem area and we have got to go at it, fine. Then let us make sure whatever we are looking for is done on good, sound grounds that can be backed up in any forum.

Mr. KELLY. Dr. Schaefer identified some very substantial problems, but he made it very clear that this was not a national sample. This was a biased sample. The survey was taken in places where there was the greatest amount of poverty and the greatest likelihood, therefore, of malnutrition.

Mr. CARDWELL. I would add that the studies themselves have a very strong health component. The staff from the National Center for Health Statistics did the basic design of the study. I think that you will find when you look at the data that the design was well developed.

Mr. CASEY. Would the gentleman yield further at that point?

They are not through with their study?

Mr. CARDWELL. That is right.

Mr. CASEY. All they have done is gather the initial data in some of these areas?

Secretary FINCH. That is correct.

Mr. CASEY. They won't have the results of this for a couple of years maybe? I don't know how long it is going to take, but I know in Texas it was done under the direction, primarily, of the State health department, data gathering. They used medical students out of the University of Texas Medical School to do some of the leg work, and one of the doctors attached to the University of Texas was one of the research men in it. They are not through with the evaluation of the data and won't be for some time.

Secretary FINCH. I understand that the Surgeon General will appear before this committee today. I think that he will be able to respond directly to questions on the study design and provide whatever additional information you want.

Mr. CASEY. What they are looking for, as I understand it, is not so much who is not getting enough food, but ignorance on the part of the American public on nutritional values.

Secretary FINCH. Education as to the right kinds of foods.

Mr. CASEY. The damage to infants during their growing stages will never be recovered. You cannot correct it later by a better diet. It is interesting to find out that you can find children in some of the wealthiest sections of town suffering from malnutrition.

Secretary FINCH. That is correct.

Mr. MICHEL. The gentleman from Kentucky, Mr. Natcher, and Mr. Hull—all three of us—serve on the Agriculture Committee on Appropriations, too. We have just been on the subject of the Agricultural Research Service, and we talked about this subject at some great length with our chairman, Mr. Whitten, bugging the folks downtown because this is a rehash over a long period of years without really getting to the people some of these fundamental things that you are taking about, such as nutritional value of certain kinds of food, what you should and should not eat.

Mr. CASEY. They will say, "Look at those poor Mexicans, all they eat is tortillas and beans." They have a better diet than a lot of other people in this country. They find in Louisiana no iodized salt. They just didn't know about it. Iodized salt doesn't cost any more than ordinary salt. It is very simple things like that that need to be talked about to the people.

Mr. MICHEL. Currently I am undergoing a little experiment of my own. I have some of this corn-soya-milk meal that we produce for shipment abroad for feeding hungry people in India and elsewhere. Seven and a half cents a pound is what it costs. I have been getting by here for a week with less than 3 ounces of that for breakfast, eating no lunch and then another slug of it in the evening. It is not the very best tasting stuff but you put a little of this no-calorie liquid sugar on it with some skim milk and it is amazing. I wish that I were able here to recite the percentages of nutrient requirements that anyone needs, that I get by virtue of that stuff. And at that very low price of 7½ cents a pound. Unfortunately we haven't been able to give this to people here in our own country, but it is authorized for shipment abroad.

Mr. CASEY. We have been shipping abroad powdered milk that has been vitamin enriched. The powdered milk we were giving in our welfare program here in the United States was not.

Mr. MICHEL. With all our ingenuity, it seems to me we ought to be able to take this meal and put it in the form of a candy bar or some such thing that the kids could take to school. It would be a very simple way of getting good nutrients to those suffering from malnutrition or inadequate diets.

INCREASE IN SOCIAL SECURITY BENEFITS

Let's move up to social security, Mr. Secretary.

You say that you are studying what the increased benefit should be. Is the proposition of tying social security benefits to the Consumer Price Index still a matter of consideration in the Department in its deliberations?

Secretary FINCH. That came up in the presidential campaign. I was traveling with the candidate at that point and I happened to take exception to the proposition. Congress looks at the benefit rate

every couple of years and, by doing so, provides a sort of built-in cost-of-living increase.

Mr. MICHEL. You are aware, I am sure, that there are a number of Members of Congress who have introduced legislation to that effect in years past?

Secretary FINCH. I recognize that it has broad support; yes.

Mr. MICHEL. Frankly, my own opinion is that it would be good, if it were feasible and practical, to take it out of the realm of politics instead of whipping it around every year or two as we do. It could be the kind of thing that would come more automatically. There wouldn't be delays in catching up for those people who say we have to get caught up every once in a while.

We find ourselves getting embroiled in political considerations every year or two in this thing and it makes an awful lot of difference as to what we do and don't do to meet this need. I don't think we ought to just foreclose any discussion of the matter since there are still a number of members who think it is workable.

Secretary FINCH. Clearly, we will respond with a Department position when that legislation is introduced.

Mr. MICHEL. I might say when we had the folks up here from the Bureau of Labor Statistics, there was a little colloquy which developed relative to the fact that if we were to do this we probably would want statistics confined to that older age group or those who would qualify for social security. We ought not to put into the mix those of us in the younger years because our requirements and purchasing patterns that go into determining the cost-of-living index are somewhat different from those in the 65-and-older group.

I think that would make quite a bit of difference in the computation.

Secretary FINCH. One of the reasons for my initial reluctance was because of the difficulties in administering the program with those input variables. I think that Mr. Ball has done an admirable job. We are pretty taxed over there to operate now, and we would not want to assess——

Mr. MICHEL. If that is the big bar, then I guess we ought to be told why and then some of us who think it is just possible would take another tack or forget about it altogether.

REDUCTIONS IN EDUCATIONAL EQUIPMENT GRANTS

On this cutback of low priority programs, on page 30 you say, in addition, the budget proposes to eliminate special programs for purchasing educational equipment for elementary and secondary and undergraduate schools. How much are we talking about here in money, dollars and cents?

Mr. CARDWELL. $78,740,000, to be exact.

Mr. KELLY. And an additional $14.5 million for higher education under the Higher Education Act.

Mr. SHRIVER. Would you yield?

How is that broken down?

Mr. KELLY. $14.5 million in higher education, and $78,740,000 in elementary and secondary. These are the 1969 appropriation levels.

Mr. SHRIVER. We added that last year?

Mr. KELLY. Yes, sir.

Mr. SHRIVER. Is this the one that had the matching program?

Mr. KELLY. Yes, sir.

Mr. SHRIVER. The local school districts?

Mr. KELLY. Fifty-fifty.

Mr. SHRIVER. Which Mr. Laird argued so very well as being a superior program to the other?

Mr. KELLY. That is right.

Mr. SHRIVER. I have it identified. Thank you.

Mr. MICHEL. What is your reasoning again for wiping it out completely? Incidentally, did the Johnson budget come up that way?

Secretary FINCH. Yes, sir.

Mr. MICHEL. You are tying your sails to that figure on this item?

Secretary FINCH. First, we have evidence that the districts themselves have put a high premium on this kind of hardware and technical equipment in recent years, but that is not now where the greatest needs really are. They are in teachers' salaries and other areas.

Also, we have various other programs that tend to move into this area. Mr. Kelly can tell you about that.

Mr. KELLY. I made the point yesterday that if you are going to have only a limited amount of funds for elementary and secondary education, the question is how to use the funds to produce the largest benefits. The conclusion was that the Elementary and Secondary Education Act formula produced the greatest benefits. The most beneficial distribution, we believe, is one that provides the greatest funds to districts with children from poor families.

In addition, this mechanism allows each school district the opportunity to decide whether to use the funds for equipment or for teachers' salaries or for some other purpose. The conclusion was that this was the preferable mechanism, for this concept gave the school districts the opportunity to make their own selections. Therefore, the funds were put under the Elementary and Secondary Education Act rather than the categorical program.

Secretary FINCH. The district could still buy the hardware under this program if they wish. But they are not constrained to use funds for a specific purpose.

Mr. MICHEL. Under that proposition it is all Federal funding. This is just not any matching?

Mr. KELLY. Matching is not required.

Mr. CARDWELL. The State can still use their matching and combine it with the other Federal money.

Mr. SMITH. Would the gentleman yield?

It is not exactly the same school district. That eliminates some school districts completely which would be eligible for NDEA funds.

Mr. KELLY. That is correct. The distribution of the National Defense Education Act funds is not related to the income of students. Therefore, its geographic distribution will be somewhat different from that which occurs under the formula of the Elementary and Secondary Act.

Mr. SMITH. The school districts eliminated don't have any choice?

Mr. KELLY. That is correct.

Mr. MICHEL. Would we expect to get some flack from those school districts?

Secretary FINCH. It is quite conceivable.

Mr. KELLY. I think you might also tend to hear from the equipment manufacturers.

NEW POSITIONS REQUESTED

Mr. MICHEL. Mr. Secretary, on page 34, when we are looking for ways and means in which to cut and retrench and forestall increases, I see 75 new jobs for civil rights compliance and 2,800 new jobs for Social Security Administration, medicaid audit, and 63 new jobs for field coordination and center community planning.

Under the Revenue and Expenditure Control Act, as I recall earlier, there has been a reduction of 4,000 people.

Mr. KELLY. That is correct.

Mr. MICHEL. As of what date?

Mr. KELLY. It is estimated as of June 30, 1969. We actually are about at that level right now.

Mr. MICHEL. What are we going to do now? Everything we cut back in 1969 we are going to add on in 1970.

Secretary FINCH. I think the cumulative figure here is substantially less than that. We took a hard look at this area and particularly, as I said yesterday, at the needs of the Social Security Administration. It is false economy to be paying all this overtime. We are dangerously stretched in terms of being able to perform the job there. I spoke at some length about the problems we are having with abuses in medicare and medicaid. We feel that these 100 new audit jobs are absolutely essential. For the whole area of civil rights compliance, which continues to be the most plaguing problem that I have, we are trying to monitor thousands of districts with about 150 complaints agents. If we are to carry out what Congress intended in the Civil Rights Act of 1964, I just have to ask for more people.

BACKLOG OF CIVIL RIGHTS CASES

Mr. MICHEL. Is there a buildup of cases in this particular area? Buildup of complaints or backlog?

Secretary FINCH. Yes, sir. There is a heavy backlog in the pipeline. They are at the regional office level in most cases.

I don't have any immediate figures but I know the backlog is very large.

Mr. MICHEL. Could we have something supplied for the record here?

Mr. KELLY. Yes, sir.

(The information follows:)

ESTIMATED COMPLIANCE WORKLOAD FOR OFFICE FOR CIVIL RIGHTS

The following table summarizes the estimated total number of institutions for which the Office for Civil Rights has responsibility. This table identifies those locations in which available information indicates serious compliance problems exist and the number of such locations which can be reviewed with the resources requested in the fiscal year 1970 budget request.

Major program	Compliance review responsibility [1] (1)	Priority review workload [2] (2)	Estimated reviews with fiscal year 1970 request (3)	Estimated backlog (2 minus 3) (4)
Education:	23,800	2,261	1,466	795
Southern, elementary and secondary	4,500	1,165	575	590
Northern, elementary and secondary	17,000	300	95	205
Higher education	2,300	796	796	----
Health and social services:	43,700	11,200	2,200	9,000
Hospitals	9,000	4,000	1,000	3,000
Nursing homes	14,000	5,000	600	4,400
Other health and social services facilities	20,000	2,000	400	1,600
Agencies	700	200	200	----
Contract compliance	3,800	3,350	480	2,870
Total	71,300	16,811	4,146	12,665

[1] Estimated number of school districts, colleges, contracts, hospitals, nursing homes, other facilities and agencies for review.
[2] Number of locations in which available information indicates serious compliance problems exist.

TRANSFER OF CIVIL RIGHTS ENFORCEMENT TO DEPARTMENT OF JUSTICE

Mr. MICHEL. Your predecessor recommended that this whole business be transferred over to Justice. What is your view, Mr. Secretary?

Secretary FINCH. I have to say in all candor that we have made some progress. The Department of Justice, on the basis of its present staff requirements and present office for civil rights compliance, is even less adequately staffed than we are. We have had a number of discussions about this and, if this function was transferred, there would be a halting of momentum. This, I think, would be directly contrary to what Congress intended in 1964, whether we agree or disagree with what that act provided.

I am convinced that, particularly in the South, there is a bona fide effort on the part of almost all districts to comply. Our trickier and our tougher areas are in the North and West. In terms of what I conceive our obligation to be under the 1964 act, I think it would be almost disastrous if we were to move out of the whole process and try to throw it over to Justice. That is my feeling.

CIVIL RIGHTS STAFF

Mr. MICHEL. Getting back to the civil rights compliance activity. Currently there are how many people in your shop involved in this activity?

Secretary FINCH. 326. This includes our technical people as well as the compliance agents—title VI staff.

Mr. MICHEL. The increase requested here is for 75?

Secretary FINCH. Yes, sir. The breakdown between technical assistance and compliance agents is now approximately what?

About 150 compliance agents?

Mr. CARDWELL. About that many.

Secretary FINCH. The balance are technical people with appropriate backgrounds to work in these districts, so it is not just a case of integrate or forget about the quality of education. We are trying desperately to make it possible for these districts to comply, because it is pretty clear what happens when we have to withdraw Federal funds. It is the disadvantaged or the poor that are hurt most when the funds are withdrawn.

Mr. MICHEL. Of those new 75, how many of those would be in the area of compliance and how many technical people?

Secretary FINCH. I would say about evenly distributed but I will have to give you a specific response later. I do not have a breakdown on that right now.

Mr. SHRIVER. What do you mean by technical people?

Secretary FINCH. Well, we have one category of compliance agents and a second category of technicians with a background in education. These people are supposed to be able to work with the affected district in order to give them suggestions, and suggest patterns of operation that will preserve the quality of education, while still complying with the Civil Rights Act of 1964. They are supposed to be people with primarily an educational expertise.

Mr. SHRIVER. Experts in civil rights?

Secretary FINCH. No, sir; they are supposed to be experts in education.

Mr. MICHEL. Are these the ones that play the numbers game or the ones who minimize this numbers game?

Secretary FINCH. The numbers game seems to have been largely confined to compliance agents, Congressman. That is the part that offends me personally. I think that is——

Mr. SMITH. Would the gentleman yield?

Are these experts in education administration or teaching?

Secretary FINCH. I would have to check the backgrounds specifically, Congressman. I think probably most of them came from school administration.

Mr. SMITH. In some cases we have had people handling administrative problems who might be fine teachers but are not specialists in school administration.

Secretary FINCH. To some extent the reverse is true, too. They may be too involved in administration and not really able to speak to the quality of teaching that is really going on in the classroom. I am very apprehensive, very concerned about some of the attitudinal problems that we have in this area. I don't want to indict anybody in my own shop, but we are looking into this with considerable care.

I think this should probably be inserted in the record at this point. This table gives the present staff distribution for the Civil Rights Office, and the number of districts affected.

Mr. MICHEL. Mr. Chairman?

Mr. NATCHER. Without objection, it is so ordered.

(The table follows:)

PRESENT STAFF DISTRIBUTION FOR ELEMENTARY AND SECONDARY EDUCATION

	Oct. 11, 1968			Mar. 1, 1969		
	Headquarters	Field	Total	Headquarters	Field	Total
School districts:						
North	27	5	32	22	31	53
South	13	54	67	10	41	51
Total	40	59	99	32	72	104

Note.—11 more staff members are expected to be assigned to the compliance program within the next 6 weeks outside the South.

Mrs. REID. Would the gentleman yield?

Then the compliance agents are not educators?

Secretary FINCH. Not in most cases.

Mrs. REID. These agents just go in to see that they comply with the law?

Secretary FINCH. They go in to obtain percentage data on the school district; the districts that may be affected.

Mr. MICHEL. Are these people competent to do that kind of a job?

Mr. KELLY. I think there were problems that occurred early in the program where some people rubbed a lot of other people the wrong way. In getting the program started a great number of people were borrowed from different parts of the Department, particularly from the Social Security Administration and the Public Health Service. They had not been adequately trained and there was some flack. Subsequently, the Congress ordered that we put this program together in the Office of the Secretary.

This is the program that the Secretary is now talking about. It is now a totally trained professional staff. These are not borrowed people and they are not students used in the summertime to do the job. I don't believe that in recent months questions about the competence of the people being sent out has been raised at all. It was in the beginning of the program.

Mrs. REID. Would the gentleman yield?

Do you feel that these people can't do the same job?

Secretary FINCH. Down the road, I think we can. Originally it was a kind of a gathering—and again I was not here and I probably should be careful in my generalization—but originally it was kind of a fact-finding operation. I have looked at the files on the number of cases. They came in with percentages that did not really explain the whole problem. I think in many early cases, decisions were based on very limited and totally statistical data that didn't really tell whether a particular district was really trying to comply.

As Mr. Kelly pointed out, these people were not trained to do much more than gather a very limited amount of statistical data.

Mrs. REID. As I understand it, half of the new people for whom you are asking would be technical people.

Secretary FINCH. Mr. Cardwell just corrected me.

Of the 75, we want 45 who would be technical assistants, seven more for compliance purposes, and 23 clerical. That is the way that 75 breaks down.

Mr. MICHEL. Having been out in the hustings before you came here, you were obviously aware there were some real deficiencies here?

Secretary FINCH. Yes, sir.

Mr. MICHEL. The situation was bad and admittedly so. We are here to make sure that you know the feeling of this committee. I think I speak for just about all of us, too, to say we want that situation cleaned up and the faster the better. If it is not, we have to carry the water and the pail for you on the floor, and there can be all kinds of Ned raised about it, if we cannot give them the kind of assurance they are looking for.

Secretary FINCH. This is one of the things that we are going to work out with our regional offices—and that is the place where the initial information comes in.

I won't go beyond that at this point.

REGIONAL DIRECTORS

Mr. MICHEL. On that point, I am reading here in the annual report of the Department, fiscal 1968, from your predecessor, Mr. Cohen. On page 17 he says, "What is more, the Secretary himself must not have his hands tied by his own bureaucracy. He must be able to continue strengthening the Department's regional offices out where the people are. The nine regional HEW directors serve as his personal representatives in the communities where Americans live and where their problems proliferate. Regional offices should have more authority and more responsibility for decisionmaking, more power to earmark funds and make certain grants and contracts, provided project * * *" et cetera.

I think that you said yesterday you were having the regional directors in. Has there been any move yet to displace those present regional directors and put in, as the Secretary said, your "personal representatives"?

Secretary FINCH. I have been advised that these are "career people." I want to assess each one on an individual basis.

Isn't that correct, Mr. Kelly?

Mr. KELLY. Yes, sir.

Secretary FINCH. I may have some interesting sessions with the Civil Service Commission. I happen to think that they should not be career people. If they are to be personal representatives of the Secretary, then they should be at least schedule C's or have some supergrade—outside the civil service categories—and they should report directly to the Secretary.

Mr. MICHEL. You are going to come to grips with this thing and, hope, within a short period of time, are you?

Secretary FINCH. As soon as we get this first round of hearings over with.

Mr. MICHEL. If that thing can't be resolved and those people eventually become your personal representatives, they should have an inclination to administer the programs the way you think best for the Department. Since it is your responsibility in the end, what recourse do you have if they don't?

Secretary FINCH. Just keep suggesting and suggesting that they are not being responsive to the Secretary, and maybe they will get the message.

ENROLLMENT IN JUNIOR COLLEGES

Mr. MICHEL. Last year the Department provided us with a chart that showed the percentage of enrollment in higher education institutions in junior colleges. I think you brought out in your statement something to the effect that 2.3 million or maybe a third of our students in institutions of higher learning are now in junior college?

Mr. KELLY. Will be in 1970.

Mr. MICHEL. I forget exactly what we asked for in that chart last year, but would you simply see it gets updated?

Secretary FINCH. All right.

(The information follows:)

Opening enrollment of institutions of higher education, fall 1968, including nondegree credit:

	Number of students	Percentage of total
2-year schools [1]	1,796,426	23.7
4-year schools	5,775,210	76.3
Total	7,571,636	100.0

[1] From "Opening Fall Enrollment in Higher Education, 1968," National Center for Educational Statistics, Office of Education, DHEW.

Total opening enrollment of 2-year institutions of higher education, fall 1968

(Data includes both degree credit and nondegree credit)

Aggregate United States	1,796,426
States and District of Columbia	1,792,296
New England	66,552
Connecticut	17,345
Maine	163
Massachusetts	40,200
New Hampshire	1,240
Rhode Island	5,742
Vermont	1,862
Mideast	268,585
Delaware	4,543
District of Columbia	3,857
Maryland	27,068
New Jersey	24,200
New York	167,997
Pennsylvania	40,920
Great Lakes	260,902
Illinois	113,716
Indiana	4,073
Michigan	99,718
Ohio	25,188
Wisconsin	18,207
Plains	86,250
Iowa	18,941
Kansas	14,116
Minnesota	15,939
Missouri	28,592
Nebraska	3,638
North Dakota	4,677
South Dakota	347
Southeast	245,828
Alabama	19,948
Arkansas	3,052
Florida	95,419
Georgia	19,174
Kentucky	2,054
Louisiana	3,459
Mississippi	21,993
North Carolina	36,394
South Carolina	10,412
Tennessee	9,048
Virginia	22,153
West Virginia	2,722
Southwest	141,511
Arizona	32,115
New Mexico	1,446
Oklahoma	10,950
Texas	97,000
Rocky Mountain	29,591
Colorado	13,172
Idaho	6,604
Montana	1,192
Utah	3,817
Wyoming	4,806
Far West	693,077
Alaska	127
California	600,830
Hawaii	165
Nevada	-------
Oregon	25,150
Washington	66,805
U.S. SERVICE SCHOOLS	
Outlying areas	4,130
Canal Zone	1,190
Guam	-------
Puerto Rico	2,940
Virgin Islands	-------

INCREASE IN MEDICALL CARE COSTS

Mr. MICHEL. Have we had spelled out very clearly how much medical and hospital costs have actually increased this past year?

Mr. KELLY. The question has not been raised. My recollection is that for hospital care costs it is 13 percent. I will get the specific figure.

Mr. MICHEL. Thirteen percent in the year? What are we talking about?

Mr. KELLY. Calendar year 1968.

Secretary FINCH. That is both hospital and doctors?

Mr. KELLY. Hospitals.

Secretary FINCH. You want both doctors and hospitals?

Mr. MICHEL. Right.

(The information follows:)

INCREASES IN MEDICAL CARE COSTS

The Consumer Price Index of the Bureau of Labor Statistics provides the following breakdown of the percentage increases in medical care costs in the calendar year 1968.

	12 months ending December 1968
Professional services:	
Medical care services, total	7.3
Physicians' fees	5.7
Hospital daily service charges	13.2

Mr. MICHEL. I am reading from a little chart here in The Wall Street Journal under date of Wednesday, February 5. It says: Medical care costs rose in December to 149.1 percent of that 1957–59 average from the 148.2 percent recorded a month earlier. These costs are components of the Consumer Price Index. That is practically a one-point increase in 1 month. We are all aware of these tremendous increases, so again you say for 1968?

Mr. KELLY. I think the figure for hospital charges is 13 percent.

Mr. MICHEL. Do you recall what it was for 1967?

Mr. KELLY. I think it was about 16 percent in 1967.

Mr. MICHEL. In 2 years running there were increases of 16 and 13 percent a year?

Mr. KELLLY. That is right.

Mr. MICHEL. What do the crystal-ball gazers see for 1969?

Mr. KELLY. I think that the latest actuarial prediction is for a 12 percent increase.

Mr. MICHEL. In other words the increase may be getting smaller?

Mr. KELLY. The percentage increase declines. It still continues to rise at a more rapid rate than the cost-of-living index. The health components, except for drugs, have all risen at a substantially faster rate than the cost-of-living increase. It is predicted that next year all components will continue to rise above the cost-of-living index.

Mr. MICHEL. That is the frightening figure. It seems to me that we have to address ourselves here to topping that out, and as our first target to keep medical expenses from increasing at a more rapid rate than the total cost-of-living index; preferably, to turn it down.

Secretary FINCH. I think it is fair to point out, Congressman——

Mr. MICHEL. Here is a chart from U.S. News & World Report entitled "Where Inflation Hits Hardest," indicates that hospitals, semiprivate per day on the average back in 1960 were $20.95; in 1968, $41.04, or an increase of 96 percent.

Secretary FINCH. There is no question about that.

Mr. MICHEL. It shows the most marked increase of any of the components that go into the Consumer Price Index.

Secretary FINCH. That is correct. Physician fees comprise less than 30 percent of this whole cost of medical services. It is hospital care and allied services costs that we are most concerned with right now.

Mr. MICHEL. What do we do to arrest it? It is just a matter of building more hospitals or what?

Secretary FINCH. I think extended care facilities is part of the answer. There again, you get into a difficult monitoring problem, as I indicated in my testimony yesterday. In many cases doctors will build an extended care facility and then go by on their way to the office, stopping briefly at each bedside, and that is a "call." That is sometimes a hard thing to judge, and so I think we have to be very careful how we move in that direction. These are the kinds of problems that you run into.

Mr. KELLY. There is a lot of different views as to how you can approach this. The one which I think is unanimous is that the greatest savings in health costs in this country will occur by decreasing unnecessary utilization of health facilities. If people can be served on an outpatient basis, or if they can get intensive treatment on an inpatient basis, permitting their rapid discharge, that will have the greatest impact on costs.

Secretary FINCH. That is why we put a premium on the neighborhood health centers. We need to pick up these potentially susceptible people early. I was amazed when I was in Grand Rapids a few weeks ago at how well one of these facilities was working. They have 1,000 people a month passing through in a heavily Negro area. They would never have gone down to the hospital, but they do go to this community center which was using volunteer doctors and nurses. Apparently, the people in the neighborhood felt comfortable at the center. They received a very adequate examination, and were then willing to go to the hospital if necessary. There is a very high threshold of resistance on the part of many of the disadvantaged to go to the hospital. That is another reason why we have to break away from the hospital-oriented syndrome we are caught up in.

RAT CONTROL

Mr. MICHEL. How much is the Department spending on rat control this year?

Mr. KELLY. $16 million.

Mr. SHRIVER. All on rats?

Mr. KELLY. These were the projects that were approved under the Partnership for Health Act. Following the congressional action, one, to extend the authorization, make it possible to carry out rat control programs, and then the expansion of funds for this purpose.

Mr. MICHEL. The total amount available in that area was what?

Mr. CARDWELL. We have to correct that. It was $20 million available and $20 million committed in the form of special project grants to local agencies.

[The figure of $20 million for the amount committed was later corrected to $15 million.]

Mr. MICHEL. In other words, everything that has been appropriated has been committed?

Mr. KELLY. Has been in an approved project. I think all of them were approved prior to the 1st of January or very shortly thereafter.

Mr. MICHEL. What is the relationship between the request for 1970 as against 1969?

Mr. KELLY. It continues at the same level.

GAO REPORT ON PAYROLL SYSTEM

Mr. MICHEL. Has the situation regarding the Controller General's report on mismanagement in the HEW payroll center been corrected?

Mr. KELLY. It has not been entirely corrected. Yesterday I offered the committee a report that we have given to the Government Operations Committee. We have made substantial improvements. We have said most corrective action is in three parts: One, the completion of the ongoing operation until we have substituted a new one; two, design of a new operation; and three, the installation of a new computer, all scheduled to be completed by the 1st of October. The Secretary directed me to accelerate the date for the accomplishment of this and within the last few weeks we have augmented our resources by contractual assistance in programs and systems design in order to make that more rapid. We have that laid out in the report that I offered the committee yesterday, the steps that we have taken to strengthen our management and improve the system.

Mr. MICHEL. Do you have a new target date other than October?

Mr. KELLY. Not yet.

Mr. MICHEL. What happens in the meantime, between now and the time it is fulfilled; are we still going to be frittering away dough on faulty checks?

Mr. KELLY. We cannot give you complete assurance that we have a foolproof system and there will not be errors that creep in. The errors have now decreased to the point where we are identifying and correcting them at an error rate of about three-quarters of 1 percent. In other words, out of one hundred-some-odd thousand people we have in the file now, about 750 errors a payday are called to our attention and corrected. The number each payday is now declining. We think that as we have improved our controls, the errors that are being detected are of lesser significance and involve lesser amounts of money.

Mr. MICHEL. Earlier this year there was a little byplay on the floor of the House when they sought to modernize our own payroll procedures up here on the Hill. Apparently the examples brought up the problem here if we couldn't do it any better than your folks are doing it down there we ought to forget about the whole thing. I have a hunch that the gentleman who brought that matter to the attention of the House at that time will be wanting to have some assurance that this thing has been remedied.

Mr. KELLY. I think we can, Mr. Michel.

WORLD HEALTH ORGANIZATION BUDGET

Mr. MICHEL. A recent GAO review pointed out that our country has no systematic procedure for evaluating World Health Organization projects and programs. Actually, in the past 3 out of 4 years the United States voted against proposed budgets that were higher than we considered appropriate, but were outvoted, therefore contributing to budgets greater than we wished to support.

Have we done anything on the GAO recommendation to obtain the factual data necessary to make sufficient analysis of World Health Organization programs and budgets in order to exert meaningful influence on both.

Mr. KELLY. We have filed a report with the Comptroller General responding to that review, and we have endeavored to strengthen the Surgeon General's ability to review proposals of the World Health Organization. I do not believe it changes the basic concept that we are just one of the participants in the World Health Organization, and therefore have one vote with respect to what their program and plans are. But we are endeavoring to bring before the World Health Organization the results of our review in as factual and as detailed a way as possible in order that we can make a valuable input in their decisionmaking process.

Mr. CARDWELL. I would add, Mr. Michel, that the Surgeon General now has on his staff a man who will, among other things, monitor this particular problem.

GAO REPORT ON GENERAL CLINICAL RESEARCH CENTERS

Mr. MICHEL. What actions have been taken on the GAO recommendation that you direct the HEW Audit Agency to make audits of grantees' records for grants under General Clinical Research Center grants administered by HEW? I think they said there was a $678,000 overpayment.

Has that been recovered, or any of it?

Mr. KELLY. I cannot say on the recovery. As a result of the Comptroller General's review two things happened: First, this was made an integral part of the consolidated audit program of the Department. Second, the responsibility for establishing the method for calculating the costs of the research centers was given to the Grants Administration Policy Division which handles all settlement negotiations.

Mr. MICHEL. Supply for the record if you will what, if any, of that amount has been recovered.

Mr. KELLY. Yes.

(The information follows:)

The General Accounting Office took exception to $678,600, of which $326,000 was indirect cost. The Department has recovered approximately $121,000 of the indirect cost overpayments. The remaining $205,000, plus the $352,600 of hospitalization overpayments, is currently under review, and the Department expects these accounts to be settled by June 30, 1969.

ROCKEFELLER PROPOSALS REGARDING EDUCATION AND WELFARE COSTS

Mr. MICHEL. Recently Governor Rockefeller of New York came up with a two-pronged proposal including the gradual assumption by the Government of the total cost of local welfare programs and to increase

aid to local education from revenues produced by the 10-percent Internal Revenue tax surcharge, and the Governor claims he is doing this at your request and has hired your predecessor, Mr. Secretary, to draft the legislation.

Do you have any comment on this?

Secretary FINCH. I am shocked about the suggestion he did this at my request. When he made the presentation at the Governors' conference, I spoke vociferously against the idea that the Federal Government should assume the whole burden of the welfare program.

I said quite directly yesterday that I think under our federal system each level of government has to accept the responsibility for its own component. I have said privately and publicly that I have no intention for this Department to become the "Department of the Dole," and in anyway prejudice our activities in the health and education field.

Mr. MICHEL. I think some of the articles we read were probably somewhat in error.

Secretary FINCH. Right. As I said yesterday——

Mr. MICHEL. It did get wide distribution.

Secretary FINCH. The Governor has a way of attracting that kind of attention.

Mr. MICHEL. I think you have developed pretty well in answer to the chairman's questions with respect to campus disorders your general disposition and feeling on that problem that plagues the country.

And also, I think you have expressed yourself on Headstart.

VOCATIONAL EDUCATION

In the area of vocational education, has there been a top level policy decision made by the White House as to where the leadership in vocational education will be lodged within the Federal structure? Is this to go to Labor? Where will it be?

Secretary FINCH. No, I do not think there has yet been a firm decision. This is one of the agenda items set for the Urban Council meeting this coming Monday.

Mr. MICHEL. When would we know about it, do you suppose?

Secretary FINCH. Based on the speed that it has taken on some of the other items, I would say probably several weeks. We get quite a confrontation of various personalities involved in some of these areas.

Mr. MICHEL. Do you think we have been putting too much money, in the area of vocational education, into the public school system as distinguished from doing it outside the public school system?

Secretary FINCH. No. I would hope that eventually we might put an even greater vocational emphasis in the public system, including public community colleges. This is my general reaction, especially at the community college level.

REGIONAL EDUCATION LABORATORIES

Mr. MICHEL. Mr. Secretary, do you have a good evaluation study of the regional educational laboratories?

Secretary FINCH. No, I am not sure we do. We are looking at that very hard now. My predecessor recommended that five of these be cut off in 6 months' time—that Federal funding be cut off.

Mr. MICHEL. Is that an economy measure or are there other reasons?

Mr. KELLY. I would say that we do not think of it as an economy measure. Within the funds that this Congress made available for the educational laboratories, it was realized that those funds could be expended more profitably in fewer institutions. We were not going to get much for our money if we continued to help fund 20 institutions. So an evaluation was made of each institution. Decisions were made as to which were of least demonstrated quality, and five contracts were established for termination on that basis.

Secretary FINCH. And part of the concept was that this was a backup of resource people that helped enrich the other systems. As I understand it, in these five cases they simply had not been able to pull together the right kind of people with the right kind of expertise to provide services of the highest quality. So it was a combination of factors that led to that judgment.

PRESIDENT'S TASK FORCE ON EDUCATION

Mr. MICHEL. This Pifer study that recommends spending a billion dollars a year more for education—who were the people and what was the composition of this study group?

Secretary FINCH. I can explain the background.

Prior to the election Dr. Glenn Olds was selected by the candidate's staff to set up a whole series of task forces covering the whole spectrum of public concerns. Dr. Pifer was asked to head the education committee. I had an entirely different role at that time, of course, and had no hand in the selection of the people. They were all prominent educators.

Mr. MICHEL. These were all appointments to this commission under the previous administration?

Secretary FINCH. This was a body that had no governmental sanction at all. It was appointed prior to the election. They began their work in some cases prior to the election. They were supposed to be alienists, or people not attached to any administration. In fact there were more Democrats than Republicans on these task forces.

As the President said when we had our final meeting with the committee, 75 percent of them probably voted for Humphrey. They were picked because they had expertise in these various fields.

We had a separate report within our own resources after I was appointed, in which we evaluated the Pifer report of course, and the so-called Rivlin report. Dr. Rivlin was then the Assistant Secretary for Planning and Evaluation. That, the Kerr report, the Carnegie report, and the Pifer report—all were evaluated and they are not too far apart in their general thrust.

Mr. MICHEL. Are you going to be following any of their recommendations?

Secretary FINCH. We are looking at them all very carefully right now. Very clearly, we cannot meet the kind of budgetary requests that they call for. Just in the field of medical education, for example, the Carnegie Commission said we need to have 24 new medical schools begun, by 1976 in different geographical areas because, obviously, where a doctor trains has a great deal of influence on where he goes to practice. Many will argue that we have enough doctors, but that they

are not distributed properly and there are not enough inducements for them to go out and practice in some areas.

In some areas—you may know of them—we have had small hospitals built under Hill-Burton funds. Perhaps only a couple of doctors were there. Then one moved and one died, and now the hospital is there all right, but no doctors.

I would argue that while it may be desirable to have more medical schools in time, regionally distributed, I think the dollars we have now ought to go into building up existing plants so that we can get a more immediate output of doctors and dentists. We need to build on existing plants, because it takes so long to mature a medical school and staff—maybe several decades—to the point where it begins to produce a supply of trained personnel.

BLOC GRANTS

Mr. MICHEL. How do you define a bloc grant?

Secretary FINCH. I will file with you the same statement I am now preparing for the House Education and Labor Committee. This has become something like the term "urban problems". It has different meanings depending on various frames of reference.

Mr. MICHEL. You say you are preparing a statement. Will you submit it for our record?

Secretary FINCH. Yes. I will submit the statement.

Mr. MICHEL. Thank you, I would like to have it firm in my own mind, and the committee here does, also. We talk about it from time to time and we would all like to be talking about the same thing, or at least have a universal bench mark.

Secretary FINCH. One of the points I tried to make before the Education Committee—and I think it has considerable merit—is that we might consolidate some of these programs where they are so many different formulas. By doing so, we would get a better end product, and require fewer forms for the administrators to fill out.

That is another form of the same problem, and that in some people's eyes could be called a bloc grant. I will give you what we regard as the technical definition of a bloc grant in this statement if I may.

(The information follows:)

STATEMENT BY SECRETARY ROBERT H. FINCH ON BLOC GRANTS PREPARED FOR THE HOUSE OF REPRESENTATIVES COMMITTEE ON EDUCATION AND LABOR

This administration has as one of its primary goals the consolidation and simplification of the many categorical grant programs. In the field of education, we are studying the possibilities for regrouping a number of existing, narrowly defined programs into what might be called lower order bloc grants, or groupings of closely related categories funded under a single grant. Such grants would lessen the burden on State, local, and institutional officials in applying for Federal funds, and strengthen their administrative capacities. This kind of bloc grant would safeguard Federal responsibilities for meeting national needs and for assuring appropriate accountability and evaluation. Such consolidated grants should be distinguished from broad grants designated to cover all aspects of a single major function of government.

Mr. MICHEL. Thank you very much, Mr. Secretary, for your appearance and your candid response to the questions I have posed. I apologize to my fellow committee members for the duration of time I have taken.

Mr. NATCHER. Mr. Smith?

INCREASING SUPPLY OF DOCTORS

Mr. SMITH. Do you think that putting more money into these medical schools will really get more doctors, or would it be used to add another year to the educational requirements?

Secretary FINCH. I think a year ago I would have been uncertain about that. In my experience, as a regent of the four medical schools in California, and from the traveling I have done around the country since, I am convinced that the administrators of these medical facilities are acutely aware that they are under great attack. They have really got to shape up in terms of the number of graduates that are produced by each of these institutions.

Mr. SMITH. We become very discouraged here, or I did anyway, as late as last year when the President of Howard University, which we could expand if money is all it takes, as well as other universities, told us that they had no possibility of expanding by 1975 enough to increase graduates by more than 10 percent, and we know medical services will be needed in excess of an expansion of 10 percent. This means our supply of physicians could not possibly keep up with demand if we depend exclusively upon the same medical schools we have now according to their testimony.

Secretary FINCH. I met with some of the leaders in these areas just this morning. The AMA is deeply disturbed, because in the last several years almost 40 percent of the total of new doctors qualifying in the States have come from abroad. This is a pretty severe indictment of our own ability.

Mr. SMITH. And we accept doctors from abroad that have not had as much education as is required here.

Secretary FINCH. Yes. And we cannot be sure because each State has a little different kind of licensing procedure, a different definition of what is acceptable.

HOWARD UNIVERSITY

Mr. SMITH. Since I mentioned Howard, I want to mention to you I was a little bit surprised at the response yesterday concerning the authority you have over Howard University.

I will note to you here that under the Code it says:

> The Secretary of HEW or his designated agent or agents have authority to visit and inspect such university and control and supervise the expenditure therein of all moneys paid under said appropriation.

You have complete control. It seems to me the problems out there with students are bound to come up on the floor when we reach the floor with this bill. The law provides you with responsibility or opportunity to act and I feel sure you have the sympathy of this committee, to really do something meaningful with regard to medical education.

With the authority you have, you could surely do whatever is necessary to get them to increase the number of doctors graduated.

The response we got last year from the president out there was, he did not think they could get more than a 10-percent increase by 1975. That seems terribly defeatist to me.

Secretary FINCH. I would have to observe, Congressman, we may have a slightly different situation here, and a trend that disturbs me

greatly. I do not have very precise data, but even though apparently we have an enormous increase in the number of Negroes who are attending higher educational facilities, we have a lesser percentage of the total who are studying for the professions—medicine, law, and education—and a greater percentage who are simply studying the social sciences.

Again, because we have had a rather imperfect system of training in the so-called ghetto areas, it is probably harder for institutions like Howard to recruit people.

Mr. SMITH. Most of them tell us they rely on the assumption that it would be difficult to get enough professors even if they had the facilities. It seems to me there has got to be some way to meet the problem so at least by 1975 we will not be as far behind or farther behind than we are now.

Mr. FINCH. I must confess I did not realize the magnitude of my authority with respect to Howard University. I thought that I or my designee was simply a member of the board.

REGIONAL OFFICES

Mr. SMITH. With regard to these regional offices, have you made a firm decision to keep them?

Secretary FINCH. Certainly to keep the offices, yes, sir.

As I say, with regard to the chief official of each regional office, I am going to have to talk with and then evaluate each one.

Mr. SMITH. Of course I believe the Secretary ought to have fairly wide discretion on setting up his organization, but I do want to mention a substantial body of opinion among the institutions that are served is that they are not as close to those so-called field people as they are to Washington.

From northern Iowa, it takes longer by air to get to the regional office than it does to get to Washington. You can make a telephone call in the same length of time no matter where it is in the United States. Those regional offices are really not in the field with the people. In many cases that is just an illusion.

Secretary FINCH. I think that is a fair comment. From what I have been able to gather, there is a great disparity in how well these regional offices work with the States in evolving the State plans required under the various programs. That is something I certainly have to get into.

EFFECT OF REVENUE AND EXPENDITURE CONTROL ACT

Mr. SMITH. Am I being fair if I say that the Expenditure Control Act, according to your study, so far did not really save any money with regard to your Department, but just delayed the work and gave the money to fewer employees?

Secretary FINCH. That is my impression and I think, because of the rigidity of that act, it has made it harder for us to perform well in some areas. It has badly stretched our capabilities in social security, for example.

I would appreciate Mr. Kelly's comment on that.

Mr. KELLY. We did specifically eliminate $38 million worth of expenditures that would otherwise have been incurred. We did of course

give effect to the reductions which you made in the Appropriation Act last year.

Mr. SMITH. But in doing so, as I understand it, what you really did was to delay work that still has to be done.

Secretary FINCH. That coupled with a substantial amount of overtime in the case of social security, which might end up exceeding the $38 million over the long haul.

Mr. SMITH. What is the nature of those jobs in social security?

Mr. KELLY. There are some 600 district offices and 200 branch offices, altogether about 800 field establishments, which issue the social security number, and which receive and process the claims.

Mr. SMITH. Interviewers. Is that what you are short?

Mr. KELLY. Interviewers in the district offices as well as the staff in the payment centers where the claim is authorized. There we are maintaining about 24 million people on the rolls and issuing checks to them every month. Then, in the central office, a large part of the job is the maintenance of the lifetime earnings records of all the employed people in the United States.

The workload which results from that act is a compulsory workload. If you do not process it on a current basis, and you start building a backlog, it is almost impossible to catch up again. Complaining letters and congressional inquiries come flooding in. And this organization includes about 52,000 of the Department's employees.

PROVISION PROHIBITING PAYMENTS TO PERSONS CONVICTED OF CERTAIN CRIMES RELATING TO CAMPUS DISORDERS

Mr. SMITH. You mentioned the loan cutoff provision, Mr. Secretary, in the Appropriation Act.

Secretary FINCH. Are you talking about the students, sir?

Mr. SMITH. Yes. There have been some rumblings to the effect that people in the Department, at least prior to your coming down there, took the position that these loans could only be cut off by the Department and that they would review each individual case rather than it being one additional criteria that the university would use in determining eligibility. Have you gone into that?

Secretary FINCH. Yes, sir; and I feel very strongly this is a matter that must rest with local boards and the institutions themselves. We are in a terrible bind trying to enforce the Civil Rights Act of 1964 with a very limited number of people. I want to try to move toward working with the States rather than the Department having to deal district by district by district. This just becomes an onerous and impossible task.

I want to put the burden of administration on the governing board of the institutions. They are processing the dollars that are involved, and so it is a matter of their telling their comptroller to cut off the funds to those who have been convicted of certain felonies and misdemeanors, and of violating campus regulations.

We are going to follow up and, in the letter we are preparing now, we are going to ask for periodic reports.

Mr. SMITH. They have to determine need and a number of other things. This is just one more thing to determine in order to determine eligibility.

Secretary FINCH. We do not want to get in the business of trying to run institutions other than the special institutions we now have.

INTEREST SUBSIDY GRANTS VERSUS HIGHER EDUCATION FACILITIES CONSTRUCTION LOANS

Mr. SMITH. With regard to construction funds, I understood that there is $153 million that possibly may be rescinded. Is that loan funds only?

Mr. KELLY. It is the loan fund. When the Revenue and Expenditure Control Act was enacted, we decided to stop making direct loans and seek the authority to use the newly authorized subsidized interest method of funding the nongrant part of higher educational facilities under the 1970 budget.

Under that approach we pay $4 million now and then the balance of the interest differential on $145 million over the next 40 years. The value of the loan is $145 million and subsidized interest would be paid over the lifetime of that loan. I do not know what it would add up to.

Mr. SMITH. In that case, too, under this expenditure control Act, in order to cut back on money all we are doing is accumulating more debt but have less payout this year.

Mr. KELLY. I think if there had not been an Expenditure Control Act we would use both the authorized loan and the subsidized loan. We have elected to use only the latter.

Mr. SMITH. I would just like to point out, Mr. Secretary, that I think it would be a mistake if you do not do all you can to keep this from being rescinded and go ahead and use it, because it seems to me it is going to be very difficult to sell the Congress on starting a program where you pay $4 million down and have an $145 million obligation and stretch it out for 40 years.

Secretary FINCH. I think the point is well taken.

Mr. SMITH. If you are going to rely on this, you may come up with no construction at all. We went through the same kind of thing on rent supplements. The real problem there was we got into the area of guaranteeing for 40 years somebody's building. Is there any grant money up for rescission?

Secretary FINCH. Not that I know of.

Mr. SMITH. And also with regard to construction, I think the committee's position has been the last couple of years that construction is important, that the administration decision has been to cut back on construction and take this money and use it for graduate fellowships and other things.

I take it that you are of the opinion that construction does need to be expanded. This is an important area.

Secretary FINCH. Yes, sir, and with particular emphasis on the community college program. This obviously will have to involve start-ups and construction funds as we refine that program.

You know the argument of bricks and mortar as over against teachers, and the tension between the two forces. We are going to try to approach them both on a balanced basis.

In the field of higher education we are advised that we will hit a plateau in the mid-1970's in this enormous growth we have seen. I think we have to take that into account, but we will try to maintain an even-handed approach overall.

Mr. SMITH. But between now and then there is another problem and that is, if you rely on the subsidy loan program, all you have done is

to help them temporarily finance the building of a building. But you have not helped them to get the money they need to pay it off. And the figures I have seen all indicate that from all anticipated resources these institutions would not have enough money to pay for the buildings.

Secretary FINCH. I think that crisis is clearly before us.

Mr. SMITH. Delaying the payment is not going to solve the problem.

Secretary FINCH. That is right. There are some innovative techniques that schools are using, aside from getting a person to donate a building with his name on it. For example, the California State colleges and universities built combination facilities that involved parking areas where the student pays to park his car. They found that they were able to get local conventional financing. I think we have to give a lot more thought to that kind of thing, because no one is going to want to donate a garage bearing his name to a university.

Mr. SMITH. And then if you come along to the idea of using the interest subsidy to overcome this budget problem, you eventually end up too with only a loan program, without a grant program, and I want to point out that penalizes those State institutions which have no statutory permission to use loans at all.

Secretary FINCH. That is right.

GRANTS AND FELLOWSHIPS VERSUS STUDENT LOANS

Mr. SMITH. But at the same time we have moved in the area of student aid toward allocating a larger and larger portion of the actual Federal money, if you exclude the guarantees, to grants instead of loans.

It seems to me this is backward. As long as we do not have enough money there ought to be more loans than grants so we can use the money over, because the student can repay whereas the institution may never be able to repay. They need the grants and the students can use the loan.

Secretary FINCH. I think that is valid.

Mr. SMITH. So I can better understand the budget thrust in that regard, I would like for you or the staff to further develop the figures here that I have been given with regard to requests for these graduate fellowships and opportunity grants and so forth so that the breakdown clearly shows how much of this money is for new grants and how much is for continuing grants. It is difficult to analyze really what direction you are moving without that.

Secretary FINCH. You would want this in all of the grants?

Mr. SMITH. Yes.

Secretary FINCH. Throughout the Department?

Mr. SMITH. Yes.

You know other departments have similar programs. This is all you can get.

Secretary FINCH. I wanted to make sure you were confining it to one area.

Mr. SMITH. All we want is your Department. We find they are in the Space Administration, Defense, and everywhere else.

Secretary FINCH. Yes, sir.

(The information follows:)

CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE—STUDENT AID AND TRAINING PROGRAMS

[In thousands of dollars]

Appropriation	1970		
	New	Continuing	Total
Air pollution control:			
Fellowships	234	266	500
Training grants	1,274	1,726	3,000
Environmental control:			
Fellowships		50	50
Training grants	186	3,373	3,559
Total, CPEHS:			
Fellowships	234	316	550
Training grants	1,460	5,099	6,559

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION—STUDENT AID AND TRAINING PROGRAMS

[In thousands of dollars]

Appropriation	1970		
	New	Continuing	Total
Mental health:			
Training grants	23,653	88,847	112,500
Fellowships	4,692	6,174	10,866
Health services research and development:			
Training grants	4,404	1,157	5,561
Fellowships	552	122	674
Comprehensive health planning and services: Training grants		3,500	3,500
Total, HSMHA:			
Training grants	28,057	93,504	121,561
Fellowships	5,244	6,296	11,540

NATIONAL INSTITUTES OF HEALTH—STUDENT AID AND TRAINING PROGRAMS

National Cancer Institute:			
Fellowships	1,367	2,834	4,201
Training grants	3,017	8,169	11,186
National Heart Institute:			
Fellowships	1,723	5,586	7,309
Training grants	3,650	13,792	17,442
National Institute of Dental Research:			
Fellowships	382	1,312	1,694
Training grants	1,390	4,000	5,390
National Institute of Arthritis and Metabolic Diseases:			
Fellowships	2,295	4,180	6,475
Training grants	3,048	12,432	15,480
National Institute of Neurological Diseases and Stroke:			
Fellowships	989	2,096	3,085
Training grants	5,597	9,450	15,047
National Institute of Allergy and Infectious Diseases:			
Fellowships	1,409	2,782	4,191
Training grants	1,118	8,000	9,118

STUDENT AID AND TRAINING PROGRAMS

[In thousands of dollars]

Appropriation	1970 New	1970 Continuing	1970 Total
National Institute of General Medical Sciences:			
Fellowships	5,582	14,458	20,040
Training grants	8,330	37,238	45,568
National Institute of Child Health and Human Development:			
Fellowships	952	3,075	4,027
Training grants	1,778	7,843	9,621
National Eye Institute:			
Fellowships	206	444	650
Training grants	1,131	2,331	3,462
Environmental health sciences:			
Fellowships	71	123	194
Training grants	917	2,823	3,740
General research and services:			
Fellowships	45	101	146
Training grants	80	284	364
Health manpower:			
Fellowships	110	540	650
Training grants	120	678	798
Scholarships	8,781	20,219	29,000
Traineeships		20,020	20,020
Dental health:			
Fellowships	105	45	150
Training grants	1,470	3,806	5,276
National Library of Medicine: Training grants		1,000	1,000
Total, National Institutes of Health:			
Fellowships	15,236	37,576	52,812
Training grants	31,646	111,846	143,492
Scholarships	8,781	20,219	29,000
Traineeships		20,020	20,020

OFFICE OF EDUCATION—STUDENT AID AND TRAINING PROGRAMS

[In thousands of dollars]

Appropriation	1970 New	1970 Continuing	1970 Total
Education professions development: Training grants	$81,330	$7,170	$88,500
Teacher Corps: Training grants	9,046	22,054	31,100
	(5,975)	(7,948)	(13,923)
Higher education:			
Fellowships	30,600	41,372	71,972
Training grants	72,712	109,388	182,100
Libraries and community services:			
Fellowships	4,500	0	4,500
Training grants	3,750	0	3,750
Education for the handicapped:			
Fellowships	10,670	7,446	18,116
Training grants	7,641	1,350	8,991
Research and training: Training grants	2,220	3,555	5,775
Education in foreign language and world affairs:			
Fellowships	6,620	0	6,620
Training grants	3,000	0	3,000
Total, Office of Education:			
Fellowships	52,390	48,818	101,208
Training grants	179,699	143,517	323,216

SOCIAL AND REHABILITATION SERVICE

STUDENT AID AND TRAINING PROGRAMS

[In thousands of dollars]

Appropriation	1970 New	1970 Continuing	1970 Total
Juvenile delinquency prevention and control: Training grants	$2,600		$2,600
Social services and administration: Training grants		$3,000	3,000
Rehabilitation research and training:			
Fellowships		16,305	16,305
Training grants		570	570
Mental retardation: Training grants	2,500		2,500
Development of programs for the aging: Training grants		2,610	2,610
Maternal and child health: Training grants		11,710	11,710
Child welfare: Training grants		2,431	2,431
Total, Social and Rehabilitation Service:			
Fellowships		16,305	16,305
Training grants	5,100	20,321	25,421

STUDENT AID AND TRAINING PROGRAMS

[In thousands of dollars]

	1970 New	1970 Continuing	1970 Total
Total, Department of Health, Education, and Welfare.:			
Fellowships	$73,104	$109,311	$182,415
Training grants	245,962	374,287	620,249
Scholarships	8,781	20,219	29,000
Traineeships		20,020	20,020

PROGRAMS TARGETED ON SPECIFIC GEOGRAPHIC AREAS

Mr. SMITH. On page 17 you said:

"The budget completely ignores another section of the amendments, however, which authorizes a new program for training the disadvantaged student. The program would target assistance to areas of high unemployment."

I take it this would be another program where you would arbitrarily draw boundaries and a student within the boundary is eligible and those outside are not eligible.

Mr. KELLY. Geographic boundary or criterion boundary?

Mr. SMITH. Geographic.

Mr. KELLY. I think it would be on the basis of student eligibility.

Secretary FINCH. I do not know of any geographic prohibition or constraint.

Mr. SMITH. I was concerned about that because we have some Government programs that draw the boundary.

Secretary FINCH. Like model cities.

Mr. SMITH. Which in effect penalize, the family——

Secretary FINCH. Across the street.

Mr. SMITH. Or that moves out. In other words, you have to stay in the ghetto to get the benefit.

EXPERIMENTAL EDUCATION PROGRAMS

You mentioned several times the need for testing and experimental programs and that you wanted to expand. Are you talking about title III of ESEA?

Secretary FINCH. That is part of it. As far as the Elementary and Secondary Act is concerned, we have asked for authority to use 1 percent of the funds for evaluation in all titles.

Mr. SMITH. I noticed the increase in the budget request was from 165 up to 172 and that would hardly take care of any expansion.

Mr. CARDWELL. That is right.

There are two issues here. One would be the proposal that the legislative authority be strengthened to recognize the need for evaluation. That is the point to which the Secretary referred.

And the other is the budget itself, which has an $8 million increase.

Mr. SMITH. Seven million on 165 is not going to give you much increase, is it?

Mr. CARDWELL. No, sir.

Mr. KELLY. But targeted types of research and evaluation, such as the experimental schools, are best funded under the authority of the educational research program rather than under the ESEA. That is the case now with regard to the District of Columbia model school project.

Mr. SMITH. There is a great need, as I am sure you are all aware, to have some new methods of testing and to have some new methods of teaching for that matter, so that we do not miss the innovative child. Now it is all geared on which one can memorize and recall. That is the whole deal.

As I mentioned before, Einstein and Edison both flunked out under this method of testing. But we have no real method to determine who these kids are that can use whatever other abilities they have to great advantage as these two men did.

I take it this research is going to dwell on that at least partly.

Secretary FINCH. Yes, sir; and it is my hope that when we come back here next year we will have some very precise examples of what we have found and what techniques we think are applicable and viable. I am afraid that right now about the only thing we are reasonably sure of is that the best teachers are the teachers who have been at it the longest.

Mr. SMITH. I have become convinced if we had bloc grants at this juncture, all they would do is continue to spend it the same way they have spent it for a hundred years.

Secretary FINCH. I think that is right.

Mr. SMITH. If there is going to be any research done, it has got to be done through Federal appropriation and contract.

INCOME MAINTENANCE EXPERIMENTS

You mentioned a minimum income experiment in New Jersey. Is there not one in Wisconsin too?

Mr. KELLY. The University of Wisconsin is conducting it. It is being held in New Jersey.

Secretary FINCH. That is an OEO program.

Mr. KELLY. Yes.

Mr. SHRIVER. Will the gentleman yield?

Mr. SMITH. Yes.

Mr. SHRIVER. Is that not an experiment on the guaranteed income, or negative income tax?

Mr. KELLY. I think it is really a combination of the two It is a money payment that will bring the family up to a given level. It is for families that are headed by an employed male, that because of the size of family and so forth, are living in poverty.

Mr. SHRIVER. Thank you.

INVOLVEMENT OF THE PRIVATE SECTOR

Mr. SMITH. When you itemize your interim strategy, one of the points that sounds good—"programs that mobilize the vast resources of the independent sectors that genuinely and substantially involve private enterprise and voluntary initiative."

Insofar as we are concerned with budgeting, are you talking about programs that we will appropriate money for, or more reliance on tax credits, or what?

Secretary FINCH. There are a whole variety of things we want to look at.

Particularly in higher education, it is obvious that we must devise programs that will bring in a good many non-governmental dollars.

Mr. SMITH. Nothing that really affects this budget then. In other words, the legislation will not affect this budget anyway?

Secretary FINCH. No.

Mr. SMITH. Before I yield, may I say, Mr. Secretary, in addition to asking those questions, I am very interested in your statement and it seems to me it is the obvious intent to look at all of these things and not to foreclose any of the possibilities.

I wish you well because I think you have one of the hardest departments to administer that was ever created. It is the biggest collection of fiefdoms in history. I wish you well.

Secretary FINCH. I take assurances and expressions of that kind very deeply to heart, Congressman.

Mr. NATCHER. Mr. Shriver?

EMPLOYMENT PROVISIONS OF THE REVENUE AND EXPENDITURE CONTROL ACT

Mr. SHRIVER. Mr. Kelly, a I understood you when you were discussing the Expenditure Control Act of last year, you said the position of Congress was either untenable or unattainable. Which?

Mr. KELLY. I think both. Congress enacted the provision that said the entire Federal Government must decline to the employment level of June 30, 1966. This probably was attainable, although it might have required adjustments and so forth to be attained.

Congress subsequently exempted from that provision of law a very substantial portion of the total Federal Government, but did not change the requirement that the whole Federal Government has to get down to the June 30 level before this exemption is lifted. Therefore those still left under the restriction will have to get down to zero, and

you will still be short. I do not think that is attainable nor do I think it is tenable.

Mr. SHRIVER. Perhaps it would have been better had we set ceilings?

Mr. KELLY. I will just say that if you exempt that many organizations, I think you have to take a new look at what your objective is, and what the manpower planning is supposed to do.

Mr. SHRIVER. Of course, the objective was to get the surtax passed at that time.

STAGGERING OF SOCIAL SECURITY BENEFIT CHECKS

There was considerable discussion of payroll procedures relative to social security. I have had a number of letters recently from constituents wondering if it would be possible to scatter throughout the month the checks that are received so that there is not a big burden on the banks, upon the Post Office Department, of this vast number of social security checks coming out about the same time.

Is that feasible if it were started without changing all of them on the books? You said a while ago there were 24 million people and billions of dollars involved.

Mr. KELLY. There was a study made of this several years ago. At the time of the study one of the principal concerns was the tremendous burden that was placed on the Post Office Department. It was found that the burden placed on the Post Office Department was not predominantly a burden on the carrier, but on the sorting system. Dumping these huge volumes of mail into big city post offices where we have payment centers constituted a serious problem.

We did find a solution to that. We now give the Post Office Department our mail presorted. The Post Office Department told us how they want it and we now make that sorting by computer. When the Post Office Department gets the mail, it is all in mailbags sorted as to what trains it is going on and how it is going to be distributed.

So we have removed some of the burden there.

The part about the banks really relates to a problem that concerns the whole economy. All kinds of systems have been set up where people pay rent on the first of the month and do things in certain ways. It is astonishing the extent to which the recipients of social security are expecting that check on a given day at a given time. The devices that have been considered as methods to distribute the workload are devices we would use only for new people coming on the rolls so that we would not adversely affect the people already on the rolls.

As I say, several studies have been made of these problems, but the only solution we have undertaken was to presort the mail.

Mr. SHRIVER. Are there written reports on those studies?

Mr. KELLY. Yes, there are. I am not sure we made them public, but they would certainly be available to you.

Mr. SHRIVER. Mr. Chairman, it is 12 o'clock. I can proceed now or at 2 o'clock, as you wish.

Mr. NATCHER. Thank you. The committee will adjourn until 2 o'clock.

AFTERNOON SESSION

Mr. FLOOD. I think Mr. Shriver had the witness when we recessed.

Mr. SHRIVER. Thank you, Mr. Chairman.

REDUCTION IN STUDENT LOANS

You devoted, Mr Secretary, quite a bit of attention in your statement to student aid of various kinds. That is on pages 13 and 14.

The 1968–69 appropriation for NDEA loans was $190 million. The 1969–70 proposal I think is about $155 million.

This has been a successful loan program for helping the low-income students and I am wondering why you are reducing in this area of great interest to the people of the country.

Secretary FINCH. I am advised that, when the family income ceiling was lowered to $10,000, that then reduced the demand for NDEA loans. On this basis the amount budgeted is a realistic figure.

Mr. SHRIVER. There is less demand for NDEA loans?

Mr. CARDWELL. If you put in that ceiling.

Secretary FINCH. If you invoke that $10,000 income cutoff.

Mr. KELLY. The National Defense Education Act places upon the institution the responsibility of seeing that the funds go to needy students. Across the country there are variances in what constitutes a needy student. An examination of the program shows that a substantial number of students from families with an income of above $10,000 were drawing student loans. The conclusion reached in trying to put together a constrained budget was that students whose families have an income of above $10,000 should first endeavor to get loan funds under the guaranteed student loan program from financial institutions. Failing to get that, they should not be deprived of a student loan; they should then be able to come back to the educational institution for an NDEA loan.

The estimate was put together on the basis that only 20 percent of the students who had a family income above $10,000 would be unable to obtain a loan from a financial institution under the guaranteed student loan program. That 20 percent would be given loans under NDEA. The budget before you would give as many student loans as last year to students with family incomes below $10,000 but would give only 20 percent as many as last year to students with family incomes above $10,000.

Mr. SHRIVER. Who defines this family income level? What do you mean by that?

Secretary FINCH. In the guaranteed student loan program, the Congress defined it. It is called adjusted family income. They said that, for a family income below $15,000, the Federal Government would subsidize the interest. Above $15,000 the Federal Government would offer the guarantee but not subsidize the interest.

Mr. SHRIVER. What is the figure?

Secretary FINCH. The total income. The student fills out a form similar to the form used by the Princeton Testing Association as to the ability of the family to pay. The family income is related to the number of children in the family in arriving at adjusted family income.

Mr. SHRIVER. The legislative amendments of 1968 provided that students in vocational and preparatory type schools are eligible for NDEA loans if the appropriation exceeds $190 million.

Was it the intent of the Office of Education to exclude these students by not asking for additional NDEA loan funds?

Secretary FINCH. That is not my impression. No, sir. I don't think there was any ceiling made with that purpose in mind, Congressman. It is simply a reflection of these new criteria.

AVAILABILITY OF BANK LOANS FOR NEEDY STUDENTS

Mr. SHRIVER. You think that the banks are going to loan money at 7 percent to the student from a low-income family?

Mr. KELLY. A substantial number of the 450,000 students getting NDEA loans this year are from families in the income range of $10,000 to $15,000.

Mr. SHRIVER. You think banks are going to increase their loans? Do you think they are going to handle the needs?

Mr. KELLY. Mr. Shriver, the budget is based on a concept that 923,000 students next year will be able to get guaranteed student loans. If the inflationary effect on interest makes it impossible to borrow money at this level, it will not just adversely affect those that would otherwise get NDEA student loans. It would be relatively catastrophic, and legislation would have to be enacted to make loan funds available.

This year 750,000 students are dependent on guaranteed student loans. Next year it is anticipated that 923,000 students will get at least part of their assistance to go to college from this source.

NEED FOR INCREASED STUDENT AID FUNDS

Mr. SHRIVER. I am concerned because the Office of Education has gone out to the schools in the past 3 years and asked them to get the low-income students, not to be dropouts, and there has been quite a movement in this regard. I don't think that the program should be reduced, neither the educational opportunity grants program, the loan program, nor the grant program.

Probably we need a mix of all three of them, at least at the same level.

Secretary FINCH. Of course, we have increased the educational opportunity grant total by $51 million. So far as the private banks are concerned, Congressman, I know that recently several banks that I was counsel to systematically set up an amount for student loans that was put out, whatever the prevailing rate was, because it was good community relations. Obviously now I can not say what will happen nationally.

Mr. KELLY. There is one other aspect of the student loan program that it might be helpful to mention. While the direct loan appropriation figure was $193,400,000 in 1969, it is proposed at $161,900,000 in 1970. The amount of student loan funds under this program available to the colleges, including repayments, was $265 million in 1969. It is estimated at $250 million in 1970. While the direct appropriation is a reduction of $31 million, the reduction in funds available for student loans, including reuse of payments, is estimated at $14 million.

Mr. SHRIVER. You said that the work-study program is going to be increased?

Mr. KELLY. That is correct.

Secretary FINCH. Yes, sir; by $14 million.

Mr. SHRIVER. In connection with that, the institutions are going to have to pay increased minimum wage amounts, I believe?

Mr. KELLY. That is correct.

Mr. SHRIVER. This is not much of an increase when you take that into consideration.

SIZE OF THE HEW BUDGET

In the Secretary's introduction to the fiscal year 1968 report of the Department, your predecessor wrote a person holding your office "must necessarily argue for increased appropriations because no budget is ever adequate to meet all the health, education, and welfare needs of a great and growing Nation."

Would you agree with that?

Secretary FINCH. I think obviously you have to reflect the increases in population. What we are trying to thrash out here is the quality of judgment as to how we use those resources. This is why I come down hard on the evaluating process and why we want to be able to come back to you, we hope next year, with a much better accounting for the programs that we are operating now. Obviously many of these programs are not operating as efficiently as they should be. Given good programs, yes, sir, you are probably going to have to ask for more dollars because you have more people to serve.

INCOME MAINTENANCE EXPERIMENTS

Mr. SHRIVER. On page 5, the budget requests an additional $3 million for practical experiments designed to improve our sagging welfare system.

What specifically are you talking about as to the goals of this testing project? You mentioned a project in New Jersey, now in existence. What are your goals?

Secretary FINCH. There has been a lot of rhetoric about separating income maintenance programs and social service programs. I think that way offers some hope. I cannot really respond to that. I have very little expertise in welfare programs. Maybe my associates can help on that.

As I said in my earlier testimony, this is probably the thorniest problem that we have and we are going to try to attack it during the coming year.

Mr. SHRIVER. You are asking for $3 million.

Mr. KELLY. Mr. Shriver, there are a great many people that have proposals as to how you can solve the welfare problem, whether it be a negative income tax, family allowances, or increased social services and incentives to work. The professional people in social work feel that there are a great many unanswered questions as to what would be the result if you made various changes in the system. They are asking the Secretary to provide them with the resources to conduct research contrasting a group getting new types of assistance with a control group getting regular assistance. In this way they could answer the question whether these hypotheses will or will not produce the result which the proponents claim.

That is the concept behind the conduct of this kind of research.

Secretary FINCH. In all candor, some of these proposals I just don't understand. I am not sure how they work.

Mr. SHRIVER. Relative to the $3 million, Why is it 3 and not 4 or 2?

Mr. KELLY. Yes, sir. When the social welfare people are before you they will describe the projects.

Mr. SHRIVER. Very well.

Secretary FINCH. That was related, I was told, to the $1.5 million figure used in the New Jersey experiment conducted by OEO.

Mr. CARDWELL. Maybe we could add that the Secretary's task force that reviewed the welfare budget concluded that this was not enough money. It would take a great deal more money to really examine all the alternatives in an effective way.

Mr. SHRIVER. If you found a better way, it would be worth it.

Mr. CARDWELL. Right.

EMPLOYMENT OF RETURNING VETERANS AS MEDICAL TECHNICIANS

Mr. SHRIVER. I certainly would commend you on the proposal to make more use of paramedical technicians both for a domestic labor force and returning veterans from Vietnam in our health manpower needs.

I can understand that this approach can be, and to a limited extent has been, used in the field of education manpower.

Secretary FINCH. Yes, sir.

Mr. SHRIVER. Is there sufficient legislative authority to expand these programs under the Education Professions Development Act? Vocational Education Act?

Secretary FINCH. I think there is. Our big problem now is to persuade the various State licensing bodies and the medical societies that there ought to be a recognition of something between a male nurse and a physician who can do a limited amount of diagnostic work. We may have to come up with a recommendation on a uniform standard which would provide for certain educational criteria and lay out what the minimum would be with respect to training for these intermediate or technical assistants, whatever title one chooses to give them.

I had a meeting with the head of the AMA on this matter. They are going to take it up at their national meeting. They have been a little reluctant, as you know, even to recognize a function or status of this kind.

FINANCIAL NEEDS OF MEDICAL AND DENTAL SCHOOLS

Mr. SHRIVER. On page 11 you say that 20 medical schools and 15 dental schools are in serious financial trouble. I believe that you are asking an increase of $75 million to assist these schools.

Is this $75 million in addition to that which will be appropriated for the National Institutes of Health and providing for support of medical schools?

Mr. KELLY. It is under the Bureau of Health Manpower which is one of the components of the National Institutes of Health. This year, under the educational improvement grants, they are providing $66 million. In the 1970 budget they ask for $96 million. Then in connection with——

Mr. SHRIVER. Is this in addition to that we are supplying through the National Institutes of Health for research?

Mr. KELLY. Yes, sir. Absolutely. This is entirely related to assistance for the regular educational program.

Mr. SHRIVER. There still is a long waiting list of applicants for admission to these schools. What is wrong? Why the financial breakdown of medical schools? Their graduates are making the most money of any group in the country. Is their tuition adequate?

Mr. KELLY. To pay for the cost of education?

Mr. SHRIVER. Yes.

Mr. KELLY. No, it does not come anywhere near it, Mr. Shriver. We are making a study jointly with the American Association of Medical Schools to get at the question of what it costs to operate a medical school. This includes research, the education of undergraduates and postgraduates; continuing education for practicing physicians, and medical care in the teaching hospitals.

Mr. FLOOD. This question is not peculiar to medical schools.

Mr. KELLY. In none of the systems does tuition pay for the cost of education.

In connection with the health profession schools, the tuition is a longer way from covering the cost of a medical education. The cost of a medical education is much higher than the cost of education in any other part of the system.

Secretary FINCH. We found a partial answer in California when we put together new medical centers in Davis and San Diego and Riverside. In each case, we created a central complex for training veterinarians, dentists, and doctors, with a common library and common laboratories. We realized considerable savings and cut down on the overhead Mr. Kelly referred to by virtue of combining those resources. We were able, by planning this way, to cut the cost somewhat. But it is not easy to do.

Mr. SHRIVER. The only answer is the Federal Government, then?

Secretary FINCH. In the situation in which we find ourselves, yes.

VOCATIONAL EDUCATION FOR THE DISADVANTAGED

Mr. SHRIVER. On page 17 you say that you are considering budget amendments to fund the new programs to train disadvantaged students. Would you explain that further? How does it differ from the ongoing programs, and what is the estimated cost?

Secretary FINCH. This is a new program authorized by the 1968 amendments which as Mr. Cardwell indicated, has not been funded. The features of it are 100 percent Federal funding, targeting funds on areas of high unemployment and allowing private school children to take part in certain training projects. This is simply an effort to respond to the congressional mandate with a modest amount, $15 million. Here again we have been asked to do something by Congress, and we are trying to do it.

Mr. SHRIVER. I am not criticizing but trying to find out.

Secretary FINCH. We could probably effectively spend much more than $15 million.

NUTRITION

Mr. SHRIVER. What type of innovative help in demonstration do you have in mind to combat the nutrition gap that you mentioned? How much for that activity?

Secretary FINCH. Aside from the surveys which I have already alluded to, I noticed in the press this morning that we were criticized

because we were not doing enough specific work to prevent children from consuming improper foods that contain worms which show up in the bowels. As I recall our discussions correctly, it would be these kinds of programs that we would undertake, rather than simply pinpointing where there was undernutrition. We think we can get a greater use of volunteers during a lunch hour to prepare food and train children in nutrition so that teachers would have some time off away from the children and the children themselves would get a better learning experience.

These are the kinds of programs that we have been talking about.

Mr. SHRIVER. That is the kind of innovative help in demonstrations?

Secretary FINCH. Yes, but with a nutritional input because a lot of these lunch programs don't have that kind of input now.

PREMIUM LEVEL FOR SUPPLEMENTARY MEDICAL INSURANCE

Mr. SHRIVER. On page 24 you mention the question of the actuarial soundness of the $8 a person premium for supplementary medical insurance. Is an increase in that premium planned?

Secretary FINCH. I don't have to make that decision, as I understand it, until the end of the year. It is something I want to look at long and hard. I don't have any firm conviction about it at this point except that there is obviously a lot of pressure from many sources to increase the Federal Government's share. I think the really surprising thing about this—we were discussing this in our staff meeting the other day—is that they have been able to get 96 percent enrollment in this program and these people are paying their $4 just like clockwork. Within the target group in question, I think Mr. Ball indicated there are only about 700,000 eligible in the whole country who have not signed up.

I think I would have to look at it a little longer before I make a final determination.

Mr. SHRIVER. Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Hull?

Mr. HULL. Thank you, Mr. Chairman.

IMPROVEMENTS IN WELFARE SYSTEM

Mr. Secretary, I am pleased to note your concern over the welfare system as it is now operating. You suggest continued examination be made of the proposals to improve the program. I wonder if you would have any feelings as to which direction this would eventually look for a solution.

Secretary FINCH. Obviously, if we can do our job in education we will cut the welfare rolls. I have made the statement that we are going to have to commit a portion of Federal resources to set minimum standards of maintenance payments to bridge the great disparity between what the more affluent States and the less affluent States pay. At the same time, we can't just free the States from their burden. They have an ongoing responsibility. Hopefully, if our other programs work out, if we can make WIN work more productively, if we can

make Upward Bound, the community college, and vocational education programs work more effectively, we will have responded to the technological challenge and we will get at this welfare load. I cannot give you a simple answer. I wish that I could.

Mr. HULL. I wish that you could, too.

INCREASED FEDERAL FUNDS FOR EDUCATION

Many innovative techniques in the field of education have been developed as a result of Federal grants to schools and individuals. Do you feel that it would be possible to implement them without greatly increasing Federal education funds?

Secretary FINCH. I have a general feeling—if I understand your question correctly—that in the field of higher education many Federal grants, particularly those that come out of Defense and NASA, are so tightly conditioned that they really burden the institution very badly. I would hope, under the programs we have put forward here, that these institutions—which are, all of them, fighting fiscal problems—would have greater freedom to use the moneys as they see fit.

Mr. KELLY. There is one aspect of it that is quite interesting. Remember the Secretary talked this morning about the need for increased funds for evaluation. If you take all of the projects that have been funded under the Elementary and Secondary Education Act at the local level and those funded under title III at the State level, you have a tremendous reservoir of attempts to deal with the problem of innovation in education and particularly compensatory education for the disadvantaged youngster. If these evaluation funds can really zero in on those projects which have had the greatest payoff and those attempts that really have not been productive, and you can disseminate this information to all school districts, I think school districts will make these funds accomplish much more for their youngsters.

If a talented, objective, professional group can identify the approaches that are really the most productive, I think that you will get a wide dissemination and use of them.

FOOD STAMP PROGRAM

Mr. HULL. Mr. Secretary, is it your feeling that the Department of Health, Education, and Welfare is better prepared to administer Federal food distribution programs than the Department of Agriculture?

Secretary FINCH. No, sir. I think we can be a good deal more helpful in providing them the information on which basis they can make their distribution. I have a certain personal bias against some of the limitations of the food stamp program, but that happens to be the system we now have and that is the one we are trying to improve, working with Agriculture.

I do not desire more programs to administer in my present position. I think that there would be a massive problem of absorption, if we got into that business, even though it is an imperfect system now and we have nutritional input to get into the present program.

COST OF LIVING INCREASE IN SOCIAL SECURITY BENEFITS

Mr. HULL. From time to time there are suggestions that the Social Security program should be changed to provide for an automatic cost-of-living increase. Do you have anything to add to your previous testimony on that?

Secretary FINCH. I counseled candidate Nixon against the idea. Again, it is only my viewpoint. As I said, I think Congress has responded every few years in reflecting the upward living-cost pressures. I think Congress has responded responsibly. We get into very serious administrative and technical problems if we try to build in these variables. If we start building them into the system, we would have to make some drastic and expensive changes, so that I would be disposed to leave this to the Congress.

SHORTCOMINGS OF THE EDUCATIONAL SYSTEM

Mr. HULL. Mr. Secretary, I note in your statement that established school systems are doing neither the job they can do nor the job they ought to be doing.

I wonder if you would pinpoint what you believe are the principal failings of our school systems today. How might we be able to solve these problems without endless escalation of appropriations in the field of education?

Secretary FINCH. I would begin by saying that I suspect we ask really too much of our educational system, taken as a whole. We ask it to do a great many things and, as we go through this technical explosion, we ask even more.

Mr. HULL. This is rather an indictment of the teachers, I guess, across the Nation?

Secretary FINCH. No. I suspect if I were to be more specific I would probably tend to indict board members and superintendents and administration officials who, particularly at the elementary and secondary level, tend to react as they did 20, 30, 40 years ago. They simply don't take cognizance of the fact that, for example, the child who comes into kindergarten now, unlike the time we came into kindergarten, has had 3,000 or 4,000 unstructured hours of watching television in his background. This just shoots him right past the old conventional system.

A bright child who has not had a chance to sort out all this experience comes into a classic, orthodox kindergarten or first grade, and he is not challenged. I have heard the example used, and I think it makes sense, that here a child is watching television and even with regard to a spot commercial, he is hit with a message conceived by the best brains of Madison Avenue. He goes from that to a schoolroom situation which is hardly designed to provide the same kind of provocative motivation. I am not suggesting that we can compete in the classroom, but I think that our system has failed to relate to this societal input.

We also have to rethink the use of our bricks and mortar. Is it wise to have everybody—just in terms of what our natural resources are—is it wise to have everybody out at the same time in the summer months fighting their way into the public parks?

There are broad social questions involved in how we use our time and our school buildings.

Can we stagger our system so that we don't have everybody on the streets in the hot summer at the same time?

I just do not think that our administrators, by and large, have responded to the rapid technical changes in our social order.

Mr. HULL. Thank you, sir.

Secretary FINCH. Thank you.

Mr. FLOOD. Mr. Casey?

Mr. CASEY. Thank you, Mr. Chairman.

INSTITUTIONAL AID VERSUS STUDENT AID IN HIGHER EDUCATION

Mr. Secretary, I got back to my office today at noon and found a copy of a letter from the coordinating board, Texas College and University System. It was signed by the commissioner and evidently circulated to every college and university in the Texas system.

It points out the decrease in institutional aid while there is an increase in the aid to the students. It makes the observation and says this approach, if continued, will result in more students entering college as economic barriers are reduced. However, if Federal institutional aid programs are cut back, an increasing number of students will find that their costs will rise as colleges have to obtain funds from them for operating costs and construction of the facilities.

That is along the line Mr. Smith was mentioning earlier.

I believe that your response was that you think there ought to be a balance?

Secretary FINCH. Yes, sir.

Mr. CASEY. Is that correct?

Secretary FINCH. Yes, sir.

Mr. CASEY. I interpret your response that way.

Secretary FINCH. Yes, sir.

Mr. CASEY. Do you think there is going to be any change in this budget along that line in the next couple of weeks that you can anticipate?

Secretary FINCH. Not in what we are presenting to you now. The reason is, this varies from State to State. Another reason, in addition to the ones I already mentioned in earlier testimony, is that we find where we get into the problem of bloc grants to institutions, the whole problem of a balance between public and private higher educational institutions also is involved. Our experience in California has been that many private colleges do not have the history of endowment that many such institutions have in the East or Midwest.

We were later to come into this field. Many of our private institutions are not well funded and, by contrast, we have been extraordinarily liberal in California in funding our State colleges and universities. It has given the private institutions a very tough way to go. We have evolved there a State student-aid program which provides merit scholarship. This gives the student a chance to choose the public or private higher institution he wants to go to. The striking thing is that better than 60 percent of those students go to the private schools. This is a great assistance to that sector of higher education.

That is one of the reasons we are putting our emphasis on direct aid to the student as opposed to institutions.

Again I recognize that this pattern varies from State to State.

Mr. Cardwell advises me that we do have pending a community college amendment which involves about $9 million that would also be responsive to your point.

Mr. CASEY. You think the level proposed in this budget is sufficient provision of funds for facilities and student aid?

Secretary FINCH. I would like both increased slightly, but given our present constraints we think this is realistic; yes, sir.

Mr. CASEY. This letter cites again the title I undergraduate facilities program is proposed to be reduced from $216 million in 1969 to $130 million next year. Is that correct?

Mr. KELLY. Expressed in terms of appropriations, it is correct. In terms of the amount of money that will be obligated during fiscal year 1970, the decrease is not as sharp. When you put together the funds for subsidized loans and the funds for grants, it is contemplated there will be about $400 million worth of assistance in 1970 as compared to $392 million in 1969. More of it will be in the form of loan guarantees or subsidized interest payments.

Secretary FINCH. To be directly responsive, I would like to ask permission of the chairman to insert in the record at this point a complete breakdown of construction and institutional aid as opposed to student aid.

Mr. CASEY. Can you send me a copy of that also?

Mr. FLOOD. Without objection, it will be made a part of the record.

(The information follows:)

HIGHER EDUCATION—A COMPARISON OF STUDENT AID AND INSTITUTIONAL AID SUPPORT AS CONTAINED IN THE FISCAL YEAR 1970 BUDGET

	Student aid		
	1969	1970	Change
Insured loans	$76,400,000	$63,900,000	−$12,500,000
Program level	641,250,000	794,241,000	+512,991,000
Educational opportunity grants	126,600,000	175,600,000	+51,000,000
Program level	144,787,000	175,600,000	+30,813,000
Direct loans	193,400,000	161,900,000	−31,500,000
Program level	265,100,000	250,699,000	−41,401,000
Work-study programs	139,900,000	154,000,000	+14,100,000
Program level	146,050,000	154,000,000	+7,970,000
Cooperative education		1,000,000	+1,000,000
Specill programs for disadvantaged students:			
1. Talent Search	4,000,000	5,000,000	+1,000,000
2. Upward Bound	29,800,000	30,000,000	+200,000
3. Special services in college		10,000,000	+10,000,000
Total, appropriations	568,100,000	601,400,000	+33,300,000
Program level	1,230,987,000	1,420,540,000	+189,553,000
INSTITUTIONAL AID			
Construction:			
Grants	$91,000,000	$150,000,000	+$59,000,000
Program level	242,000,000	150,000,000	−92,000,000
Direct loans	5,000,000		−5,000,000
Program level	5,000,000		−5,000,000
Subsidized loans	3,920,000	10,670,000	+6,750,000
Program level	145,000,000	250,000,000	+105,000,000
Total, appropriations	99,920,000	160,670,000	+60,750,000
Program level	392,000,000	400,000,000	+8,000,000
OTHER INSTITUTIONAL AID			
Strengthening developing institutions	$30,000,000	$35,000,000	+$5,000,000
College library resources	25,000,000	25,000,000	
Colleges of agriculture and mechanic arts	11,950,000	12,120,000	+170,000
Undergraduate instructional equipment and minor remodeling	14,500,000		−14,500,000
Institutional sharing of resources		750,000	+750,000
Improvement of graduate schools		750,000	+750,000
Total, appropriations	81,450,000	73,620,000	−7,830,000

PROGRAM LEVEL

As the above figures show, the 1970 budget submitted by the Johnson administration—and currently under review—provides an increase in the program level for student aid of approximately $190 million. Over three-fourths of this increase is in the form of loans to students—loans insured and subsidized by the Federal Government. Institutional aid remains at about the same level as in 1969. The above totals, of course, are net figures including both increases and decreases in specific program areas.

Program levels are referred to when they differ significantly from appropriations. Under the insured loan program the Federal Government helps subsidize the interest costs of private loans to students. Federal funds, therefore, actually support a much larger overall program dollar level. The actual operational levels for the educational opportunity grants and work-study programs in 1969 are higher than the appropriations by the amount of funds carried forward from fiscal year 1968. In the case of the National Defense Student Loan program—direct loans—the Federal appropriation makes up only a part of the total program. The total funds available to colleges also include repayments by students on previous loans.

In the area of construction of higher education facilities, it should also be noted that the appropriated funds support a much larger lending level. The 1970 budget proposes greater reliance on loans made by private institutions where the interest is subsidized by the Federal Government. Offsetting the increase in subsidized loans will be decreases in grants and direct loans. Overall, the $8 million increase in construction assistance is offset by a nearly equal decrease in other forms of institutional aid.

The above amounts reflect the priorities of the previous administration. They are currently under review and are subject to change.

MEDICARE PAYMENTS TO HOSPITALS

Mr. CASEY. Mr. Secretary, the costs on medicare, hospital costs, vary from locality to locality and hospital to hospital; is that right?

Secretary FINCH. They sure do.

Mr. CASEY. You spend a lot of money auditing these costs?

Secretary FINCH. Yes, sir.

Mr. CASEY. You said earlier, I believe, you hate to go to fixed costs, but what is wrong with hospitals operating on what Blue Cross pays?

Secretary FINCH. That is one of the proposals we are considering. We are also trying to work with the intermediaries on how we can tighten up their surveillance of this whole program. I know that there are some strong feelings about this.

Mr. KELLY. There is a strong similarity between what we are doing and what Blue Cross is doing. As a matter of fact, Blue Cross is serving as the agent of the Social Security Administration for determining reimbursement for a tremendous proportion of the hospitals in the country. The essence of the program is determining what it did cost to provide the care and reimbursing for that. To do this it is necessary to establish principles of cost and audit the statements. We use public accounting firms to do these audits. The problem that exists is that there is no method for determining what constitutes minimum cost, and requiring that that minimum be adhered to.

The present system reimburses for actual costs incurred and in some hospitals this is greater than in others. But the fact that the cost is greater in one hospital than another does not necessarily lead you to the conclusion that one is more efficient than the other. One may be saving lives the other is not able to save. The present system, whether it be Blue Cross, medicare, or medicaid, has not learned to measure what the necessary minimum is for the provision of the service. It has recently achieved the capability of measuring what the costs actually were for any group of patients that you can reasonably identify, so that we don't pay either too much or too little for it

That is the present state of the art. It does leave much to be desired.

Mr. CASEY. Do you ever pay more under medicare than Blue Cross pays the same hospital?

Mr. KELLY. You could on a given patient; yes, sir. In the aggregate, the only differences between Blue Cross and medicare are whether or not Blue Cross fully allows for depreciation and whether they allow the 2 percent that is in the medicare cost principles as an overall undetermined cost allocation.

Mr. CASEY. You take in depreciation and other items. Sometimes you pay over 100 percent of what the actual cash outlay is for that hospital.

Mr. KELLY. More than the cash outlay is, because we do allow for prior costs and depreciation of facilities and equipment.

Mr. CASEY. That is something Blue Cross doesn't do?

Mr. KELLY. There are variations. They may not do it exactly the way we do it.

Mr. CASEY. The reason I ask that is because the operator of this particular private hospital didn't want anything. He said, "We are being paid for our services." He said, "As a citizen I do not see why a hospital in the same community should be rewarded for sorry administration and for laxness in the operation of their hospital." He said, "You spend a lot of money auditing them all the time."

His proposal sounds simple.

He said, "What is wrong with say in Houston, Tex., using Blue Cross as a guide in setting what the rate is and that should be it." You do away with all this expensive auditing all the time.

Mr. KELLY. I think it is an oversimplification. Blue Cross does very much what we are doing. We use them as our agent. Their cost principles and ours are not identical. But they are tending to move in our direction. We have a study underway now in the State of Massachusetts in which the State Blue Cross and insurance companies such as Hartford and Aetna are participating. The Social Security Administration, the Social and Rehabilitation Service and the National Institutes of Health are all working together to arrive at one set of cost principles in Massachusetts, one cost allocation, and one audit. If we are successful, it will be a demonstration that we hope others throughout the country will pick up and use.

Blue Cross is doing very similar work in making their decisions and making audits very similar to the kind we are makng. We hope that we can avoid an overlap.

Mr. CASEY. I didn't think that was throwing anything new at you. I am sure that you had somebody mention it or thought of it yourself as simplifying this program, and still be equitable, and not spend so much time auditing individual hospitals. That is what you are doing now?

Mr. KELLY. Yes, sir.

BLACK STUDIES PROGRAMS

Mr. CASEY. Mr. Secretary, the other day on the radio—and I don't hold everyone responsible for what is attributed to them over the radio—it had to do with your admonishing the universities about the enforcement of the penalties for rioting. This was also coupled with something about integration of colleges. Was that part of your announcement at that time?

Secretary FINCH. No, sir. Those were two separate statements—independent of my office, that is, the Office of the Secretary. The Office of Civil Rights, in its continuing review of the enforcement of the 1964 Civil Rights Act, made it pretty clear that where you have so-called black study programs limited to black students, or limited to an all-black faculty, and where you also have an all-black dormitory, these are clear violations of the 1964 act.

If a white student wants to enroll, or if a white faculty member knows more about whatever kind of history it is that they are talking

about, that should be a decision left up to the administrators. Obviously restrictions like this are in violation of the act. We are simply putting these people on notice that such is the case. It cuts both ways.

Mr. FLOOD. It is segregation?

Secretary FINCH. Yes, sir.

NEGRO COLLEGES

Mr. CASEY. I notice on page 15 you are talking about the various aids such as the $400 million for construction. In addition to student aid and construction, program assistance also is offered principally to developing institutions such as Southern Negro colleges and former teachers colleges. In other words, your idea is not necessarily to keep them a Negro college?

Secretary FINCH. No. What we are striving for there is to get more Negro teachers into the educational systems where we are badly understaffed, particularly in the so-called ghetto area. There has been a great disparity in the quality of teachers that comes out of some of the schools in one State as against other schools.

Mr. CASEY. Upgrading the institution?

Secretary FINCH. Yes, sir.

Mr. FLOOD. You are running into piracy, too?

Secretary FINCH. Yes, sir.

Mr. FLOOD. In their eagerness to show they are not segregating, they are pirating topflight instructors from schools traditionally with a colored majority?

Secretary FINCH. That is correct.

Mr. FLOOD. They can afford to pay them?

Secretary FINCH. That is why I get upset with the numbers game in this enforcement business, as I think I indicated in my earlier testimony. It is unreasonable for us or anyone else to come into a district in the South where they pay lower salaries to their teachers across the board, because their resources are limited, and say arbitrarily, "You have to have such-and-such a percent of Negro teachers." A good Negro teacher may have gone north or west where he gets twice the salary. Sticking to a certain percentage means that a school district is going to take a Negro teacher because he is a Negro teacher, no matter how well qualified he may be. If he does not have the proper training the effect will be to deteriorate the quality of education.

That is just not right. Our whole problem in this field is to carry out what the Congress intended in the 1964 act, and at the same time preserve quality public education. If we are not very sophisticated in the way we approach these two problems, we simply force many districts to set up private white schools. That is not the way to help public education.

BUSING OF SCHOOLCHILDREN

Mr. CASEY. Mr. Secretary, are you familiar with the efforts of this committee last year to put a limitation or restriction on the use of the funds with reference to transporting of students from one school to another?

Secretary FINCH. Yes, sir; I am acquainted with the specific language that came out in the rider.

Mr. CASEY. That was in the bill?

Secretary FINCH. Yes, sir.

Mr. CASEY. Are you familiar with the one that we had out of our committee? You know the Senate version is what was finally adopted?

Secretary FINCH. I cannot say I know it in full detail; no, sir.

Mr. CASEY. Basically it was the same as their bill except the words "overcome racial imbalance" were not in our rider. In other words, our amendment provided that none of the funds could be used to require transportation of students to any school without the consent of the parents.

Still leaving the freedom of choice, preserving that which I think under the law—freedom of choice is essential.

Do you feel that in some instances students should be transported just for the purpose, without any other reason, of overcoming racial imbalance against the wishes of the parents?

Secretary FINCH. My personal view, and I think it is sustained by the line of court decisions, is that the only justification you can have for busing is if you are in fact improving the educational opportunity of those being bused.

Mr. CASEY. What if the parent disagrees with you?

Secretary FINCH. That is something they have to take up with the local school board. But I would assume if it were clearly demonstrable that the child was getting a better education in another school, that would be unlikely to happen without the parent's support. I certainly do not believe in busing for busing's sake.

Mr. CASEY. I would not think so, but we have had some that appeared before this committee that were of the opinion that a child's education would be enhanced simply on the basis that he, against his parents' consent, be compelled to go to a school where he would associate with a different social level, a different economic level, and a different race and so on. They think that would be part of his education and would be beneficial. What do you think?

Secretary FINCH. I am trying to picture that particular situation in my mind.

Mr. CASEY. Right now there has been a suit filed or reopened in Houston in which I think the reopening was initiated primarily by the NAACP and the Attorney General has intervened, and they want a mixing for mixing purposes. They have picked out certain allocations—when I say "they" I am not talking about the Attorney General because I have not seen his petition or read it in detail—but petitioners state you should bring so many students from area A and exchange them with students in area B and try to reach a better proportion of the races. The NAACP of course is primarily trying to find a racial balance and they think and say there will be a better educational system with that type of a mixture.

Secretary FINCH. I cannot speak to the facts in Houston, but if you drive that argument to its ultimate conclusion, we are in for a very difficult time indeed. If you look at the classic pattern in most large metropolitan areas, you have a core area which is 99-percent black in enrollment, and a secondary area where there is a mix of one kind or another, and then you have a tertiary area which is primarily white. The only reason that they can comply is because the district as a whole comes out with some kind of balance.

But you have de facto segregation involved here. As I understand the current posture of the Supreme Court, they have said that segregation in and of itself is not a violation of the Constitution; that is, a school that is all black or all white can be in compliance, unless there is a clear-cut and demonstrable pattern of deliberate discrimination. That is an evidentiary matter to be established in each given case.

Mr. SMITH. Will the gentleman yield?

Mr. CASEY. Yes.

Mr. SMITH. I believe the Hannah Commission report, which concluded and recommended that we should have educational centers rather than the normal centers that most metropolitan centers have. I believe that report was based on the assumption that it would be educationally desirable to have a mixing of economic groups and races and so forth.

This Commission report is a substantial body of opinion apparently.

Secretary FINCH. I have not had a chance to read that report. I was trying to reflect the law as I understood it and as it now stands under Supreme Court decisions and the 1964 act.

Mr. CASEY. I do not know whether I ever heard your response as to whether you think that requiring students to attend a school other than theirs or their parents' choice would be enriching their education, where it is just for that purpose.

Secretary FINCH. It seems to me that is a decision which the family has ultimately to make for themselves.

Mr. CASEY. I agree with you on that.

Secretary FINCH. It seems to me very difficult to conceive a situation where a local board would force a child to go to a school——

CIVIL RIGHTS GUIDELINES

Mr. CASEY. Have you looked at your guidelines that you inherited?

Secretary FINCH. I look at them every day. Not a day goes by that I am not exposed to them.

Mr. CASEY. Some of those guidelines were enforced in the past, by not telling a school they had to bus or they had to make teachers serve in some other school that they do not want to—the Department was not going to tell them how to do it, but the Department thought that such was desirable and would stand back and let the school work it out and when they do, they get the money. That is what they have done in the past.

They put out an order, directing a start on integrating the faculty, if you had an all-white teacher school or all-colored teacher school, the school was to put one of the opposite race in the school this year, double that the next year, and the following year, and it was the school's problem how to do it.

Secretary FINCH. This is one of the obviously gray areas, Congressman. This is really what I was talking about earlier when I said we were trying to upgrade our technical assistance people, to be able to take a slightly different approach, a more sophisticated approach, than the percentage one. I think it probably comes down to something like this, and this is the direction our discussions are taking with the Department of Justice now—that given the aggregate resources in a given district, is the district affording to each child,

whatever his race, the best possible opportunity for education, looking at curriculums, hardware, facilities, and faculty. Then it is up to the parents to decide where they think their child can get the best education.

That is the direction our thinking is going.

Mr. CASEY. Does the Justice Department consult you before they file a suit with reference to the school situation?

Secretary FINCH. It just happens in the case of the Houston one, no, but there may have been some contact at the staff level that did not come to my attention.

One of the things I am trying to work out with the Attorney General is an arrangement where we work a good deal closer together. Given the limited number of attorneys we have to work on these matters, if we are going to have a national strategy of maintaining quality public education and also achieving what Congress said it wanted in the 1964 act, we have to work a lot closer than has been the case in the past.

Mr. CASEY. I personally, of course, think a lot of this will work itself out if you do not take an ax to them to do it. You are getting good teachers in the schools.

My own daughter teaches in a predominantly Negro school in Houston. She wants to teach there because it is not too far from where she lives. She enjoys teaching there and the kids enjoy her evidently. She has no problems.

But when you start stirring up something like you have going in Houston that is something else. I would like you to visit there sometime, but let's say let's wait a while.

Secretary FINCH. I hope I would be welcome.

Mr. CASEY. I do not think they know you yet but when they do I know you will be very welcome.

Secretary FINCH. The Postmaster General the other day observed with a southern drawl, "Mr. Secretary, I am not sure whether you are more unpopular in the South or I am since we have cut off the postmasters' patronage."

Mr. CASEY. I am glad to have your response, Mr. Secretary. I know you have to look over these guidelines that you inherited and it sounds to me like you have a reasonable approach to it.

Secretary FINCH. I would have to say this, too, Congressman: Given the limited number of people we have to work on these things, I think we got ourselves into a difficult position when we began by trying to fight this district by district. We are talking about thousands of districts across the country. One of the things we are trying to do now is work more closely with the States, because the States, after all, have a great obligation here and a deep concern.

I do not think we have really involved the State superintendents and the State governing bodies to the extent that we should. We can keep the heat on, but we need some help to accomplish what Congress intended in 1964. So we are working in that direction as well.

I am appalled at the lack of real information I have about a community whose case comes across my desk. I feel there are a lot of questions I would like to go out and ask. Obviously I cannot sit there and research all these cases in depth. So we have to do a better basic fact-finding job.

I am not questioning the bona fides of most of these people, any place in the country where you have de facto or de jure segregation, because I think in most cases they recognize what it is that Congress has enacted. They want to move in this direction. There are a lot of buttons we can push. We do not have to go in with an ax; we can and should use a scalpel, and work with the leadership in the community. That is what we are trying to do. I think we need more help from the States in doing it. That is really what I am saying.

Mr. CASEY. In this proposal that was filed down in Houston, the distribution of students was worked out by a woman in Boston who has never been to Houston. She used the information of census tracts and a computer and worked it all out. She had never been to Houston.

That is the kind of thing you are dealing with down there.

Thank you on that, Mr. Secretary.

VOCATIONAL EDUCATION

Earlier I believe you stated it is possible you might put more emphasis on the vocational education in the public school system and community colleges rather than try to build it up more in the OEO. The vocational teachers, those who are associated with the public schools and community colleges, make a pretty good case, stating that if they were given adequate financing and could change their curriculums too, they believe they could save some of these dropouts.

Right now there are too many of them required to try to get a college entrance education and they believe if they had more counseling with some of these youngsters, and start getting into that difficulty with the regular high school academic work, they could work them into the vocational field within the framework of the public school system and community colleges.

Secretary FINCH. That is unquestionably true. I think we have fallen into what I call a "liberal arts syndrome" to the point where we have badly prejudiced vocational education across the country, at every level.

Mr. CASEY. Do you think they are being adequately financed in this budget request here?

Secretary FINCH. I think the emphasis we are trying to build into all of our programs is going to help the cause.

Mr. CASEY. I say adequately. I do not think quite a bit of this is adequately financed.

Secretary FINCH. I think we are putting a proper priority in this budget on the whole problem of vocational education, given the constraints we are all operating under.

Mr. CASEY. Mr. Secretary, I think my colleagues ahead of me covered a lot I thought of and a lot more I did not think of. I want to thank you for your presentation here. It has been very enlightening and as far as I am concerned it has been on the plus side because I did have the opportunity to talk to you and get some of your views. I wish you well in your endeavors.

Secretary FINCH. I appreciate your comments and this has been very helpful to me, of course.

Mr. FLOOD. Mrs. Reid?

PROGRAM EVALUATION

Mrs. REID. Mr. Secretary, your comment on the need for procedures for systematically evaluating programs and program effectiveness strikes a very responsive note with me, and I do think that many Members of Congress and the public in general feel that this is a major difficulty in welfare programs—how to assess their effectiveness and discontinue those which are no longer needed.

I personally feel the need to do this is even greater this year than any other time.

Do I understand that the $21 million being requested for 1970 will go largely to the Office of Education?

Secretary FINCH. The evaluation budget for the whole department is $20.5 million, of which $14.3 million is for the Office of Education.

Mrs. REID. Do you feel the need is greater in education than in welfare programs?

Secretary FINCH. I do because I think we have enough ongoing material in welfare programs so that we can begin to study them and come back to Congress—very shortly I hope—with some specific recommendations. It is going to take us longer—we are talking about a much broader and more complex area in education—to come back, because we are talking about so many different aspects of education, everything from nutrition to preschool programs, and particularly our evaluation of Headstart. So we are putting very heavy emphasis on education. In my earlier remarks in which I indicted elementary and secondary education perhaps a little harshly, I was trying to build a case that we needed to look at this more closely. And as Mr. Kelly said, once we begin to find the things that work, we want to get the information out to the other school districts.

Mrs. REID. Are you looking for substantial savings as well as better performance through these evaluations?

Secretary FINCH. I think we can find savings, yes, because we can do away with some programs that I think have been very wasteful.

Mrs. REID. Do you have a regular systematic procedure all planned for this evaluation?

Secretary FINCH. Mr. Butler, whom you met yesterday, is spending a good deal of time on this. I do not know how far you want to go in describing what we have done, Jim.

Mr. KELLY. The concept of the Assistant Secretary for Planning and Evaluation is to utilize the results that come out of the evaluation programs throughout the Department. So the Secretary has instructed all of the operating agencies that whatever funds are available to them for evaluation have to be spent in coordination with the Assistant Secretary for Planning and Evaluation so that he can design a balanced system.

The plan now being laid out calls for most of the evaluation to be done under contract with outside groups, such as the kind of groups that the Department of Defense has used, and colleges and universities. So we are not just using our own people to, in effect, evaluate their own performance. We are not just using the State educational institutions to evaluate their performance. But we are trying to bring thinking from the outside into this field. It is a very difficult job.

Secretary FINCH. We are trying to get objective input from outside the Department and get away from the situation we have had often in the past where agencies within the Department evaluate themselves, with very little of it coming to the Secretary.

PROLIFERATION OF EDUCATION PROGRAMS

Mrs. REID. I read a recent survey which revealed there are over 470 education programs spread out among 20 agencies and departments, and I think 112 programs relating to assistance to the poor. Is it true that through the survey you would be able to eliminate duplication?

Secretary FINCH. This is what we would hope for. Unquestionably, there is some duplication and a great deal of confusion on the part of school administrators as to what programs are available to them. This is what we are trying to rationalize.

Mrs. REID. Do you have any actual figures on these various programs?

Secretary FINCH. We can give you the number in our department. As I indicated, there are programs in Defense and NASA too.

Mrs. REID. If you can, would you provide those for the record?

Secretary FINCH. We will give you all that we can, both in-house and from the other departments.

(The information follows:)

The Bureau of the Budget prepares an education analysis which is used as backup for part of the educational statistics in the "Special Analysis" of the President's Budget. This analysis does not include the "manpower" programs. The activities are grouped by level of education, and although some activities were listed under more than one level, they were only counted once. After eliminating this duplication, there are 385 educational activities listed for funding in fiscal year 1970. They are spread among 23 departments and agencies as follows:

Health, Education, and Welfare	194
Defense	41
National Science Foundation	31
Atomic Energy Commission	15
Interior	15
Office of Economic Opportunity	11
All others [1]	78
Total	385

[1] Smithsonian Institute, 4; Small Business Administration, 2; U.S. Information Agency, 3; Agency for International Development, 3; Library of Congress, 2; State Department, 8; Agriculture, 7; National Aeronautics and Space Administration, 7; Housing and Urban Development, 7; Veterans' Administration, 8; Transportation, 5; Justice, 4; Commerce, 3; National Foundation on the Arts and Humanities, 4; Panama Canal Company, 4; Tennessee Valley Authority, 2; and Peace Corps, 2.

POLICY ON FEDERAL ASSISTANCE TO CAMPUS DEMONSTRATORS

Mrs. REID. You have talked at some length about your stand on the campus demonstrations and the memo you sent to schools warning that demonstrators could lose their eligibility for Federal grants and loans. Of course this was to spur more positive action, I am sure, by the school administration.

Has there been time for any response at all to this?

Secretary FINCH. No. Because we are having a violent conflict among the lawyers, that letter has not gone out yet.

Mrs. REID. It has not?

Secretary FINCH. No. There was an earlier memorandum sent to each board about a month ago, just around the time we came into office, putting them on notice. We have asked our regional offices to give us a survey of the schools within their region. I am not sure how much that is going to tell us. We are trying to be very precise about this letter in making several points: That it is up to the administrations and the governing boards to administer the provisions of both acts; that the students themselves should be notified in the catalogs that if they are participating in a federally funded program and they conduct themselves in a way that violates the law or campus regulations, they are subject to having their assistance terminated. And we are asking for copies of the material that they are distributing to their students.

Then we are going to ask them to certify to us cases where they do cut off funds. This will all be in this rather complicated letter we are working on now.

Mrs. REID. This is what you discussed before the Education and Labor Committee. You mentioned the memo at that time?

Secretary FINCH. Right.

Mrs. REID. Why do you suppose the Department has been so slow in issuing guidelines in this area?

Secretary FINCH. The law was not passed until last year, and it only really affects the student that comes in this next fall—September of 1969.

I think, without being critical of my predecessor, it would probably have been helpful if something very specific could have been sent forthwith, but in his opinion—Mrs. Green, I know, does not agree—there was a basic conflict between how the two laws could be administered. He thought they were incompatible and so indicated. We do not think that is the case, but we do have some other legal problems. That is the only reason I can give.

Mrs. REID. This I think is becoming of greater concern to people throughout the country every day. Now, when a young person goes to college, he has to consider the situation on campus before he even thinks of going to certain schools.

Secretary FINCH. There is no question about it.

I do not think anybody here missed it. I do not recall which poll it was in the morning paper, but I think a flat 81 percent of those polled said Federal funds should be withheld from any student who violates the law. That I can tell you is very strongly the view in California where I think we felt it worst and first.

Mrs. REID. I have received numerous letters about this problem as I am sure most members have. This is the general feeling in my district, also.

PRIVATE SOURCES OF FUNDING FOR HIGHER EDUCATION

Now, you called our attention to the number of medical and dental schools bordering on bankruptcy.

Secretary FINCH. Right.

Mrs. REID. I am sure you know there is one theory that after the advent of Federal aid in this field that private and philanthropic support began to dwindle. Do you feel this is a valid criticism?

Secretary FINCH. Do you mean across the board?

Mrs. REID. Yes. Has it increased or decreased?

Secretary FINCH. I have not seen any evidence one way or the other. I do not even know of any study.

Mr. KELLY. I do not know a figure. If you were to take the whole process of higher education though, you would see that ever since World War II what has been happening is that in order to meet the expanded enrollment, we have moved from a system in which the majority of the medical colleges were private institutions to where the overwhelming majority are now public institutions. The resources for higher education first became plentiful in the period of our history when the taxation was different and money going into educational institutions was more from the private sector. Increasingly, we have been dependent on the public sector.

You never talk to the university president who does not decry the problem. There is not a university that does not divide the institution into two budgets, its medical school and all the rest. The students do not divide the same way the money does.

Secretary FINCH. The other complaint they make, and it is true also of law schools, my own and others, is that they do not feel the beneficiaries of that education contribute to the extent they should. The doctors, lawyers, and dentists are some of the worst offenders.

By the same token, largely due to more concerted efforts in alumni fundraising, the percentage of voluntary contributions from alumni has gone up markedly since World War II.

NUTRITION SURVEYS

Mrs. REID. With reference to the national nutrition survey, it seems to me this is not really national in scope but confined, as you say, to a relatively small sample of States and localities.

Secretary FINCH. The first round was, yes.

Mrs. REID. I would think that extreme caution would have to be exercised in the sample procedure in order to make this survey truly meaningful. How do you go about this and to what use do you put the information that comes through this selected sampling?

Secretary FINCH. Several Congressmen alluded to this earlier in the day and Dr. Schaefer will be here and give you the specific way the survey is structured.

I do want to repeat, we have been working closely with county boards and State boards and using local facilities to gather this information. Dr. Schaefer will give you the exact details of the operation.

Mrs. REID. Then I will go into that later.

FAMILY PLANNING SERVICES

You mentioned that in fiscal 1970, assuming that the budget is approved, about 1.3 million women would receive family planning services. This is the first year of that program, I believe, 1969. Do you have a program in operation now?

Secretary FINCH. Yes.

Mr. CARDWELL. The maternal and child health family planning grants are at a level of $18 million in 1969. In 1970, $29.8 million is requested for these formula and project grants.

Mrs. REID. This information is made available——

Secretary FINCH. Through neighborhood health centers, through hospitals, and a whole variety of private and public agencies.

Mrs. REID. How do you let women know that this information is available to them?

Secretary FINCH. I am not sure we do as good a job on that as we might. I think we need to give it more attention. The basic material is fine from what I have seen. But I think much of what we are talking about is to get the message across better, to have a better delivery system of conveying the information and materials.

Mrs. REID. I think that would be extremely important.

Secretary FINCH. This is a big part of the increase that we are seeking.

INVOLVEMENT OF THE PRIVATE SECTOR

Mrs. REID. I certainly applaud the objective of obtaining greater involvement of private and independent sectors in these programs, and I assume, from your statement, that this is to receive high priority in your administration, and certainly there is a great deal of enthusiasm for this approach, I think.

But of course I am sure you are aware that, like everything else, this enthusiasm will disappear unless there is some concrete program to follow. Do you have any timetable for this?

Secretary FINCH. We have a number of specific programs that will be announced later by the administration. I am not at liberty to discuss them now.

But, in dealing with voluntary groups, with corporations and unions, if they know what the priorities are and they know what they can do, they will react. In many cases they overreact or react in a clumsy way. We would hope to take one specific program, such as the vaccine program, where we could make a much greater use of volunteers. This was done rather effectively in the polio program where they were used to spot the people that ought to be vaccinated. If a community organization is given that as a challenge, they will respond.

We are trying to build this in wherever we can. I think we can make much better use of voluntary groups in family planning than we have in the past.

Mrs. REID. I would certainly hope you would continue this approach.

I think my other questions have been asked by other members. So I thank you very much, Mr. Secretary.

Secretary FINCH. Thank you.

IMPACTED AREA AID

Mr. SMITH. With regard to the impact aid, of course, as you know, the Eisenhower administration and Kennedy administration and the Johnson administration all concluded that impact aid was too great in comparison with other programs for education.

I took from your comment in your statement that you are in agreement with that.

Secretary FINCH. Yes, sir; and also, we do have this study that will be completed in September, before the next budget, which is supposed to be a comprehensive study of the whole impacted area problem.

Mr. SMITH. Last year this committee looked at the proportion of entitlement to be funded in the budget, which was running 80 to 90 percent on impact, and 46 percent on ESEA, and we came to the same conclusion but on the floor we were reversed.

I do note this, however: On whether or not to have a rollcall vote, that only passed by one vote. Nobody can ever remember when less people wanted to see a rollcall vote, which indicates with strong attention to this you may have some success. We had language in there apparently you agree with, with regard to preferring category *A*.

Secretary FINCH. Yes, sir.

Mr. SMITH. And I assume you think it would be good for the committee to do that again?

Secretary FINCH. Yes, sir; and I would like to have the privilege, Mr. Chairman, to insert in the record a statement I made on that before the Committee on Education.

Mr. SMITH. I think that would be good.

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

(The information follows:)

STATEMENT OF THE SECRETARY

Mr. Chairman and members of the committee, it is a pleasure to meet with you this morning in my first appearance before this committee. I would like to take this occasion to emphasize the high priority this administration places on education.

We firmly support extension of the Elementary and Secondary Education Act. We also support the concept of advance funding for education programs in order to assure more orderly planning and expenditure of funds by State and local agencies.

We also support the concept of long-term authorization of proven programs to give greater stability to efforts to strengthen the educational system. However, we are now conducting a careful review of existing programs, and we expect this process to produce some more substantive recommendations for improvements in ESEA. Therefore, at this time I would propose that the legislation be extended only through fiscal year 1972, with the understanding that I will return to this committee with further recommendations at a later date.

One of our greatest concerns is to find better ways to meet the educational crisis in the cities. School people and board members across the country are frightened by what they are calling the "Youngstown phenomenon"—the complete shutdown of their schools for lack of funds. Cities like Philadelphia, Chicago, Baltimore, Los Angeles, and Detroit, to name a few, are facing severe financial crises. Some, like Baltimore, have made the most strenuous efforts to obtain additional resources, and are still finding their needs to be far beyond their capacities.

The core cities contain the highest concentration of the poor and educationally deprived, and they are experiencing mounting difficulties in finding adequate resources to support their school systems.

According to the study, "Crisis in Education":

"The average Negro student in the core city school is more likely to come from a broken home than the average white student in the school. He is more likely to come from a poor family, more likely to come from a large family, more likely to live in a crowded home, more likely to live in substandard housing, more likely to be forced to work part time, more likely to change school districts and schools, more likely to attend a school with serious social problems, and more likely to be a dropout."

This study conducted by five Congressmen—four of them members of this committee—found that ghetto youths attend schools with a poorer academic curriculum and learning environment, generally poorer facilities, and fewer libraries,

books, and librarians than suburban schools. Their teachers are also different from those teaching in the suburbs: they are more likely to have attended a college which gives less than a regular teaching certificate, more likely to have scored lower on verbal aptitude tests, they are absent slightly more than suburban teachers, and they are required to teach more students per class.

As a result, the study concludes:

"It becomes obvious that merely offering identical educational opportunities to urban Negroes and suburban whites will not begin to serve the goal of equivalent skills upon entering the job market. The environment of the urban Negro student makes him more difficult to teach than the suburban white student. Identical education systems will leave the urban Negro behind—and they have.

"America must create an urban education system attuned to the environmental disadvantages from which urban students suffer. If the urban Negro and the suburban white are ever to enter the job market with equivalent skills the environmental advantage of the suburban student must in effect be equalized by an educational advantage of the urban student. Put in other words, urban education must be made superior to suburban education if the graduates of both are to have equivalent skills."

I wholeheartedly agree with these conclusions. The necessity for providing quality education for the disadvantaged children in our cities, as in rural areas, rises not only for the sake of poverty's children; it is imperative for the sake of all in an increasingly urbanized America.

This problem will be among the most important priorities in our search for improved ways to respond to the needs of America's schools and schoolchildren. We must devise better approaches and methods to assure that needed funds get to our central city school systems.

I would also like to emphasize at the outset that evaluation is a necessary foundation for effective implementation and judicious modification of our existing programs. At this point, evaluation is probably more important than the addition of new laws to an already extensive list of educational statutes.

Evaluation will provide the information we require to strengthen weak programs, fully support effective programs, and drop those which simply are not fulfilling the objectives intended by the Congress when the programs were originally enacted.

Evaluation in the field of education has not played its part in the management process at HEW in the past, for three reasons: (1) useful, thorough evaluation of educational programs is extremely difficult, (2) such efforts are necessarily long range and require long leadtime in the accumulation of data, and (3) funds for evaluation have been insufficient for an effective program.

Accordingly, I recommend that a provision be added to H.R. 514 that would authorize the Secretary to use up to 1 percent of appropriated program funds, across-the-board, for program evaluation. Language that would carry out this recommendation is attached.

This approach to the funding of evaluation is, as you know so well, not a new departure. In the health field, statutory authority has been provided and used for setting aside a fraction of appropriated program funds for this purpose. I cannot stress too strongly the importance of extending this concept to the field of education.

There are a number of other important problem areas which we are now reviewing. In the meantime, I would like to suggest some changes which we would recommend in H.R. 514.

Now let me turn to the individual titles of the legislation up for renewal. My predecessor testified earlier about the scope and activities of most of these programs, and I will not take your time today with a repetition of the facts and figures, which I am appending to this testimony—appendix A—and ask to have included in the record of these hearings. Instead, I would like to offer some of my own views on what these figures add up to in terms of the promise of these programs.

TITLE I OF ESEA

Title I of the ESEA, though representing an extremely small proportion of the annual Federal budget, is HEW's largest effort to focus funds on a single and pressing problem in American education. Since the program's inception 3 years ago, local educators have used some $3 billion under title I in their search for more effective ways to educate the children who for decades have come out on the short end of our education process: the children of the Nation's poor.

Last month, President Nixon reaffirmed this administration's commitment to explore all possible means to attack the human costs of poverty. We know that education must be one of the major weapons for that attack. As the President has said of the antipoverty effort, "Precedents are weak and knowledge uncertain. These past years of increasing Federal involvement have begun to make clear how vast is the range of what we do not know, and how fragile are projections based on partial understanding. But we have learned some lessons about what works and what does not."

On the education front, it is title I that has been teaching us those lessons; it is title I that is making it possible for local educators to put them to work. Perhaps the most important function title I has served has been to focus the attention of educational leadership at the local and State level on the specific disadvantages and special educational needs of poor children. It has made the public, educators, and legislators alike more aware that our school system has not done enough to insure poor children a more equal chance in life, and that many more resources and energies are going to have to go into the effort.

Title I has marked the first commitment of resources on a national scale to help combat the inadequacies in schooling presently offered the poorest and neediest of our children. While the current level of title I funding does not match the tremendous need, it has at least given some 16,000 school districts across the country the chance to face the task with something more than good intentions. It has brought special educational services to millions of disadvantaged children. It has encouraged new and more relevant teaching approaches, bolstered motivation to stay in school, enhanced cultural exposure, and brought medical care and even food to children who had every reason to believe that the bounty and benefits of American life were hopelessly beyond their reach. Title I has also provided important support for the classroom teacher and the school administrator.

At the same time, I think it is important to recognize the hard limitations of title I. Its effort to upgrade education for disadvantaged children has faced a number of serious obstacles, many of them inherent in the nature of the problem. First of all, since the special needs of disadvantaged children have been so long overlooked, we are only just beginning to come up with some firm ideas about how these children can be most effectively educated. Second, many of the approaches that have emerged are costly, requiring specially trained staff and equipment beyond the reach of present title I resources. And third, compensatory education must bear the burden not only of compensating for inadequate schooling, but also of compensating for all the other deprivations of the child's total environment.

Administration of title I funds has in many cases limited the impact of the program. Late appropriations have been a persistent problem for local educators. It is hardly fair for us at the national level to ask that local school systems develop well-planned, comprehensive title I projects when we cannot even guarantee them a particular level of funds on which to plan. It is hardly appropriate for us to lok to local administrators for quality education and for fresh approaches to the problems of the education of disadvantaged youngsters when they receive funds at midyear or later; when they can hire only the teaching staff passed over at prime hiring time in the spring; when summer activities must be planned and staffed well after June. Therefore, I heartily endorse advance funding of title I, well before the school year for which the funds are to be used.

Title I's impact has also been limited by the tendency of local administrators to try to reach as many children as possible with available Federal funds. In many school districts, this has meant the dilution of projects to the point that few children receive the full range of services they need to make clear educational progress. Certainly, we would like to see every disadvantaged child in America benefit from title I. However, we must recognize that this goal is not presently feasible, not only in terms of the level of support, but also in terms of the state of knowledge: we do not know just what approaches are most effective, or how they can be reproduced in other school systems. Therefore, we are currently urging State and local title I administrators to focus their money on a comprehensive range of services for those children most in need of them.

There are a number of other changes I believe would improve the administration of title I. One would facilitate joint funding or programs by two or more agencies. This and other minor and technical amendments which I suggest be included in the bill at this time are described in appendix B of my testimony and I hope they will speak for themselves. The attached language also supplies some omissions from the bill which I understand are inadvertent. These changes do not represent an exhaustive list of possible improvements to title I. Many other

suggestions for improvement have been made. We intend to give these extensive consideration, and we may want to recommend further improvements or new initiatives at another date.

Finally, I would like to comment on the formula of title I, an issue that has been running through these hearings. Like all formulas attempting to deal with complex social issues, it is not perfect and will always be to some extent a product of compromise. As I understand the formula, it uses the only national poverty data available. Even though decennial census data do become rapidly obsolete in our highly mobile society, the legislation does utilize annually current AFDC data as a modifier, and under the 1967 amendment, the States are given considerable authority to change the basis for distribution where they can show that they have more realistic data. The fact that this authority is virtually unused may indicate that an alternate is not easy to come by.

I do not have any recommendation for change at this time, but I might add my voice to the many who have called for the establishment of a quinquennial census. Its urgency may be somewhat dimmed as we prepare for the 1970 census, but if action is not taken, we will not be ready for 1975.

Because of the size of the title I program, it will be the subject of continuing review, and we will bring before you any recommended changes in the formula which might emerge from such a review, if they offer a promise of improvement.

EXTENSION OF TITLES II, III, AND V OF ESEA

Moving now to the other titles of the Elementary and Secondary Education Act, I would like to recommend an extension of the following program:

The title II program for school library resources, textbooks, and other instructional materials.

The title III program for supplementary educational centers and services, and for innovative projects.

The title V program for strengthening State educational agencies.

Title II provides State allocations for the purchase of school library resources, instructional textbooks, periodicals, films, video tapes, and other printed and published, materials. It is estimated that 44 million of the Nation's public and private school children have benefited from title II since 1966. In addition, title II has helped to stimulate the establishment of thousands of new public school libraries throughout the country.

Title III offers 100-percent grants to State and local education agencies for the development of innovative and exemplary elementary and secondary education projects (the PACE program: projects to advance creativity in education). Since the program's inception, over 2,800 title III projects have been funded, serving some 10 million schoolchildren and school personnel. This fiscal year, 75 percent of the funds and about 1,000 projects are being administered by the States. The remainder of the funds, supporting approximately 200 projects, are funded directly through the Office of Education. Next year, of course, the States will be overseeing all local projects, except those continuing from prior years on special projects grants from the Commissioner.

At the national level, top pirority for title III projects has gone to strengthening education for disadvantaged children in core cities, equalizing minority group education, improving educational opportunities in isolated rural areas, and setting up model programs for early childhood education.

These PACE projects were intended to provide new innovative thrusts into the educational process, with successes to become models for general application. The purpose is critically important; after 3 years and one major administrative turn (from local to predominantly State control), I doubt that we can truly measure title III's impact. I think the program should definitely be continued, with a special eye, however, to retaining the "model building" emphasis. Once a model has been shaped and perfected, its future funding should not constitute a drain on title III's seed money.

Title V authorized grants to State education agencies to help them identify needs in elementary and secondary education and exert State leadership for change. The statistical and supervisory services formerly provided under titles X and III of the National Defense Education Act are now being funded under title V of the Elementary and Secondary Education Act. Five percent of each State allocation is reserved for special project grants, and 10 percent goes to local education agencies for their use in strengthening local leadership and identifying local needs.

With the help of title V, over 1,000 professionals were added to State education agencies in 1968 alone. Title V funds and the extra personnel they support have enabled States to broaden consultative and technical assistance to local education agencies. They have provided for the coordination of planning, development, and research cooperation at the State level. Funds have also bolstered State management capabilities, and increased other services to local agencies, such as school and teacher accreditation.

Overall, these programs have shown their worth, even under limited funding, and we will be looking with interest at the fully developed State role in connection with title III of ESEA beginning next fiscal year. This, coupled with the strengthening effects of title V, may set the direction for future aid programs.

TITLE VI, EDUCATION OF HANDICAPPED CHILDREN

An extension is requested for part A of title VI, the State grant program, for part B, the regional resource centers; for part C, centers and services for deaf-blind centers; and for part D, the recruitment of personnel and information on education of the handicapped.

Part A of title VI of the Elementary and Secondary Education Act authorizes grants to States to assist them in the initiation, expansion, and improvement of programs and projects for the education of handicapped children at the preschool, elementary, and secondary levels. It has made an impact both in terms of short-range and long-range objectives and programs, in many States. It has stimulated increased State and local expenditures and programs for handicapped children. At the same time, it has stimulated greater awareness of handicapped children, their needs, and methods to meet these needs on the part of the general public, administrators, both regular and special education teachers, and personnel in various nonschool agencies working with the handicapped.

Altogether, it is estimated that 182,000 handicapped children will receive benefits this school year under this program.

Parts B, C, and D of title VI are still in the first stages of development.

Part B of title VI authorizes the establishment of regional resource centers. Four such centers will be selected for establishment this fiscal year at a cost of $125,000 each.

These centers will provide the backup resources to enable the teacher of handicapped children to do more effective teaching. They will handle the work of the diagnostician, curriculum development specialist, educational evaluator, and media specialist.

Part C of title VI authorizes centers and services for deaf-blind children, 8 to 10 of which will be established this year and next year. These centers will serve the large new population (an estimated 1,250) of deaf-blind children struck by the German measles epidemic of 1964 and 1965 who are now 3- and 4-year-olds. Currently, only about 100 of approximately 550 school-age, deaf-blind children are enrolled in special classes with instruction designed for their dual handicap, and preschool programs are almost nonexistent. The new centers will be located strategically to serve a population and geographic region, rather than an area within State boundaries.

Part D of title VI authorizes a program to establish and support special information centers and to recruit young people for the special education professions.

TITLE VII, BILINGUAL EDUCATION PROGRAM

One of our most popular new programs is the bilingual education program, and we recommend that it be extended. This program is designed to meet the special educational needs of children of limited English-speaking ability in schools having a high concentration of such children from families of low income. These children, who number around 3 million of school age, are deprived of equal educational opportunity because of their limited communication skills. For example, the approximately 1½ million Spanish-speaking children of school age in the five southwestern States average 7.1 years of school as compared with 11.1 years for all schoolchildren in the region.

Altogether, the Office of Education received 312 preliminary proposals requesting over $41 million for projects to deal with this ever-increasing problem. Of these, 78 were selected for funding this year at a cost of $7.5 million. These projects will serve some 139,000 pupils, 64 percent of them in urban communities. The majority of projects will deal with children from Spanish-speaking backgrounds; five deal with American-Indian dialect backgrounds, four deal with

students from Portuguese-speaking families, and two deal with children from French-speaking backgrounds. The projects are located in 22 States, and include preschool storefront centers, the development of special curriculum materials, inservice education in bilingual methodology for bilingual staffs, and summer bilingual programs. This program holds great promise for children with language difficulties which prevent them from obtaining the full benefits of our educational system. Through bilingual instruction, they will come to speak and comprehend two languages with equal competence and with pride in their bilingual heritage.

One of the amendments I am recommending would make children in Indian schools eligible for services under this title.

TITLE VIII, DROPOUT PREVENTION PROGRAM

Section 807 of title VIII of the Elementary and Secondary Education Amendments of 1967 (Public Law 90-247) authorizes the dropout prevention program. Its primary purpose is to develop and demonstrate educational practices for the reduction and prevention of dropouts in urban and rural schools having a high concentration of children from low-income families and a high dropout rate. This program holds great promise, and we ask that it be extended.

The Office of Education received a total of 369 preliminary proposals for participation in the dropout prevention program; more than $67 million was requested by these proposals. Since the total appropriation was $5 million, only 20 preliminary proposals have been selected. Local educational agencies may receive up to $20,000 each for comprehensive program planning. Formal proposals will be submitted by each agency in May 1969, and only about 10 will be made operational this year. The rest can be funded for operations in fiscal year 1970 if the increased funds requested are appropriated.

TITLE VIII, DISSEMINATION ACTIVITIES

Section 806 of the Elementary and Secondary Education Act of 1965 authorizes dissemination activities and new programs of technical assistance to rural areas. All the activities authorized in this section are now encompassed by the more comprehensive provisions for collection and dissemination of information and technical assistance in section 303 of title III of the Vocational Education Amendments of 1968, which authorizes the appropriation of such sums as may be necessary through fiscal year 1972. In fact, Congress specified in section 303(e) that:

"Section 806 of the Elementary and Secondary Education Act of 1965 shall become ineffective the first fiscal year for which funds are appropriated to carry out the provisions of this section."

The Budget for fiscal year 1970 requests funds under section 303; therefore section 806 does not need to be extended.

ADULT BASIC EDUCATION

We support an extension of the adult basic education program. This program has been in successful operation and is meeting the established need for adult literacy and educational deficiency for a population that is increasingly aware of the importance of continuing education for every man and woman.

PUBLIC LAW 815 AND 874 (IMPACTED AREAS)

My predecessor transmitted to the Congress draft legislation substantially modifying the entitlement formula and making other substantive changes in Public Law 874. I believe that it is important, however, at this point to note that a major study of the Federal impacted area programs is being conducted by the Battelle Institute under authority and funds granted by the last Congress. We expect this study to be completed by the end of the year and, after an evaluation of their recommendations, we may wish to return with proposals for modification of the Public Law 874 and 815 programs.

In the meantime, and in the light of proposed budgetary levels for these programs, I would urge an amendment to section 5(c) of Public Law 874, so that, whenever appropriations are insufficient to meet all entitlements in full, the funds would be applied toward satisfying entitlements under section 3(a), involving so-called "A" children whose parents live and work on Federal property, before funds are applied to entitlements under section 3(b) with respect to "B" children

whose parents do not live on, but work on Federal property. This amendment would protect the school districts receiving a large proportion of their school budget from this program. (Of the 138 districts where impacted areas grants equal 25 percent or more of school revenues, 130 received the vast majority of such grants under section 3(a).) Under the amendment we propose, any reduced appropriations would only affect districts which receive a relatively small proportion of their revenues from impacted grants, largely under section 3(b).

CONCLUSION

I have limited my testimony at this time mainly to the issues presented by H.R. 514 and to technical and clarifying amendments which the Department desires. There are, of course, much broader educational issues presented by the extension of the Elementary and Secondary Education Act.

We recognize, for example, that the need to simplify the administration of programs at both Federal and State levels has been a continuing concern of this committee and of individual members on both sides of the aisle. While we are not yet prepared to make specific recommendations along these lines, this administration has as one of its primary goals the consolidation and simplification of the many categorical grant programs. Therefore, we would welcome any congressional initiative to consolidate some of the State grant programs without changing their character in ways that would prejudice any future recommendation of this administration.

There are a variety of approaches that can be taken to consolidate elementary and secondary education programs. For example, one which could provide major and immediate benefit to the States would be to amend title V to consolidate the administrative set-asides from the various titles of ESEA into one fund to be used by the States according to a plan approved by the Commissioner.

Another possible area of consolidation, which could greatly simplify and improve the efficiency and effectiveness of Federal programs, relates to those providing equipment and instructional materials. Titles which might be considered for consolidation in this area include title II of ESEA (library resources, and textbooks and instructional materials), title III of NDEA (equipment and instructional materials), title V–A of NDEA (counseling and guidance services), and section 12 of the National Foundation on the Arts and the Humanities Act (instructional equipment for arts and humanities). It may even be possible to consolidate these programs into a broader purpose grant.

There could be a number of advantages to such program consolidation, even beyond the administrative improvements. One of these could well be to make available to nonpublic schoolchildren and teachers instructional equipment on the same basis as we make library resources and textbooks available under title II of ESEA. Equitable participation of nonpublic schools could be provided by the removal of matching provisions and the addition of a Federal bypass (as in title II of ESEA).

Similarly, the Battelle Institute study, which seeks to determine the effectiveness and efficiency of Public Laws 815 and 874, may have significant bearing on the shape of Federal assistance to federally affected areas in the future. It may shed light, for example, on the question of whether children in low-rent public housing should be counted for the purpose of this legislation.

President Nixon has also advised us to welcome the clash of new ideas as a necessary price for educational progress. One way we plan to do this is through the development of experimental schools, where successful approaches and promising new ideas in education can be identified and developed.

Ever since sputnik, the necessity to improve the relevance and the quality of American education has been apparent, but our efforts to find the most effective ways to accomplish this has proliferated and broadened. The original emphasis on the uses of science and technology has given way to the more recent recognition of the multiple educational handicaps of a third of our Nation's children. ESEA and other Federal programs have helped develop many significant approaches to cure various educational ills, but these have had two serious limitations: (1) a narrow approach to isolated segments of the curriculum or population; and (2) weak or inconclusive findings on the extent of educational impact and the reasons therefore.

No existing approaches or combination of approaches can be confidently labeled as models for educational progress in America.

We believe that this situation can be improved. We plan to establish, in partnership with State and local authorities, a network of experimental schools

which will attempt to design models of comprehensive educational environments. These will incorporate the best ideas that have been developed in the past decade and focus them on the most important social and educational issues which face our schools. An important feature of these experiments will be a thorough and rigorous documentation of their educational processes, so that we can know with confidence what educational approaches will likely work, in what circumstances, to overcome the educational disabilities of our children.

I have already stressed our intention of developing educational programs which will better meet the critical problems of our core cities. There are other major areas which we intend to explore; for example, the need for new and expanded means of educating the handicapped.

Today I urge the committee to extend the Elementary and Secondary Education Act through fiscal year 1972, rather than fiscal year 1975 as proposed by H.R. 514. This would accomplish the immediate and pressing goal of providing sufficient authorization to allow for advance funding of title I. It would provide continuity to local school officials, assuring them that programs begun under the act will not be suddenly terminated. And, such an extension would allow for an orderly phase-in of any new or revised programs which may be suggested by the results of our various studies. When I return to propose more substantive changes or additions to current programs for elementary and secondary education, I would also hope to support a longer extension of this legislation.

Appendix A

Title I, Facts and Figures

Since title I's inception in 1965, the Federal Government has invested almost $3 billion in a nationwide, locally based effort to make schooling more responsive to the needs of poor children. In its initial year, almost 8.3 million children received title I assistance in 17,500 school districts. In fiscal year 1967, 16,400 school districts carried out title I programs benefiting just over 9 million children. Last year (fiscal year 1968), it is estimated that 9.2 million children were served by title I programs in 16,000 school districts. (The decreasing number of school districts reported as administering title I reflects the growing tendency of school districts to join together in a single title I program.)

As Congress mandated, many of these disadvantaged children served by title I projects attend nonpublic schools. In 1966, 526,000 nonpublic school pupils participated in the benefits of title I projects; in 1967, 466,000 nonpublic school children were included.

Over the 3 full years of title I's operation, local school districts have designed programs with an increasing stress on activities most directly serving the student's needs: improving the quality of instruction and offering such services as medical care, guidance and counseling, and food. In title I's first year, only 52 percent of the funds went for instruction; a year later, school districts had allotted 66 percent of all title I funds for instruction. Pupil services rose from 7 to 10 percent the second year. Construction and equipment expenditures dropped during that period, from 21 to 8 percent for equipment and 10 to 5 percent for construction.

In addition to the title I resources applied to the problems of educating disadvantaged children in general, title I funds have also gone into special programs for congressionally designated populations of disadvantaged children: children of migratory farmworkers, children in State institutions for the neglected and delinquent, handicapped children, and children in Bureau of Indian Affairs schools. These groups of disadvantaged children received special attention during the school year 1966–67, when Congress funded amendments to title I to aid in their schooling.

Beginning with $9.7 million in 1967, the title I migrant program has now reached almost the $45 million mark. The State-administered migrant programs helped to strengthen educational services for some 185,000 children of migratory farm laborers.

Title I aids almost 1,200 institutions for neglected and delinquent children, serving almost 16,500 children each year. An estimated $30 million has gone for such programs in the last 2 years.

Finally, the special provisions of title I are aiding in the education of children with physical and mental handicaps and poverty stricken Indian children in Bureau of Indian Affairs schools. In the most recent year for which we have complete data, fiscal year 1967, $12.9 million was spent on special educational

services for handicapped children; $5 million went to the Bureau of Indian Affairs for educational services for Indian children. In 1967, approximately 80,000 handicapped children in 700 State institutions received special and improved services under title I; approximately 50,000 children in Bureau of Indian Affairs schools were aided by title I.

APPENDIX B

PROPOSED AMENDMENTS TO H.R. 514

The following amendments to H.R. 514 are recommended by the Department of Health, Education, and Welfare: (Suggested legislative language (except as to duration of extension of program) is included after the description of each change.)

Evaluation of education programs

1. Amend title IV of the Elementary and Secondary Education Amendments of 1967 to authorize the Secretary of Health, Education, and Welfare to use up to 1 percent of appropriated funds in the education field for across-the-board program evaluation in lieu of the present authorization for a separate appropriation for evaluation purposes.

AMENDMENTS TO TITLE IV OF THE ELEMENTARY AND SECONDARY EDUCATION AMENDMENTS OF 1967

"PROVIDING FOR EVALUATION OF EDUCATION PROGRAMS

"SEC. —. (a) Section 402 of the Elementary and Secondary Education Amendments of 1967 (Public Law 90–247) is amended—

"(1) by inserting '(a)' after 'SEC. 402.';

"(2) by striking out '(1)' before 'planning', and striking out 'and (2) evaluation of programs or projects so authorized'; and

"(3) by inserting the following new subsection at the end of such section:

"'(b) Such portion as the Secretary may determine, but not more than 1 per centum, of any appropriation for grants, contracts, or other payments under any Act referred to in section 401 for any fiscal year shall be available to him for evaluation (directly or by grants or contracts) of the programs authorized by any such Act, and, in the case of allotments from any such appropriation, the amount available for allotment shall be reduced accordingly."

"(b) The amendments made by subsection (a) shall apply to appropriations for fiscal years ending after June 30, 1969."

Procedures in cases of joint funding

2. Provide that, pursuant to regulations of the President, in the event of joint funding of programs or projects in which the Office of Education participates, any one agency could be designated to act for all, a single non-Federal share could be established, and any technical grant or contract requirements not otherwise imposed by the administering agency could be waived. (Such provisions are now included in the Juvenile Delinquency Prevention and Control Act of 1968 and in the Economic Opportunity Act of 1964.)

"JOINT FUNDING

"SEC.—. Pursuant to regulations prescribed by the President, where funds are advanced by the Office of Education and one or more other Federal agencies for a project or other activity funded in whole or in part under a statute for the administration of which the Commissioner of Education has responsibility (either as provided by statute or by delegation), any one Federal agency may be designated to act for all in administering the funds advanced. In such cases, a single non-Federal share requirement may be establishment according to the proportion of funds advanced by each agency, and any such agency may waive any technical grant or contract requirement (as defined by such regulations) which is inconsistent with the similar requirements of the administering agency or which the administering agency does not impose."

Duration of programs

3. Extend authorizations for education programs (extended by H.R. 514) for a period of 2 years, that is, through fiscal year 1972, rather than for a period of 5 years as proposed in the bill.

Title I of ESEA

4. Amend section 103(a)(2) to enable a State educational agency to assume responsibility for educational services to institutionalized neglected and delinquent children now counted in the local formula, upon its determination that a local educational agency cannot or will not provide for the special needs of these children. Ordinarily, the local educational agency would receive an allocation based on the number of children in institutions (other than State-supported institutions for the neglected and delinquent. The amendment would provide that in the special cases above mentioned the portion of the local educational agency's allocation based on the number of neglected and delinquent children in institutions would go instead to the State agency for provision of services to the children in question if the State assumes responsibility for providing such services.

"ASSUMPTION OF RESPONSIBILITY BY STATE EDUCATIONAL AGENCY FOR PROVISION OF SPECIAL EDUCATIONAL SERVICES FOR INSTITUTIONALIZED NEGLECTED AND DELINQUENT CHILDREN

"SEC. —. Section 103(a)(2) of title I of the Elementary and Secondary Education Act of 1965 (title II of the Act of September 30, 1950, Public Law 874, Eighty-first Congress), is amended by adding at the end thereof the following sentence: 'Notwithstanding the foregoing provisions of this paragraph, upon determination by the State educational agency that a local educational agency in the State is unable or unwilling to provide for the special educational needs of children, described in clause (C) of the first sentence of this paragraph, who are living in institutions for neglected or delinquent children, the State educational agency shall, if it assumes responsibility for the special educational needs of such children, be eligible to receive the portion of the allocation to such local educational agency which is attributable to such neglected and delinquent children.'"

5. Amend section 103(a)(6) to provide that the formula for determining a State's maximum grant for programs for children of migratory agricultural workers shall be based on the number of such children to be served in the State, rather than on the estimated number residing in a State. At present, because the data for 1 year's allocation must come from the previous year, children are sometimes counted for allocation in one State, but must be served in another. The change would ensure that funds go to the State in which the children are actually to be served.

"CHANGE OF FORMULA FOR MIGRATORY CHILDREN FROM THOSE RESIDING IN, TO THOSE SERVED BY, A STATE

"SEC. —. Paragraph (6) of section 103(a) of title I of the Elementary and Secondary Act of 1965 (title II of the Act of September 30, 1950, Public Law 874, Eighty-first Congress), is, effective with the first allocation of funds pursuant to such title by the Commissioner, amended to read as follows:

"'(6) A State educational agency which has submitted and had approved an application under section 103(c) for any fiscal year shall be entitled to receive a grant for that year under this part, based on the number of migratory children of migratory agricultural workers to be served, for establishing or improving programs for such children. The maximum total of grants which shall be available to any State for such purpose for any fiscal year shall be an amount equal to the Federal percentage of the average per pupil expenditure in that State or, if greater, in the United States, multiplied by the estimated number of such migratory children aged five to seventeen, inclusive, as determined by the Commissioner.'"

6. Amend sections 103(d) and 103(e) to allow for the use of "the most recent satisfactory data available" in determining the number of children in foster homes and the average per pupil expenditures. With the advent of advance funding, there have been difficulties in securing data for the second preceding fiscal year, as the law now requires.

"USE OF MOST RECENT DATA UNDER TITLE I

"SEC. —. (a) The third sentence of section 103(d) of title I of the Elementary and Secondary Education Act of 1965 (title II of the Act of September 30, 1950, Public Law 874, Eighty-first Congress) is amended by inserting immediately before the period at the end thereof the following: 'or, to the extent that such

data are not available to him at the time of such determination, then on the basis of the most recent satisfactory data available to him'.

"(b) Section 103(e) of such title is amended by inserting the following after 'during the second fiscal year for which the computation is made': '(or, if satisfactory data for that year are not available at the time of computation, then during the earliest preceding fiscal year for which satisfactory data are available)'."

7. Amend section 105(a)(1)(B) of ESEA by changing from $2,500 to $10,000 the minimum cost of a program or project which may be funded under title I. It is felt that programs or projects under $10,000 are too small to have any significant impact. By raising the minimum, two or more school districts planning very small title I programs or projects will be encouraged to join together in a project of a more significant size and impact.

"MINIMUM GRANT ALLOWANCE TO LOCAL EDUCATIONAL AGENCIES

"SEC. —. Section 105(a)(1) of title I of the Elementary and Secondary Education Act of 1965 (title II of the Act of September 30, 1950, Public Law 874, Eighty-first Congress), is amended by striking out '$2,500' wherever it appears and inserting in lieu thereof '$10,000'."

8. Amend section 106(a)(3)(A) to require that the results of research and replication studies be included in the periodic State evaluation reports to the commissioner.

"CONTENT OF PERIODIC STATE EVALUATION REPORTS

"SEC. —. The parenthetical phrase in clause (A) of section 106(a)(3) of title I of the Elementary and Secondary Education Act of 1965 (title II of the Act of September 30, 1950, Public Law 874, Eighty-first Congress) is amended by inserting 'and of research and replication studies' immediately before the closing parenthesis."

9. Amend section 303 of Public Law 874, 81st Congress, (definitions) to exclude "Wake Island" from the definition of "State" for purposes of title II of that act (title I of the ESEA). Wake Island, which is ineligible for title I program money, is now theoretically eligible for title I administration funds.

"WAKE ISLAND NOT A STATE FOR PURPOSES OF TITLE I OF ELEMENTARY AND SECONDARY EDUCATION ACT OF 1965

"SEC. —. Section 303(8) of the Act of September 30, 1950 (Public Law 874, Eighty-first Congress), is amended (1) by striking out 'Wake Island,'; and (2) by striking out 'for purposes of title II, such term includes the Trust Territory of the Pacific Islands' and inserting in lieu thereof the following: 'includes Wake Island for purposes of title I and the Trust Territory of the Pacific Islands for purposes of title II'."

Title III, ESEA

10. Amend section 302(a)(1) of ESEA to extend title III services to children in Bureau of Indian Affairs and Department of Defense overseas dependents schools.

"EXTENSION OF TITLE III SERVICES FOR INDIAN SCHOOLS AND DEPARTMENT OF DEFENSE OVERSEAS DEPENDENTS SCHOOLS

"SEC. —. The third sentence of section 302(a)(1) of the Elementary and Secondary Education Act, relating to schools for Indian children and Defense Department overseas dependents schools, is amended by striking out 'for each fiscal year ending prior to July 1, 1969,'."

11. Amend section 307(b)(2) of ESEA to remove the fiscal year June 30, 1970 termination date. That clause provides that the amount paid for administration of the State plan during fiscal year 1970 shall not exceed 5 percent of the State's allotment or $100,000, whichever is greater.

"EXTENSION OF PROVISIONS RELATING TO STATE PLAN ADMINISTRATIVE COSTS

"SEC. —. Clause (2) of section 307(b) of the Elementary and Secondary Education Act of 1965, relating to the limitation on amounts paid for State plan administration, is amended by striking out 'during the fiscal year ending June 30, 1970' and inserting in lieu thereof 'for any fiscal year ending after June 30, 1969.'"

Public Law 85–926

12. Extend through fiscal year 1972 the appropriation authorization (sec. 7) of Public Law 85–926 (Grants for Teaching in the Education of Handicapped Children), and amend section 1 of Public Law 85–926 to include training for subprofessional personnel and other staff who do not require professional or advanced training.

"EXTENSION OF AUTHORIZATION FOR GRANTS FOR TEACHING IN THE EDUCATION OF HANDICAPPED CHILDREN; TRAINING OF SUBPROFESSIONAL PERSONNEL

"SEC. —. (a) Section 7 of the Act of September 6, 1958 (Public Law 926, Eighty-fifth Congress, 20 U.S.C. 617), is amended by striking out 'and' before '$55,000,000' and by inserting the following after 'June 30, 1970': ', and such sums as may be necessary for each of the two succeeding fiscal years'.

"(b) The second sentence of the first section of such Act (20 U.S.C. 611) is amended (1) by striking out 'professional or advanced' before 'training', and (2) by striking out 'specialists' before 'providing special services' and inserting in lieu thereof 'special personnel'."

Public Law 88–164

13. Extend through fiscal year 1972 title V of Public Law 88–164 (Training of Physical Educators and Recreation Personnel for Mentally Retarded and Other Handicapped Children); amend such title to authorize training for subprofessional personnel or other staff who do not require professional or advanced training; and conform section 502(a)(1) to a recent amendment to section 302 of Public Law 88–164 by allowing direct research, and research contracts with any public or private agency.

"EXTENSION OF AUTHORIZATIONS AND TECHNICAL AMENDMENTS IN PROVISIONS FOR TRAINING OF PHYSICAL EDUCATORS AND RECREATION PERSONNEL FOR MENTALLY RETARDED AND OTHER HANDICAPPED CHILDREN

"SEC. —. (a)(1) Section 501(b) of the Act of October 31, 1963 (Public Law 164, Eighty-eighth Congress, 42 U.S.C. 2698), is amended by striking out 'and' after '$2,000,000'; and by inserting the following after '$3,000,000'; '; and for each of the two succeeding fiscal years such sums as may be necessary'.

"(2) Section 501(a) of such Act is amended by striking out 'professional or advanced' before 'training', and by inserting 'educators or' before 'supervisors'.

"(b)(1) Section 502(a)(1) of such Act (42 U.S.C. 2698a) is amended by striking out 'and' after '$1,000,000,' and by inserting the following after '$1,500,000,': 'and for each of the two succeeding fiscal years such sums as may be necessary,'.

"(2) Section 502(a)(1) of such Act is further amended by (A) striking out so much of the sentence as follows 'organizations,' and (B) inserting in lieu thereof 'and to make contracts with States, State or local educational agencies, public and private institutions of higher learning, and other public or private educational or research agencies and organizations, for research and related purposes (as defined in section 302(i) of this Act) relating to physical education or recreation for mentally retarded and other handicapped children (as defined in section 302(a) of this Act), and to conduct research, surveys, or demonstrations relating to physical education or recreation for such children.'."

Title VII of ESEA

14. Amend the Bilingual Education Act—title VII of ESEA—to make its benefits available for payments by the Commissioner of Education to the Department of the Interior for programs to meet the special needs of persons on reservations serviced by schools operated for Indian children by that Department.

"SEC. —. Title VII of the Elementary and Secondary Education Act of 1965—known as the Bilingual Education Act—is amended by redesignating subsection (c) of section 705 as subsection (d) and by inserting the following new subsection immediately after subsection (b):

" '(c) From the sums appropriated pursuant to section 703, the Commissioner may also make payments to the Secretary of the Interior for elementary and secondary school programs to carry out the policy of section 702 with respect to individuals on reservations serviced by elementary and secondary schools operated for Indian children by the Department of the Interior. The terms upon which payments for that purpose may be made to the Secretary of the Interior shall be

determined pursuant to such criteria as the Commissioner determines will best carry out the policy of section 702.'

"SEC. 2. Section 706(a) of such Act is amended by inserting the following before the period at the end thereof: 'or, in the case of payments to the Secretary of the Interior, an amount determined pursuant to section 705(c)'."

15. Amend section 707(a) of ESEA to increase the membership of the Advisory Committee on the Education of Bilingual Children from nine to 15 members.

"INCREASE IN MEMBERSHIP OF ADVISORY COMMITTEE ON THE EDUCATION OF BILINGUAL CHILDREN

"Sec. —. The first sentence of section 707(a) of the Elementary and Secondary Education Act is amended by striking out 'nine' and inserting in lieu thereof 'fifteen'."

Title VIII, General Provisions

16. Amend section 803(c)(2) of ESEA to provide that in administering the ESEA and any act amended by it the Commissioner shall require that effective procedures be adopted by State and local authorities to (1) involve parents and community representatives in the development, operation, and evaluation of programs through a local advisory committee or other appropriate means, and (2) to insure adequate dissemination of program plans and evaluations to parents, community representatives, and the public at large. The addition would encourage the establishment of mechanisms to help channel valuable community energies toward the improvement of title I and encourage the accountability of title I administrators to those whom title I serves.

"AMENDMENT OF FEDERAL ADMINISTRATION PROVISIONS WITH RESPECT TO PARENTAL AND COMMUNITY INVOLVEMENT

"SEC. —. Clause (2) of section 803(c) of the Elementary and Secondary Education Act of 1965 is amended by inserting '(A)' after 'authorities' and by inserting the following immediately before the period at the end thereof: '; (B) to involve parents and community representatives in the development and operation of such programs and projects through a local advisory committee or other appropriate means; and (C) to insure adequate dissemination of program plans and evaluations to parents, community representatives, and the public at large'."

17. Delete section 15 of H.R. 514. This section of the bill would amend section 806 of ESEA (dissemination activities and programs of technical assistance to rural areas) which, in effect, has been superseded by more comprehensive provisions of section 303 of Public Law 90–576. That section authorizes appropriations of such sums as may be necessary through fiscal year 1972, and provides that section 806 of ESEA shall cease to be effective upon the enactment of the first appropriation for section 303. The fiscal year 1970 budget proposes funding of section 303.

Adult Education Act

18. Amend section 310(b) of the Adult Education Act so as to provide that the Advisory Committee on Adult Basic Education shall consist of 15 members rather than eight, and to delete the requirement of present law that the Commissioner of Education be chairman of the committee.

"INCREASE IN ADVISORY COMMITTEE MEMBERSHIP—COMMISSIONER NOT TO BE EX OFFICIO CHAIRMAN

"SEC. —. Section 310(b) of the Adult Education Act of 1966 (title III of the Elementary and Secondary Education Amendments of 1966) is amended by striking out 'eight members consisting of the Commissioner of Education, who shall be Chairman, and seven other members', and inserting in lieu thereof 'fifteen members, consisting of a chairman, designated by the President, and fourteen other members'."

Public Law 874

19. Amend section 5(c) of Public Law 81–874 (assistance to schools in federally impacted areas) to provide that, whenever appropriations are insufficient to meet all entitlements in full, the funds shall be applied toward satisfying en-

titlements under section 3(a), involving so-called "A" children, whose parents live and work on Federal property, before funds are applied to entitlements under section 3(b) with respect to "B" children, whose parents do not live on, but work on, Federal property.

"PRIORITY FOR CATEGORY 'A' CHILDREN IN DISTRIBUTION OF FUNDS UNDER PUBLIC LAW 874

"SEC. —. (a) Subsection (c) of section 5 of the act of September 30, 1950 (Public Law 874, Eighty-first Congress), is amended by inserting "(1)" immediately after "(c)", and by adding at the end thereof the following new paragraph:

"'(2) Notwithstanding the provisions of paragraph (1) of this subsection, in the event of such insufficiency of funds for any fiscal year, the entitlements of local educational agencies with respect to children determined under subsection (a) of section 3 shall be fully satisfied prior to allocation of such funds with respect to entitlements under other provisions of this title (except section 6). Adjustments in the allocation of funds required by paragraph (1) with respect to section 3 (and computations required with a view to such adjustments) shall be made only with respect to children determined under subsection (b) of such section."

"(b) The first sentence of section 5(c) of such act is amended by striking out "If the funds appropriated for a fiscal year" and substituting in lieu thereof "except as provided in paragraph (2), if the funds appropriated for a fiscal year".

"(c) The amendments made by this section shall be effective with respect to appropriations for fiscal years beginning after June 30, 1969."

REQUIREMENT TO SPEND FUNDS APPROPRIATED BY CONGRESS

Mr. SMITH. The Congress, or the majority, voted to appropriate some $540 million. Are you going to spend it?

Secretary FINCH. You are talking about the impact aid program?

Mr. SMITH. Yes.

Mr. KELLY. We will obligate all of the funds in this fiscal year. But the disbursement will not all occur in this fiscal year. Part of it will carry over to fiscal 1970.

Mr. SMITH. Of course there will be nothing new about appropriating the full entitlement, but if the administration felt strongly enough about it they do not have to spend the money.

Mr. KELLY. There was a provision placed in the law last year, section 406 of the Vocational Education Act, which said, in effect, that irrespective of the Revenue and Expenditure Control Act, all of the funds appropriated for education shall remain available for obligation.

Mr. SMITH. I know, but under separation of power, many times the Congress has directed that the Executive spend money and if he does not want to do it, he does not do it.

Mr. KELLY. Interestingly enough, in the whole history of HEW there are very few examples of where that issue has been drawn.

Mr. SMITH. Anyway, it is clear you do not have to if you do not want to. So my question is, if we go ahead and appropriate the excess funds over what you think ought to be committed—in effect you will draw them from somewhere else—do you have any opinion at this time as to whether or not you would spend them even if we appropriated more than you wanted?

Secretary FINCH. I do not think we would have much choice, and still return to the Congress in good faith.

Mr. SMITH. If that is the case, you should go ahead and spend the money appropriated for construction too. We appropriated that and other items that are being held back.

Secretary FINCH. When Congress has spoken, we are going to—as Mr. KELLY indicated, I think we are going to do what we are told.

Mr. SMITH. But you do not do it in all cases, that is the point.

Mr. FLOOD. That was started by George Washington. Remember him. It has been followed by a long line of Presidents ever since.

Secretary FINCH. I do tend to regard HEW as a slightly different kind of arm of the administration. In the administrative process the President has certain prerogatives, and what any Secretary has really comes from the President.

In this whole very sensitive area of serving people there are different issues that may be involved than with the Department of Defense, for example, or with the Attorney General. I think that is the climate under which we in this Department have had the degree of compliance with the Congress that Mr. Kelly alludes to.

Mr. SMITH. I take from that then you are going to make sure that the $153 million of construction funds are not rescinded, that you are going ahead and use them.

Secretary FINCH. I know of no reason that would inhibit us in doing so.

Mr. KELLY. I think what we have done, Mr. Smith, is present to you an alternative. Because of a recent enactment that authorizes an interest subsidy program rather than a direct loan program, we have come before you in a supplemental and offered you an alternative way of achieving the same program level within a new authorization. That is what we recommend you do.

Mr. SMITH. That is fair enough, and if we do not accept that alternative, you will then go ahead and use the appropriated money.

Mr. CARDWELL. We will take the matter up with the Bureau of the Budget.

Mr. SMITH. It might be an exception to this rule we just had.

Mr. KELLY. We might even try to persuade the Senate if we do not persuade the House.

SUBSTITUTION OF LOAN GUARANTEES FOR DIRECT LOANS

Mr. SMITH. My only other question has to do with the fear I have that there is more and more reliance, due to budgetary problems, upon guaranteed loans for students in lieu of direct loans and other forms of student aid. I find two things bad about this.

One is, to start with, that banks in many parts of the country just do not do the job that you expect them to do. It depends upon the local banks. And to start with, they need a selling campaign. Many do not want to be bothered with some student borrowing $1,000 and paying it back over a 10-year period when they can make one big loan for a $1 million and get it back whenever they want it. They do not want to be bothered with the student loans. That makes a hardship on the student if the Government has no alternative for the student to go to. I think we are drifting toward that being the only avenue many of these students have.

The other thing is that I find that the students that are getting these loans are not the ones that need them the worst because the most needy one is the one that has no contact with the bank and the bank is less willing to work out the arrangement with him. If his parents

have a bank account there, they are more likely to work out an arrangement. I think it is a mistake to rely upon these guarantees more and more as the only financing.

My other point is that I would hope the department would perhaps get together with the American Bankers Association or some people who could promote the guarantee loan program with their local banks and make them see they have a responsibility to their community as well as the desire to make money.

Secretary FINCH. We can do that. There is another input here too, Congressman, since the loan programs include the savings and loan associations as sources. And of course the savings and loans have been trying desperately to get into the banking field for years. I say this as a former president of a savings and loan. They have been pretty good about reaching out, because this gives them a little beachhead.

I think we can encourage them a great deal more than has been done previously.

Mr. SMITH. That is all I have, Mr. Chairman.

SMOKING AND HEALTH

Mr. FLOOD. Mr. Secretary, I have delayed the remark I am going to make until now because I had the impression that other members of the subcommittee would raise the question. I think it is imperative we say something about the problem of smoking and health. But I understand the members interested are going to reserve that interrogation for the Surgeon General. However, I feel as Secretary the question should also be addressed to you as well as just to the Surgeon General.

I repeat for the purpose of emphasis the necessity for bringing the problem to your attention. I did go into this at some length 2 years ago with Secretary Gardner. I felt to be consistent I should raise it with you.

During the hearings of the House Appropriations Committee in March of 1967, at which time the antismoking program of the Department of Health, Education, and Welfare was discussed, the then Secretary, John Gardner, stated that:

> There are going to be a great many people who will never stop smoking and we must get going with the kind of research that will persuade the tobacco industry to pursue the kinds of research that will result in a safe cigarette.

At that time I was very disappointed in the lack of progress being made. I also realized that the only hope was a safer cigarette.

Since then neither the tobacco industry nor the Government or for that matter any other scientists, except the one laboratory which I have previously talked about, have come up with anything worthwhile in this regard; however, the Department of Health, Education, and Welfare did submit a statement on smoking that was published. Part of it reads:

> We must work towards the development of a less hazardous cigarette—and concurrently, help develop a climate of opinion so that if such a cigarette is developed, smokers will turn to it. There is no other way to protect those millions of present smokers who probably never will be willing or able to give up smoking.

REDUCTION OF BENZPYRENE IN CIGARETTES

At this time, Government scientists and the industry are fully aware of the fact that more important than the harmful tars in cigarette smoke is another substance called benzpyrene, which is the real culprit in cigarette smoking. There had already been a tremendous amount of research conducted for the purpose of reducing benzpyrene in cigarette smoke, but in every case the chemicals used to accomplish this were either themselves toxic or so changed the taste and aroma of cigarettes that they had were not acceptable to the smoking public.

Fortunately, there was one laboratory which was at the time of our March 1967 hearings experimenting with a chemical which significantly reduced benzpyrene, was nontoxic, and did not adversely affect the taste and aroma of cigarettes. Their formulation also reduces tars and nicotines, and when used in conjunction with a filter thereby has the cumulative effect of acting with the filter for maximum tar and nicotine reduction.

In March of 1967, however, the testing of this product had not been sufficiently completed to warrant its commercial utilization. Unknown to me at the time I was conducting the March 1967 hearings, this laboratory had already been in contact with the National Cancer Institute. On March 7, 1967, the National Cancer Institute wrote to them that:

> The concept of reducing the amount of benzpyrene in cigarette smoke to improve combustion is not only a sound concept but shown to be feasible under some conditions by the U.S. Department of Agriculture scientists.

The Surgeon General has consistently stated that benzpyrene is one of the most harmful ingredients in cigarette smoke. This is because benzpyrene not only is a carcinogenic agent itself, but it has a synergistic power and acts as a trigger causing other ingredients in tobacco smoke to become actively harmful.

As recently as November 1968, Drs. Wynder and Hoffman stated in an article entitled "Experimental Tobacco Carcinogenesis":

> A significant reduction (more than 25 percent) in the benzpyrene concentration in the "tar" has so far always been found to relate to a significant reduction in the tumorigenicity of the "tar."

It is very important therefore that the importance of reducing the benzpyrene immediately be brought to the attention of the public so that they understand the significance of this harmful substance and its effect on other substances in cigarette smoke, and that they be educated to realize the necessity of reducing benzpyrene in cigarette smoke as well as tars and nicotine.

Since my last hearings in March 1967, the work started by the laboratory previously mentioned—which incidentally is called the High Tor Foundation—under the guidance of Dr. Perry B. Hudson—has been completed. There have been extensive injection and skin-painting tests on mice in accordance with the recommendations of the National Cancer Institute and which they themselves use. There have been several types of biochemical tests performed, based upon instructions from the Department of Health, Education, and Welfare and the National Cancer Institute.

On December 20, 1968, the Department of Health, Education, and Welfare submitted a letter to this laboratory in which, based upon a

review of the work by the National Institutes of Health, it was acknowledged that the tests that were performed were properly designed and conducted, that the benzpyrene was reduced significantly by the use of the formulation that this laboratory had developed, and that:

> The data you have presented from animal experiments suggests that tumorgenicity in mice injected or skin painted with cigarette condensates was reduced or eliminated by pretreatment of the cigarette tobacco with the process under the reported conditions of your experiments.

This letter is, therefore, an acknowledgement by the Department of Health, Education, and Welfare that there has been a breakthrough, and there is a less hazardous cigarette that can be made available to the public. The letter further suggested corroboration by scientists working independently, but this has all been done by now and the results of both the independent scientists and Stanford Research Institute substantiate the claims made by the High Tor Foundation. Furthermore, letters from Government agencies have shown that the formulation is nontoxic.

I am pleased to be the first one to report to you that in the 2 years since my hearings, at which Secretary Gardner was present, a formulation has, in fact, now been developed which results in a safer cigarette and the effectiveness of this formulation, which incidentally is called chemosol, in reducing benzpyrene as well as tars and nicotines has been proven beyond a reasonable doubt. Neither the Government nor the cigarette industry, nor for that matter any other scientists, have found anything of significance to equal this discovery, and, I believe, in the interest of the smoking public this formulation and its accomplishments should now be brought to the attention of the public and used by the cigarette industry.

Furthermore, I believe that it is the duty of the Department of Health, Education, and Welfare, as a follow-up to their previous letter of December 20, 1968, to acknowledge that there is now a less hazardous cigarette that can be made available to the public and the claims of the product have been properly and completely substantiated.

I also believe that the scientists at the National Institutes of Health and the Department of Health, Education, and Welfare should cooperate fully in informing the smoking public that for the first time there can be made available a less hazardous, or safer if you will, cigarette. That is their obligation to the taxpayers and responsibility to the Government.

I am sure that you will agree that we must move on this quite rapidly, Mr. Secretary.

Secretary FINCH. I will follow through on the information you have provided me, and I will check with the knowledgeable scientists in the Department to obtain their opinions and advice on this claim of a new technique for reducing benzpyrene in cigarette smoke. I will move as rapidly as scientific facts and judgment permit.

Mr. FLOOD. Do you not feel that it is in the taxpayers' interest to acknowledge this kind of private research such as has been done on chemosol since here is a situation where the Government will save many millions of dollars because of an investment in the private sector?

Secretary FINCH. It is my firm intention to encourage private enterprise or the private sector of the American economy to participate increasingly in the planning, organization, and operations of the manifold activities of this Department.

Mr. FLOOD. Do you feel that the cigarette industry has been materially hurt by the Government's antismoking campaign?

Secretary FINCH. The six firms which are the major cigarette producers in the United States do not appear to be suffering materially and continue to be financially prosperous. One reason may be their increasing diversification.

Mr. FLOOD. I guess people will always smoke. I feel that if a less hazardous cigarette were acceptable to the smoker, the industry would sell it. I feel that it is up to you people to bring it to the attention of the public as you have done with so many other fine things. Do you not think that you should do this now?

Secretary FINCH. Without having evaluated the data on a specific proposal for a less hazardous cigarette I do not feel that I can make a judgment as to what the Department's policy should be.

Mr. FLOOD. Do you not think that the Federal Trade Commission should let the public know that a truly less hazardous cigarette exists by permitting advertising to this effect?

Secretary FINCH. If a less hazardous means of cigarette smoking is available I would trust that the Government would use all appropriate means to so inform the public and to help create a consumer climate of acceptability.

Mr. FLOOD. The Public Health Service has already published a pamphlet that people should smoke cigarettes with less tar and nicotine. Now that scientists, and the industry for that matter, recognize the importance of reducing benzpyrene, do you not think that the public should be told in your pamphlet to smoke cigarettes with less benzpyrene?

Secretary FINCH. I agree that if we have evidence clearly demonstrating that cigarette smoke with less benzpyrene is less hazardous to man, then the public should be so informed.

Mr. FLOOD. Well, now that we have a way of properly reducing benzpyrene I think, as Secretary Gardner has stated, we must help to develop a climate of opinion so smokers will turn to the less hazardous cigarette. This I believe would be a worthwhile use of funds.

Secretary FINCH. I believe, first of all, that we should encourage our young people not to begin smoking cigarettes; that we should encourage those who now smoke to stop smoking cigarettes; and that, finally, we should continue and increase our efforts to produce less hazardous cigarettes which are acceptable to those individuals who continue to smoke.

Mr. FLOOD. Thank you very much.

Secretary FINCH. I appreciate the tender loving care of the committee, and the very fine treatment I have been accorded by the chairman. It has been very helpful and educational to me in my early cram course of 6 weeks, Mr. Chairman.

PROGRAM INFORMATION AND STATISTICS

(The following program information and statistics were prepared for the hearing record at the request of the committee:)

PROGRAM INFORMATION AND STATISTICS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REPORT ON POPULATION AND FAMILY PLANNING ACTIVITIES

A REPORT TO THE
HOUSE COMMITTEE ON APPROPRIATIONS

PREPARED BY

THE OFFICE OF THE DEPUTY ASSISTANT SECRETARY
FOR POPULATION AND FAMILY PLANNING
OFFICE OF ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS

FEBRUARY, 1969

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
POPULATION AND FAMILY PLANNING ACTIVITIES

Obligations, FY 1966 -- FY 1970

Agency and Program	Fiscal Year 1966	1967	1968	1969	1970
		(in dollars)			
Total, Department of Health, Education, and Welfare	13,380,000	19,719,000	29,255,000	47,242,000	68,653,500
SOCIAL AND REHABILITATION SERVICE:					
Maternal and Child Health:					
Maternal and child health formula grants to States	1,800,000	2,500,000	3,500,000	3,500,000	3,500,000
Project grants for maternity and infant care	1,200,000	2,500,000	2,500,000	14,500,000	26,300,000
Research and training in Maternal and child health	600,000	500,000	500,000	500,000	1,700,000
Public assistance:					
Social Services	2,000,000	3,000,000	6,300,000	8,300,000	10,300,000
Medical Assistance	1,000,000	1,500,000	3,000,000	4,500,000	6,400,000
Cooperative research to prevent and reduce dependency	---	---	200,000	200,000	300,000
Subtotal, Social and Rehabilitation Service	6,600,000	10,000,000	16,000,000	31,500,000	48,500,000

Agency and Program	Fiscal Year 1966	1967	1968	1969	1970
PUBLIC HEALTH SERVICE					
Consumer Protection and Environmental Health Service:					
Food and drug administration, research contracts	---	82,000	569,000	843,000	1,118,000
Subtotal, Consumer Protection and Environmental Health Service	---	82,000	569,000	843,000	1,118,000
Health Services and Mental Health Administration:					
Patient care and Special Health Services	---	---	160,000	220,000	254,000
Indian Health Service	152,000	181,000	273,000	323,000	425,000
National Communicable Disease Center	---	20,000	20,000	38,000	43,000
National Institute of Mental Health	416,000	481,000	554,000	635,000	644,000
National Center for Health Statistics	---	---	---	64,000	314,000
Comprehensive Health Planning: Partnership for Health	---	125,000	171,000	391,000	500,000
Subtotal, Health Services and Mental Health Administration	568,000	807,000	1,178,000	1,671,000	2,180,000

Agency and Program	Fiscal Year 1966	1967	1968	1969	1970
National Institutes of Health:					
National Institute of Child Health and Human Development	5,257,000	7,219,000	8,113,000	9,632,000	13,145,000
Health Manpower, training grants	81,000	199,000	417,000	483,000	443,000
Subtotal, National Institutes of Health	5,338,000	7,418,000	8,530,000	10,115,000	13,588,000
Subtotal, Public Health Service	5,906,000	8,307,000	10,360,000	12,586,000	16,843,000
OFFICE OF EDUCATION					
Elementary and Secondary Education:					
Supplementary educational centers and services	63,000	502,000	1,485,000	1,500,000	1,500,000
Grants to States for guidance, counseling, and testing	233,000	233,000	233,000	161,500	161,500
Dropout prevention program	---	---	---	8,000	20,000
Higher Education:					
Grants to States for community service and continuing education	175,000	225,000	315,000	380,000	410,000
Prospective elementary and secondary teacher fellowships	72,000	121,000	121,000	100,000	162,000

Agency and Program	Fiscal Year 1966	1967	1968	1969	1970
OFFICE OF EDUCATION (Continued)					
EPDA Institute Programs.....	---	---	---	230,000	200,000
Adult Education:					
Adult basic education programs	317,000	317,000	644,000	720,000	800,000
Grants to States for vocational education	14,000	14,000	14,000	14,000	14,000
Subtotal, Office of Education	874,000	1,412,000	2,812,000	3,113,500	3,267,500
Scientific Activities Overseas * (Special Foreign Currency Programs, P.L. 480)	(---)	(---)	(314,000)	(2,400,000)	(3,500,000)

* Not included in the DHEW total.

INTRODUCTION

This report describes the family planning activities supported by the Department of Health, Education, and Welfare during the year 1969. The history of family planning activities in the department, and the effects of the establishment of the departmental policy by Secretary Gardner on January 24, 1966 on State and local programs, were presented in the 1968 report to the House Appropriations Subcommittee.

Family planning activities in the Department of Health, Education, and Welfare include the promotion and support of services -- making family planning information and services available and accessible to all in the population who desire and need them; training -- meeting the professional and lay manpower needs in health, social services, and education; research -- promoting and supporting research and research training in the biomedical and broad behavioral aspects of fertility and sterility; and public education -- increasing opportunities for sex education and public understanding of human sexuality.

Family planning services, as an integral part of adequate medical care, have been routinely and easily available to the majority of the population. The importance of equal opportunity for all families to have the freedom to choose the number of children they want and when they want them, regardless of income, color or location of residence, is widely accepted. Yet the poor have not had the same access as the non-poor to family planning services under medical supervision. There are nearly 5 million women among the poor and the near-poor who could have access to such services only through public and voluntary agencies. Under recent legislations, particularly the Social Security Amendments of 1967 (P.L. 90-248) such services are available through a variety of sources to some of those who want but cannot afford them.

It is estimated that over 1.5 million women will receive services in FY 1969 through public or voluntary agencies, about 1.2 million through programs aided by the Department of Health, Education, and Welfare.

One of the primary aims of family planning services in projects supported by the Department is the reduction of infant mortality. During the decade 1955-65, infant mortality declined by only 5%. In the period 1964 through 1967, the rate declined from 24.7 per 1,000 live births to 22.1 a reduction of about 10%. This decline has also been evident in cities where Children's Bureau maternity and infant care projects which include family planning services have been active. (See page 5, Section III)

Highlights of the Year's Activities:

(1) On January 2, 1968, President Johnson signed the Social Security Amendments of 1967. These amendments for the first time spelled out family planning as a regular part of health services and earmarked for family planning services not less than 6% of the amounts appropriated for Maternal and Child Health.

(2) On January 31, 1968, the first Deputy Assistant Secretary for Population and Family Planning in DHEW was sworn into office.

(3) Departmental policy and objectives in family planning were outlined by Secretary Gardner in his memorandum of January 31, 1968, which expands and extends existing family planning programs based on enacted legislation and increased appropriations. (Estimated DHEW family planning obligations are 47.3 million in FY 1969 and over $69.1 million in FY 1970.)

(4) Following up on the Secretary's Policy Directive of January 31, 1968, the Assistant Secretary for Health and Scientific Affairs and the Deputy Assistant Secretary for Population and Family Planning jointly issued a memorandum to the heads of operating agencies outlining the next steps to be taken in service, training, and research in order to achieve the Department's objectives of family planning programs.

(5) On May 29, 1968, the Bureau of the Budget designated the Office of the Assistant Secretary, DHEW, for Health and Scientific Affairs as the focal agency for family planning reports and statistics throughout the Federal Government. As a first step in this direction the Office of the Deputy Assistant Secretary for Population and Family Planning has taken the leadership in the development of a uniform reporting system for family planning services. In November 1968, operating responsibility for the development of a uniform national reporting system for family planning services has been assigned to the National Center for Health Statistics. A provisional reporting system covering clinics supported by Children's Bureau and OEO programs will be in operation early in 1969. The national system will provide full coverage of the major Federally supported services for family planning.

(6) On July 16, 1968, the President appointed an Advisory Committee on Population and Family Planning under the co-chairmanship of Secretary Wilbur J. Cohen and John D. Rockefeller, 3rd. The Committee was asked to make a careful review of Federal policies and programs in relation to worldwide and domestic needs and report to the President recommending additional steps to be taken and providing an estimate of the costs of an effective five-year program plan in research, training, and services. Specifically, the Committee was charged:

-- to determine ways of providing the American people with meaningful information about population change and assuring that its significance will be understood by the rising generation.

-- to define the Federal Government's direct role in research and training in population matters including the physiology of human reproduction, in fertility control and the development of new contraceptives, and the Government's role in supporting such research and training in private institutions at home and overseas.

-- to define the responsibility of the Federal Government, in cooperation with State, community, and private agencies in assuring that all families have access to information and services that will enable them to plan the number and spacing of their children.

-- to suggest actions which the United States should take in concert with other countries with international organizations to help the developing countries of the world to understand and to deal effectively with their high rates of population growth.

The Office of Population and Family planning served as staff to the Committee. The Report of the Committee is attached.

(7) The Center for Population Research was established within the National Institute of Child Health and Human Development in August, 1968. The Center will serve two primary functions: (1) to organize and direct a contract program for research in population and human reproduction, and (2) to be the focus of information for research activities in these areas throughout the Federal establishment.

Table 1 summarizes HEW family planning programs for delivery of services by function, local delivery agency, and HEW operating agency with funding and program responsibility.

Table 2 summarizes other HEW family planning programs (research training, education, and evaluation) by function and HEW operating agency with funding and program responsibility.

These tables follow:

Table 1

DHEW Programs for Delivery of Family Planning Services by Function, Local Delivery Agency, and DHEW Operating Agency

Function	Local Delivery Agency	DHEW Operating Agency with Funding and Program Responsibility
Medical Services (either as separately organized services or integrated into larger systems of maternal or comprehensive care), Information, Counseling, and Referral	Hospitals and Clinic Services	SRS -- Children's Bureau -- Medical Services Administration -- Assistance Payments Administration HSMHA-- Indian Health Services -- Federal Health Programs Service -- National Institute of Mental Health
	Health Departments	SRS -- Children's Bureau -- Medical Services Administration -- Assistance Payments Administration HSMHA-- Community Health Service -- Federal Health Programs Service
	Voluntary Health Agencies	SRS -- Children's Bureau -- Medical Services Administration -- Assistance Payments Administration HSMHA-- Community Health Service -- Federal Health Programs Service
	Private Physicians	SRS -- Medical Services Administration -- Assistance Payments Administration

Table 1 (Cont'd)

DHEW Programs for Delivery of Family Planning Services
by Function, Local Delivery Agency, and DHEW Operating Agency

Function	Local Delivery Agency	DHEW Operating Agency with Funding and Program Responsibility
Information, Counseling, and Referral only	Public Assistance Agencies	SRS -- Children's Bureau -- Medical Services Administration -- Assistance Payments Administration
	Voluntary Social Agencies	SRS -- Children's Bureau -- Medical Services Administration -- Assistance Payments Administration
	Employee Health Services	HSMHA -- Federal Health Programs Service

Table 2

Other DHEW Population and Family Planning Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
Training Programs for Population and Family Planning	
1. Short-term Pre-Service and In-Service Training of:	
(a) Physicians, nurses other professional health personnel	SRS -- Children's Bureau NIH -- Bureau of Health Professions, Manpower and Training HSMHA -- National Institute of Mental Health -- National Communicable Disease Center
(b) Social workers and other public assistance personnel	SRS -- Children's Bureau -- Assistance Payments Administration -- Office of Research and Demonstrations HSMHA -- National Institute of Mental Health
(c) Teachers	OE HSMHA -- National Institute of Mental Health
(d) Subprofessional workers	SRS -- Children's Bureau -- Medical Services Administration -- Assistance Payments Administration NIH -- Bureau of Health Professions, Manpower and Training OE -- Adult and Vocational Education

Table 2 (Cont'd)

Other DHEW Population and Family Planning
Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
2. Curriculum Development for Above Programs	SRS -- Children's Bureau NIH -- Bureau of Health Professions, Manpower and Training OE
Research Training in Population and Family Planning	NIH -- National Institute of Child Health and Human Development HSMHA -- National Institute of Mental Health
Education Programs	
1. Sex and Family Life Education at Elementary and Secondary School and College Levels	OE HSMHA -- National Institute of Mental Health
2. Professional Schools --	
(a) Physicians, nurses, and other health professions	SRS -- Children's Bureau NIH -- Bureau of Health Professions, Manpower and Training
(b) Social workers	SRS -- Children's Bureau -- Office of Research and Demonstrations
(c) Demographers	NIH -- National Institute of General Medical Sciences
(d) Teachers	OE

Table 2 (Cont'd)

Other DHEW Population and Family Planning
Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
3. Curriculum Development for Above Programs	SRS -- Children's Bureau NIH -- Bureau of Health Professions, Manpower and Training OE HSMHA -- National Institute of Mental Health
Research	
1. Reproductive Physiology and Contraceptive Development; evaluation of safety and possible adverse effects	NIH -- National Institute of Child Health and Human Development CPEHS -- Food and Drug Administration
2. Social Research	SRS -- Children's Bureau -- Office of Research and Demonstrations HSMHA -- National Institute of Mental Health -- National Center for Health Statistics NIH -- National Institute of Child Health and Human Development
3. Administrative Research	
(a) Utilization studies	SRS -- Children's Bureau -- Medical Services Administration -- Assistance Payments Administration HSMHA -- National Center for Health Statistics -- National Center for Health Services Research and Development -- Community Health Service
(b) Demonstrations in innovative service delivery mechanisms	
(c) Evaluation methods	

Table 2 (Cont'd)

Other DHEW Population and Family Planning
Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
4. Facilities	
Construction	NIH -- Division of Research Facilities and Resources
Evaluation	
1. Overall Evaluation and Coordination	Office of the Secretary -- Assistant Secretary for Health and Scientific Affairs -- Deputy Assistant Secretary for Population and Family Planning Assistant Secretary for Planning and Evaluation
2. Medical Services Evaluation	SRS -- Children's Bureau HSMHA -- National Center for Health Services Research and Development -- National Institute of Mental Health
3. Social Services Evaluation	SRS -- Children's Bureau -- Medical Services Administration -- Assistance Payments Administration HSMHA -- National Institute of Mental Health

OFFICE OF THE SECRETARY

Office of the Assistant Secretary for Health and Scientific Affairs

The Office of the Deputy Assistant Secretary for Population and Family Planning serves as a focal point for Departmental policy and program coordination, and reviews and evaluates policies and programs.

In addition to direct coordination of programs within DHEW, the Office is working in close cooperation, and is giving leadership to family planning activities of other agencies in the Federal Government. Close coordination has been maintained especially with the Department of Housing and Urban Development in relation to the Model Cities Programs and with the Family Planning Programs of the Office of Economic Opportunity. The Deputy Assistant Secretary for Population and Family Planning has taken the leadership in the development of a uniform reporting system for family planning services. Under the Chairmanship of the Deputy Assistant Secretary, an Interagency Committee representing government operating agencies supporting family planning services -- Children's Bureau, Health Services and Mental Health Administration in DHEW, Office of Economic Opportunity -- and the voluntary agency, Planned parenthood-World Population, have actively participated in this endeavor.

The Office of the Deputy Assistant Secretary for Population and Family Planning participated with the Office of Economic Opportunity in seven regional conferences to encourage family planning services project development. This was an attempt to inform State and local agencies of the various Federal resources available to their programs.

A continuing partnership is essential between the Government and other concerned organizations. The past work of private agencies in fields related to population and family planning has laid a foundation on which extensive governmental activity can be constructed. Therefore effective liaison and cooperation with interested public and private organizations has been given high priority during the year by the Deputy Assistant Secretary.

Close communication is maintained with the major universities which have population centers so that training of future personnel could be geared to the actual needs as they are revealed in the on-going programs of HEW.

Assistance is provided to professional organizations such as the Council on Social Work Education in developing curriculum not only for the basic professional graduate student but for in-service training and short-term institutes. Similarly, it is important to give leadership in the development of auxiliary personnel. (Training of such personnel is mandatory under the 1967 Amendments to the Social Security Act.) These workers serve as health aides, community aides, or teacher corps aides. This prospective personnel requires appropriate training in the area of family planning.

Special projects include consultation and conferences with experts from medical or social and behavioral sciences and other fields to work on the problems of resistance by special sub-groups in the population. The aim is to establish guidelines for personnel to work more effectively on practical problems of making services available and acceptable. During the year the office had paid special attention to the problems of teenage pregnancy and the role of the parents, health and welfare agencies, schools and others who serve and influence these young girls.

In order to stimulate concerned professional and citizen groups, the Office of the Deputy Assistant Secretary provides leadership at regional meetings, conferences or other activities which will help develop family planning resources.

Departmental publications and reports are being prepared to add visibility to the multiple approaches to meet the problems in this field of government endeavor.

Publications:

(1) "Family Planning Nationwide Opportunities for Action", prepared by the Office of the Deputy Assistant Secretary for Population and Family Planning, DHEW, November, 1968.

(2) "The School of Social Work's Responsibilities in Family Planning Education", by Mrs. Katherine B. Oettinger, Deputy Assistant Secretary for Population and Family Planning, DHEW, January, 1968.

(3) "Report of the Conference on Teenage Contraception" (to be published).

(4) "Education for Family Planning and Responsible Parenthood" (to be published).

The Office of International Health develops policy and provides coordination for the special foreign currency program. During fiscal 1969, $2.40 million in U.S. owned excess foreign currencies (P.L. 480) have been earmarked for support of family planning and population research projects. By January 1, the Department had approved or had under review 10 such projects totaling $1.06 million. These projects vary from basic studies in reproductive biology and the mode of action of oral contraceptives, to studies of the knowledge, attitudes and practices of individuals concerning family planning. Research in population dynamics, the improvement of vital registration, and demographic analysis of a population in transition are also included.

Efforts will continue to establish new overseas contracts, solicit new proposals, and negotiate projects. An estimated $3.50 million worth of U.S. owned excess foreign currencies will be used to support family planning and population research projects during fiscal year 1970. Anticipated projects will include studies on the effects of oral contraceptives and IUD's, a determination of the emotional, social and health effects of population densities, and the evaluation of family planning service programs.

All of these studies are viewed as an extension of domestic programs in population research. As the domestic program becomes more defined and important knowledge gaps are identified new research directions will be required including those supported by special foreign currencies.

Office of the Assistant Secretary for Community and Field Services

The Center for Community Planning coordinates the Model Cities and the Neighborhood Service Programs which call for new approaches to the delivery of social health services, and emphasizing family planning.

Neighborhood Service Programs in Chattanooga and Louisville have begun family planning programs. Many of the 150 Model Cities are proposing family planning activities. The Children's Bureau has set aside $8 million of its FY 1969 funds for programs in Model Cities. Other DHEW agencies will also give priority attention to meeting the needs of Model Cities and Neighborhood Service Programs for family planning services. Existing programs will be used, but the emphasis will be placed on delivering family planning services in a coordinated way, along with other services.

Office of Field Coordination is the central office for the DHEW regional offices. The DHEW Regional Directors participate with regional, State, city, and civic groups in family planning activities. They convene conferences and meetings, coordinate technical assistance to public and private groups, and stimulate information to the public regarding the Department's family planning programs. The Regional Directors report to the Secretary on progress in family planning in the regions, and periodically participate in special Departmental studies of these programs.

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation has primary responsibility for the preparation of the five-year budget plan and the Department's program memoranda. This office is also responsible for the overall evaluation of the Department's programs. This office is involved by the Office of the Deputy Assistant Secretary for Population and Family Planning in its activities when appropriate. At the present time, the Office of Planning and Evaluation is working with the Children's Bureau in the development of a plan for the evaluation of family planning services.

SOCIAL AND REHABILITATION SERVICE

Summary of Programs Related to Family Planning

Social and Rehabilitation Service has the responsibility to provide family planning services as a regular part of health services for the underpriviledged, in particular AFDC recipients and other low-income families; for those eligible for medical assistance (both men and women); and for mothers and children in low-income urban and rural areas in order to promote their health, reduce maternal and infant mortality and morbidity, help reduce out-of-wedlock pregnancies; and enable State welfare departments to carry out their responsibilities in work-training and employment programs for AFDC recipients. It has carefully targeted program research and demonstration projects in family planning.

The Social Security Amendments of 1967, (P.L. 90-248), administered by the Social and Rehabilitation Service, are especially pertinent to family planning programs. This legislation provides added authority to make family planning services in our society available, accessible, and free from coercion to individuals with little or no income. Implementation of the following provisions makes possible progress towards fulfilling several of the Departmental objectives in its family planning programs:

(1) Under Title V of the Act (The Child Health Act of 1967), a substantial increase in Federal funds is authorized for the Maternal and Child Health Programs, and the Maternity and Infant Care, and Children and Youth projects of the Children's Bureau. Not less than 6 percent of the amount appropriated for this title for the fiscal year ending June 20, 1969 and each fiscal year thereafter is earmarked for family planning services. This authorizes for the first time project grants to meet up to 75 percent of the cost of family planning services. Such grants may be made to health departments, hospitals, and any public or non-profit voluntary organizations.

As a condition of State plan approval, the plan for maternal and child health services must provide for the development of demonstration projects with special attention to family planning services for mothers in needy areas and among groups in special need. Acceptance of family planning services must be voluntary and not a prerequisite of eligibility for the receipt of services under the plan. The amendments further require a State to make a satisfactory showing that it is extending the provision of services under its plan, including family planning services, with a view to making such services available in all parts of the State by July 1, 1975.

(2) Under Title IV, Part A, of this Act, effective July 1, 1968, States will be required to offer family planning services to appropriate recipients of Aid to Families with Dependent Children (AFDC). They may also use Federal matching to offer these services to other former or potential AFDC recipients. From the date of enactment (January 2, 1968) until July 1, 1969, Federal funds will be available at the matching rate of 85 percent and, subsequently, at the rate of 75 percent. The acceptance of family planning services must be voluntary and must not be a prerequisite to eligibility for receipt of any other agency service or aid.

States will be required to develop a program for each child, relative and other "essential" persons in the home, which in appropriate cases is to include the objective of preventing or reducing the incidence of births out-of-wedlock. The same effective dates and rates of Federal matching apply.

States are required to report the results of implementing the cited provisions to the Secretary, and the Secretary is required to make similar annual reports to Congress. The first such report is due no later than July 1, 1970.

The regulations for service programs for families and children, Title IV Parts A and B of the Social Security Act were published in the Federal Register on January 28, 1969.

(3) Title XI of the Social Security Act authorizes cooperative research or demonstration projects relating to the prevention and reduction of dependency, aid in effecting coordination of planning between private and public welfare agencies, or which will help improve the administration and effectiveness of programs carried on or assisted under the Social Security Act and programs related thereto. These projects may be supported by grants to States and public and other non-profit organizations and agencies, and contracts or jointly financed cooperative arrangements with public or private organizations and agencies. $5 million are authorized for the support of these projects in each fiscal year. In addition, up to $4 million of the aggregate amount appropriated for payments to States under Titles I, IV, Part A, X, XIV, XVI or XIX is available in any fiscal year, to cover the cost of such projects as is not covered by payments under such Titles and is not included as part of the cost of projects mentioned above for experimental, pilot, or demonstration projects which, in the judgment of the Secretary, are likely to assist in promoting the objectives of these Titles.

(4) Title XIX of the Social Security Act provides for Federal sharing from 50 to 83 percent of costs of health services for the indigent and the medically indigent. To participate in the program, each State must develop a State plan and the plan may include the provision of hospital in-patient and out-patient physician services and out of hospital physician services. All of these physician services could include family planning services. Moreover, Federal policies specifically authorize the inclusion of family planning services, drugs, supplies, and devices, when such services are under the supervision of a physician. To date 39 States and four jurisdictions have programs in operation under Federally approved plans.

The 1967 Amendments to the Vocational Rehabilitation Act, (P.L. 90-99), provide project grants for services to handicapped agricultural migrant workers and non-handicapped members of their families. Family planning services should be included in the comprehensive services offered these individuals. Federal sharing up to 90 percent of the cost of projects is authorized.

The Mental Retardation Amendments of 1967, (P.L. 90-170), provides for the staffing of new services and facilities for the mentally retarded. Family planning education and services should be included in the comprehensive services offered the mentally retarded. The law authorizes $10 million this year, and $14 million next year for initial grants, and additional sums for subsequent years.

Current and Projected Family Planning Activities in the Social and Rehabilitation Service

State plan requirements for maternal and child health, child welfare and AFDC services have been rewritten to conform to the 1967 amendments and are currently under review. A booklet of guidelines for family planning grant applications under Title V, Sec. 508 has been prepared and is being reviewed. This includes an application form.

In approving applications for family planning project grants, priority is given to designated model cities and to the 42 counties in which, in the period 1961-1965, occurred 400 or more infant deaths in excess of the expected number, had the tenth percentile county rate (17.8 per 1,000) or lower, prevailed. Consultation will be directed to assisting these communities in the development of programs large enough in scope and size to have a significant effect upon the infant mortality rate.

Equal stress has been placed on the development of social as well as medical services. Social services related to family planning include provision of information, referrals for medical care, personal counseling regarding the many social and psychological aspects of family planning, follow-up of medical referrals, provision for transportation and child-care arrangements so that parents may obtain medical care, and the development of medical resources when none exist. Related social service activities include helping families obtain basic education (including family life and sex education, as well as literacy training), job-training, and job-placement. Family planning programs are likely to be most effective when they are linked to other relevant services that, together, upgrade the economic, occupational, physical, emotional and educational level of the entire family.

An annual analysis is planned of the AFDC caseload to determine special groups for concentrated services. The purposes of this analysis is to determine the groups needing special services or requiring services to be provided on an intensive basis. Research and demonstration projects developed on the basis of these findings will be encouraged.

All the research evidence confirms that family planning programs are not likely to be accepted or continuously used by low-income families unless their total life situation improves. Therefore, efforts have been made to coordinate family planning programs along with other related areas, such as those in overall medical care, basic education, job training and placement, and income maintenance.

A statement of guidelines for training in family planning has been drafted. It presents information regarding training opportunities provided under Title V, for the training of personnel for health care and related services for mothers and children. Such personnel may be professional or non-professional who may be based in health, welfare, or education departments or in community voluntary agencies. Short or long-term training and institutes for continuing education are included.

In the administration of Child Welfare Training Grants under Title IV, Sec. 426, special attention is given to applications by institutions of higher learning for the training of social workers in family planning.

Children's Bureau

The two major sources of support for family planning services in the Children's Bureau are the Maternal and Child Health formula grants and the special project grants for Maternity and Infant Care.

The Maternal and Child Health grants assist the States to extend and improve their services for the promotion of the health of mothers and children, especially in rural areas. The States have broad discretion in the use of these funds but the programs are generally characterized as being primarily preventive health services in nature.

Typical services are the provisions of Maternal and Child Health services in well-baby clinics, maternity services in postpartum clinics, providing payment for hospital delivery care for babies or mothers at high-risk in respect to complications in childbearing, school health services, immunizations, nutrition services, public health nursing and related services. In FY 1968, 347,000 women received family planning services in this program. In the same year there were 83,000 new registrants for family planning services in the 53 Maternity and Infant Care projects located in the low-income urban and rural areas. In addition to these new patients, it is estimated that the Maternity and Infant Care projects served 50% of their previous year's family planning caseload in FY 1968 (@ 40,000).

According to the 1970 proposed budget, Children's Bureau expenditures will increase by $23 million, to a total of $216 million. Of this total, about $31 million will be for family planning services and research projects, 13 million more than in FY 1969. About 1.3 million needy women are expected to receive family planning services in Children's Bureau projects in FY 1970. As seen in the following table, one of the primary objectives of these projects -- the reduction of infant mortality -- is being achieved. The decline observed in the national infant mortality rate has been evident in cities where Children's Bureau Maternity and Infant Care projects have been active.

SELECTED INFANT MORTALITY RATES[1/]

	Infant mortality rate per 1,000 live births			
	1964	1965	1966	1967
Nationwide	24.8	24.7	23.7	22.1
Major cities with maternity and infant care projects:				
Baltimore	31.0[2/]	28.4	28.0	26.8
Chicago	30.4[2/]	33.3	32.5	29.4
District of Columbia	34.5	34.7[2/]	35.3	32.6
Houston	28.4[2/]	25.0	26.4[2/]	22.1
New York City	26.9[2/]	25.7	24.9	23.9

1/ Years shown are calendar years.
2/ Indicates year projects began operation.

State plan materials and guidelines have been developed in response to the amendment in Title IV of the Social Security Amendments of 1967 in which State welfare departments are required to offer family planning services under certain conditions. The Children's Bureau has participated in a series of meetings of the Interagency Committee chaired by the Deputy Assistant Secretary for Population and Family Planning on the development of a national reporting system for family planning services. The Division of Research in parallel activity conducted a preliminary pretest in the District of Columbia, North Carolina State Health Department and in the Maternal and Infant project at Grady Hospital, Atlanta. The information obtained from this study will be useful in the development of the national system.

Plans are underway for a joint project with FDA's Bureau of Medicine, funded by FDA, to improve record systems in an Obstetric Department of a medical institution with a related Maternity and Infant Care project. The objective, assuming reliable observations, recording, storage, is to gradually develop a set of sites where (a) Children's Bureau could conduct occasional surveys, and (b) FDA could similarly use these sites for special studies on "adverse drug reactions."

Research and Demonstration Grant Projects:

The School of Public Health University of North Carolina is conducting a study of controlled content of family planning programs. Funding for this project began June 1, 1967 and is expected to end May 30, 1973. The purpose of this study is to design a set of model family planning programs and evaluate the effectiveness of these programs.

The Planned Parenthood Federation of America Incorporated is conducting a study of family planning clinics and cost evaluation. Funding of this study began July 1, 1968 and is expected to end June 30, 1969. The purpose of this study is to provide information to administrators about the relationships between resources devoted to family planning and the resulting outcomes.

The Tulane University School of Public Health and Tropical Medicine is conducting a study of fertility, family structure and family planning. Funding for this project began December 1, 1964 and is expected to end November 30, 1970. The purposes of this study are to (1) evaluate family planning programs, (2) develop criteria for utilization and various types of allied health manpower, (3) study compositional changes in family structure, (4) study clinical and sociological epidemiology of reproductive wastage and (5) motivational and behavioral variables in acceptors and rejectors of family planning.

The Bowman Gray School of Medicine is conducting a study of various family planning approaches among high risk females. Funding for this program began July 1, 1968 and is expected to end June 30, 1971. The purpose of this project is to evaluate various programmatic approaches to increasing and maintaining the proportion of females in a specified high risk group who become effectual and consistant in practicing family planning.

The School of Public Health University of California, Berkeley is conducting a study of recidivism among unmarried pregnant girls. Funding for this project began January 1, 1968 and is expected to end July 31, 1971. The purpose of this study is to follow a cohort of girls in the San Francisco area who delivered a first child out-of-wedlock in the years 1959-1962.

The University of Pittsburgh Graduate School of Public Health is conducting a study of maternity care of adolescents. Funding of this project began July 1, 1968 and is expected to end June 30, 1973. This project will investigate the efficiency and effectiveness of critical components of a maternity program for teenage girls.

The Johns Hopkins School of Hygiene and Public Health is conducting a study of Children's Bureau programs that serve adolescents who are pregnant out-of-wedlock. Funding for the program began July 1, 1968 and is expected to end June 30, 1969. The purpose of the study is to examine these Children's Bureau programs to identify the basis for measuring accomplishments, gaps in necessary data and current programs, and to make recommendations regarding current and future programs.

The Yale University School of Medicine is conducting a study of programs of teenage unwed mothers. Funding for this project began July 1, 1967 and is expected to end June 30, 1972. The purposes of this study are to evaluate the impact of a hospital based, comprehensive medical, social and education program for the teenage unwed mother.

The Emory University School of Medicine is conducting comprehensive, multidisciplinary program of educational and obstetrical care for young adolescents. Funding for this program began July 1, 1968 and is expected to end June 30, 1971. The purposes of this study are to (1) increase the number of girls who remain in school during pregnancy and after childbirth, (2) to decrease recidivism, (3) to improve pregnancy outcome and (4) to improve the opportunities to establish stable family life for the girl and her child.

Publications:

(1) "Multiservice Programs for Pregnant School Girls", DHEW, Social and Rehabilitation Service (CB), 1968.

(2) "Mothers at Risk", DHEW, Social and Rehabilitation Service (CB), 1968.

(3) "Family Planning", DHEW, Welfare Administration (CB), 1966.

(4) "Selected References for Social Workers on Family Planning: An Annotated List", DHEW, Social and Rehabilitation Service (CB), 1968.

(5) "The Webster School: A District of Columbia Program for Pregnant Girls", DHEW, Social and Rehabilitation Service (CB), 1968.

(6) "Project Grants to Provide Family Planning Services", DHEW, Social and Rehabilitation Service (CB), May, 1968.

Office of Research and Demonstration

Under the Section 1115 program, the 1970 budget includes $6,100,000 for demonstrations aimed at improving the delivery of direct social services, an increase of $3,740,000 over the 1968 level of $2,360,000. The 1970 increase will finance 70 projects, 30 continuations and 40 new projects. These will include demonstrations in comprehensive services to families and individuals, family planning and coordinated services to the aged, in model cities, neighborhood service centers, the center cities and rural poverty areas.

Through an in-service program to provide knowledge and skills needed by public welfare employees, a project is being developed to enable them to provide more effective and beneficial services to families in the area of family planning.

Consideration is being given to the continuation of a project in family life education in a neighborhood service center in St. Louis, Missouri. We expect to have the evaluation of the effect on the neighborhood population in the near future. Other similar projects are being developed.

Two projects are in operation in which individual and group counseling are given to AFDC families on family planning. These projects are in Oregon and Virginia. They are continuations which will go on through FY 1969 and FY 1970. Similar projects for AFDC families are being developed in other states.

The following activities relate only to the Intramural Research Division:

After completion of a survey of family planning publications judged to be useful for low income persons with limited reading ability, results indicated that with an exception of two or three pamphlets the mass of material reviewed indicated that they were unsuitable for the reading level, the culture of the people, or they were not based on best available scientific knowledge. Preliminary discussions between the Intramural Research Division and the Research Utilization Unit of the R & D Division have opened possibilities for the development of a film. Fiscal 1970 would include planning and development of a film for low income people which would be broader based than family planning, e.g., family life education, but would include a heavy component of family planning.

A proposal on inventory and assessment of neighborhood service centers is now ready for financing. Where family planning services are a part of those multi-service centers, there will be special information collected and analyzed. Approval of the financing of this contract is expected in June, Fiscal 1969, with the work to be conducted and completed by the end of Fiscal 1970.

The Intramural Research Division expects to publish another article in its series of analysis and dissemination of social and psychology research related to family planning. It is expected that the article will appear in Welfare in Review, and will make available in form for use by agencies and practitioners, an updated summary of the social and psychological aspects of family planning.

Medical Services Administration

The Social Security Amendments of 1965 (P.L. 89-97, July 30, 1965), added a new and important title to the Act, Title XIX, "Grants to the States for Medical Assistance Programs."

Under the State-Federal medical assistance program known as "Medicaid," medical care is made available not only to those on public assistance, but also to low-income families who are considered to be "medically indigent," i.e., their income is sufficient for basic needs but not medical needs. Initially, the inclusion of the latter group is optional with the States. The medical assistance may include payments for medical examinations and diagnoses, medical counseling on family planning, medical treatment, and for drugs, supplies and devices. It also includes vendor payments for medical services under other public assistance titles for those States that have not yet implemented Title XIX.

As of January 1, 1969, 39 States and four jurisdictions (District of Columbia, Puerto Rico, Guam, and the Virgin Islands) had set up medical assistance programs under Title XIX, but not all have explicit family planning programs. However, all provide physician services.

Prior to the establishment of the Medical Services Administration in August 1967, its predecessor organization, the Medical Services Division of the Bureau of Family Services, Welfare Administration, participated with the Welfare Services Division in the preparation of a number of documents on family planning projects and activities. Included in these documents is a detailed course outline in "Social Work Services in Family Planning" for use of staff development personnel in public welfare agencies. A three-day intensive training institute on "Family Planning Services as a Function of Public Welfare", to increase the competence of social workers in family planning has been worked out in terms of objectives, methodology and content. It is designed for the use of regional staff development personnel in cooperation with appropriate medical and social work staff in public and voluntary agencies, and in family planning clinics.

On July 12, 1968, an SRS Position Paper on Family Planning Services was prepared. It has recently been revised and has been approved by the Administrator, Social and Rehabilitation Service. It will be distributed to the SRS staff shortly.

Family planning activities in the Medical Services Administration during the balance of FY 1969 and FY 1970 will continue to be aimed at making family planning services readily available to all persons eligible for medical assistance (both men and women) who desire such services. To achieve this end, the following activities are planned:

States will be urged to identify family planning services by name in the listing of items of medical care provided in Title XIX programs. At present such services, though provided, are hidden within such terms as "physicians' services," "clinic services," "drugs," etc., with the result that there is uncertainty on the part of the person seeking family planning services, and sometimes on the part of the provider as well, regarding the provision of such services. All brochures and informational pamphlets describing the scope of services provided under Title XIX will specify family planning services by name to eliminate any possibility of doubt. The pamphlet, "Questions and Answers", issued June, 1968 with reference to the Medicaid program, specifically identifies family planning as a service that may be available under a State's Title XIX Program.

Services necessary to effect utilization of family planning services are being developed. This means close collaboration with AFDC programs since, in family planning, social and medical services are two halves of the whole, and cannot be separated. For the medically needy, few social services are now available. Ways to fill this gap in service will have to be worked out.

Systems of data collection will be developed. At present there are no data to indicate even the extent of utilization or the amount of money spent on family planning services in medical assistance programs; much less the more specific information necessary for program planning.

Community organization activities will be promoted to utilize all existing resources, to develop resources where they are inadequate, and to fill gaps in services.

Adequate staffing at Central and Regional Offices must be developed. Although this is last on the list, it is first in importance, since the plans outlined above will remain on paper unless there is staff to put them in operation. At present, only a fraction of the time of one staff member in this Medical Services Administration can be devoted to family planning. Competence in this area in State Medical Assistance Units is also a necessity and will be promoted.

Rehabilitation Services Administration

The Vocational Rehabilitation Act has not previously specifically authorized the Rehabilitation Services Administration to provide Federal funds to States for family planning purposes. However, the Vocational Rehabilitation Amendments of 1968 authorize services to families of handicapped vocational rehabilitation clients when such services will contribute substantially to the rehabilitation of the handicapped individual. Family planning services for family members and the handicapped client may be included for that purpose.

Regulations under the 1968 Amendments were published in the Federal Register on January 30, 1969, as a Notice of Propose Rule Making. Following final promulgation of the Regulations (with revisions, if any, indicated by the comments received), guidelines for provision of services to family members will be issued to State vocational rehabilitation agencies.

State vocational rehabilitation agencies can refer interested clients to family planning resources and provide them with whatever appropriate literature might be available. These State agencies would normally look to such programs in the provision of family planning services for handicapped clients.

Vocational Rehabilitation agencies can cooperate with public welfare and other health and welfare agencies in promoting family planning information and counseling in the communities.

Towards these ends, in FY 1970 the Rehabilitation Services Administration will communicate with State vocational rehabilitation agencies to urge their fullest cooperation in actively supporting family planning programs, provide them with guidelines, and available literature for client use.

Rehabilitation Services Administration carries responsibility for social services to current, former, and potential applicants and recipients of Aid to the Blind (AB) and Aid to the Permanently and Totally Disabled (APTD). However, public welfare workers require additional training in family planning in order to help make the program of maximum usefulness.

Homemakers in public welfare and home teachers in agencies serving the blind can also be helpful in doing such things as casefinding, providing information and making referrals to caseworkers or family planning resources as appropriate.

Available pertinent materials with respect to such activities by homemakers will be provided to State welfare departments. Since the Rehabilitation Services Administration is most deeply involved with home teachers for the blind, it will distribute pertinent materials to the appropriate State agencies.

PUBLIC HEALTH SERVICE

Consumer Protection and Environmental Health Service

Summary of Programs Related to Family Planning

Under the authority of the Food, Drug and Cosmetic Act of 1938, as amended, the Food and Drug Administration (FDA) is responsible for approving contraceptive drugs for safety and effectiveness before they are marketed and for maintaining surveillance over the drugs after their approval.

The first oral contraceptive agents were approved by the Bureau of Medicine of FDA for general use in 1961 after some years of research, testing, and evaluation. By 1967 there were eleven such agents on the market.

Studies are being carried out under contract to evaluate the experience of human populations utilizing oral contraceptives. FDA is supporting studies to evaluate various reported or suspected side effects in human and animal populations.

Although the Food and Drug Administration does not have pre-marketing controls over contraceptive devices, it is responsible for maintaining surveillance over such devices to ensure their safety. At the present time there are no standards of manufacturing or pre-marketing investigation required by law. However, the FDA has taken steps to set such standards and to provide such consumer protection as is possible under the Food, Drug, and Comestic Act of 1938, as amended.

The FDA established an expert Advisory Committee to assist it in its programming of activities related to family planning. The Advisory Committee on Obstetrics and Gynecology is made up of some 13 outstanding obstetricians, gynecologists, epidemiologists, and consultants in oncology.

As part of its ongoing program activity, FDA also consults frequently with scientific and administrative representatives of pharmaceutical firms in its programs to ensure safety and effectiveness of contraceptive drugs to the women who use them, to the doctors that prescribe them, and to the pharmacists who dispense them.

Current and Projected Family Planning Activities

The activities of the Food and Drug Administration do not include provision of either services or training programs which might be utilized by the recipients in family planning projects.

Of more direct concern to the FDA is the development of adequate information to assure the safety and effectiveness of those methods, both pharmacological and mechanical, which are being promoted by such programs. To this end, a number of research projects are either in active development or in actual progress.

A case-control analysis of hospital records, relating to the occurrence of idiopathic thrombotic episodes, is being conducted at John Hopkins University School of Public Health. The primary study objective concerns a possible relationship of such events to the oral contraceptives. Information concerning carcinoma is also being collected. Completion of data collection is scheduled for early 1969.

Since an appreciable number of women treated with oral contraceptives develop carbohydrate intolerance, a study to characterize the mechanism of this effect is underway at the University of Miami School of Medicine. In order to achieve adequate follow-up of study subjects, the study will extend over two to three years.

A long-term study, using dogs and monkeys, of the carcinogenic potential of two oral contraceptive formulations, and an estrogenic ingredient of most oral contraceptives was begun in 1968, by the International Research and Development Corporation, Mattawan, Michigan. The primary objective of the study is to determine whether oral contraceptives cause cancer after prolonged use. The design of this study forms a model to be followed by pharmaceutical manufacturers in their own investigations of experimental compounds. The anticipated duration of the study is seven to ten years.

Also begun in 1968, was a study to determine the correlation between oral contraceptives and changes in serum lipids, evidence of vascular damage, and change in tissue lipids which might be associated with increased likelihood of malignancy. The study is also designed to determine whether the possible alternations in the blood are permanent or reversible. The study is being conducted at Temple University School of Medicine. Current estimates are that the study will last three to five years.

Plans are proceeding to develop an epidemiological study of the possible effects of oral contraceptives on cytology. Two interested and qualified investigative groups have been contacted and negotiations are proceeding. Extra impetus was given to the implementation of such studies by preliminary reports which suggested that adverse effects were being observed. Full publication of the results of these studies is still awaited.

Efforts are underway to increase the recruitment of sexually active adolescent females into family planning clinics for obvious social reasons. Consequently, increased numbers of relatively sexually immature patients will be receiving hormonal contraceptives.

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Certain questions of safety about this practice have been raised, since little is known about the effects of protracted therapy on, for example, the pituitary or bone growth and development. Suitable projects are currently being designed to explore this problem further.

Negotiations are underway to develop collaborative studies of the effects of oral contraceptives on thromboembolic phenomena, cervical and breast cancer, glucose tolerance and outcome of pregnancy in Poland and Yugoslavia through the support of funds from the P.L. 480 program. Appropriate exploratory meetings will be held with foreign investigators in the immediate future. These studies, if found to be feasible, will be planned to continue for periods up to 10 years depending on the nature of the problem.

Recently completed epidemiologic studies conducted in Great Britian have documented an increased risk of various thromboembolic diseases in women being treated with oral contraceptives. Similarly designed studies carried out in the United States with FDA support will be completed in early 1969. Although numerous laboratory investigations of this problem have been conducted, these have not contributed substantially to explaining the possible mechanisms of this causative relationship. Elucidation of this information would not only contribute to the overall understanding of blood coagulation phenomena, but, more specifically, lead to possible early identification of individuals at high risk of incurring this effect. Based on previous observations, more detailed explorations of blood coagulation mechanisms will be explored in a laboratory study now nearing final negotiation. This should begin during early 1969.

FDA maintains a continuing liaison with appropriate groups within the Department since certain of the family planning clinics supported by other agencies in the Department may provide suitable patient populations and investigative staff to perform specific studies as required by FDA in the performance of its surveillance duties.

The FDA maintains an adverse reaction reporting system which receives information on adverse reactions including those to oral contraceptives and serves as a clearing house for such information.

Publications:

(1) "Report on Intrauterine Contraceptive Devices" by the Advisory Committee on Obstetrics and Gynecology, Food and Drug Administration, January 1968.

(2) "Report on the Oral Contraceptives" by the Advisory Committee on Obstetrics and Gynecology, Food and Drug Administration, August 1, 1966.

Health Services and Mental Health Administration

Summary of Programs Related to Family Planning

Health Services and Mental Health Administration (HSMHA) provides leadership and direction to programs and activities designed to improve physical and mental health services -- which include adequate family planning services -- for all people of the United States and to achieve the development of health care and maintenance systems adequately financed, comprehensive, interrelated, and responsive to the needs of individuals and families in all socio-economic and ethnic groups.

The HSMHA has the responsibility to provide data on births, fetal deaths, marriages and on the receipt of family planning services; to conduct and support research and development, technical assistance, and information activities to improve the organization and delivery of health services; to provide leadership and support for State and area comprehensive health planning; and to plan, direct and coordinate the development of physical and mental health service programs.

Under P.L. 89-749, "Comprehensive Health Planning and Public Health Services Amendments of 1966," P.L. 90-174, the "Partnership of Health Amendments of 1967" the HSMHA has an opportunity to make an important contribution in the development of family planning services as part of comprehensive health programs. Through Comprehensive Health Planning, each State Planning Agency and area planning group has been encouraged by the Surgeon General to assign priority to family planning services. The Regional Offices provide consultation and technical assistance in the development of comprehensive health service project proposals. Priority is given to family planning projects when proposals are reviewed for funding. In the training of personnel for planning agencies adequate attention must be given to population and family planning considerations.

Public Laws 87-692 and 89-109 provide for project grants for health services for domestic agricultural migrant workers and their families, and family planning services may be included in these projects. The Community Health Service, HSMHA, is responsible for the administration of this program. Under provisions of the Public Health Service Act for the improvement of the organization and delivery of health services, the Community Health Service supports research and demonstrations related to family planning services through grants and contracts.

The HSMHA is responsible for direct health services to certain Federal beneficiaries. These direct health services include family planning services. The basic Public Health Service Act,

(P.L. 410, 78th Congress, 58 Stat. 683, 1944), and as amended, particularly Sections 321-346 and the Dependents Medical Care Act and its amendments (P.L. 84-569) provide for comprehensive in-patient and out-patient medical services through the Federal Health Programs Service in the HSMHA. This service also administers the medical assistance program for Cuban refugees under the Migration and Refugee Assistance Act (P.L. 87-510. Family planning services may be provided through this program. Information and counseling on family planning for Federal employees may be provided through the Federal Employee Health Program. Authorization for this program is through P.L. 79-658 and administration is by the Division of Federal Employee Health, Federal Health Programs Services, HSMHA.

Comprehensive health services, including family planning, are provided to American Indians and Alaskan natives by the Division of Indian Health under the Indian Health Services Act (P.L. 83-568).

The National Communicable Disease Center, HSMHA, under the Public Health Service Act has the authority to train Epidemic Intelligence Service (EIS) Officers. This program is being used to train individuals in an epidemiological approach to evaluating family planning and population programs.

The authority for the activities of the National Center for Health Statistics (NCHS) in population derives from the general data collection and research provisions of the National Health Survey Act of 1956, (P.L. 84-652), and the transferring of certain functions of the Census Bureau relating to vital statistics to the Public Health Service. NCHS is responsible for collecting and analyzing the wide range of health and demographic statistics needed for health planning and program evaluation.

The National Institute of Mental Health is authorized to serve as the principal focus for research and training in the behavioral and basic sciences related to the causes, diagnosis, treatment and prevention of disorders in the biological and psycho-social factors that determine human behavior and development. Under this broad mandate many activities related to family planning are supported.

Current and Projected Family Planning Activities

The Surgeon General included family planning in his Priority Statement on the Partnership for Health Program issued on November 7, 1967. An increasing number of the comprehensive State health plans (developed under Section 314 (d) of P.L. 89-749) indicated interest in and support for family planning activities after issuance of the Surgeon General's statement. (There are significant increases in the number of family planning activities supported by State health departments, but these are funded

mostly through the Maternal and Child Health Programs under Title V of the Social Security Act discussed in Section III). Under the project grant authority, 314 (e), of P.L. 89-749, two family planning service projects are currently being supported. One is in Galveston, Texas and the other in Jacksonville, Florida. The Comprehensive Health Program is administered by the Community Health Service.

The Community Health Service is supporting three contract demonstrations to evaluate the effectiveness of indigenous workers in extending family planning services. The contract recipients are the Muscogee County Health Department in Columbus, Georgia, the Planned Parenthood League of Alabama, and the Planned Parenthood Association of New York. The Georgia project evaluates the effectiveness and the cost of using community workers in urban and rural settings; the Alabama project compares the effectiveness of professional and non-professional workers in providing family planning information and services in eight rural counties characterized by marked poverty and high fertility; and the New York Project is utilizing neighborhood workers to assist postpartum mothers in Negro and Puerto Rican areas to return for services. Under development are projects demonstrating the effective integration of family planning services into community-wide systems of health care services. The Community Health Service also supports comprehensive health services to domestic agricultural migrants in more than a hundred projects using public or private health facilities. Many of these projects include family planning services.

The Federal Health Program Service through its system of hospitals and out-patient clinics provides comprehensive family planning services to its eligible beneficiaries. At the Public Health Service Hospitals which have obstetrical services (Staten Island and New Orleans) all postpartum patients are offered family planning information and services as part of the medical care rendered. It is estimated that approximately 5,000 patients received family planning services at these two facilities during FY 1968. Community oriented family planning services are provided at the Boston Public Health Service Hospital through an agreement with the Massachusetts State Department of Health and the St. Elizabeth's Hospital and at a Neighborhood Health Center in Washington, D.C., through an agreement with the D.C. Department of Health.

The Division of Federal Employee plans to incorporate family planning education and counseling services into the present health unit operation through the following steps during FY 1969: (1) in-service educational programs for health professionals on modern methods of contraception, concepts of child spacing, and counseling techniques; (2) family planning literature will be made available to employees upon request; (3) individual employees will have access to appropriate consultation resources with a

physician and/or a nurse to discuss family planning; and (4) employees upon request, will be referred to public and private health care facilities for family planning services.

The Indian Health Service has been active in the field of family planning since Fiscal Year 1965. Since that time through June 30, 1968, family planning services have been provided to 21,477 or 28.5% of Indian and Alaskan native women of childbearing age. In Fiscal Year 1968 there were 23,883 medical visits by 11,236 Indian and Alaskan native women for family planning services.

The Epidemic Intelligence Service of the National Communicable Disease Center has been engaged in training and supporting health personnel in the evaluation of clinical family planning services. In FY 1967 three officers were assigned to family planning evaluation projects in three cities. Six additional officers were assigned to projects in FY 1968 and five additional officers have been assigned during FY 1969. Plans are to assign three additional officers in FY 1970.

The National Center for Health Statistics (NCHS) has among its on-going programs the collection and publication of natality statistics, marriage and divorce statistics, and mortality statistics. It also engages in research on the dynamics of population change and examines some of the social and economic factors associated with change. NCHS is conducting annual vital records surveys. If funds become available, NCHS proposes to establish a continuing survey of family growth in the United States in order to determine trends in childbearing patterns and factors affecting the American birth rate. A methodological study for the proposed survey of family growth is now being carried on by NCHS in cooperation with the NICHD. NCHS and the Research Triangle Institute in North Carolina are collaborating in the development of a computer model intended to simulate the dynamics of population growth in conjunction with the Research Triangle Institute and the University of North Carolina a method to estimate birth and death rates from household surveys is being studied. Under contract the University of North Carolina is carrying out a survey of recently married persons to obtain information not available through marriage certificates.

NCHS has been assigned operating responsibility for the development of a uniform national family planning reporting system. The development of this reporting system will fall into two stages. Initially the NCHS will work with the Children's Bureau, the Office of Economic Opportunity, National Communicable Disease Center, Planned Parenthood-World Population and other governmental and private family planning groups to establish a provisional family planning reporting system. This provisional system will provide data on the availability and utilization of family planning services which are financed at least in part by Federal funds and for which there is an immediate program need for data. Based on the experience gained from the operation of this provisional system plus more intensive planning than was possible

in the provisional system, NCHS will develop and propose a national system to be used by all Federally supported family planning programs, clinics, and service points, and by other agencies that wish to participate in the reporting system. This final system will provide a meaningful body of data essential for the efficient and effective development, operation, and evaluation of family planning programs throughout the nation.

The National Institute of Mental Health (NIMH) supports research in the mental health and behavioral aspects of fertility and family life, to recognize the special contributions that can be made in clinical family planning services by mental health-trained personnel, and to encourage increasing efforts to meet the family planning needs of psychiatric patients. The NIMH plans to encourage and support the inclusion of family planning services in community mental health facilities whenever possible. Through the various manpower training activities of the NIMH support is planned for new programs of training for workers in the family planning field, and to train mental health specialists in this subject. It is also planned to support summer programs for teachers involved in sex education and health education, using the skills of mental health professionals. The NIMH plans to stimulate programs for the training of clergymen, public health nurses, social workers, probation officers and others whose work brings them in direct contact with people who may have need for information and services related to family planning. The focus of NIMH activity on family planning resides in the Center for Studies of Child and Family Mental Health. Examples of research grant projects supported by the NIMH deal directly with family planning, e.g., (1) changing patterns of family life; (2) family structure and feminine role; (3) progress towards premanence in marriage; (4) development of marital interaction tests; (5) casework with marital problems; (6) evaluation study of marriage counseling; (7) role failure and satisfaction in area of marriage; (8) improving decision-making in young low-income couples. A large group of research grant projects bear indirectly on the topic; communication and decision-making within families, motivation, sex education, and birth order studies. The NIMH Division of Intramural Research is carrying out projects on family formation, child spacing, and animal studies of population density.

National Institutes of Health

Summary of Programs Related to Family Planning

The basic research programs of the DHEW in the field of population and human reproduction are centered in the National Institute of Child Health and Human Development (NICHD). Section 444 of the Public Health Service Act authorizes the NICHD to conduct and support research and training relating to maternal health, child health, and human development, including research and training in the special health programs and requirements to mothers and children and in the basic sciences relating to the processes of human growth and development, including prenatal development. The Center for Population Research established within the NICHD in August, 1968 has two primary functions: (1) to organize and direct a contract program in population and (2) to be the focus of information for the variety of population research efforts throughout the Federal Government.

In addition to the major NICHD effort, other components of the National Institutes of Health provided $7.7 million in FY 1967 to support a variety of activities with important implications for population research. Within the National Institute of Arthritis and Metabolic Diseases a number of activities in the field of endocrinology make an important contribution to knowledge of basic mechanisms in reproduction as a springboard for the development of new methods for controlling normal reproductive processes. The National Cancer Institute has long standing interest in fundamental research in reproductive endocrinology and the knowledge produced by a number of NCI programs is highly relevant to normal reproductive physiology and fertility control. The National Institute of General Medical Sciences has supported a number of grants for research training in reproductive physiology as well as several directly focused on demography and population dynamics. A number of studies supported by the National Heart Institute include the effects of estrogens, progestins or steroid contraceptives as aspects of broader investigations of blood clotting mechanisms or circulatory physiology. The National Institute of Neurological Diseases and Stroke supports several studies in reproductive neuroendocrinology. The Division of Research Facilities and Resources provides general research support for a variety of investigations in areas relevant to the population field and also provides grants for the construction and operation laboratory, animal and clinical facilities where population research is conducted.

The Bureau of Health Professions Education and Manpower Training promotes and supports the education, training, utilization and practice of professional and allied personnel in all areas of health. Bureau activities, therefore, are generally non-categorical but encourage the incorporation of specific content, based on

new or continuing public health problems, into educational programs, projects, demonstrations and research. Bureau support in this area, to a major extent, is provided through the use of grant funds for the training of health personnel in family planning, population control, demographic studies, maternal and infant care, and related content. Information and services of the Bureau specifically related to family planning are provided to universities and teaching institutions, State and local health agencies through Bureau of Health Professions Education and Manpower Training consultants in the Central office and Regional offices.

Current and Projected Family Planning Activities

Within NICHD the total population research budget for grants, contracts and intramural research was over $7.7 million for FY 1968 and supported more than 230 separate projects. About 50% of the Institute's total population research budget in FY 1968 supported projects designed to obtain fundamental information on reproductive processes; smaller proportions were devoted to studies of contraceptive methods, to the social sciences, and to intramural research, primarily through the Reproductive Research Branch.

NICHD's first contract for population research was for a national survey of American family planning practices. The primary purpose of this survey was to discover how many American women use oral contraceptives and are therefore at potential risk. The survey was undertaken in September 1965 and showed that approximately 6.4 million women in the United States had used oral contraceptives at one time or another and that another 4.7 million expected to use them in the future. (It is estimated that about 8 million American women and 5 million in other countries are now using this method.) Other useful information was also obtained from the survey, including data on the use of contraception by various population groups. It is anticipated that the survey will eventually result in a monograph. This survey probably will be repeated in 1970.

In 1967 NICHD launched three contracts to evaluate the medical effects of oral contraceptives with funds specifically allocated by Congress for this purpose. The largest of these contracts is a long term study of a variety of medical effects of oral contraceptives in women. The study is being conducted in California and involves special examinations of about 20,000 women, half of whom are expected to be on oral contraceptives and half using other methods of contraception. The examinations employ the multiphasic screening technique and are designed to detect both biological and behavioral indicators of problems associated with the use of contraceptives. Some data will be available by the end of this year, but information on the long term effects of oral contraceptives, such as the possible relationship between their use and carcinoma of the breast or cervix, will take several years and will require an increased number of participants.

The other two contracts to study oral contraceptives are of somewhat more restricted nature. One is designed to see if there is a relationship between the use of oral contraceptives and the progression of cervical dysplasia, a pathological condition which can lead to carcinoma of the cervix. This project will yield information within two years and should help resolve the question now under intense discussion which asks if a positive relationship exists. The third contract is with the University of London and is devoted to the study of relationships between oral contraceptives and glucose and lipid metabolism. A number of studies in recent months have shown that these agents produce alterations in these and allied substances. The study is designed to measure these changes and to evaluate their significance. Results from this study and others were discussed in detail in December 1968 at a NICHD-sponsored conference on the metabolic effects of these agents. The conference can be summarized by stating that the effects of oral contraceptives and protean and profound.

Contract funds were also used in 1967 to support studies of the mechanism of action of intrauterine devices, the training of physicians in the epidemiology of fertility regulation through the National Communicable Disease Center in Atlanta, and a conference on the mammalian oviduct, a subject of special interest to the Institute since remarkably little is known about the anatomy and physiology of the structure in which important early events in reproduction take place. Lastly, a contract was written in 1967 with the National Academy of Sciences Committee on Population, chaired by Professor William McElroy, to provide an analysis of several problems in the population and family planning field and to provide suggestions for improvements in contraceptive technology, the economic aspects of population control, and the standardization of population surveys.

Funds for Fiscal Years 1968 and 1969 continue to support the oral contraceptive studies launched in 1967 and other studies will be started. One new start will be a study of the effects of oral contraceptives on children born to women who have taken oral contraceptives before or during their pregnancies; another will be a retrospective study to ascertain any possible relationship between the oral contraceptives and breast or cervical cancer.

In 1969, the Center for Population Research will launch contract research concentrated in two areas of investigation: the development of new contraceptives and population research in the social sciences. Institute staff and its advisors (including the members of the Population Research Advisory Committee established in October 1967) have selected four areas for emphasis in the field of contraceptive development:

(1) Maturation and fertilizing capacity of spermatozoa. The goal of this inquiry is the development of modern contraceptives administered to men or women which alter normal sperm development in the male reproductive

tract or in the uterus of the female. This latter process, termed capacitation, is known to occur in certain animals and is the poorly understood obligatory change which occurs in sperm exposed to uterine fluids, making them capable of fertilizing the ovum. It is known with certainty if this process occurs in primates, but, if it does, agents interfering with it may provide new methods of contraception.

(2) Oviduct function and gamete transport. Important early events in the reproductive process, such as sperm penetration of the ovum, occur in the oviduct. For example, the oviduct has some differential effect on the sperm and ovum, which permits sperm to ascend the tube and ova to descend. It seems likely that means can be developed to interfere with the ductal musculature, the cilia which line the tube, or the normal composition of ductal fluid and thus prevent fertilization from occurring.

(3) Corpus luteum function and implantation. The corpus luteum is a progesterone-producing structure which forms on the ovary shortly after fertilization and, in a number of animals, is known to be essential to the continuation of the reproductive process. There are now leads to several means of interrupting the function of the corpus luteum, either through the use of normally occurring leuteolytic agents derived from the uterus of certain animals or through the use of antiprogestational agents and other drugs. This approach is particularly attractive to organizers of family planning programs since it would require a woman to take a pill only once a month, at the time of her expected period.

(4) The biology of pre-implantation ovum. The goal in this area is the development of new contraceptives which will prevent ovulation or interfere with the development or implantation of the fertilized ovum. It is not clear what factors are responsible for the maturation of one ovarian follicle each month while other follicles become atretic. Studies in such areas as the mechanism of secretion of follicular fluid and the enzymes involved in rupture of the follicular wall may result in new, locally acting methods of preventing ovulation. The fertilized ovum remains free in the uterine cavity for several days before it lodges in the wall of the uterus, and it seems particularly susceptible to treatment during this period. One method may be to interfere with the means by which this structure, the blastocyst, escapes from its surrounding membrane, the zona pellucida,

which in many species is composed of highly polymerized neutral or weakly acid mucoproteins.

The Institute staff and its advisors also examined the application of the social sciences to population research. This is a much broader field of investigation and its goals are not amenable to such a precise definition as they are for the biological sciences. Nevertheless, four topics have been identified for special concentration and for the use of our contract funds:

(1) Trends in fertility and related variables. All advisors agreed that there is a need for regular interview surveys on the use of contraception and other fertility-related variables in order to document changes in patterns of childbearing and fertility control.

(2) The antecedents, processes, and consequences of population structure, distribution, and change. Research projects in this area will relate the major demographic variables to social and economic change.

(3) Population policies. Projects in this area will assess the effects of various kinds of government action on population change, regardless of whether the action was intended to influence any demographic variable. They will also develop methods of measuring the effects of efforts intended to implement population policies.

(4) Family structure, sexual behavior, and the relationship between childbearing patterns and child development. Research in this area will describe how family structure and patterns of sexual behavior outside marriage are changing and show the impact of these changes on the number of children born and their subsequent development.

The Center for Population Research has established for the eight priority areas mentioned above, ad hoc panels (composed of members of the Population Research Advisory Committee, appropriate Study Section, and other scientists) which have already begun work to identify specific research areas, to conduct scientific review of contract proposals received, and to assist the Center staff in the overall direction and surveillance of its contract program.

In organizing this panel system the Center has looked beyond its immediate requirements and has engineered the system to manage a larger program in the future and to provide scientific consultation and assistance to other Federal agencies involved in population research.

The Center for Population Research also has the responsibility to serve as information source about population research conducted by all agencies and to stimulate and coordinate the various Federal

efforts. The Center discharges its leadership responsibility within DHEW by working through the Office of Population and Family Planning under the Assistant Secretary for Health and Scientific Affairs and by chairing the DHEW Population Research Committee. The Center's Federal role is carried out in part through the Federal Council for Science and Technology under whose aegis an ad hoc group on population research, chaired and staffed by the Center, is already working to define the field, identify relevant activities throughout the Federal structure, and report to the Council before July 1, 1969.

In 1967, Congress allocated $1 million to NICHD to undertake studies of the medical effects and mechanism of action of various contraceptives now is use, particularly the oral contraceptives. These agents have received particular attention because of their widespread use in the United States and abroad and because of the concern held by many respected scientists over the theoretical or actual problems implicit in their use. These problems extend beyond the immediate side effects and include: (1) effects on blood coagulation and the cardiovascular system; (2) alterations in endocrinological relationships; (3) changes in glucose and lipid metabolism; (4) possible carcinogenic effects; and (5) effects on progeny.

The Bureau of Health Professions Education and Manpower Training supports trainees in population and family planning, under the Public Health Service Act. Section 309 of this Act authorizes grants for graduate or specialized training in public health which may include training in family planning, and which cover faculty salaries, travel, consultant and guest lecture fees, equipment, and other expenses necessary to the successful development of such training programs. Section 306 of the Act authorizes support of traineeships in public health. This authority is exercised by five types of training grants: (1) general purpose, awarded in blocks to accredited schools of public health for distribution to their students; (2) special purpose, awarded in blocks to special training programs selected on a competitive basis for distribution to students who would be enrolled in these programs; (3) short-term, awarded in blocks to agencies offering special training programs selected on a competitive basis, and designed to cover the expenses of offering such programs and stipends for students; (4) residencies in public health and preventive medicine, awarded to residents through applicant institutions or agencies whose residencies must be approved by the American Board of Preventive Medicine and Public Health; and (5) apprenticeships, awarded in blocks to institutions and agencies for the support of field experience in public health and preventive medicine for medical students. During FY's 1967 and 1968 two special purpose traineeship grants have been awarded in this area. The first to the University of California at Berkeley supported 17 trainees in 1967 and 10 trainees in 1968. Although this grant terminates June 30, 1969, it is expected that they will submit a renewal application for continued support at the same level.

The other grant to the University of Hawaii supported 5 trainees in 1967, 7 trainees in 1968 and a projected 7 trainees in 1969. Short-term traineeships in family planning were awarded to three agencies in support of a total of 240 trainees in 1967 and have been awarded to four agencies in support of 760 trainees during FY 1968. These programs are for the development of State and local family planning services, policies, resources and training.

It is estimated that in FY 1969 approximately $196,000 will be awarded for long and short term Public Health Training and graduate Public Health Training grants related to family planning. For FY 1970 it is anticipated that grant awards will be made at approximately the same level as the previous year.

The Division of Nursing, under the Nurse Training Act, is supporting projects to develop ways of improving nursing curriculum in the area of family planning and related subjects. There are two major contracts, one with a Visiting Nurse Association and one with a university which contain elements of family planning. Other project grants are made to Schools of Nursing who are developing curriculum in maternal and infant care. (Since 1965, 10 schools have developed demonstration and research projects in this area which have been supported in the amount of $363,000.)

OFFICE OF EDUCATION

Summary of Programs Related to Family Life and Sex Education

The Office of Education does not prescribe State and local school curricula. However, through its varied grant programs made possible under general legislation, it has enabled education institutions at all levels, to include family life and sex education in their programs and has given financial support to innovative demonstration projects.

Family life and sex education is being increasingly emphasized in the Nation's schools with course content and methodology invariably determined by local school authorities.

Legislation beginning with the National Defense Education Act of 1958, Title V (P.L. 85-864), has made it possible for the Office of Education to support training and curriculum development in family life and sex education. The recently enacted P.L. 90-35, the Education Professions Development Act, modifies the professional training aspects of some of the authorizations. Support for special training of professional education personnel in family life and sex education is possible through the following: Titles V-B of the National Defense Education Act of 1958, providing for institutes for advanced study for guidance and counseling personnel and for teachers, supervisors, and trainers of teachers and education media specialists, were subsumed in 1968 under Title V of the Higher Education Act, the Education Professions Development Act.

The new Title V-D of the Higher Education Act authorizes the Commissioner to make grants to or contract with institutions of higher education and State and local educational agencies for projects to improve the qualifications of teachers and prospective teachers in vocational, elementary, and secondary schools. These funds may be used for training institutes or for preservice and inservice training.

Title V-B and Title XI of the National Defense Education Act were absorbed in the Education Professions Development Act of 1967 (P.L 90-35). Preparation programs formerly funded under these titles are now included under the new provisions of P.L. 90-35 with broadened authority to include training other professional personnel and aides in addition to those listed under the two NDEA titles.

The Elementary and Secondary Education Act of 1965, (P.L. 89-10) and its amendments provide several titles under which family life and sex education activities are eligible for support. The purposes of Title I are to assist in expanding and improving education programs which contribute particularly to meeting the special educational needs of educationally deprived children; namely, through payments to State educational agencies for:

(1) Grants to local educational agencies having concentrations of children from low-income families.

(2) Grants to State agencies operating or supporting schools for handicapped children.

(3) Grants to State agencies operating or supporting institutions for delinquent or neglected children.

(4) Grants to State educational agencies for establishing or improving programs for children of migratory agriculture workers.

(5) Administering the program.

In addition, payments are made to the Secretary of the Interior for grants with respect to educationally deprived Indian children in Bureau of Indian Affairs schools and for payments by the Secretary of the Interior to local educational agencies with respect to the out-of-State Indian children in elementary or secondary schools of such agencies under special contracts with the Department of Interior.

Grantees may use the money for programs for dropouts, preschoolers, and teenage unwed mothers, or other approaches to remedying educational deprivation.

Title II of the Elementary and Secondary Education Act of 1965, as amended, provides formula grants to States for supplementary educational materials to enable educational agencies to acquire library resources, textbooks, and other printed and published instructional materials for the use of children and teachers in public and private elementary and secondary schools. Instructional material on family life and sex education may be purchased under this authority. In addition, a new part B added in 1968 to Title III of the NDEA authorizes grants to local education agencies for the acquisition of instructional materials and equipment for programs meeting the special educational needs of disadvantaged children.

Title III of the same Act, ESEA as amended, known as the PACE (Projects to Advance Creativity in Education), enables schools to provide programs presently unavailable to children, to raise the quality of educational services already offered, and to stimulate the development and evaluation of experimental elementary and secondary education programs to serve as models. Orginally, the Commissioner made grants directly to local education agencies. Beginning in FY 1969, 75 percent of Title III funds were administered by State educational agency, with 25 percent to be used at the Commissioners discretion. All funds are to be State-administered beginning in Fiscal Year 1970.

Since 1954, the Cooperative Research Act has supported educational research projects of colleges, universities, and State educational agencies. Title IV of the Elementary and Secondary Education Act amends the Cooperative Research Act to strengthen and broaden the scope of educational research and development. It establishes a new training program for education researchers by providing grants to colleges and other participating agencies and makes other grants to students for research traineeships, internships, and fellowships. Title IV also provides for the establishment of a system of regional education laboratories. The laboratories provide classroom facilities where teaching experiments can be conducted and newly developed techniques demonstrated and evaluated. Universities, colleges, and other public or non-profit private agencies, institutions, and organizations, and individuals may apply for grants for educational research, surveys, and demonstrations, and to establish and maintain research and traineeships, internships, personnel exchanges, and pre-and post-doctoral fellowships.

Title I of the Higher Education Act of 1965: (P.L. 89-329), provides financial assistance in the solution of community problems through college and university extension and continuing education programs. A National Advisory Council is required to review the administration and effectiveness of all Federally-supported extension and continuing education programs, including community service programs. A State desiring to receive its allotment of Federal funds under this title must designate or create a State agency or institution to participate in the program are required to submit a State plan to the Commissioner for approval. The State plan must set forth the criteria for determining which institutions of higher education in the State are to participate and the policies and procedures to be followed by a State agency in selecting the community problems to be solved.

Title V of the Higher Education Act as amended by the Education Professions Development Act provides for the Teacher Corps. The purpose of this subpart is to strengthen the educational opportunities available to children in areas having concentrations of low-income families and to encourage colleges and universities to broaden their programs of teacher preparation by --

(1) Attracting and training qualified teachers who will be made available to local educational agencies for teaching in such areas; and

(2) Attracting and training inexperienced teacher-interns who will be made available for teaching and inservice training to local educational agencies in such areas in teams led by an experienced teacher.

A major program first included in the Economic Opportunity Act of 1964, (P.L. 88-452), and renewed by the Adult Education Act of 1966, is the Adult Basic Education Program administered by the Office of Education. It is designed to encourage and expand basic education programs for adults to enable them to overcome English language limitations, to improve their basic education in preparation for occupational training and more profitable employment, and to become more productive and responsible citizens. These programs frequently include education for family living.

The Elementary and Secondary Education Amendments of 1967, (P.L. 90-247), contains a new section 807 in Title VIII: "Dropout Prevention Projects" which may have far-reaching effect on the continuing education of teen-age pregnant girls.

Under this section, appropriations not to exceed $30 million for FY 1969 and FY 1970 are authorized for the establishment by the Commissioner of Education, under contract grant or otherwise with local educational agencies, of projects in low-income areas and in areas where a high percentage of children do not complete elementary or secondary school education. Demonstration projects involving the use of innovative methods, materials, systems or programs, designed to reduce the number of dropouts, may be supported. (FY 1969 appropriations, $5 million)

Since pregnancy and/or early marriage constitute the largest cause of dropout by teen-age girls the need for inclusion of family life and sex education in a comprehensive school program is apparent.

Current and Projected Activities in Family Life and Sex Education

It is becoming increasingly clear that the education component in the extension of family planning services to people seeking them should be strengthened. It seems appropriate for the Office to call this to the attention of school and college personnel who might assist the providers of these services in planning the education aspects of the program; e.g., counselors, health educators, teachers, psychologists, social workers, nurses and health aides.

The Office of Education believes that the education component should be positive and strong in the extension of family planning services to people seeking them. It would seem appropriate for the Office to call attention to school and college personnel who might work with the providers of these services in deciding on the educational aspects of the program; e.g., counselors, teachers, health educators, school psychologists, social workers, and aides in education and school health.

The Office of Education is also interested in meeting manpower needs in the family planning field. The Education Professions Develpment Act offers a broad opportunity for training nurses aides and others under various education programs. Becuase of the problem of training priorities, the Office of Education would have to give serious consideration to setting a high priority in the area of preparation of family life and sex education personnel.

The Office of Education initiated a series of discussions on family life and sex education with representatives of various professions and disciplines, ethnic and cultural groups and lay leaders. In 1968, two such conferences were hosted by OE Regional Offices in San Francisco and Boston. These meetings offered a chance for in-depth exploration of the subject at hand. It is hoped that additional meetings will be held.

Approximately 18 projects designed by State and local school systems to help students understand human growth and development and family life are using funds provided under Title III ESEA. This fiscal year. It is anticipated that a similar number will be supported nextyear.

As the role of the Office of Education in population and family planning becomes clearer, steps will be taken to implement the OE policy that evolves.

MENTAL RETARDATION ACTIVITIES OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Prepared by Secretary's
Committee on Mental Retardation

Prepared for House
Appropriations Subcommittee

January 10, 1969

SUMMARY OF MENTAL RETARDATION ACTIVITIES

The 1969 Appropriations Act of the Department of Health, Education, and Welfare makes available over $507,963 million for mental retardation program activities in the current fiscal year. Of this amount $198,700 is to be used for income maintenance of persons who are mentally retarded. 1/

The mental retardation activities of the Department have been arranged according to the following categories: preventive services, basic and supportive services, training of personnel, research, construction, and income maintenance.

Preventive Services

Preventive services are defined as those services rendered as a part of programs designed to reduce the incidence of mental retardation. The major programs in this area are administered by the Children's Bureau, Social and Rehabilitation Service. Maternity and Infant Care Projects support programs which provide necessary health care to prospective mothers in high risk populations. By December 1968, fifty-three such projects were in operation. Grants which support screening programs for phenylketonuria (PKU) and other metabolic diseases also are awarded by the Children's Bureau. As of December 1968, forty-three States had enacted laws related to PKU, most of them making screening for this disorder mandatory.

The Public Health Service carries on preventive services in relation to the health services provided beneficiaries of the Service.

Basic and Supportive Services

Basic and supportive services are defined as those services rendered to or for persons who are mentally retarded.

State health departments, crippled children's agencies and State welfare agencies use funds administered by the Children's Bureau for programs designed to: increase the health and welfare services available to the retarded, enlarge existing mental retardation clinics by adding clinic staff, increase the numer of clinics, begin evaluations of children in institutions, extend screening programs, provide treatment services for physically handicapped retarded youngsters, increase inservice training opportunities, and provide homemaker and other care services for the mentally retarded.

The mentally retarded receive a variety of services through the vocational rehabilitation program supported by the Rehabilitation Services Administration: medical diagnosis, physical restoration, counseling and testing during the rehabilitation process, assistance in job placement and follow-up to insure successful rehabilitation. Public Law 90-391, "Vocational Rehabilitation Act amendments of 1968," will assist in the rehabilitation of additional mentally retarded persons to productive life.

The Health Services and Mental Health Administration, in conjunction with the Division of Mental Retardation, Rehabilitation Services Administration, support projects for the retarded which have service components of well integrated

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1/ A Table of Obligations for Fiscal Years 1966-1968 is included on page 65.

comprehensive health programs.

The Division of Mental Retardation through its initial staffing grant program is able to provide part of the initial cost of professional and technical personnel in the operation of new facilities or new services in existing facilities for the retarded. Over $8 million was appropriated in fiscal year 1969 for this program.

In addition, the Division of Mental Retardation also supports two programs directed at improving the quality of State institutional care and treatment for the mentally retarded. These programs are the Hospital Improvement and Hospital Inservice Training Programs.

With the enactment of the Elementary and Secondary Education Act of 1965 (P.L. 89-10) and its subsequent amendments, has come a number of new programs and services for the mentally retarded. The mentally retarded have especially benefitted from the provisions of Title VI of the aforementioned act, which provides opportunities for local school districts to develop new and creative programs for all handicapped children.

Training of Personnel

Training programs form an integral part of most of the mental retardation programs of the Department. These programs include support of professional preparation in the following areas: research training in the basic and clinical biological, medical and behavioral sciences; training of professional personnel for the provision of health, social and rehabilitative services for the mentally retarded; inservice training of workers in institutions for the mentally retarded; teachers and other education personnel related to the education of mentally retarded children; and training of personnel in recreation and physical education activities for the mentally retarded and other handicapped children.

Research

The National Institutes of Health estimates that more than $21,501 million will be devoted in fiscal year 1969 to the support of research related to mental retardation.

The Office of Education administers a program of grants for research and demonstration projects in the field of education of mentally retarded and other handicapped children, and projects related to the application and adaption of communications media to educational problems of the mentally retarded. Title V of Public Law 90-170 provides for grants for research or demonstration projects relating to physical education or recreation for mentally retarded and other handicapped children.

The Social and Rehabilitation Service supports selected demonstration projects that seek to coordinate community resources for the mentally retarded. Particular attention is given to coordination between special education and vocational rehabilitation agencies. Rehabilitation Research and Training Centers for the mentally retarded provide for the diagnosis, evaluation, treatment and training, vocational counseling and placement of the mentally retarded.

Research grants administered by the Children's Bureau support projects directed toward the evaluation of programs and improving the development, management and effectiveness of maternal and child health and crippled children's services.

Construction

The university-affiliated facility and the community facility construction programs are administered by the Rehabilitation Services Administration.

University-affiliated facilities for the mentally retarded provides for training of physicians and other professional personnel vitally needed to work with the mentally retarded. Fourteen applications have been approved and funded under this program.

To date 175 projects for the construction of community facilities for the mentally retarded have been approved. The facilities constructed under this legislation will include a variety of services: diagnosis, treatment, education, training or care of the mentally retarded, including sheltered workshops.

Income Maintenance

The Social and Rehabilitation Service administers the five federally-supported public assistance programs. These programs assist children who are deprived of parental support or care, the needy aged, the medically indigent aged, the needy blind, and the permanently and totally disabled. Mental retardation itself is an eligibility factor only in the category of aid to the permanently and totally disabled.

The social security program, administered by the Social Security Administration, contributes to the maintenance of the mentally retarded through the payment of monthly benefits to eligible recipients.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Introduction

The Health Services and Mental Health Administration provides leadership and direction to programs and activities designed to improve physical and mental health services for all the people of the United States and to achieve the development of health care and maintenance systems adequately financed, comprehensive, interrelated and responsive to the needs of individuals and families in all socio-economic and ethnic groups.

More specifically, the Health Services and Mental Health Administration collects, analyzes, and disseminates data on births, deaths, disease incidence, health resources, and the state of the Nation's health. It plans, directs and coordinates a national effort to improve the physical health of all Americans through the development of services to promote and sustain physical health, prevent physical illnesses and provide care and treatment for physically ill persons. And, similarly, it strives to improve mental health by developing knowledge, manpower and services to promote and sustain mental health, prevent mental illness and treat and rehabilitate mentally ill persons.

I. Preventive Services

A. Prevention of Organically-based mental retardation

The prevention of mental retardation caused by organic factors is best accomplished by continuous, comprehensive, and high quality medical care of pregnant women and their offspring throughout the prenatal, perinatal and postnatal periods. The Indian Health Service, through its efforts to provide exemplary medical care to its beneficiaries, is reducing the incidence of organically-based mental retardation as well as the wide variety of other diseases and conditions in mothers and infants which the state of the art in medicine now makes at least partially controllable.

In addition, certain services in prenatal and postnatal care and in family planning are also offered to persons who qualify under community-cooperative programs of the Federal Health Programs Service.

In the 48 Indian Health Service general hospitals which operate obstetrical services, comprehensive prenatal and neonatal care is given specifically to reduce the incidence of mental retardation. Phenylketonuria (PKU) tests are performed on all newborn infants, and infants with a depressed Apgar score or who are prematurely born are evaluated for PKU or other evidence of brain damage.

Both the Indian Health Service and the Federal Health Programs Service provide comprehensive medical care during prenatal, perinatal and postnatal periods. In the Federal Health Programs Service patients of the Federal Health Programs Service who may need specific information on genetic studies or genetic counseling are referred to other agencies for such help; whereas the Indian Health Service attempts to provide genetic counseling when it is indicated.

The Indian Health Service has increased the number and frequency of maternal clinics for Indian mothers during the prenatal period and has also expanded its measles immunization program for Indian and Alaska Native children, to help prevent the measles encephalitis which has a high residual of brain damage of which mental retardation can be one of several adverse consequences.

The Indian Health Service continues to develop its PKU blood screening program concurrently with the development of laboratory facilities by States in which their facilities are located. Individual Indian Health Area Offices cooperate with State and local health departments and regional offices in planning mental retardation programs made possible through grants-in-aid funds from the Children's Bureau. Also, the Indian Health Service is working with the Children's Bureau to determine the best utilization of the professionally trained nurse-midwife in the prevention of mental retardation through improved care of expectant mothers and newborn infants.

Recent studies have indicated the value of child-spacing as a measure to prevent mental retardation. An active family planning program is conducted by the Indian Health Service. Family planning assistance, as one phase of the health and welfare continuum is much broader than birth control and includes infertility services as well as the promotion of responsible parenthood. In this broad concept it is implemented in the Indian Health Service. Since the inception of the family planning program in fiscal year 1965, 21,477 female Indian beneficiaries were provided with birth control services (28.5 percent of female Indian beneficiaries 15-44 years of age). In fiscal year 1968, 11,200 women were rendered birth control services with 23,800 visits to physicians.

The National Communicable Disease Center through its Measles Immunization Program has all but eliminated this once common childhood disease. In fact, by the end of 1968 over 30 million children had been vaccinated against measles. Measles morbidity is now less than one-tenth of that reported only two years ago, and with the current emphasis on improved measles surveillance, the actual decrease may be considerably greater. As a corollary to the near eradication of this disease, the problems of measles-associated encephalitis and mental retardation are also diminishing.

The Immunization Program of the National Communicable Disease Center has provided the leadership of the national measles eradication effort. Working through 72 grant-assisted State and local health department projects which serve over 90 percent of the nation's population, the Immunization Program has collaborated with numerous health agencies in conducting community-wide measles immunization campaigns, and in establishing more effective infant immunization programs. It is conservatively estimated that 25 million cases of measles, 25 thousand cases of measles encephalitis, and over ten thousand cases of mental retardation have already been prevented. Aside from the immeasurable humanitarian benefits accrued from reduced suffering, the economic benefits resulting from reduced health care costs and from savings in educational time and funds lost through school absenteeism, have already far exceeded and more than justified the funds initially appropriated for this effort.

B. Prevention of functionally-based mental retardation

As part of the ongoing comprehensive health program on Indian reservations, mental health projects include prevention, detection, and treatment planning for functional mental retardation. The Indian Health Service is cooperatively working with Head Start Program throughout all of its areas.

II. Basic and Supportive Services

A. Foreign Quarantine Program, National Communicable Disease Center

This program has worked closely with other Federal agencies and voluntary groups to make the best possible arrangements for the reception and treatment of the mentally retarded coming to this country as immigrants.

Mental retardation is one of the conditions specified in the Immigration and Nationality Act causing an alien to be considered ineligible to receive a visa except under waiver. The program is responsible for the review of findings in such cases and the decision on the suitability of proposed care.

For those mentally retarded aliens admitted to the United States, the Service is responsible for complete reports and review of arrangements for treatment in this country. A record is then kept covering the first five years of the individual's treatment in this country, which must be provided in institutions or special facilities approved by the Public Health Service. Semi-annual reports showing kind of treatment and progress made are required and kept on file at the Quarantine Station in New York.

B. Medical and Social Services for American Indians

Medical services and medical social services are provided either directly, under contract, or through State Crippled Children's Services to all Indian beneficiaries discovered to be mentally retarded.

Because of cultural barriers and transportation problems, case-finding continues to be a major problem in this area.

III. Professional Preparation

A. Indian Health Training Programs

The Indian Health Service conducts physician residency training programs in pediatrics in its hospitals at Phoenix and Anchorage. This includes clinical training in the prevention, diagnosis, treatment, and rehabilitation of mental retardation.

The Indian Health Service continues to provide both in-service and out-of-service training in maternal and child health nursing to ensure continuity of service from hospital to home and community. An average of 12 nurses are trained each year. The Indian Health Service continues to develop and use coordinated teaching guides for hospital and public health nursing personnel, designed as aids in teaching and good health practices to maternity patients and their families.

B. Education and Training Efforts by the Bureau of Health Services

Coping with mental retardation among its legal beneficiaries is only one of the many health responsibilities for which Bureau of Health Services personnel must be prepared; nevertheless, several aspects of the Bureau's training program are clearly relevant and important to the attack on mental retardation.

Post-graduate training programs in Public Health Service Hospitals include rotating internships, and residencies in internal medicine and obstetrics which involve maternal and pediatric clinical training and the diagnosis and treatment of mental retardation as it arises in the patient population. Research training is conducted in matabolism and endocrinology, disciplines basic to some forms of mental retardation.

C. Training Efforts of the National Institute of Mental Health

The President's Committee on Mental Retardation recommends "greatly expanded" support and increased effort " . . . to attract scientists and professional

specialists in education, the medical and behavioral sciences and related fields into research and service . . ." Since the Inservice Training Program in Mental Retardation has been transferred from the Institute, the National Institute of Mental Health supports no training program specifically focused on the field of retardation. A number of programs, however, incorporate some emphasis on the area. Residency training in basic and child psychiatry, for example, includes education in mental retardation as a standard part of the curriculum. Also, training in psychiatric social work and other behavioral science areas includes field or classroom work in mental retardation.

The training programs vary widely in mission and content. Psychiatric residencies include training in intake, diagnostic, and evaluative studies of the retarded, as well as psychotherapeutic work with the emotionally disturbed retarded and their families. Pre- and post-doctoral training in clinical and school psychology includes instruction as well.

It should be noted that the subject of retardation is an element in all undergraduate nursing education and in most of the curricula integrating psychiatric and behavioral science concepts.

In summary, mental retardation is a multifaceted program area which incorporates many of the Institute's focal concerns such as the study and remediation of learning difficulties, cultural deprivation, and the enhancement of optimal development. The breadth and ramifications of mental retardation research makes it critical to the extension of knowledge in the mental health field.

D. Partnership for Health Training Activities

The Partnership for Health Amendments of 1967 (P.L. 90-174) through Section 314(c) authorized project grants for training, studies, and demonstrations in health planning. Public and nonprofit agencies and organizations are eligible to apply for such support. During the fiscal year 1968, $1,410,000 was obligated through the Partnership for Health Program for mental retardation training activities.

IV. Research and Development Activities

A. Research Related to Organically-Based Mental Retardation

A pilot project conducted by the Indian Health Service in cooperation with the Bureau of Indian Affairs utilizes an interdisciplinary approach to identify both organically and functionally retarded children. The medical, psychological and sociological screening of these children provides a diagnostic basis for determination of required medical treatment and specialized curriculum to meet individual learning needs. In fiscal year 1970, this will be expanded and will be involving a number of medical schools located near reservations.

A study recently completed on the White River Reservation showed a correlation between cultural and social problems and incidence of prematurity, which frequently accompanies mental retardation.

A five-year study of American Indian Congenital Malformations, carried out jointly by the Indian Health Service and the Human Genetics Branch of the National Institute of Dental Research, is in its fourth year. When completed, the study will supply data that will help to evaluate congenital defects in relation to total health status of the Indian. It will also help to identify high frequencies of specific defects due to causes which can be remedied, and will make possible racial comparisons of congenital defects which are of basic genetic interest in trying to determine the etiology of these defects.

A long-term study of a group of 643 Alaskan Eskimo children born between 1960 and 1962 is continuing under the joint sponsorship of the Arctic Health Research Laboratory and the Indian Health Service. A recent report on the growth, morbidity and mortality of these children was presented at the American Public Health Association meeting November 13, 1968.

B. Research Concerning Functional Mental Retardation, National Institute of Mental Health

Over the past decades, the National Institute of Mental Health (NIMH) has supported a broad range of research and training projects in the field of mental retardation. In the past several years, new and reorganized agencies within the Department of Health, Education, and Welfare have enlarged their programs in mental retardation, absorbing a variety of NIMH efforts - particularly in the areas of demonstrations, inservice training and basic research in child development. Summarized below are those research and training programs which remain as part of the Institute's overall mental health mission.

In the report MR 68: The Edge of Change, the President's Committee on Mental Retardation recommends ". . . intensification of research in the social and other behavioral sciences . . ." to isolate and define social and cultural factors in mental retardation (p. 25). The current NIMH research effort in retardation is consonant with this recommendation, falling into three categories: (1) studies of learning, with careful attention to the special learning problems of the retarded; (2) analyses of the effects of cultural and social deprivation; and (3) studies of the behavioral and biological aspects of retardation which relate to mental health and illness.

In the area of learning, investigators are conducting a variety of analyses of the learning process as it operates among the mentally retarded, with a view toward identifying those interventions and those techniques which may facilitate the learning process. Such variables as attention span, capacity for retention, distortions of perception and visual discrimination are being scrutinized to increase the retardate's ability to absorb and profit from his experiences, and to facilitate his intellectual and social development. A specific goal of this work is to develop improved teaching methods. For example, automated teaching techniques are being used in several studies, focusing on programmed learning to develop reading and other skills. Although a number of programs involve attempts to help already damaged children, a primary emphasis overall is the prevention of retardation in high risk populations.

In studies of cultural and social deprivation, investigators are defining the role of poverty, inadequate schooling and community disorganization in causing or contributing to various forms of mental retardation. The aim here is to provide new training and educational approaches for culturally handicapped children; to teach improved child-rearing practices to parents in deprived areas; and to modify attitudes of fear and rejection of the mentally retarded among those who are themselves economically and culturally deprived. Approaches range from broad interdisciplinary efforts to establish controlled therapeutic settings, to the development of skills such as operant conditioning among those who attempt to teach the retarded self-sufficiency, self-control, and social adjustment.

In studies of behavioral and biological aspects of retardation, investigators are concerned with developing improved techniques for diagnosing and treating those psychological and physical abnormalities found among the retarded. A major issue here is the degree to which emotional factors contribute to retardation - the role of psychopathology and personality disorganization in the retardate's patterns of functioning. As in the case of such disorders as schizophrenia, the relative contribution of biological, social, and psychological factors remains to be accurately defined.

V. Construction

A. Community Mental Health Centers

Public Law 88-164, passed in 1963, authorized the NIMH to finance up to two-thirds of the cost of construction of new facilities or renovation of existing facilities for a community mental health center. Related legislation passed in 1965 authorized the NIMH to make grants over a 51-month period to community mental health centers to cover part of their cost of professional and technical personnel. To be eligible for either construction or staffing grants an applicant must present a plan for providing a program of at least five essential services of a community mental health center, namely, impatient, outpatient, partial hospitalization, emergency, and consultation and education. These must be offered in a comprehensive and integrated fashion to the center's community, defined as a catchment area of 75,000 to 200,000 persons. These centers, in which the mentally retarded are eligible to receive treatment and services, serve as the nucleus of the National Mental Health Program. Working in unison with other facets of the national programs in mental retardation and mental health, the NIMH assists States and communities to achieve comprehensive treatment in the community for all who need it. Prevention of mental illness in the community is also one of the major objectives of the centers.

Institute data reveal, for example, that nationally, an estimated four million children under the age of 14 are in need of some kind of psychiatric help because of emotional difficulties. Other estimates are that from 10 to 20 percent of school children show symptoms indicative of pathology which require at least preventive mental health services.

Since the passage of the Community Mental Health Centers Act, the NIMH has supported the development of hundreds of community mental health centers in 49 States, the District of Columbia, and Puerto Rico. The services and programs of many of these centers extend to and include mentally retarded persons. Seventeen percent of the centers funded so far are located in cities of a half-million or more persons; 50 percent are in cities of 25,000 to 500,000, and 33 percent are in cities of 25,000 of less. Centers have been funded that will serve 21 percent of the 500 poorest counties in the United States.

VI. Other Activities

A. Partnership for Health

The Partnership for Health Amendments of 1967 (P.L. 90-174) expanded and extended through fiscal year 1970 the authorizations contained in Sections 314(a), (b),(c),(d), and (e) of the Public Health Service Act, as amended by P.L. 89-749. Grants under Section 314 are administered through the DHEW Regional Offices.

1. Section 314(a) authorized formula grants to States for comprehensive health planning, which would include mental retardation, among other physical, mental, and environmental health concerns.

2. Section 314(b) authorized project grants for areawide comprehensive health planning (including mental retardation). Public and nonprofit private agencies or organizations are eligible to apply for such support.

3. Section 314(c) authorized project grants for training, studies, and demonstrations in health planning. Public and nonprofit private agencies and organizations are eligible to apply for such support.

4. Section 314(d) authorized formula grants to States for public health and mental health services. Mental retardation programs may be supported in accord with a State's plans for health services or mental health services.

5. Section 314(e) authorized project grants for health services development. Public or nonprofit private agencies, institutions or organizations are eligible to apply for such support. Mental retardation projects (including related training) should be for service components of well-integrated comprehensive health services programs. Highest priority will be given to project applications which provide previously unavailable special health services to the mentally retarded or their families as integral parts of programs for model cities, ghettos, neighborhood health centers, family planning, or coordinated health programs.

Since 1964 a mental retardation information activity has been operated as part of the National Clearinghouse for Mental Health Information. Because knowledge about mental retardation comes from many scientific disciplines and professions, this service will improve both research and practice and thus have a decided effect on the prevention and treatment of mental retardation.

To maintain this service, the National Clearinghouse for Mental Health Information has had until September 1968, a contract with the American Association on Mental Deficiency to collect current literature on mental retardation, write informative abstracts, index the literature in depth, compile annotated bibliographies on special topics and prepare critical reviews.

From 1964 to 1967 a total of 12,500 current articles, books and monographs were collected, abstracted and indexed in the Clearinghouse system. To provide a more extensive coverage of information for retrieval purposes, an additional 3,500 indexed abstracts of documents published from 1957 through 1963 were added to this system.

Special annotated bibliographies have been prepared on: (1) Programmed Instruction for the Retarded; (2) Literature for Parents; (3) Application on the Stanford-Binet and Wechsler Intelligence Scales with the Mentally Retarded; (4) Nursing and Mental Retardation; (5) Family Care and Adoption of Retarded Children; (6) Psychotherapy with the Mentally Retarded; (7) Recreation for the Retarded; (8) Counseling Parents of the Mentally Retarded; (9) Sheltered Workshops for the Mentally Retarded; (10) Films on Mental Retardation; (11) Psychopharmacological Therapy with the Mentally Retarded; (12) Electroencephalographic Studies Relating to Mental Retardation; (13) Hydrocephalus; (14) Mental Retardation and Religion.

Review articles and critiques have been prepared on: (1) Mental Retardation; Definition, Classification, and Prevalence; (2) Research on Linquistic Problems of the Mentally Retarded; (3) Attendant Personnel: Their Selection, Training, and Role; (4) Research on Personality Disorders and Characteristics of the Mentally Retarded; (5) Effects of Severely Mentally Retarded Children on Family Relationships; (6) Factor Analysis and Structure of Intellect Applied to Mental Retardation; (7) Counseling Parents of the Mentally Retarded; (8) Genetic Aspects of Mental Retardation; (9) Instrumental Learning in Mental Retardates; (10) Vocational Rehabilitation of the Mentally Retarded: The Sheltered Workshop; (11) Relationships Between Educational Programs for the Mentally Retarded and the Culturally Deprived; (12) A Decade of Research on the Education of the Mentally Retarded.

The abstracts, annotated bibliographies and reviews appear in the quarterly journal, Mental Retardation Abstracts, which is distributed gratis to approximately 7,600 individuals engaged in research and practice in mental retardation and is also for sale by the Superintendent of Documents.

In September 1968 the Division of Mental Retardation, Rehabilitation Services Administration, Social and Rehabilitation Service, assumed responsibility for the contract with the American Association on Mental Deficiency for the collection and abstraction of documents and preparation of Mental Retardation Abstracts, beginning with Volume 6, No. 1, January 1969. The Division is making plans to develop its own data processing and information services program.

In the interim, the Clearinghouse, in order to provide uninterrupted service, continues to answer inquiries in the mental retardation field. Furthermore, the National Clearinghouse for Mental Health Information, in accord with the Institute's current programs in mental retardation will continue to acquire and disseminate information on mental retardation as it relates to: (1) the learning process, learning disorders, and other broad developmental issues with applied applications; (2) emotional and biological conditions as etiology or effect of mental retardation; (3) social and cultural factors as etiology or effects of mental retardation.

B. Institutional and Case Statistics

1. Inpatient facilities: Information is obtained from public inpatient mental retardation facilities, on such patient characteristics as age, sex, medical classification, measured intelligence level for first admissions, and for resident patients.

2. Outpatient Psychiatric Clinics: Information is obtained on the number of terminated patients diagnosed with mental retardation, by age, sex, and degree of deficiency (mild, moderate, severe), whether treated or not treated.

3. Maryland Psychiatric Case Register: Data are routinely collected on demographic patient characteristics, type of service, referral service, and disposition of all patients diagnosed as mentally retarded in all psychiatric clinics and public and private institutions for the mentally retarded.

NATIONAL INSTITUTES OF HEALTH

Introduction

Mental retardation today afflicts the lives of an estimated 6 million persons in the United States. Its impact is directly felt by the some 20 million family members who share the burden and problems of care of the retarded whose inadequate intellectual development impairs their ability to learn and to adapt to the demands of society.

The causes of mental retardation are multiple and involve both physical and environmental factors operating singly or in subtle interactions. Resolution of this complex problem requires the scientific talent from many disciplines--biological, behavioral and social--in a concerted effort involving basic, clinical and applied research over an age span from conception through maturity. The Institute's program of research and research training support represents a major arm of our nation's effort to combat the problem of mental retardation which ranks as a major health, social and economic problem.

In fulfillment of its responsibilities in this area, NIH is supporting a broad attack upon the problems associated with mental retardation. The goals sought are the prevention of mental retardation in the future, the cure of existing mental retardates, or, if this is not possible, the amelioration of their condition and the training and upgrading of such individuals to a point where they can come as close to self-sufficiency as their endowment permits. To these ends the Mental Retardation Program is facilitating research on the diagnosis, prevention, correction and amelioration of mental retardation. Investigations are being supported in basic sciences, both biological and behavioral, as well as clinical disciplines.

I. Training of Personnel

A. National Institute of Child Health and Human Development (NICHD)

The critical need for more research workers from all fields whose primary interests lie in areas related to mental retardation continues. This is evident from the strenuous recruiting efforts which have been observed in the staffing of the Mental Retardation Research Centers, even those whose construction is not yet completed. Fortunately the research training programs have resumed the growth which they were undergoing in fiscal year 1966 and fiscal year 1967. From 13 training grants providing training for 60 trainees in fiscal year 1968, the program has grown to 18 training programs serving 124 trainees. The areas in which training is available under these 18 grants are as follows: behavioral studies - 7; basic biomedical studies - 1; sociology - 1; combined behavioral, clinical and basic biomedical studies - 2; combined clinical and basic biomedical studies - 6; combined clinical and behavioral studies - 1. Of the 124 trainees being served by these programs 76 were predoctoral, 7 received Master of Arts degrees, 25 were in Ph.D. or M.D. programs, 6 received Ph.D. or M.D. degrees, and 10 were postdoctoral trainees. In addition to the trainees who received stipends from these programs several program directors pointed out that a total of 63 other students in a variety of programs benefited from the existence of these NICHD research training programs. These were individuals who participated in the same training courses as those receiving stipends and also worked in research programs alongside those receiving stipends. These additional trainees were supported by other programs, either Federal or local but were able to take advantage of courses and

research programs which were instituted under NICHD funded training programs.

In addition to the trainees under these programs the Institute is supporting on an individual basis 9 Fellows and 4 Research Career Development Awardees. In addition to these individuals whose programs are specifically directed towards research in mental retardation the NICHD currently supports fellowships, research career awards, and training grants in areas which are highly relevant to mental retardation but which are funded under other programs. There is a large amount of interaction between the Mental Retardation Program and other Programs in the NICHD such as the Growth and Development Program, the Reproductive Biology Program and the Perinatal and Infant Mortality Program.

B. National Institute of Neurological Diseases and Stroke (NINDS)

While the training program of the National Institute of Neurological Diseases and Stroke is not specifically and exclusively directed towards mental retardation, it is directed toward the development of clinical neurologists and competent research scientists in the fields associated with the diseases of the nervous system. These disciplines provide the basic tools required for any serious attack on the problem of organically-based mental retardation. Particularly important are the Institute programs for the training of pediatric neurologists, who are very often required to make the initial diagnosis of mental retardation. Training programs in speech pathology and audiology are fundamental to therapy in the mentally retarded and receive strong support from the Institute.

II. Research

A. National Institute of Child Health and Human Development (NICHD)

Scientists being supported to work in mental retardation are utilizing a vast array of techniques from the classical observation and descriptive techniques all the way to the most advanced and sophisticated electronic recording and statistical methods. Since for some kinds of work it is neither feasible nor desirable to use human subjects a number of investigators are currently attempting to develop appropriate animal models for research use.

The biological sciences are moving on a broad front from highly advanced biochemical macromolecular investigations through cellular levels to whole organ studies on through research in primates and humans. Clinical specialists are using very delicate and complex diagnostic techniques which could not even have been considered as little as five years ago. In a few fortunate cases, such as some of the diseases from inborn errors of metabolism, therapeusis is also at a level of sophistication which would not have been thought possible only recently. Behavioral scientists, ranging from psychologists through psychiatrists, and sociologists are steadily refining their tools for diagnosis and treatment. This is evidenced by the ever increasing numbers of subentities being identified under the main heading of mental retardation which at one time was an indivisible term. More and more attention is being paid to disorders of communication and perceptual visual problems so that both diagnosis and remedial training moves a little closer to the ideal.

The complexity of mental retardation requires multidisciplinary research approaches and it is encouraging to observe that not only are the obvious combinations such as biochemists working with psychopharmacologists becoming more and more common but less expected combinations such as behavioralists working closely with clinical and basic scientists are beginning to be seen. The Mental Retardation Research Centers which are funded by Congress under specific construction legislation (P.L. 88-164) are serving to facilitate this kind of interdisciplinary effort.

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In fiscal year 1969 approximately 270 investigators in 28 specialties or subspecialties are being supported. Some of these specialties are pediatrics, psychology, psychiatry, biochemistry, genetics, education, nutrition, pathology, neurobiology, physiology, anatomy, communications engineering, mathematics, microbiology, obstetrics and gynecology, radiology, social work, sociology, veterinary medicine, and virology. Many of these investigators while working independently are finding it to their mutual advantage to discuss problems with each other and to utilize the insights and techniques of each others' specialties in their own work. The Centers are providing a setting where this is especially easy since in many cases they are, or will be, working in the same physical structures. NICHD staff are encouraging as much as possible interdisciplinary approaches, staff seminars, and other administrative means of obtaining multidisciplinary efforts. It is interesting to note that even in those Centers which have not yet completed their construction that the same kinds of staff interactions are occurring. The required planning is resulting in consultation across disciplinary lines and this consultation is creating contacts among investigators which might not otherwise have occurred. In many cases these contacts are resulting in scientific interactions to the benefit of the program.

One primary thrust of research supported by NICHD continues to be in cytogenetics and the inborn errors of metabolism which result in mental retardation. Both areas are beginning to take advantage of tissue culture techniques which in the latter case provide large amounts of tissue to work with outside the patient himself, yet with material that responds in many ways as the patient does. In the other case large numbers of cells can be studied to observe what is actually happening in the chromosomes. There is also considerable interplay between the cytogenetic and biochemical study of tissue cultured cells addressing the questions of the relationships between chromosomes, enzymes and end results.

Many research projects being funded are at institutions which now have or will have, operating Mental Retardation Research Centers. Congress, in 1963, recognized the limited resources devoted to mental retardation research and requirements for centers of research competence with special capability for meeting the research demands of this multifaceted program. P.L. 88-164 authorized the construction of Mental Retardation Research Centers for the purpose of finding the causes and means for preventing and ameliorating mental retardation. Implementation of this authority was assigned the NICHD in close cooperation with the Division of Research Facilities and Resources/NIH. The NICHD has continuing responsibility for programmatic development of the centers. When operational the centers will provide the major thrust for the Institute's program to combat mental retardation.

The interval between center construction grant awards and completion of construction represents a significant lapse of time. The Institute has acted to reduce the time lag for bringing the centers to fuller operational strength through interim development and strengthening of existing research activities to be included in the centers on completion of construction. These activities are supported by program project research grants awarded the institutions following competitive review for scientific merit by appropriate National Institutes of Health review committee.

Four of the centers were completed and became operational in fiscal year 1968; these were the Children's Hospital Research Foundation, Cincinnati, Ohio; George Peabody College for Teachers, Nashville, Tennessee; the University of Chicago, Chicago, Illinois; and the University of Colorado Medical Center, Denver, Colorado.

Three centers are scheduled for opening in fiscal year 1969; these are: the University of Washington, Seattle, Washington; Albert Einstein College of Medicine, Bronx, New York; and, the University of California at Los Angeles,

Los Angeles, California.

Centers at the University of Kansas, Lawrence, Kansas; University of North Carolina, Chapel Hill, North Carolina; Walter E. Fernald State School, Waltham, Massachusetts; and, the Children's Hospital Medical Center, Boston, Massachusetts, are scheduled to begin operations in fiscal year 1970. Plans for the University of Wisconsin Center, Madison, Wisconsin, call for completion of construction in fiscal year 1971.

Existing programs under center aegis at the University of Kansas are making notable progress on poverty-linked retardation with research support from the Institute. Their research demonstrates the crucial role of disadvantaged mothers in facilitating the development of intelligence in their preschool aged children, means for changing the behavior of mothers in parent-child interactions so that their children learn more readily and the importance of community support and involvement in creating constructive research and service programs for the children of poverty.

Methods for constructive intervention to prevent or ameliorate poverty-linked retardation are, or will be studied at the George Peabody, Wisconsin and North Carolina centers. The George Peabody College Center in Nashville, Tennessee, is well established in its research program to study the effects of different methods of educational intervention.

The University of North Carolina Center at Chapel Hill, North Carolina, plans and is piloting studies concerned with preventing retardation among the disadvantaged through a program stressing psycho-social interventions beginning in early infancy and childhood. Closely related to this effort are parallel studies concerned with the control of infectious diseases in children under group day-care. The importance of these efforts and companion efforts elsewhere is stressed by the fact that large numbers of elementary school aged children from disadvantaged homes in the Chapel Hill area have IQ's below 80.

Staff from the University of Wisconsin Center are currently engaged in a major program of research concerned with rehabilitative approaches and methods for use with the disadvantaged. Basic research in learning and human development will expand and complement these applied rehabilitative efforts when construction of the center is completed in fiscal year 1971.

Focal research efforts concerned with poverty-linked retardation are active or planned at other mental retardation research centers. Among these are studies of epidemiology of poverty-linked retardation at the Albert Einstein College of Medicine Center, New York, and at the University of California at Los Angeles, California.

Longitudinal studies of development from the period of pregnancy through the elementary school years are crucial to our full understanding of aberrant and subnormal development. Too frequently the significant events of pregnancy, the neonatal period and early infancy and childhood are lost to investigators concerned with subnormal development and faulty learning as experienced by the school age child because of lack of resources for systematically relating events from early to later age levels. The mental retardation research centers, as never before, offer great opportunities for the conduct of sound, scientific studies of longitudinal development in retarded populations and populations at risk of becoming retarded.

One of the major longitudinal studies attacking these issues is currently under development by researchers in the neurological sciences at the University of Washington Center. These investigators propose studies relating the carefully

studied events of pregnancy and the neonatal period to neurological electrophysiological, and neuropathological data obtained during the neonatal period and early infancy. These data will, in turn, be related to patterns of behavior and intellectual functioning during the school years. Careful clinical supervision and recording of life events by the center's excellent and comprehensive resources for diagnostic, treatment and service follow-up will provide a sound base for obtaining the most meaningful results in terms of developmental outcomes.

A major contribution to the epidemiology of mental retardation is expected shortly with the publication of work by Institute supported investigators from the Albert Einstein Center. The study, conducted in Aberdeen, Scotland, utilizes excellent social background, pregnancy, obstetrical and prenatal data from the total population of births in that city collected since 1951. The Aberdeen population is highly stable and excellent cooperation has been obtained from both the health and educational authorities. These conditions have made possible long-term follow-up studies of children deriving from their well studied births. The investigators, therefore, have been able to relate obstetrical and social antecedents characteristic of the birth of the child to his functioning during the school years. Studies of all mentally subnormal children born in birth years 1952 through 1954 and varying in age from 8-11 years at close of follow-up have been readied for report. The first manuscript will treat the interaction of class, central nervous system damage and psychiatric status with mental subnormality.

The Growth and Development Program of NICHD is involved in several activities directly concerned with mental retardation. Presumptive evidence in a variety of animal species, supplemented by scattered tests in humans, indicates that protein-calorie deprivation may have an inhibiting effect on mental and social development. In animal studies, these effects seem to depend upon fairly acute nutritional deprivation of the type only seen in grossly malnourished children. NICHD has therefore organized several studies in South and Central America where protein-calorie malnutrition is endemic, thereby providing a natural test area for the relationships between nutritional deprivation and intellectual and social development.

The largest of these studies is supported by a contract with the Pan American Health Organization for work to be done in the Guatemala highlands by the Institute for Nutrition of Central America and Panama. This study involves matching pairs of rural, isolated villages on a number of factors, and then providing a protein rich food supplement to one village in each pair. The other village will also receive medical care (but no supplement), with provisions to match social inputs that might positively influence intellectual development. Careful study design permits investigation of a variety of factors such as social status, family interrelationships, and parental expectations which influence child development. Now in its fourth year, the study has just entered the definitive stage with initiation of the supplementation program. Continuous data monitoring will measure intellectual development up through age six.

A second study, also under contract, is designed to study the development of pairs of siblings living in urban ghettos in Bogota, Columbia. These pairs of children, all under the age of three years, will include one acutely malnourished and one adequately nourished child, both of whom will be supplemented throughout the study. This design permits control of genetic variables and, to a considerable degree, the social and environmental factors surrounding malnutrition. Many of the tests being used in the Guatemala study will be used in Bogota, plus other measures for delving more deeply into emotional development. This project now entering its second year, is jointly conducted by Harvard University and the National Institute of Nutrition, Bogota.

Recently awarded grants support two other studies in the Western Hemisphere. In Mexico a small, elegantly designed study is focusing on nutrition of the mother and the infant, including controlled studies of breast milk consumption; premature weaning without adequate nourishing food is increasingly recognized as a probable factor in impaired development of the central nervous system and in possible behavior deficits in deprived children. Another project, in Chili, is utilizing children who have been hospitalized with acute malnutrition at a very early age, often as young as 6-8 months. The behavioral patterns of these children following nutritional rehabilitation are being monitored. A very interesting facet of this project is the development of a method of cerebral transillumination which provides clear indications of fluids within the cranial cavity, thereby indicating the relative reduction in brain size as a result of nutritional deprivation.

While these studies do not relate to severe degrees of mental retardation, they will help provide information on the relationship between the malnutrition in half the world's children and their resultant intellectual, social and physical development. An active program is now underway to locate investigators and opportunities to extend these studies into the United States where ghetto populations may experience varying degrees of marginal malnutrition with only occasional gross situations of the type seen overseas. One research grant to study rural southern populations has been approved and is awaiting funding; several others are in various stages of development.

As a further means of assisting the research community NICHD supports scientific conferences when it is apparent that such conferences will be useful and stimulating. A conference was supported on "Social Science and Mental Retardation: Family Components" which was intended to stimulate social science research in parent-child interactions and other family related aspects of intellectual development and behavior of children. The published proceedings of this conference will be available in January, 1969. A conference of specialists was held this year on the Lesch-Nyhan syndrome which is an inheritable disease of metabolism involving a reduced or absent enzyme. This conference was published in the July-August issue of the Federation Proceedings. Another conference was held in which some 15 specialists in cytogenetics participated in the initial planning for a conference on cytogenetics and mental retardation to be held in June, 1970. This will be the first cytogenetics conference to be devoted primarily and entirely to the problem of mental retardation.

Other programs such as Reproductive Biology, and Perinatal and Infant Mortality cooperate with the Mental Retardation Program in support of research of mutual interest.

Intramurally the NICHD continues to provide clinical service and research in mental retardation at the Children's Diagnostic and Study Branch. The staff of this branch is an interdisciplinary group which works together in research and to treat the whole child. It contains clinical specialists as well as psychologists and social workers who combine their efforts in diagnosing and devising treatment plans for children who are referred to them as a result of observed difficulties in adapting to their environment. This group is currently studying a child with congenital anesthesia to pain, temperature and tactile stimuli, but with normal intelligence. Another child being studied is a case with phenotypic mongolism but genotypically normal leukocytes. Both cases raise very interesting theoretical research questions. Other intramural programs also conduct research of significance to mental retardation, directly or indirectly.

B. National Institute of Neurological Diseases and Stroke (NINDS)

The National Institute of Neurological Diseases and Stroke sponsors no research in mental retardation per se but its interest in mental retardation appears

when mental retardation arises as a symptom complication or a sequela of some disease of the central nervous system. Consequently a large number of research projects supported by NINDS can be said to be relevant to mental retardation research, although the interest of the scientist may be in the study of some particular phase of disease rather than in mental retardation research directly. The research projects involved cover nearly all of the scientific disciplines to some degree.

One of the Institute's major efforts which has great interest for mental retardation research is a collaborative project with 14 cooperating institutions investigating the prenatal, perinatal and postnatal factors relating to the development of children. The "Collaborative Study in Cerebral Palsy and Other Neurological and Sensory Disorders in Infancy and Childhood" is following the offspring of more than 50,000 mothers from early pregnancy through labor and delivery until the children are at least through the first year of school. The data are in the process of being analyzed and this project should yield a large amount of valuable information related to mental retardation. The Institute is also supporting epidemiological and genetic studies to establish possible patterns of inheritance or other causative factors leading to neurological disease and mental retardation. These include inborn metabolic errors, chromosomal abnormalities and congenital malformations.

Intra-uterine infections occurring in the first trimester of pregnancy are important factors leading to severe destruction of the brain and major mental impairments. The Laboratory of Perinatal Physiology in Puerto Rico is attempting to determine if the monkey can be used as an animal model for German measles infection. If this proves to be the case research into the mechanisms by which German measles affects the central nervous system will be greatly potentiated.

Research into inborn metabolic errors is being supported in order to discover how early these diseases appear and when to begin treatment. There are more than 200 known metabolic abnormalities of which no more than 6 may be amenable to present therapeutic approaches. Continued study is necessary to enlarge these treatment programs. The biochemistry of these diseases and the relationship of the biochemical activities to brain function are being studied. These studies are directly relevant to the development of mental retardation.

Studies are underway to attempt to link the pathological patterns of brain damage to functional development. In this area the Collaborative Study will be valuable in providing both normative data and incidence statistics relative to mental retardation.

The early diagnosis of mental retardation is frequently extremely difficult. The Institute continues to support programs for the refinement of diagnostic techniques. The problem of minimal brain dysfunction is undergoing reevaluation to assess the current status of and to apply advance techniques to this difficult area.

Mental retardation often follows hydrocephalus and brain tumors in childhood.. Development of appropriate surgical or pharmacological therapy remains an objective of the Institute. The Institute is also supporting programs which investigate the mechanisms involved in meningitis or meningoencephalopathy to determine proper preventive and therapeutic approaches.

OFFICE OF EDUCATION

Introduction

Programs dealing with handicapped children in the Office of Education have been placed under the administrative direction of the Bureau of Education for the Handicapped. This is consistent with the efforts of the Office of Education to provide maximum educational programming for all children. The Bureau is responsible for supervising and implementing current and new legislative authorities to provide funds for projects and programs relating to the education, training and research of handicapped children and youth. These children include those who are mentally retarded as well as those who are hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired and require special education.

The Bureau is specifically charged with the task of helping each handicapped child develop to the maximum those skills and talents which will enable him to become independent and self-sufficient as an adult. The Bureau, through its various support mechanisms, directs programs designed to (1) increase the number of qualified professional personnel; (2) improve educational services in local and State programs; (3) stimulate acquisition, evaluation, and utilization of modern educational equipment, media, and teaching materials; and (4) encourage theoretical and applied research, the use of successfully tested research, and advanced educational techniques.

The Bureau of Education for the Handicapped also assumes a major leadership role in the field of special education. To insure effective and capable leadership, the Bureau maintains a constant state of alertness and keeps attuned to new inputs and changes affecting the area of special education. Indicative of its effort to keep in touch with changes occuring in the field, seven special education conferences were held during the first half of 1968. Regionally located, the conferences were attended by approximately 1,000 special educators from all 50 States representing public school programs, institutions for the handicapped, State departments of education, institutions of higher education, and other public and private agencies interested in serving handicapped children.

The seven conferences provided an abundance of information regarding current problems existing in the field of special education as well as projecting possible avenues for their solution. This information is being analyzed and follow-up conferences will be held to study further the efficacy of the proposed solutions. The follow-up conferences, like the above conferences, will be working conferences with an emphasis on two-way communication between educators in the Federal government and those in the field.

The impetus for change and its challenge is part of the climate of the Bureau. It is reflected in the mood and feeling of its professional staff in their drive for commitment and awareness to innovate, to initiate, to lead, to evaluate, and "to be first" to enter new areas to benefit the handicapped. The Bureau provides leadership at every level to provide resources, knowledge, and awareness not limited by lack of preception, or vision, or by lack of dedication to the handicapped by those responsible for effecting policy.

In order to efficiently implement its assigned responsibilities the Bureau is administratively organized into three major divisions and an Office of the Associate Commissioner which includes a Program Planning and Evaluation Office; an Information and Reports Office; an Executive Office; and an Office for the Development of New Programs. This latter office is responsible for developing guidelines to

effectively implement new legislation which expands and creates educational opportunities for handicapped children.

Each of the three divisions provide an important element in the functions rendered by the Bureau in making up a total program of service, training, and research for the mentally retarded as well as other handicaps of children. The following pages describe these services for mentally retarded children on a divisional basis.

I. Division of Research

A. Purpose

The Division of Research promotes and supports research and related activities which show promise of leading to improvement in educational programs for handicapped children. Support is available for research, dissemination, demonstration, curriculum, and media activities.

B. History

The program now administered by the Division of Research was initiated during fiscal year 1964 with an appropriation of $1 million authorized under Title III, Section 302 of Public Law 88-164. The scope and flexibility of the program has been extended through amendments to this basic authorizing legislation in P.L. 89-105, P.L. 90-170, and P.L. 90-247. Table 1 provides data on the authorizations, appropriations, obligations, and number of projects supported under this program.

C. Impact on the Problem of Mental Retardation

It is difficult to assess the direct impact of research activities since the lag between the discovery of new knowledge and consequent changes in educational practice obsures the picture. However, some information on the impact of the program is available. As of the end of fiscal year 1968 approximately sixty final reports of research monitored by the Division of Research were made available to practitioners in the field. Many of these research projects have also resulted in other publications in the professional literature. Although the systematic collection of data on the actual implementation of research findings from these projects is just beginning, there are many instances in which these findings have had a direct impact on programs for the mentally retarded.

D. Future Goals

The history of research on handicapped children suggests that minimal gains are obtained by spreading research monies too thinly. Many of the most important problems in education require a massive effort if solutions are to be found in time to help today's children. The Division of Research proposes to support the establishment of Research and Dvelopment Centers to focus on the more difficult problems of evaluation, communication, instructional procedures, etc. Through the combined efforts of Research and Development Centers and programmatic research on specific major educational problems it can be expected that new models of instruction will be available within a few years.

At the same time, systems of dissemination will be evolved which will facilitate the acceptance of these new models by local school administrators. The new systems of dissemination will be built upon the foundation of Instructional Materials Centers already developed and a system of regional resource centers currently being developed.

As more funds for research become available, engineering technology will more and more become a part of research supported by this Division. This development has been made possible by the amendment permitting the use of contracts as well as grants for research and development activities. Engineering technology, programmed instruction, and the "systems approach" to education will occupy a major place in the Division's activities in the years to come.

E. Current Activities

The Division currently supports a wide range of activities relating to the education of mentally retarded children. One of the most visible of these is the network of instructional materials centers for handicapped children. Although serving teachers of all the handicapped, these centers have a major commitment to mental retardation. The Instructional Materials Centers, 14 in all, are scattered across the country to serve specified regions. The primary objective of each center is to keep teachers of handicapped children aware of new developments in educational materials. The centers are evaluating existing materials as to their relevance to the handicapped and assisting in the development of new materials. Since the 14 centers are connected as a network, any information located at any center is immediately relayed to all other centers.

The Comprehensive Research and Demonstration Center for Handicapped Children, now under construction at Teachers College, Columbia University, similarly has a major emphasis on the problems of the retarded, although at the same time relating to the educational problems of many categories of handicapped children. This center represents a major investment of research funds, both for construction and operation, in an attempt to develop an intense effort in this area of education.

Other research activities now under way are attacking the problems of teaching and learning with the mentally retarded. One such project has suggested that time spent in learning to learn can make a significant difference in the learning performance of retarded children. Other projects are developing and testing new curricula for the retarded.

Table 1

Division of Research - - - Historical Data

Year	Authorization	Appropriation	Obligations	#Projects
1964	2,000,000	1,000,000	999,739	34
1965	2,000,000	2,000,000	2,000,000	53
1966	6,000,000	6,000,000	5,994,231	133
1967	9,000,000	8,100,000	8,049,041	127
1968	19,500,000	11,100,000	10,794,113	135
1969	21,750,000	13,600,000	---	---
1970	28,000,000	---	---	---

II. Division of Educational Services

A. Purpose

The Division of Educational Services provides direct support to handicapped children through services at the classroom and intermediate levels. The Division offers support to State, regional, and local programs to assist in developing and maintaining leadership in the education of handicapped children.

B. Historical Development

Public Law 85-905, the Captioned Films for the Deaf Law, was passed by Congress in 1958 to provide entertainment films for the deaf. This law has subsequently been amended by P.L. 87-715 in 1962 and P.L. 89-258 in 1965 to allow for training, research, production and distribution of educational material for use by deaf children. In December 1967, this authority was again expanded to include educational services to all categories of handicapped children through the 1967 amendments to the Elementary and Secondary Education Act.

Public Law 89-313 was passed by Congress in November 1965, which extended the benefits of Title I of the Elementary and Secondary Education Act to handicapped children in State-supported programs.

During recent years, as local facilities for the handicapped have increased, State schools have found the composition of their resident populations changing from the mildly handicapped to large percentages of children who are severely mentally retarded, and those who have serious handicaps in addition to mental retardation. Model and pilot programs for these types of children have been conducted under P.L. 89-313 in many States.

These funds have enabled institutions and agencies to develop programs for children who have not previously been considered capable of responding to educational or rehabilitative services. The results in many instances have been encouraging and special educators and staff in residential institutions have raised their levels of expectations for such children. While this program has had a relatively limited funding based upon its authorization, significant results have been realized especially in terms of planning for comprehensive services. Monies allotted under P.L. 89-313 for handicapped children were $15.917 million for fiscal year 1966, $15.065 million for fiscal year 1967, and $24,747 million for fiscal year 1968, and $29.7 million for fiscal year 1969. In fiscal year 1967, 46,645 mentally retarded youngsters were assisted under this program at an expenditure of $8,473,118.

The 1966 amendments to the Elementary and Secondary Education Act provided under Title VI-A, a program of support to local education agencies through a State plan program. While this law authorized $150.0 million for fiscal year 1968, the appropriations were only $14.25 million. For fiscal year 1969, $162.5 million was authorized and $29.25 million was appropriated.

The 1968 amendments to Title III of the Elementary and Secondary Education Act, provide that 15% of the funds for fiscal year 1969 be spent for innovative and exemplary projects for handicapped children. It is estimated that $3 million of the funds for the handicapped under this Title will be expended for services to retarded youngsters during fiscal year 1969.

P.L. 90-247 provides for the development of regional centers for deaf-blind children under Title VI-C. The appropriation for 1969 is $1 million which will be used for both development of programs and for direct services to deaf-blind children and their parents. The law permits use of these funds for deaf-blind children with additional handicaps, including those who are mentally retarded.

The Handicapped Children's Early Education Assistance Act, embodied in P.L. 90-538, provides for establishment of a number of model programs for serving very young children with various handicaps. These programs will be distributed strategically throughout the country to serve as models for the development of future preschool and early childhood programs. The 1969 appropriation is $1 million, which will serve as planning and development funds during the first year of the program.

C. Impact on Mental Retardation

Programs will have a significant and far-reaching impact upon education and rehabilitation of mentally retarded individuals. Through such direct support programs Title VI (aid to local programs) P.L. 89-313 (aid to State programs), more extensive and comprehensive programs will develop which will include the utilization of the latest teaching techniques and educational technology. Media Services and Captioned Films for the Deaf with expanded responsibility should provide for an opportunity for State and local programs to take advantage of educational materials, media, and equipment especially designed to meet the needs of the handicapped.

D. Future Goals

The goals of the Division of Educational Services are to:

1. Provide significant support monies to both State-supported and local educational programs to assure quality education for all handicapped children.

2. Provide intermediate services such as comprehensive educational diagnostic resource centers on a regional base to provide services for handicapped children and their families. In addition to direct services to children, these centers will provide consultative services to State and local educational agencies to assure the latest available information from research with respect to the learning process.

3. Provide wherever needed comprehensive regional programs for severely multiply handicapped children such as deaf-blind children.

4. Provide through media services the research, production, and distribution of specially designed materials and programs for educational technology for handicapped children. To provide training in the use of media for teachers of the handicapped.

5. Provide through Instructional Material Centers educational management and information systems.

E. Current Activities

During 1968, the Division of Educational Services held five Regional Conferences to acquaint Title I (89-313) Title VI-A and Title III Coordinators with exemplary projects for the handicapped. The Division staff met with over 600 professional and interested parties to discuss the overall service program of the Bureau at these conferences.

During fiscal year 1969, the total funds available for services to handicapped children from this Division will excede $88 million. Most of this money will be made available through State Plan programs. Under the State Plan programs, it is estimated that 25 to 30 percent of the funds will be expended for retarded children.

These programs have led to an interest in comprehensive planning. The Division plans to work with State and project personnel to develop long-range plans and evaluation procedures during 1969. These activities are serving the special educational and related needs of retarded children through such programs as preschool, elementary, and secondary education projects which may include: curriculum enrichment, expansion, and improvement; summer school programs; preschool and school readiness programs; physical education and recreation; prevocational and vocational training; inservice training of teachers; and improved diagnostic services.

III. Division of Training

A. Purpose

The Division of Training Programs initiates, maintains, and improves programs for the preparation of professional leadership and teaching personnel to educate handicapped children. Divisional programs which are designed to implement this purpose are two-fold in their attack, in that they must provide: (1) classroom and administrative personnel for State and local special education programs; and (2) personnel for higher education institutions responsible for preparing administrative and classroom personnel. The Division of Training Programs in an effort to effectively implement training programs for the mentally retarded has organized a Mental Retardation Branch. This Branch, one of three in the Division, is responsible for the coordination and administration of all programs in the area of mental retardation.

B. Need

As more States legislate mandatory education for handicapped children the major problem faced in implementing such legislation is an acute shortage of qualified personnel. Current estimates indicate a need for approximately 300,000 teachers to meet the educational needs of all categories of handicapped children. However, only 70,000 teachers are now available, with the prospect of an additional 21,000 to be trained by 1969. Of the 70,000 teachers available now, approximately one-fourth are not fully qualified. If general turnover rates applicable to the profession are applied, approximately 10% of the special education teachers will leave the field each year. At current rates of preparing professional personnel, sixteen years would be needed to close the gap between supply and demand.

As a result of the teacher shortage, approximately two-thirds of the more than five million handicapped children of school age are not receiving special educational services they require. Many of the established programs are actually of minimal quality, because they have been started with less than fully qualified personnel. This current deficit, as in the past, not only retards the systematic growth of special education, but simultaneously requires the majority of our nation's handicapped children to accept an educational program inappropriate to their needs.

C. History

In 1958, Public Law 85-926 was passed by Congress authorizing an appropriation of $1 million per year for the preparation of professional personnel in the education of the mentally retarded. This initial piece of legislation was directed at preparing college and university personnel to staff the then existing programs, and much needed new programs for preparing personnel to work with the handicapped in State and local school systems. Between academic years 1959-60 and 1963-64, 692 graduate fellowships were granted to 484 individuals. The majority of these individuals became college and university professors while others became State and local special education leadership personnel. In fact, a recent survey made of the above fellowship recipients indicated that approximately 75% of all programs in mental retardation at colleges and universities are directed or coordinated by these individuals.

On October 31, 1963, P.L. 88-164 was signed into law. Section 301 of this act amended P.L. 85-926 to: (1) expand the program to include not just the area of mental retardation, but also the areas of the visually handicapped, deaf,

crippled and other health impaired, speech and hearing impaired, and the emotionally disturbed; (2) allow for the preparation of teachers and other specialists in addition to leadership personnel at the graduate level; (3) extension downward into the senior year undergraduate levels; and (4) increase the monies authorized for these purposes. Since P.L. 85-926 was passed in 1958, approximately 17,000 fellowships and traineeships have been awarded to individuals preparing to work with mentally handicapped children. This includes both short term and full academic year awards.

A study conducted in February of 1964, of 245 former P.L. 85-926 fellowship recipients revealed that over 90 percent of them were engaged in the field of special education, including the mentally retarded, and about 70 percent were engaged primarily in the field of mental retardation. Sixty-eight of the 245 former fellows indicated that they were currently employed by a college or university, 80 were employed in an administrative or supervisory capacity (19 of these were employed by State educational agencies), and 54 returned to the classroom as teachers of the mentally retarded.

Public Law 85-926 was further amended with the passage of Public Law 89-105 and 90-170. These amendments expanded and extended the program through fiscal year 1970, authorizing appropriations of $29.5 million for fiscal year 1967; $34 million for fiscal year 1968; $37.5 million for fiscal year 1969; and $55 million for fiscal year 1970. These funds have been, and will be, used as stipends for students as well as to support colleges, universities, and State education agencies with the cost of instruction.

Table I - Awards made in the area of mental retardation since the passage of P.L. 85-926 (Fiscal Years 1960 through 1967)

Fiscal Year	Number of Traineeships & Fellowships	Number of Higher Education Institutions Participating	Number of State Education Agencies Participating	Total Amount Obligated
1960	177	16	23	$ 985,222
1961	164	18	41	993,433
1962	160	20	46	997,000
1963	163	19	48	996,433
1964	2,357	108	50	6,419,332
1965	2,506	153	50	6,569,815
1966	3,110	162	52	7,658,002
1967	3,816	177	53	8,891,072
1968	4,521	177	53	8,493,668
1969**				

**Appropriations will be approximately equivalent to fiscal year 1968 (awards not available at time of this report)

The number of individuals being trained in mental retardation under this grant program is significant. The improvement and expansion of the many teacher-training programs in mental retardation throughout the Nation -- resulting directly and indirectly from the grant program -- will, in the long-run, be of even greater significance. Evidence suggests that the support grants which accompany traineeships and fellowships have enabled a great many of the currently participating colleges and universities to add staff, expand the course offerings,

and better supervise the observation and student teaching experiences of the students. The total number of students benefiting from these program improvements at the various colleges and universities will, in most instances, far exceed the number of students who are on a fellowship or traineeship.

It is readily apparent that the "old" P.L. 85-296 program, and its major amendment, P.L. 88-164, has enabled a great number of colleges and universities to develop and/or expand their teacher-training programs in mental retardation. A current analysis of the more than 220 institutions requesting funds in the area of mental retardation indicates that more than 150 of them have on their faculties former fellows who review training under Public Law 85-926.

It will be a number of years before there will be a great reduction in the gap between the number of trained teachers and "leadership personnel" in the area of mental retardation who are needed and the number who are available. However, Public Law 85-926 -- prior to and since the amendments by Section 301 of Public Law 88-164 -- has provided the necessary beginning in the effort to close this gap.

1. Program Development Conference

A two day conference was sponsored during the month of May by the Division of Training Programs for special educators from institutions of higher education which had been awarded new program development grants for fiscal year 1968 (academic year 1968-69). Five new institutions with programs in the area of mental retardation participated, in addition to seven institutions which had received program development grants in the area in fiscal year 1967. During the conference, directors of programs in higher education institutions which had already completed one year on a program development grant communicated their experiences to those just entering their first year. The sharing of ideas by "new" and "old" directors of program development grants was found to be most stimulating and beneficial to all in attendance.

A similar conference is planned for the spring of 1969, for recipients of program development grants for fiscal year 1969.

2. University Affiliated Facilities Conference

A two day conference was held in July to more clearly delineate the role of special education training components in university affiliated facilities for the mentally retarded. Participants included personnel from the Bureau of Education for the Handicapped; Social and Rehabilitation Service; the President's Committee on Mental Retardation; the Secretary's Committee on Mental Retardation; directors of university affiliated facilities; and, Office of Education consultants in the area of mental retardation.

The types of models for interdisciplinary training of personnel to be developed in university affiliated programs; criteria for evaluating such programs; and, projected patterns of funding were discussed. Future conferences of this nature were recommended and are being contemplated for the coming year.

D. Current Activities

The Division of Training Programs in an effort to utilize all resources in the provision of quality educational programs for all retarded children has entered into cooperative funding or working arrangements with other personnel training programs in the Office of Education and the Social and Rehabilitation Service. The following are three examples of the Division's cooperative efforts:

1. Teacher Corps

The Teacher Corps and the Division of Training Programs are jointly supporting a teacher corps program at the State College of Arkansas in Conway, Arkansas. Specifically, the Division provided funds for the support of one teacher corps team (six master's level teachers) who will be instructed in special education of the mentally retarded. Concurrent with their instruction, the teacher corps team members will be working in public school systems with rural disadvantaged children throughout the State of Arkansas.

2. University Affiliated Facility Program

The Division of Training Programs in cooperation with the Division of Mental Retardation within the Social and Rehabilitation Service provided monies to support special education components in six university affiliated facility programs for fiscal year 1968. The extent of the Division's support ranges from approximately $11,500 to $30,000 with a total expenditure of $150,000 for the six supported facilities.

The Division will support a special educator on the university affiliated facility core faculty. The special educator will be responsible for instructing medical students, psychologists, social workers, and other related medical personnel as well as students majoring in special education. He will serve to effectively integrate special education concepts into the over-all interdisciplinary training program of the university affiliated facility.

The six programs funded were: John Hopkins University, Baltimore; University of Georgia; University of Miami, Miami; University of California at Los Angeles; Georgetown University, Washington, D.C.; and the University of Alabama, Birmingham.

3. Education Professions Development Act - P.L. 90-35

The Bureau of Educational Personnel Development and the Bureau of Education for the Handicapped have agreed to cooperate in the funding or programs which provide special education training to regular educational personnel who are working with handicapped children. Approximately 15 percent of the funds available under Parts C and D of the above Act will be used in programs to train regular educational personnel such as counselors, educational technology specialists, teachers, and administrators who have an interest or need to become more knowledgeable regarding the problems of the handicapped.

This cooperative program is being coordinated through the Division of Training Programs. The Division director works very closely with personnel within the Bureau of Educational Personnel Development in arriving at funding decisions for projects that involve training in the area of the handicapped. All proposals for example, having a handicapped conponent or orientation are screened initially by the staff of the Division of Training Programs.

When one considers an earlier statement made in this publication to the effect that approximately two thirds of all handicapped children are not receiving specialized educational intervention, it becomes quite obvious that this cooperative agreement will have great impact on improving services for the handicapped. The program, when fully implemented will facilitate greater cooperative interactions between regular and special educators. This will ultimately lead the way to maximum educational programs for all handicapped children.

E. New Programs

1. Special Projects

Training programs to be truly effective must reflect the growth and evolution of special education programs brought about through expansion of research and service activities. As a result training programs must be flexible and enable a continual, but systematic modification of their approaches. Proven traditional approaches to training should be retained, but every opportunity to blend the old approaches with new directions as increased knowledge and experience becomes available, should be encouraged.

To provide means for developing new models in the closing months of fiscal year 1968, the Division of Training Programs implemented a new Special Projects Program Development Grant Award Program. The purpose of the program is to plan; to try new models of training; and to evaluate the effectiveness and efficiency of these new nodels in preparing personnel to work with handicapped children. These grants are designed to provide the wherewithal for the field of special education to develop, implement, and test new approaches for the preparation of personnel to meet current and projected needs in the education of handicapped children.

There are two types of grants within the special projects award program: planning and prototype (including evaluation). Planning grants will be utilized to provide funds for the support of personnel, travel, and other costs necessary for developing a detailed plan for implementation of a prototype.

Prototype grants will be utilized to implement and test new training approaches. Successfully implemented prototype grants which provide viable approaches to training will be placed into the regular award program for future funding to other training agencies in the United States.

Six planning grants were awarded for fiscal year 1968, in amounts ranging from $12,900 to $28,998. The universities receiving the initial awards were: American University; University of Minnesota; George Peabody College; Southern Connecticut State College; University of Illinois; and the University of Iowa.

2. Training of Physical Educators and Recreation Personnel

In addition to the amendments of 85-926 cited earlier, P.L. 90-170, Title V established a program entitled "Training of Physical Educators and Recreation Personnel for Mentally Retarded and Other Handicapped Children." Section 501 of this bill authorized appropriations of $1 million for fiscal year 1968, $2 million for fiscal year 1969 and $3 million for fiscal year 1970.

The Bureau of Education for the Handicapped through the Division of Training Programs will assist universities and colleges in providing advanced professional training to physical educators and recreation personnel working with handicapped children. It is anticipated that planning and program development grants will be awarded to approximately ten to fifteen schools of physical education or recreation to establish graduate level curriculum related to the preparation of college instructors, to some short term training courses designed to stimulate better programming for the handicapped child.

An appropriation of $300,000 was made for the implementation of this program in fiscal year 1969.

F. Future Goals

The goals of the Division of Training Services are to:

1. Develop "quality" personnel preparation programs at all levels -- undergraduate through graduate.

2. Provide greater opportunities for the interaction of Division staff with university personnel regarding issues in the training of professional personnel.

3. Establish a clear and well defined "State of the Art."

4. Continue cooperating with State departments of education to effect comprehensive planning for the training of personnel in special education.

5. Provide continued leadership to the developing university affiliated programs to insure the incorporation of strong special education components into each program.

6. Produce informative materials concerning the education of mentally retarded children and the training of professional personnel to work with them in educational and related placements.

7. Develop realistic new training programs for personnel at pre-school and work-study levels.

8. Effectuate qualitative evaluation of all current programs preparing personnel in mental retardation.

IV. Other Office of Education Programs for the Mentally Retarded

The Cooperative Research Act (P.L. 89-10, Title IV) is supporting several projects concerned with mental retardation. Some of the activities funded under this program touched upon the development of a project for educable mentally retarded children to receive vocational training in food service; the relationship between the training experience and certain personality characteristics of teachers and the progress their trainable mentally retarded students made; and a comparison of two learning and retention techniques with mentally retarded children.

The Vocational Education Amendments of 1968 provide that at least 10 percent of each State's allotment for basic grants must be used for programs for persons who are handicapped, including persons who are mentally retarded or seriously emotionally disturbed. This provision of the Act becomes effective in fiscal year 1970. It is anticipated that about 50,000 mentally retarded persons will be served with about $11,500,000.

SOCIAL AND REHABILITATION SERVICE

Introduction

The Social and Rehabilitation Service (SRS) was established August 15, 1967, by the Secretary of Health, Education, and Welfare to join under a single leadership the Department's income support programs for needy Americans and the social and rehabilitation programs that many families and individuals need.

The organization is designed to provide a stronger emphasis on rehabilitation in social and welfare programs.

Key features of the organization are:

--The uniting in a single agency of the various HEW services that deal with special groups -- the aged, the handicapped, and families, especially children.

--The separation of the administration of income-maintenance programs for needy persons from rehabilitation and social service programs.

--Decentralization of certain authority to the Department's nine Regional Offices and the appointment of a single Social and Rehabilitation Service Regional Commissioner in each region to make it easier for States and communities to do business with the Federal Government.

The five major components of the agency are: the Administration on Aging; Assistance Payments Administration; Children's Bureau; Medical Services Administration; and the Rehabilitation Services Administration.

All of these component agencies have major responsibilities in the area of mental retardation except for the Assistance Payments Administration. The reorganization has placed new responsibilities for the mentally retarded on the Administration on Aging, the Children's Bureau, and the Rehabilitation Services Administration, which are now concerned with the provision of social and rehabilitative services to various categories of public assistance recipients. The Rehabilitation Services Administration also includes the Division of Mental Retardation.

Also located in SRS is the Office of Research, Demonstrations and Training. This office administers a program of grants to States and to public and private, nonprofit agencies to pay part of the cost for research, demonstrations, and the establishment of special facilities and services contributing to the field of rehabilitation.

New legislation has reaffirmed and expanded the Nation's commitment to programs on behalf of the mentally retarded. This includes the Mental Retardation Amendments of 1967, the Vocational Rehabilitation Amendments of 1965, 1967 and 1968, and various aspects of the Social Security Amendments of 1967.

The responsibilities and activities of the component agencies of the Social and Rehabilitation Service and the provisions of the new legislation with respect to programs for the mentally retarded are described on pages 27 to 61.

Office of Research, Demonstration and Training

1. Rehabilitation Research Branch Program of the Research and Demonstration Grants Division

This Branch carries on a substantial program of research on problems of rehabilitation of retardates. Areas covered include evaluation of aptitudes and abilities, analysis of jobs which the retarded can perform, opening of new occupational areas for the retarded, improvement of counseling techniques, development of new methods of training and job adjustment and evaluation of facilities and programs to assist the transition of the retardate from the institution or other sheltered environment to community participation. The 1965 Amendments to the Vocational Rehabilitation Act recognized in particular the needs of retardates by providing up to eighteen months of services during which the individual is evaluated for employment potential. These amendments also recognized the need for continuing care and study in the form of provision for improved workshops for retardates and other handicapped persons.

The Amendments of 1968 have focused attention on the necessity for research on retardation as a function of cultural deprivation. Current programs of research and demonstration are, therefore, increasingly concerned with new approaches to retardation in ghetto areas, and especially model city neighborhoods. Rehabilitation techniques already developed through research are being extended to problems of the hard core welfare client.

Emphasis is placed on the coordination and focusing of all relevant community agencies on the problems of the retarded. Projects in five different cities have demonstrated ways of most fruitfully bringing together the services of agencies involved in programs for the retarded. An additional study evaluated the efforts of one of these coordinated services programs.

Culture-fair assessment of rehabilitation clients has become of increasing importance as selection for jobs has extended to cultural handicaps. A simple pictorial inventory which will assist in solving this problem for retardates is the recently completed Vocational Interest and Sophistication Assessment Test standardized on 3,000 retarded persons and predicting what job an individual will find most satisfying to him in terms of his interests.

A variety of community based projects demonstrating involvement of community resources for training of retarded and for their transition to the wider community are the results of recent research efforts. For example, the San Francisco Aid for Retarded Children, Inc., worked with several retarded adults who had little or no employment background. It was found that 50 percent of the experimental sample could be trained and placed in outside employment. Last year witnessed the completion of a substantial number of work study programs for retarded adolescents. These have been sponsored by State Divisions of Vocational Rehabilitation jointly with local school boards, parent organizations, private schools, and State departments of education. In these projects of even severely retarded adolescents, 40 percent have been placed in outside jobs. All projects were taken over by the community at completion.

The Bourbon County Schools work-study project, one of several in Appalachia, was established in Kentucky, a State with one of the highest dropout rates in the nation. The retarded subjects were children of impoverished parents; the majority were from homes of tenant or farm laborers with earnings well below poverty level. Despite the massive handicaps of cultural deprivation and mental retardation among the youngsters studied, this project, over its three-year term,

reported a dropout rate of only 5 percent. Moreover, 88 percent of the sample of youngsters served have been trained and placed in jobs thus contributing not only to their own independence, but also to the economic welfare of their parents and the community at large.

During the past two years the State Divisions of Vocational Rehabilitation have conducted energetic programs to place the retarded in a wide variety of civil service jobs. The District of Columbia, DVR and George Washington University are now engaged in a follow-up study of the first 2,000 mentally retarded workers placed with the Federal government throughout the country to determine how effective the program has been and how to improve and expand it to State governments as well.

In order to accelerate training and make it more widely available, the research program has supported a number of projects demonstrating automated teaching techniques for the retarded. One of these, a research demonstration completed last year by the Devereux Foundation, Devon, Pennsylvania, found that automated teaching methods combined with regular classroom work proved more effective than machine methods alone or classroom instruction alone in enabling retarded students to utilize learned material in a practical work situation. To increase manpower for assisting the retarded, the research program extended support to research demonstrating techniques for training volunteers to work with retardates. The MacDonald Training Center Foundation, Tampa, Florida, last year completed a project that developed effective methods of selecting, orienting, and training volunteers whose activities will supplement services of professionals to mentally retarded persons.

2. Rehabilitation Research and Training Centers Program

The Research and Training Centers Division of the Office of Research, Demonstrations, and Training has responsibility for administering three Rehabilitation Research and Training Centers in Mental Retardation. These centers are distinct organizational and physical entities providing a continuing framework for psychological, social, vocational and rehabilitation research and training, and at least on a demonstration basis, a comprehensive program of evaluation, training, counseling and placement of the mentally retarded individual. The three Mental Retardation Research and Training Centers currently sponsored by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare, are the University of Wisconsin, the University of Texas, and the University of Oregon.

The research conducted by these centers encompasses many aspects of the rehabilitation process, from onset to training and placement of the retarded individual. It is broadly directed to a wide range of psychosocial, vocational, or other fields of rehabilitation, and also to specific problems in the many aspects of rehabilitation of the retarded.

The training program of these centers provide training of all types, long-term as well as short-term, professional, technical, and for all categories of students, graduate or undergraduate, working in the medical, health-related or other professions engaged in rehabilitation. The program provides training in such areas as the principles of rehabilitation of the retarded and the special problems related to individual or groups of educational, psychosocial, vocational, and medical and other disciplines in the practice of rehabilitation. In all instances, training has been based upon a defined, organized program of instruction designed for undergraduate and graduate students, interns, and professional workers in the field of rehabilitation. Selected sub-professional workers have also been trained.

In 1968, the three Mental Retardation Centers conducted 51 research projects. Of this number, eighteen are continuing to seek out the cause of retardation, to assess the potential for education and rehabilitation, to develop training and remedial programs suited to the needs of the retarded, and to ascertain the actual learning and socialization difficulties encountered by the retarded. Also being emphasized is the development of adequate motivation for work in the retarded through family, school, and community resources.

The Mental Retardation Research and Training Centers have proposed more than thirty continuing projects directed to the analysis of behavior of the retarded in a variety of settings, the socialization processes, and the mechanisms of acquiring adaptive behavior. Such studies will enable new conceptualizations, not previously available, to be utilized in preparing the retarded for productive, independent living. This research knowledge will also be helpful in planning and developing remedial and rehabilitation programs for the disadvantaged and culturally deprived in becoming more self-sufficient.

As an example, a "high-risk" population laboratory has been established by the University of Wisconsin Research and Training Center in the Milwaukee innercity area of economic and cultural deprivation, which is characterized by an extremely high incidence of mental retardation. Studies revealed that although the area comprises only 2½ percent of the city's population, it yields 33-1/3 percent of the total number of children identified as educable mentally retarded. Also, 45.4 percent of the mothers who had IQ's below 80 accounted for 78.2 percent of the children with IQ's below 80. This laboratory survey is maintained on an ongoing basis, with the findings of individual studies of value to the retarded population, their families and public and private agencies serving the needs of this population.

In the area of training, 33 short-term courses attended by 2,332 trainees were sponsored by the three Mental Retardation Research and Training Centers. One center alone provided training for more than 600 rehabilitation counselors and special education personnel in specific rehabilitation techniques leading to employment of the retarded.

A continuing emphasis will be maintained by the three Mental Retardation Centers in 1970 on the departmental priorities of model cities, neighborhood service centers, motivating people to work, rural poverty, and other priority areas as they relate to mental retardation.

During the 1969 fiscal year, the Department of Health, Education, and Welfare appropriation to the three centers was $1,075,000.

3. Division of International Activities

The Division of International Activities is the focal point for the development of all SRS international activities. These include program operations in the fields of maternal and child health, services to crippled children, social welfare, and vocational rehabilitation of the physically handicapped and the mentally retarded. As part of a reorganization of August 1967, international staff of the Welfare Administration, Children's Bureau and the Vocational Rehabilitation Administration were brought together in one unit to administer programs designed to supplement and complement domestic programs and to strengthen relationships with other countries as well as to further U.S. foreign policy goals.

A major segment of the international program has been the development and support of cooperative research and demonstration projects in certain foreign countries.

This program, financed with U.S. owned foreign currencies derived from the sale of agricultural commodities, was initiated by the Vocational Rehabilitation Administration in 1961. A vital adjunct to these research activities is the interchange of experts program authorized under the International Health Research Act. As a result of this authority, the Social and Rehabilitation Service has arranged for the interchange of scientists and experts engaged in research between the U. S. and countries participating in this cooperative program.

Since the beginning of the research and demonstration program in 1961, 22 projects in various aspects of mental retardation have been approved by the Division of International Activities. The range of research interest is very broad encompassing both medical and non-medical projects as well as clients of all ages. Types of projects that are now in progress include: investigations concerning the incidence of phenylketonuria; experimentation with new techniques for training the mentally retarded; and investigations on the medical, psychological, social and cultural aspects of mental retardation. During the past year, projects dealing with mental retardation were approved in Celon, India, Israel, Poland and Tunisia.

The Administration on Aging

1. Older Americans Act - Title III Program

Title III of the Older Americans Act of 1965 provides for funds from the Administration on Aging to stimulate the establishment of a single agency in each State to be responsible for the coordination of all State activities and programs in aging. Once the governor has designated such an agency and the State plan has been approved, allotments are made to the State. The State, in turn, makes grants to public and nonprofit private agencies for (1) community planning and demonstration of programs in aging; (2) for demonstration of new programs or activities beneficial to older people; (3) training special personnel for such programs; and (4) establishment of new or expansion of existing programs, including senior centers.

Under a Title III grant, the Boulder River Junior Chamber of Commerce, in Boulder, Montana, is operating a project called "Senior Citizens Conducting Programs for the Mentally Retarded Aged." The program was initiated because existing services and programs at the Montana State Training School and Hospital were focused on younger residents and the older population was being neglected.

During the first year of the project six older people were trained to provide services to over 100 mentally retarded aged at the School. As a result 25 of these aged residents were placed in the community during the year, some in fulltime jobs and a few in nursing homes. During the second year, two additional older people were recruited and trained to work at the School and a part-time social worker was added to the project staff to help place and follow-up mentally retarded aged who return to their home communities. The project expects to return about 30 additional residents from the group to their communities by the end of the year.

2. Older Americans Act - Title IV Program

Title IV of the Older Americans Act authorizes the Administration on Aging to make direct grants or to contract for research and demonstration projects of national or regional interest and value. Under a Title IV grant to the Community Service Society of New York, a demonstration project is being conducted on

Staten Island in the recruitment, training, placement and retention of older people as volunteers in community service. Of the 256 volunteers, with an average age of almost 70, currently active in the program, 130 are serving at the Willowbrook State School, a 6,000-bed institution for the mentally retarded of all ages. Thirty-nine of the volunteers have been working at Willowbrook more than 2½ years.

Volunteers serve from 4 to 6 hours one or two days a week and perform such functions as feeding and playing with babies and young children, helping in the school rooms, and in the occupational therapy programs, sewing, stamping garments, and repairing toys and furniture in the shops. In addition, a group of women mend clothing for the School at the Stapleton Senior Center, and a folk dance group from another center visits the School once a week to teach dancing to teenage residents of a specially selected ward.

3. The Foster Grandparent Program

The Administration on Aging also administers the Foster Grandparent Program under contract with the Office of Economic Opportunity. The Foster Grandparent Program recruits and trains low-income men and women over 60 years of age to serve as foster grandparents to children in institutional and community settings. "Grandparents" provide two hours of individual attention to each of two children daily, and usually work five days a week.

In December 1968, there were 68 projects in 40 States and Puerto Rico. About 8,000 children--5,500 of whom are mentally retarded--in 203 institutional and community settings are served by 4,000 foster grandparents. Over 120 communities are affected by the program and many more have expressed interest in developing a project.

The work of the foster grandparents is entirely child-related, on a one-to-one basis, and aimed at providing personal attention to neglected and deprived children, not to relieve institution staff of routine care tasks. Administrative staff of institutions for the mentally retarded report that the children show improvement in self-care skills and motor skills and that, in addition, the positive results which the children show often serve to raise the morale of the institution staff.

There have been quite a few evaluations of individual Foster Grandparent projects within the past two years. All of them conclude that, based on the project studied, the program is a viable one which has great potential for further expansion and growth. The report of the findings of a two-year study of the program at the Denton State School, Denton, Texas, conducted by Dr. Hiram J. Friedsam and Mr. H.R. Dick, North Texas State University, concludes:

> "No matter how fleeting the contact or how limited the carryover, the program does enrich the lives of the children it touches, and anyone who is familiar with institutions for retarded children will not judge this to be a minor success."

In one project for retarded children, seven children achieved the level of functioning that enabled them to enter Head Start classes; four were admitted to special education classes; one boy thought to be retarded was enrolled in summer Head Start and then registered for a regular classroom program. In another project, "Grandparents" are working within a public school, enabling retarded children to attend regular classes.

Grandparents are forming a link between the community and the institutions, bringing the outside in to the children and bringing to the community a new attitude on the subject of mental retardation.

Further information may be obtained from the Commissioner, Administration on Aging, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D.C. 20201, or the Office of Older Persons Programs, Office of Economic Opportunity, Washington, D.C. 20506.

Children's Bureau

Introduction

The concern of the Children's Bureau for mentally retarded children and their families stems initially from its responsibility under the Basic Act of 1912 to "investigate and report on all matters pertaining to the welfare of children and child life." In the first 6 years of its existence, three of the major studies produced by the Bureau dealt with mental retardation.

The passage of the Social Security Act in 1935 and the assignment to the Bureau of the added responsibility of administering Federal grants for maternal and child health, crippled children, and child welfare services, emphasized the principle that all of the people, through the Federal government, share with the State and local governments responsibility for helping to provide community services that children need to have for a good start in life. The Social Security Act also afforded the Bureau an opportunity to help the States develop demonstrations and special programs in areas where there were gaps in services.

As recently as 1954, maternal and child health activities in the Children's Bureau on behalf of mentally retarded children and their families were extremely limited. Many local public health nurses were reporting suspected mentally retarded children in their caseloads, but for the most part, they had few or no resources for establishing a diagnosis. By age groups, the greatest gap in available services was in relation to infants and preschool children. It appeared that many of the services that were lacking could best be provided through program emphasis within the framework of the maternal and child health program. The basic interests of this program - that is, preventive health services, child health supervision, growth and development and the fostering of good parent-child relationships - are also the basic interests of a program for mentally retarded children.

It was on this basis and to achieve these goals that the Congress for fiscal year 1957, increased the Children's Bureau's annual maternal and child health appropriation and earmarked $1 million specifically for special projects serving this group of children. The Appropriations Committee also expressed the hope that an additional million dollars of the increase, which was to be distributed to the States on a regular formula basis, would be used to implement services for the mentally retarded. The enactment of P.L. 88-156 in 1963 increased the authorization and has resulted in increased appropriations both for special projects for mentally retarded children and in the amount of regular formula funds designated for this purpose. P.L. 89-97, "Social Security Amendments of 1965," made further improvements, including the provision of grants for the training of professional health personnel to work with crippled children, particularly the mentally retarded and those with multiple handicaps.

P.L. 89-97 also made available project grants to provide comprehensive health care and services for children and youth of preschool or school age, particularly in areas with concentration of low-income families. The appropriation for the fiscal year 1966 for this program was $15 million; for fiscal year 1967 $35 million; for fiscal year 1968 $37 million; and for fiscal year 1969 $39 million.

Mentally retarded children and their families are also aided by the Children's Bureau's program of child welfare services. The goal of this program is the provision of "public social services which supplement, or substitute for, parental care and supervision for the purpose of (1) preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation, or delinquency of children, (2) protecting and caring for homeless, dependent or neglected children, (3) protecting and promoting the welfare of children of working mothers, and (4) otherwise protecting and promoting the welfare of children, including the strengthening of their own homes where possible, or, where needed, the provision of adequate care of children away from their homes in foster family homes or day-care or other child-care facilities." The States used grant-in-aid funds for child welfare services, authorized by the Social Security Act, early in scattered instances to provide services in behalf of retarded children, including foster care, and for child welfare workers who gave some service to this special group of children. It was not until 1957, however, that special child welfare staff was provided by the Children's Bureau to assist the States in providing services to these children. The years since, as part of the Bureau's overall effort to reach out to special groups of children, have seen substantially increased child welfare services extended to the mentally retarded. Although programs for the mentally retarded have developed markedly, a considerable need for service to this group remains.

A further impetus to improving care of retarded children was provided by the Child Welfare Research and Demonstration Grants Program authorized by the Social Security Amendments of 1960 and by the Maternal and Child Health and Crippled Children's Services Research Projects authorized by the 1963 amendments. Some of the program research conducted under both of these programs pertains to mentally retarded children.

The Child Health Act of 1967, which is included in P.L. 90-248, the "Social Security Amendments of 1967," makes provision for the following: (1) increased authorizations for child health under Title V; (2) services for reducing infant mortality and otherwise promoting the health of mothers and children; (3) family planning services; (4) continuation of the programs of maternity and infant care project grants and of comprehensive grants for the health of preschool and school-age children; (5) new dental health service projects; (6) emphasis on early identification of health defects of children; and (7) broadening the scope of research and training authorizations. Reducing the incidence of mental retardation and improving care to mentally retarded children are among the objectives of these provisions.

The "Social Security Amendments of 1967" authorize grants to States for services to families and children receiving Aid to Families with Dependent Children (AFDC). Based on each such family's special circumstances and requirements, services are provided for assisting the family to obtain or retain capability for self-support and care, maintain and strengthen family life and foster child development. Handicapped children and their families receiving AFDC are included in this program.

I. Preventive Services

A. Maternity and Infant Care Projects

The report of the President's Panel on Mental Retardation emphasized the interrelationships of lack of prenatal care, prematurity, and mental retardation. A recent major emphasis in Children's Bureau programs has been the Maternity and Infant Care Projects, authorized by P.L. 88-156, "Maternal and Child Health and Mental Retardation Planning Amendments of 1963." This law provides for a new

authorization for project grants to meet up to 75 percent of the cost of projects for the provision of necessary health care to prospective mothers who have, or who are likely to have, conditions associated with childbearing which increase the hazards to the health of the mothers or their infants, and whom the State or local health department determines will not receive necessary health care because they are from low-income families or for other reasons beyond their control. In addition, the legislation provides for medical and hospital care for premature infants and other infants at risk. Late in fiscal year 1964, $5 million was appropriated for this program, and eight projects were approved. For fiscal year 1965, $15 million was appropriated; for fiscal year 1966, $30 million, for fiscal year 1967, $30 million; for fiscal year 1968, $30 million, and for fiscal year 1969, $36 million. By the end of December 1968, 53 projects were in operation.

P.L. 90-248 extends the program of maternity and infant care projects until June 30, 1972, after which they become a special part of each State health services plan. The new legislation continues the intent to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing, and in addition calls for services for helping to reduce infant and maternal mortality. It also adds authority for projects for intensive care of infants and for family planning services.

B. Phenylketonuria and Other Metabolic Diseases

A second major emphasis in prevention within the past few years has been in relation to phenylketonuria (PKU). This inborn error of metabolism has in the past been responsible for one percent of the population in our State institutions for the mentally retarded. By detecting families with the condition and by placing young infants with the condition on a special diet, mental retardation can usually be prevented. The Children's Bureau had been working with State health departments in developing and trying out various screening and detection programs, developing the necessary laboratory facilities, and assisting States in providing the special diet and follow-up programs for these families. When the Guthrie inhibition assay method for screening newborn babies was developed, the Children's Bureau supported field trials of this test. More than 400,000 newborn babies in 29 States were screened, and 39 cases of PKU were found, an incidence of almost one in 10,000.

The Children's Bureau is now urging that all States have a program for screening infants for PKU. Although such a program may be initiated without a legislative requirement, in many States laws have been enacted on this subject. As of the end of December 1968, 43 States had such laws, most of them making screening for PKU mandatory. The 43 States are:

Alabama	Illinois	Missouri	Oregon
Alaska	Indiana	Montana	Pennsylvania
Arkansas	Iowa	Nebraska	Rhode Island
California	Kansas	Nevada	South Carolina
Colorado	Kentucky	New Hampshire	Tennessee
Connecticut	Louisiana	New Jersey	Texas
Florida	Maine	New Mexico	Utah
Georgia	Maryland	New York	Virginia
Hawaii	Massachusetts	North Dakota	Washington
Idaho	Michigan	Ohio	West Virginia
	Minnesota	Oklahoma	Wisconsin

As more children with PKU are found, the problems relating to treatment services are receiving increased attention. Funds were granted for planning a 5-year collaborative study of treated phenylketonuric children, for purposes of

increasing knowledge of methods of treatment of children with this disease; this study is now under way, with a number of clinics participating. A grant has also been made to develop a reference and standard service for phenylalanine determinations needed in screening and treatment. In April 1966, an important meeting was financed by the Children's Bureau to discuss PKU screening and treatment problems, pathogenesis of the disease, and other relevant topics. The proceedings of this Conference have been published under the title, "Phenylketonuria and Allied Metabolic Diseases." "Recommended Guidelines for PKU Programs" have also been prepared to make known the Children's Bureau recommendations for a comprehensive PKU program.

Interest is also increasing in metabolic diseases other than PKU that lead to mental retardation. The Children's Bureau is continuing to support a study of the clinical application of screening tests to detect galactosemia, maple syrup urine disease, and histidinemia. Also, support is being given to studies of new approaches to broader screening methods; for example, support is being given to a study which would make available a battery of automated tests for screening metabolic diseases. In addition, field trials are being conducted of a simple method to determine elevations of 10 different amino acids, for detection of metabolic disorders.

C. Lead Poisoning

In the area of prevention, increasing attention is being paid to lead poisoning. Despite present-day manufacture and use of lead-free paint, many children become mentally retarded or suffer other damage from ingestion of chips of lead-containing paint from walls and woodwork in old, dilapidated housing. A publication, "Lead Poisoning in Children," addressed to public health workers, has been prepared, suggesting a program of prevention, casefinding, follow-up of cases, and other measures to cope with this problem. Some of the Children and Youth projects have had a special interest in finding and treating children with lead poisoning.

D. Immunizations

From experience with immunization of children against diphtheria, tetanus, and pertussis, and against measles, it has been learned that special efforts need to be made to reach children in the low-income neighborhoods of many cities. To achieve the maximum effect when the rubella vaccine is licensed, therefore, a major public health program will have to be launched. As a first step in this direction, the Children's Bureau prepared and distributed a brochure on the subject of Rubella.

E. Familial Mental Retardation

Interest is increasing in mental retardation associated with poverty. The Children's Bureau has published "Children of Deprivation," a report of a project at the University of Iowa dealing with this problem, and some of the Children's Bureau-supported mental retardation clinics are now showing more active concern with this cause of mental retardation.

II. Basic and Supportive Services

A. Casefinding and Screening

The Children's Bureau has, from the beginning of its work in financing programs for retarded children, emphasized the importance of early detection and casefinding. Preference to young children as new cases has been encouraged in

the clinics supported by Children's Bureau funds. In recent years training, particularly for nurses, has emphasized the skills necessary for early detection. "A Developmental Approach to Casefinding with Special Reference to Cerebral Palsy, Mental Retardation, and Related Disorders," written by a nurse, was published in 1967 to provide a tool for developing such competency.

B. Clinical Services

Support of clinical services for mentally retarded children is one of the most important uses for Children's Bureau mental retardation funds. The services provided include diagnosis, evaluation of a child's capacity for growth, the development of a treatment and management plan, interpretation of findings to parents and follow-up care and supervision. As of the end of November 1966, of the almost 200 mental retardation clinics in the country, the staff and services of 135 were supported in whole or in part by Children's Bureau funds. The Children's Bureau-supported clinics served approximately 40,000 children in fiscal year 1966. Somewhat over one-third of the children new to the program were under 5 years of age. During fiscal year 1967 and 1968, the number of Children's Bureau-supported clinics increased; by the end of fiscal year 1968 there were 150 such clinics serving approximately 43,000 children. The total number of mental retardation clinics in the United States is now 235.

The Children and Youth projects authorized by P.L. 89-97 offer an opportunity for providing increased services to mentally retarded children in the areas served by the projects. As of the end of December 1968, 58 Children and Youth projects were in operation. These projects provide comprehensive health services for children especially those living in areas with concentrations of low-income families.

C. Crippled Children's Services

Since enactment of the Social Security Act in 1935, the Federal government, through the Children's Bureau, has assisted the States in providing services to crippled children. Although exact data are not available, it is known that relatively few mentally retarded children were cared for in these programs prior to 1963. The enactment of P.L. 88-156, providing for increased funds for the crippled children's program and for the earmarking of some of the funds specifically for mentally retarded children, has resulted in more attention being paid to physically handicapped retarded children. In some States, the definition of crippling conditions is being broadened to include conditions for which services had not hitherto been given. Some children who would formerly have been turned away are now being given services.

An important use of the expanded funds available for mentally retarded crippled children is in providing services for institutionalized children; for example, orthopedic services not hitherto available to these children. In addition, the Children's Bureau staff itself has provided some consultation to the institutions, particularly in the fields of nutrition and physical therapy and to some extent in nursing.

A recent development has been a broadening of the scope of services to give more attention to children who are both physically handicapped and mentally retarded, children who have several physical handicaps, and children with serious learning disorders. Some mental retardation clinics are showing increased interest in serving these children and a number of special clinics, financed by Children's Bureau funds, have been set up.

Another use of Crippled Children's funds in the mental retardation field is a study and demonstration project now under way concerning the speech and language

skills of mentally retarded children.

In 1966, over 20,000 children with diagnoses of various forms of mental retardation received medical services in the Crippled Children's program. The 1967 amendments to the Social Security Act require that State plans for Crippled Children's services provide for more vigorous efforts to screen and treat children with disabling conditions. This provision should result in an increase in the number of mentally retarded children identified and treated.

D. Cytogenetic and Biochemical Laboratory Programs

A new use to which some of the Children's Bureau funds earmarked for mental retardation are being put is in the area of cytogenetic and biochemical laboratory services. Project grants have been approved which establish such programs as extensions of clinical services at hospitals or medical schools. Projects include chromosome analysis and diagnosis of various medical conditions which may be genetic and result in mental retardation. On the basis of these analyses, counseling may also be given to parents seeking advice on genetic questions. The biochemical laboratories may also do continuing monitoring of patients with metabolic diseases. Training in medical genetics is also an important aspect of many of these projects. By the end of December 1968, 20 such projects had been approved. In March 1966 a group of experts in this field was called in to discuss and make recommendations on present and future Bureau programs in this area.

E. Dental Programs

Programs for the dental care of handicapped children, including the mentally retarded, have been encouraged in the past; but dental care will be given new support as a result of the 1967 Social Security Amendments. These amendments authorize support of up to 75 percent of the cost of projects to provide comprehensive dental health services for children from low-income families. No appropriation for this program was made for fiscal year 1969.

F. Family and Child Welfare Services

The Children's Bureau administers child welfare services funds authorized by the Social Security Act, as amended, for the purpose of cooperating with State public welfare agencies in establishing, extending and strengthening child welfare services. These funds are allocated to States on a formula basis. The appropriation for fiscal year 1969 was $46 million. Although none of these funds are earmarked especially for serving the retarded, mentally retarded children are provided these services. Child welfare services, which can benefit the mentally retarded and their families, include parent counseling, homemaker services, day care services, foster family care, care in group homes, adoption services, services to unmarried mothers, and certain institutional pre-admission and aftercare services.

At the present time, all State public welfare programs provide some child welfare services for mentally retarded children. By conservative estimates of the Children's Bureau, 45,000 mentally retarded children receive child welfare services from public welfare agencies.

The "Social Security Amendments of 1967" authorize grants to State public welfare agencies for providing services to families and children receiving Aid to Families with Dependent Children. Federal funds are authorized to pay 85 percent of State costs for these services through fiscal year 1969. After July 1, 1969, Federal funds are authorized to pay for 75 percent of State costs. This program, also administered by the Children's Bureau, will bring increased attention to the

the special needs of the estimated 131,000 AFDC children who are mentally retarded and to the family conditions in which mental retardation is often rooted.

Following are examples of developments related to the extension and improvement of family and child welfare services to mentally retarded children and their families:

A mental retardation specialist, during the two years since he was first employed by a State public welfare agency, has contributed substantially to the development of services and facilities, including specialized foster family care, from which retarded children and their families benefit. In addition, he has been instrumental in improving coordination among the State's programs for the retarded.

A State on the basis of its experience in providing the range of child welfare services through a special unit for the retarded in one locality, is now extending increased child welfare services to retarded children and their families in other areas of the State. In another State, the school of social work has a mental retardation field instruction unit located in a county public welfare department. According to the director of the county agency, this unit, which receives Children's Bureau support, benefits the county in addition to providing a learning experience to the students. Increased services rendered by the students to the county's mentally retarded and their families is one benefit. The director also points out that the unit's emphasis on problems connected with mental retardation has served to "sharpen up all the (agency's) workers to give this particular problem more attention."

Several States report that with the support of a child welfare worker and assistance provided through this service in utilizing other community resources, parents often are able to keep their retarded children at home and keep their families intact. One agency through group counseling has assisted parents not only to meet the needs of their retarded children better but also to take action aimed at development of additional community programs for the retarded.

Another State public welfare agency describes its new homemaker service project as a "real success." This project provides 32 itinerant homemakers who specialize in serving families of retarded children. Through homemaker services, an overburdened mother can be relieved of the constant and full responsibility for the day-to-day care of her retarded child. Frequently, she acquires new skills which help her in better home management and in her special problems with child care.

Another important service provided by several State public welfare agencies to assist mentally retarded children and their families is day care service. Day care services offer both constructive experiences for some retarded children and necessary help and relief for their parents. This service often may be the key factor in determining whether a child can remain with his family. In one State, the number of licensed daytime activity centers for the retarded has quadrupled, from 21 to more than 80, in about a four-year period. The State child welfare agency licenses these centers. With concern for quality in their day care programs for the retarded, some States have given special attention to the development of standards and to training of day care personnel. The value of stronger linkage between the day care center and the family is also receiving increased attention in many of these programs. During the past year, Children's Bureau has cooperated with the National Association for Retarded Children (NARC) in planning and conducting a workshop on day care services, held in advance of the NARC Annual Convention. The general purpose of the workshop was to assist in the development and improvement of day care services for the retarded.

Most States provide some foster family care for retarded children. In all, it is estimated that 14,000 of the retarded children receiving public child welfare services are in foster family care.

Some children, who must be cared for outside their own homes, can profit from close interpersonal relationships and respond to the stimulation of foster family life. Short-term foster care at intervals or during period of crisis may enable a retarded child's family to provide adequately for him at home for the most part. For other retarded children, foster family care permits long-term benefits of family life and community living. Foster family care would be the plan of choice for many children who have been placed inappropriately in large residential facilities. In fact, some States are giving attention to the "exchange" of children between institutional and child welfare services programs to assure more appropriate services for particular children.

The experience of several States illustrates that retarded children can profit from adoption and that adoptive placement is feasible for many of these children. An article by the Children's Bureau specialist on adoptions and services to unmarried mothers, "The Adoption of Mentally Retarded Children," was published in the January-February 1968, issue of CHILDREN. As some evidence of the interest in adoption of the retarded, over 8,000 reprints of this article have been disseminated, a large portion of this number upon request.

Family and child welfare services also may have preventive aspects in relation to mental retardation. For example, day care or foster care for children from certain deprived homes may be preventive services.

Homemaker service may be preventive in nature when brought into play with some expectant mothers who need relief from the physical demands of caring for other children. Protective services can reduce child abuse as a cause of mental retardation. Services to unmarried expectant mothers can assure utilization of proper prenatal services.

Family and child welfare workers also are in a key position with regard to early casefinding, assistance with obtaining proper diagnosis and providing continuity of planning and services consistent with the needs of the individual retarded child and his family.

In spite of the efforts and potential of family and child welfare services, which have been cited, numbers of retarded children and their families need and could profit from such services not now available. Professionally skilled staff, new programs, and extension of those in existence are needed. The continuing emphasis on community services as a means of combating mental retardation will place increasing demands on family and child welfare agencies. The need for increasing these services of the public welfare agencies is expressly emphasized by the report of the President's Committee on Mental Retardation, MR 68, The Edge of Change.

G. Program Aids

The Children's Bureau has assisted in the production and circulation of films on mental retardation and has also operated an exchange of educational materials as a service to the mental retardation clinics. Since November of 1961, through this exchange, well over 400 items have been distributed to each of the mental retardation clinics in the country. Special publications have been developed which have been in great demand. In addition, pertinent articles appearing in various professional journals have been reprinted and distributed. During the calendar year 1968, more than 29,000 individual copies of publications were distributed in response to requests. A recent publication, "Selected Reading Suggestions for Parents of Mentally Retarded Children" has been very much in demand. Another new publication, "Feeding the Child with a Handicap" has also been popular.

III. Training of Personnel

A. Training for Health Services

Training activities for health services in the field of mental retardation, assisted by Children's Bureau funds, have encompassed many approaches: Grants for fellowships; support of and participation in institutes, conferences, and other short-term training sessions; consultation on course curricula; arrangements for clinical experience in mental retardation clinics; distribution of informational materials to professional workers; and recently support of the university-affiliated centers being constructed under authority of P.L. 88-164, Title I, Part B.

The following points up the wide range of disciplines involved in training activities and illustrates the variety of training approaches.

During fiscal year 1965, the Children's Bureau funded 27 pediatric fellowships in mental retardation; in fiscal year 1966, 39; and in fiscal year 1967, 26 such fellowships were funded. In nursing, assistance was given in fiscal year 1967 and continued in 1968 to 10 university schools of nursing for their graduate programs in maternal and child nursing, including mental retardation; in these programs special attention is given to the nursing role in casefinding, prevention and intervention. In addition, in both years four of these university schools of nursing were given grants for continuing education courses for nurses in mental retardation. State agencies also sponsored short-term, intensive educational programs in mental retardation for staff nurses. The Fourth National Workshop for Nurses in Mental Retardation sponsored by the Children's Bureau, held in Miami in 1967, was attended by 60 nurses.

At the University of Washington in Seattle, and at the University of Tennessee in Memphis, the Children's Bureau is supporting training programs for nutritionists in mental retardation and handicapping conditions. In the 1967-1968 academic year, eight nutritionists were enrolled for the three-month fellowship at the University of Washington, and one for the 18 months' program leading to a Master's degree. In 1968 staff discussed training programs in mental retardation at a Symposium for Research and Therapeutic Dietitians sponsored by Walter Reed Hospital, Washington, D.C., and at a major session of the Annual Meeting of the American Dietetic Association in San Francisco. About 450 dietitians were reached through these two meetings.

In the 1966-67 academic year, 45 pre-masters social work students received their training in 19 Children's Bureau-supported mental retardation clinics from 20 graduate schools of social work; some of these students received stipends through training projects supported by the Children's Bureau. During 1967-68, 59 students from 19 schools of social work, received their training in 22 such clinics. Additional students were placed in Children's Bureau-supported programs where they could have experience with mental retardation cases; there were 90 students from 18 schools of social work in improving Maternal and Child Health and Crippled Children's Services, with additional students placed in other Children's Bureau-supported projects. A small number of post-masters social work students, who are receiving stipends through Children's Bureau projects, received exposure to mental retardation in their field placements.

Training of dentists to work with mentally retarded children was stimulated, as was the training of psychologists, occupational therapists and physical therapists. In the latter two fields, special project grants to the University of Florida for occupational therapy and the University of North Carolina for physical therapy, to enhance the preparation of therapists for service to multi-handicapped children, are in their third year of development. In occupational

therapy, grants to Boston University and the University of Southern California are facilitating the development of graduate programs with emphasis on evaluation of and programming for handicapped children including the mentally retarded. During 1968, the proceedings of two seminars for occupational therapists on perceptual-motor dysfunction were reprinted and widely distributed. Staff members in both disciplines are being added to increasing numbers of university-affiliated facilities to expand the training of future therapists, in an interdisciplinary setting, for service to mentally retarded children and their families.

Children's Bureau special project funds support academic training in speech pathology and audiology in 5 universities, both for faculty and for stipends to 31 students seeking an M.A. or Ph.D. degree. Another university training program in communicative disorders supports faculty in pediatrics and otolaryngology as well as in audiology and speech pathology. A clinical fellowship program in pediatric-audiology has been expanded from 1 to 3 universities. All these training programs include a mental retardation component.

Medical genetics represents a new field of training which was begun in fiscal year 1965 and extended in subsequent fiscal years. Training programs, as part of the cytogenetic and biochemical laboratories, were set up for physicians and biochemists to specialize in aspects of medical genetics, particularly in cytogenetics, metabolic disease, and endocrinology.

The 1965 amendments to the Social Security Act made additional provision for grants for training purposes to be administered by the Children's Bureau. The amendments authorized appropriations for grants to be made to public or other nonprofit institutions of higher learning "for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps." The amounts appropriated for this program, $4 million in fiscal year 1967 and $7 million in fiscal year 1968, were used primarily to support training in the university-affiliated centers for diagnosis and treatment of the mentally retarded. For the fiscal year 1969, $9 million was appropriated for this program.

The new Section 511 of the Social Security Act as amended in 1967 replaces and expands the training authority to include all personnel involved in providing health care and related services to mothers and children, with special attention to undergraduate training. This amount, supplemented by special project funds from the MCH and CC programs, was used primarily to develop and support programs of interdisciplinary training in 22 universities. These university-affiliated programs are developing a variety of training approaches for the many disciplines involved in caring for the retarded child.

B. Training for Child Welfare Services

States are urged to provide educational leave for the training of child welfare staff. Grant-in-aid funds may be used for this purpose. All States have structures for a staff development program, including orientation, inservice training, and educational leave. These programs contribute to the overall increase of child welfare staff which is better able to serve the mentally retarded.

The 1962 Amendments of the Social Security Act provided a new avenue for augmenting the supply of trained child welfare workers by establishing grants for child welfare training projects. This program provides grants to public and other nonprofit institutions of higher learning for special projects for training personnel in the field of child welfare, including traineeships to students. Training for child welfare services to the mentally retarded and their families is included in this program.

While facts on this program are not available for the current academic year, during the 1967-68 school year five projects were funded to provide social work field instruction units in mental retardation settings. Thirty students were trained in the five units. Twenty-nine students receiving child welfare traineeships through this program were also placed in mental retardation settings by 19 schools of social work. For that academic year, also, information from schools of social work indicates that more than 75 child welfare-related mental retardation agencies were providing field instruction experience for over 200 students.

One State in cooperation with a school of social work completed a project for the training of foster parents of the mentally retarded during 1968. A total of 71 foster parents registered for this training project which was supported by a child welfare training grant from the Children's Bureau. Over 400 copies of the final report of the project were disseminated to schools of social work, State departments of public welfare, and other interested individuals.

IV. Research

The Children's Bureau Clearinghouse, which maintains an inventory of current research relating to children, recently revised its publication, "Research Relating to Mentally Retarded Children"; this is a listing of the mental retardation studies reported to the Clearinghouse during the period 1949-1965, including references to published reports.

Two research grant programs administered by the Children's Bureau can be used for program research assisting mentally retarded children:

A. Child Welfare Research and Demonstration Grants Program

The Child Welfare Research and Demonstration Grants Program, authorized by the Social Security Amendments of 1960, provides financial support for special research or demonstration projects in child welfare which are of regional or national significance, and for special demonstrations of new methods or facilities which show promise of substantial contribution to the advancement of child welfare.

Since community support is vital to improvement of child welfare services, an important function of several projects is to develop support through interpretation and communication of the problems that many children face, ranging from shattered families to mental retardation.

Projects relating to mental retardation which have been completed include: (1) a demonstration to test the feasibility and value of foster home care for deprived mentally retarded children; (2) a demonstration, training, and service project designed to test the feasibility of training and using unskilled personnel as aides to professional personnel in caring for retarded children in the areas of homemaking and child care, physical medicine and nursing care, speech therapy, play activity, and auxiliary maternal care; (3) a study of specialized foster home care for deprived mentally retarded children; and (4) a study of existing laws and their administration applicable to children suffering from mental disorders, including their commitment, care, and guardianship.

A grant was made to Howard University for a project to determine how much a day-care program, plus parent education activities, can accomplish to offset intellectual and social disadvantages encountered by environmentally deprived children on entering public school. The research component of the project was carried out by the Children's Bureau. Recently, the entire project was transferred

to George Washington University.

During fiscal year 1969, the Child Welfare Research and Demonstration Grants Program will be supporting 8 other projects with mental retardation elements. Three are day-care centers which attempt to develop techniques for supplementing the early experience of underprivileged children. These centers are located at Syracuse University, University of North Carolina, and at Cambridge, Massachusetts. The latter is sponsored by the KLH Corporation, and is an attempt to evaluate the feasibility of combining Federal and industrial funds in such a venture. Another grant is to the School of Applied Social Sciences at Case Western Reserve University to run a neighborhood multi-service center. One project deals with abused and neglected children, another with law, mental disorders and juvenile processes. The last two studies relate to work with infants and preschoolers who are prone to become mentally retarded with reasons other than genetic or congenital factors. As the vast majority of mentally retarded children appear to have functional retardation an increased effort has been launched to develop feasible programs of prevention. A study with the Family Service Association of Nassau County is aiding the cognitive growth and development of preschool children using a special day-care program combined with work with parents. At the University of Florida a special study is focusing on using child development aides who teach mothers how to stimulate and motivate their infants and toddlers without the necessity of placing them in a day-care group program.

B. Maternal and Child Health and Crippled Children's Services

The purpose of this research grant program, authorized by the Maternal and Child Health and Mental Retardation Planning Amendments of 1963, is to support studies that show promise of making a substantial contribution to the advancement of health programs for mothers and children. Programs for mentally retarded children may be included in these studies.

In the area of mental retardation, projects have been funded which will study ways to improve amounts and quality of prenatal care. These are an effort to reduce the occurrence of prematurity and as a means of preventing mental retardation due to these causes. Several projects supported in various schools of medicine have as their objective an evaluation of methods for screening children for metabolic and other inherited diseases which can lead to mental retardation. They also seek to develop procedures for screening preschool children for neurological damage and psychological deviancy.

In one project, a major step may be achieved in alleviating the critical shortage of trained professional psychologists. This project will test, in selected mental retardation clinics throughout the country, a plan for utilizing nonprofessional personnel. Another major study that has been funded proposes to uncover every case of mental retardation in a well-defined population. The prevalence of mental retardation and its relation to social, economic, and demographic characteristics of the individual and his household will be investigated in the hope of uncovering etiological relationships.

The final report of a study entitled "Medical Needs of Children in Institutions for the Mentally Retarded" makes clear that some State institutions are failing to provide the necessary services to meet the health and medical needs of the mentally retarded child. Suggestions are made to correct this long-standing problem using the financial resources of the State and the medical personnel in the local community.

The Retarded Infants Service of New York has completed its report entitled "Feasibility of Training and Using Unskilled Personnel as Aides to Professional

Personnel in Caring for Retarded Children." This study is a pioneering effort in using aides in a variety of service programs concerned with mentally retarded children and has wide applicability. Still another study examines intensively the sequelae of infants and toddlers with congenital rubella and another study will follow up low birth-weight infants.

During fiscal year 1969, the Maternal and Child Health and Crippled Children's Services Research Grants Program will be supporting 10 projects with mental retardation elements or components. One new study will undertake the treatment of serotonin deficiency in children with Down's Syndrome.

The "Social Security Amendments of 1967" provide that after June 30, 1968, special emphasis shall be given to research projects which will study need for, feasibility, costs and effectiveness of use of health personnel with varying levels of training.

Medical Services Administration

The Medical Services Administration (MSA) is the agency responsible for the administration of Title XIX of the Social Security Act.

The Mental Health Branch, Health Services Division, MSA, has the responsibility for the mental retardation activities in conjunction with the medical assistance program.

The mentally retarded who meet a State's eligibility requirements for the medical assistance program may receive the same benefits in terms of medical care, as any other recipient. The amount and scope of medical services depend on the individual State plan.

The mentally retarded who are determined eligible may also benefit from the Social Security Amendment of 1967, under assistance in the form of institutional services in Intermediate Care Facilities.

During the fiscal year July 1, 1967, to June 30, 1968, approximately $30,000,000 in Federal funds was awarded to 5 States through Title XIX for payment of medical services and skilled nursing services provided to the mentally retarded. Those States receiving assistance were: Pennsylvania, Wisconsin, Texas, Kansas and Oklahoma.

Rehabilitation Services Administration

Introduction

The Rehabilitation Services Administration is responsible for a broad range of programs designed both for the provision of diagnostic, treatment, and rehabilitation services for the mentally retarded, and for the support of special facilities and activities to expand and improve national resources for serving the mentally retarded. These programs include the State-Federal vocational rehabilitation program, as well as special project grants for the expansion and innovation of vocational rehabilitation services; the improvement of State residential institutions and sheltered workshops for the mentally retarded; the planning and construction of rehabilitation facilities and sheltered workshops, the construction and staffing of specialized community facilities, and the construction of university affiliated facilities for the mentally retarded; and training for professional, supportive and technical personnel already engaged or preparing to engage in occupations in the care and rehabilitation of the mentally retarded.

These diverse activities are unified by the common goal and objective of assisting mentally retarded individuals to achieve and maintain the maximum personal, social, and economic competence of which they are capable. Underlying these activities is the continuing concern for expanding the opportunities and resources available to the more severely mentally retarded.

I. Basic and Supportive Services

A. Vocational Rehabilitation Services

Under the public rehabilitation program, grants are made to State vocational rehabilitation agencies to assist them in providing rehabilitation services to mentally and physically disabled individuals who have substantial employment handicaps and who can reasonably be expected to be rehabilitated into gainful employment. Among the services provided by State vocational rehabilitation agencies are comprehensive medical, psychosocial and vocational evaluation; physical restoration; counseling; adjustment, pre-vocational and vocational training; maintenance and transportation during the rehabilitation process; placement in suitable employment; services to families of handicapped people when such services contribute substantially to the rehabilitation of the handicapped client; recruitment and training services to provide new careers for handicapped people in the field of rehabilitation and other public service areas; and follow-up services to assist handicapped individuals to maintain their employment.

Of the 207,918 disabled people rehabilitated through the State-Federal program in fiscal year 1968, approximately 19,100 were characterized by the primary disability of mental retardation. Looking ahead, it is projected that about 26,000 retardates will be rehabilitated through the public program in fiscal year 1969.

There are many ways in which State vocational rehabilitation agencies have been organizing and developing their services for the mentally retarded. Basic to the vocational rehabilitation effort has been the growing reliance on counselors and other vocational rehabilitation staff who work only with retarded clients. This specialized staff may be assigned to local vocational rehabilitation offices, schools, institutions, sheltered workshops, or other facilities serving the mentally retarded. By concentrating their attention on the mentally retarded clients, these counselors are successfully developing rehabilitation plans based on the special problems of the retarded and are able to be broadly responsive to the needs of both the client and his family. As special vocational rehabilitation programs and facilities for the retarded continue to be developed and expanded, the number of specialized counselors within State vocational rehabilitation agencies continue to increase.

The specialized vocational rehabilitation staff working with the mentally retarded has been particularly effective in the development of cooperative vocational rehabilitation-school programs designed to assist the retarded young person to make a satisfying transition from school to work. These cooperative school programs are found in many communities throughout the country and have greatly strengthened both special education and vocational rehabilitation efforts with the mentally retarded. The cooperative program structure varies from State to State, and the variety of approaches is extraordinary. In some States, program administration is Statewide and in others there are individual agreements with individual school districts. Some programs function only to serve the mentally retarded and others include youth with all kinds of disabilities. In some States, only vocational rehabilitation and special education are administratively involved, while in others representation includes vocational education.

Most cooperative arrangements have brought about the development of vocationally oriented curricula within the schools. All of them, however, provide for a comprehensive evaluation of the retarded young person's vocational rehabilitation potential; the provision of personal adjustment and pre-vocational training; counseling; on-the-job training and work experience; job placement, follow-up and related vocational rehabilitation case services.

The number of retarded young people enrolled in cooperative vocational rehabilitation work-study programs is increasing steadily as new programs are developed. An estimated 6,600 are enrolled in Florida; 4,180 in Texas; 3,960 in Georgia; and 3,300 in California. These cooperative programs have proven themselves effective in reducing the school dropout rate of retarded youngsters and have provided a technique for continuous service to youngsters during the school years when they are best able to benefit from them.

Another emphasis of State vocational rehabilitation agencies has been the establishment of rehabilitation facilities, such as comprehensive rehabilitation centers, evaluation centers, occupational training centers, workshops, half-way houses, and other specialized facilities serving the mentally retarded. Such rehabilitation facilities may be established by State rehabilitation agencies, by the State agency in cooperation with other public agencies, or by other public or private agencies.

State vocational rehabilitation agencies may assist in the construction of rehabilitation facilities in a variety of ways. They may construct new buildings; alter, expand or renovate existing buildings; purchase necessary equipment; and provide initial staffing support for a period of 4 years and 3 months. In some cases, State agencies provide direct grants to the facilities from State appropriated funds. In other cases, local facilities and workshops are supported by means of private contributions which may be used for Federal matching.

The rehabilitation of the mentally retarded is a major concern of the State agencies and this concern is evidenced both in programs directed specifically at serving the retarded and in programs in which the retarded are served in addition to other special groups of individuals. Projects for groups, such as Selective Service rejectees, welfare clients, public offenders and the economically disadvantaged have demonstrated a high incidence of mental retardation and have resulted in considerable service to the mentally retarded. By participating in multi-service centers, concerted services projects, pilot neighborhood activities and similar efforts, State rehabilitation agencies are extending their services in order to reach and rehabilitate greater numbers of retarded persons living in both rural and urban poverty.

Recent years have seen the development of many new job opportunities for the mentally retarded. Under a jointly sponsored Rehabilitation Services Administration-U.S. Civil Service Commission program for Federal employment of the mentally retarded, for example, State vocational rehabilitation agencies have been certifying retardates as qualified for existing vacancies in Federal installations across the country since the beginning of the program.

B. Vocational Rehabilitation Service Project Grants

Special project grants for the innovation and expansion of vocational rehabilitation services have also been utilized to extend and improve State rehabilitation agency efforts for the mentally retarded. Innovation grants provide the means for State agencies to develop new programs and techniques in order to adapt to changing needs, while expansion grants are designed specifically to increase the number of people rehabilitated by the State agency.

Under the Innovation Program, for example, a project in Idaho has made possible the remodeling of the vocational workshop center at the Idaho State School and Hospital for the Mentally Retarded. A project in Maine, conducted in cooperation with the Manpower Development Program, is preparing mentally retarded persons for suitable placement. In Montana, a rehabilitation facility for both residents and non-residents of the State training school has been supported. In Pennsylvania an evaluation unit program for the visually handicapped mentally retarded has been developed at a State school.

The Expansion Grant Program has supported the growth of sheltered workshop and other facility resources for the mentally retarded in Alaska, Indiana, Louisiana, Massachusetts, Nebraska, Oregon, and Pennsylvania. An expansion project in North Carolina has brought special services to the mentally retarded public offender incarcerated within the prison system; and a project in Washington has enabled a sheltered workshop to expand its operation into a box manufacturing plant.

Within an extensive program of rehabilitation facility improvement, the Rehabilitation Services Administration administers Workshop Improvement grants designed to upgrade the services of sheltered workshops and other facilities by supporting such activities as the employment of additional staff, technical consultation, staff development, and the purchase or rental of equipment.

During fiscal year 1968, 171 Workshop Improvement Grants totaling $3,422,000 were awarded to sheltered workshops, many of which were affiliated with local associations for retarded children. Workshop Improvement Grants were also awarded to residential institutions for the mentally retarded to improve their sheltered workshop programs.

Other rehabilitation facility improvement activities are: (1) a program of technical assistance consultation by means of which contracts may be made with State vocational rehabilitation agencies or with other expert consultants to provide workshops and other facilities with special consultation services; and (2) projects to share in the cost of providing training services for handicapped individuals in public or other nonprofit workshops and rehabilitation facilities. Federal financial participation in the Training Services grant program may assist in the cost of such services as training in occupational skills, work evaluation, work testing, provision of occupational tools and equipment necessary for training purposes and job tryouts.

During fiscal year 1968, Training Services Grants totaling $6,000,000 were awarded to 36 workshops serving the mentally retarded as well as other disabled persons.

C. Social Services within Public Welfare Agencies

The Rehabilitation Services Administration is also responsible for the promotion and maintenance of standards for social services provided by State and local public welfare agencies on behalf of disabled public assistance recipients. Such services are directed toward strengthening individual and family life and helping needy individuals attain the maximum economic and personal independence of which they are capable. Among the disabled clients within the Aid to the Blind and Aid to the Permanently and Totally Disabled Categories are an estimated 115,000 mentally retarded adults.

While there are many special problems and conditions which are of concern to the public assistance programs, mental retardation has particular significance as a frequent cause of economic dependency. Many of these retarded persons cannot live in the community unless special protective services are provided in their

behalf. These social services are particularly essential when family members through incapacity or death can no longer provide a protective environment.

Homemaker services, group work services, foster family care, group and volunteer services, and use of additional specialists, such as teachers, psychologists, and counselors, can make special contributions towards meeting the needs of the mentally retarded. Public welfare agencies are responsible for participating with the total community in developing diagnostic treatment, training and employment services, for the mentally retarded, and for developing basic social services to support, encourage, and sustain the mentally retarded in areas of family and social functioning.

The various State public welfare agencies may elect to provide as a minimum the following services: (a) those providing protection for the individual; (b) those which help the client remain in or return to the community; and (c) those services appropriate for self-support. Other services -- to persons with potentials for self-care, to those estranged from family, and to those who are former and potential public assistance applicants and recipients -- may be provided in addition. Special programs providing homemakers, volunteers and groups services may also be furnished in addition to the minimum services. When the States elect to provide these services, Federal matching in the amount of 75 percent is available to meet such costs. About two-thirds of the States have elected to provide at least the minimum services and a further expansion of social service is being encouraged.

D. Mental Retardation Hospital Improvement

The Mental Retardation Hospital Improvement Grant Program is designed to assist State institutions for the mentally retarded to improve their care, treatment, and rehabilitation service. The program is specifically focused on the demonstration of improved methods of service and care, as opposed to research exploration or the development of new knowledge.

Only State residential institutions for the mentally retarded are eligible to apply for these grants. These State institutions are defined as those residential facilities under the administrative direction of State agencies responsible for such institutions. The maximum amount of support, including direct and indirect costs, that an institution can receive under this program for any one budget period (usually 12 months) is one hundred thousand dollars ($100,000). Individual projects are normally approved for no more than a five-year period. Except in unusual instances, individual projects are completed within this approved period. Projects are planned in response to high priority needs in relation to the overall institution plan and are directed toward the ultimate improvement of resident care throughout the institution.

An analysis of the current Hospital Improvement projects shows that a majority of the projects is focused on specialized services for residents who will require long-term care and treatment. A number of these projects involve retardates functioning at the severe and profound levels of retardation; some involve multiply handicapped residents; and a few are concerned with aged residents. Demonstration projects for these more severely retarded and dependent residents are emphasizing personal development by means of self-care training, socialization experiences, intensive medical diagnosis and treatment, and opportunity for improved speech.

A number of projects have focused on special program areas, such as prevocational training for adolescents, and programs of treatment, training, and social habilitation. Other projects provide a diversified range of improved services, such as placement preparation, speech therapy, medical-physical diagnosis and treatment, recreation services, social-vocational habilitation diagnostic study with improved records and program planning and use of the unit system, all of which

enhance the development of an institution-community continuum of services.

The Mental Retardation Hospital Improvement project grant program was initiated in 1964 as an extension of the Mental Health project grant program. By the end of 1968, 91 projects in 87 State institutions for the mentally retarded had received awards. There are 169 eligible institutions at this time. This means that approximately 52 percent of the rapidly increasing number of eligible institutions are included in the program. All but five States had at least one grant for an institution for the retarded.

Although the program has been in operation for less than five years, it is already clear that many of the severely and profoundly retarded residents are benefiting. Some are able to participate in more advanced developmental programs of the institution, and others are returning to their families and communities. There is evidence that the success of the patients is changing staff attitudes and "deinstitutionalizing" staff attitudes and behavior. For many institutions the projects are stimulating improved institution-community program coordination, and making possible a more effective use of nearby community, university and college resources.

Major emphasis in this program during the next year will continue to be placed both on the extension of coverage to those institutions not yet involved in the program and on the development of long-term collaborative efforts by the staffs of the institutions receiving grants, their State mental retardation agencies, and the Rehabilitation Services Administration. Such collaboration is being developed so that project experience in solving problems of institutional care of the mentally retarded may be assessed and shared to ensure that improved methods and techniques can be widely disseminated.

The coordination of institutional programs with community service programs and Statewide comprehensive planning activities remains an important objective of the Mental Retardation Hospital Improvement Program.

E. Community Services

Although Community Service projects are administered in the Office of Community Health Service of the Health Services and Mental Health Administration, Public Health Service, the Division of Mental Retardation within the Rehabilitation Services Administration actively stimulates such projects and encourages their submission for competitive evaluation and support.

High priority is given project proposals directed to programs to individuals with moderate to profound intellectual impairment through special health services which could not usually be available through programs presently serving the general population. Grants are available for projects devoted to: (1) new or expanding existing programs to serve the mentally retarded and their families; (2) proposals designed to reflect multiple agency funding when possible; (3) proposals involving the utilization of disadvantaged persons in the program when appropriate; and (4) those involving such activities as community-wide planning, coordination and/or citizen participation as well as the provision of special health-related services such as homemaker services, special therapeutic recreation, or information and referral services.

The first area of priority is being given to projects in target cities, which provide unmet services to the retarded in model cities, ghettos, neighborhood health centers, family planning or coordinated health programs.

II. Recent Legislation

Special provisions in the 1965 Vocational Rehabilitation Amendments (P.L. 89-333) assisted States in meeting the cost of providing vocational rehabilitation services to handicapped individuals in order to determine whether they can reasonably be expected to engage in gainful employment. In the case of the mentally retarded, such services may be extended over a period of 18 months. Previously, State rehabilitation agencies were expected to determine after an initial diagnostic evaluation, but prior to the rendering of any services, whether a handicapped person could reasonably be expected to become employable after his rehabilitation program has been completed. this provision permits State rehabilitation agencies to work with an increased number of more severely retarded clients, and provide them with extended evaluative services in order to determine their real potential for ultimate employment.

Partially as a result of this new opportunity, State rehabilitation agencies are better able to give special attention to developing services for retarded persons with multiple disabilities. Special programs for the mentally retarded blind, for example, are currently being explored in a number of States.

An additional resource for aiding in the rehabilitation of the retarded is the authority in the Social Security Trust Funds for rehabilitation services to selected categories of disability beneficiaries. These supplemental funds will be especially helpful to State vocational rehabilitation agencies in serving the Disabled Children Over Age 18 group, which contains many of the more severely retarded with no past record of employment.

Under the Military Medical Benefits Amendments of 1966 (P.L. 89-614) State rehabilitation agencies are cooperating in the provision of rehabilitation services to moderately or severely mentally retarded dependents of military personnel on active duty.

The 1967 Vocational Rehabilitation Amendments (P.L. 90-99) provided that State plans for vocational rehabilitation must be amended by July 1, 1969, to ensure that no residence requirement will be imposed on eligible clients. This means that any mentally retarded individual present in a State may be evaluated for vocational rehabilitation without regard to how long he may have resided in that State.

These 1967 Amendments also authorized project grants to serve disabled migratory agricultural workers. State rehabilitation agencies and other public or private nonprofit organizations will be able to obtain Federal aid to develop projects which provide rehabilitation services no only to the disabled migratory workers but also to members of his family if such services contribute to the rehabilitation of the worker. Federal funds are expected to be available for this program in fiscal year 1970.

In addition to broadening the scope of rehabilitation services, the 1968 Vocational Rehabilitation Amendments (P.L. 90-391) authorize a new Vocational Evaluation and Work Adjustment Program to serve the disadvantaged, including the physically and mentally handicapped. The Amendments also authorize projects with industry to provide on-the-job training in work settings and eventual employment to handicapped people. Provisions are also made to recruit and train handicapped individuals, including the mentally handicapped, in a wide range of public service employment.

III. Training of Personnel

A. Training Grant Programs

The Rehabilitation Services Administration supports a variety of training grant programs designed to increase both the supply and competence of professional and subprofessional personnel qualified to provide rehabilitative, health and other services to the mentally retarded. Included within the training activity are: (1) grants to educational institutions to employ faculty or otherwise expand or improve their instructional resources (teaching grants); (2) grants to educational institutions for traineeships (stipends) to students; (3) grants to State residential institutions for the mentally retarded and State vocational rehabilitation agencies for in-service staff training; (4) contracts with educational institutions and other agencies to support short-term training programs; and (5) grants to public and private nonprofit agencies and organizations for a program of student work experience and training in mental retardation.

Under the Vocational Rehabilitation Act during fiscal year 1968 there were 39 long-term teaching grants supported at 34 different institutions or organizations, including 31 universities. There were also 6 short-term training grants during this same period. The long-term grants supported the professional education of specialists in social work, speech pathology, and audiology, rehabilitation counseling and physical therapy with 278 traineeships awarded in these areas including 4 traineeships awarded by the Research and Training Center at the University of Oregon. Short-term courses were largely conducted by three RSA-supported centers for short-term training in mental retardation--University of North Carolina, Columbia University and California State College at Los Angeles. These courses reached 743 students during 1968. Two additional courses involved 118 more students. The total amount obligated by RSA in fiscal year 1968 for support of training of rehabilitation personnel in mental retardation was 2,037,191. It is estimated that the 1969 total will be about the same.

Rehabilitation Services Administration activities in fiscal year 1969 in the field of professional preparation include:

--Maintaining level of students in graduate training programs in psychology, social work, rehabilitation counseling, physical therapy, speech pathology and audiology receiving specialized training in the rehabilitation of the mentally retarded through supervised field work in mental retardation settings;

--Improvement in curriculum content and teaching methods in training projects through support of field teachers, the development of case material and other teaching aides, the encouragement of research in the rehabilitation of the mentally retarded, and training courses dealing with the scope, nature and place of content on mental retardation in the curriculum. The teaching films produced by Parsons State Hospital, for example, should be ready for distribution and use by rehabilitation personnel shortly;

--Upgrading of personnel now serving the mentally retarded through short-term training courses of great variety in length, subject matter, intensity, depth and frequency. Included will be professional personnel in all relevant fields, sheltered workshop executives, floor supervisors and others in positions with management responsibilities;

--Encouragement of a comprehensive, interdisciplinary approach to providing care and rehabilitation of the mentally retarded through training courses focused on interdisciplinary program planning and operation of rehabilitation services;

--Stimulation of training programs for assistant or aide positions in such fields as physical therapy, occupational therapy, social work and of educational objectives, curriculum development and preparation of teaching materials;

--Support of training programs for volunteers in rehabilitation of the mentally retarded, not only for assistance to professional personnel engaged in services to individuals or groups, but also for lay leadership in community planning and program development;

--Development of training programs to prepare executives and other management personnel in rehabilitation facility administration, including workshops offering sheltered employment, vocational evaluation or occupational adjustment services;

--Extension and development of training in rehabilitative medicine to include orientation to mental retardation at the undergraduate level and at the residency level in physical medicine and rehabilitation.

Based upon continuation of 1968 projects, 1969 grants made by the RSA will include:

B. Multi-Disciplinary Programs

California State College at Los Angeles;
Columbia University, Teachers College
Devereux Foundation
University of North Carolina

In addition, the SRS-supported Research and Training Centers (Mental Retardation) receive RSA training funds for support of stipends for graduate students. They are the Universities of Oregon, Texas and Wisconsin.

C. Field Instruction Unites

1. Rehabilitation Counseling

California State College at Los Angeles
Columbia University, Teachers College
University of Florida
Michigan State University
New York Medical College
State University of New York at Buffalo
Southern Illinois University
Syracuse University
West Virginia University
University of Wisconsin, Madison

2. Social Work

Boston College
University of California (Berkeley)
University of California (Los Angeles)
University of Connecticut
University of Denver
Louisiana State University
University of Michigan
New York University
Rutgers--The State University

Simmons College
University of Texas
Tulane University
University of Utah
University of Washington
University of Wisconsin (Madison)
University of Wisconsin (Milwaukee)

3. Speech Pathology and Audiology

Michigan State University

4. Physical Therapy

University of Oklahoma

5. Occupational Therapy

Parsons State Hospital

6. Medicine

University of Mississippi
University of Rochester

7. Medical Genetics

University of California

8. Dentistry

Long Island Jewish Hospital
Montana State Board of Health

9. Medical Technology

St. Mary's Junior College
University of Wisconsin

10. Psychology

University of Alabama
Memphis State University
University of Mississippi
University of South Carolina

11. Nursing

California Board of Nursing Education
University of Tennessee

12. Program Management

Florida State University

Short-term training in mental retardation is being conducted by University of Alabama, Boston College, California State College, Columbia University, Denver Board for the Mentally Retarded and Seriously Handicapped, Inc., University of Indiana, National Recreation and Park Association, University of Minnesota, New York Academy of Science, University of North Carolina, University of Southern California, University of Wisconsin.

The long-term multidisciplinary training programs at the University of Wisconsin, the University of Oregon and the University of Texas are now operating within Social and Rehabilitation Service Research and Training Centers. Long-term traineeships at these Centers are supported by Rehabilitation Services Administration funds and 14 such traineeships were awarded by the Research and Training Centers in fiscal year 1968. Although the underlying content and intent of the multidisciplinary courses supported under the Vocational Rehabilitation Act are geared to vocational rehabilitation, the programs will serve many other professional disciplines either in their own professional grouping or in courses serving several professional disciplines.

Individual traineeship grants have also been awarded to 65 post-resident, graduate, and post-graduate nursing students to pursue professional careers in mental retardation in such fields as medicine, dentistry, psychology, social work, nursing, recreational therapy, speech therapy, and music therapy.

D. Hospital Inservice Training

The Rehabilitation Services Administration is especially concerned with improving the quality of service within institutions for the mentally retarded. Hospital Inservice Training grants have been designed to provide a continuing means for increasing the effectiveness of employees in State training schools and other state residential institutions for the mentally retarded.

One hundred and nine of the eligible State residential facilities in 46 States and 2 territories are receiving a total of $2,182,000 through the Hospital Inservice Training program and are translating the rapidly expanding body of knowledge about practices in the care of the mentally retarded into more effective services.

Hospital inservice training has been broadly defined to include: pre-service training, job-related training, inservice training, continuing education, special training and technical training needed to introduce new methods, and training of personnel which will result in an improved quality of care for the mentally retarded residing in institutions.

Because personnel such as attendants, houseparents, psychiatric aides, and others in similar personnel categories comprise the major portion of those rendering direct care to institutionalized retardates, the first major area of grant support was extended to these personnel. Grant support is available for inservice training of all professional, subprofessional, and technical personnel who have direct responsibilities for resident care and training.

Every State residential facility for the mentally retarded is eligible to participate in this program. The maximum grant to a single institution may not exceed $25,000 in any one year. These grants can be made for a period of up to seven years and are renewable.

There are four general types of training supported by inservice training grants to institutions for the mentally retarded: (a) orientation and initial on-the-job training for employees; (b) refresher, continuation, and other special job-related training courses; (c) continuation training for technical and professional staff to keep them informed of new developments in their fields which can be translated into more effective patient service; and (d) special instructor training for staff with inservice training responsibilities aimed at providing a cadre of personnel to continue and extend the institutional training program.

The personnel categories involved as trainees in these programs have been, in order of descending frequency, aides, attendants, charge aides, supervisors, registered nurses, and practical nurses.

The content of the training programs includes general instruction in the areas of mental retardation; child growth and development; nursing care skills; patient-staff relations; human behavior; intra-staff relations; supervisory skills; communications skills; and adjunctive therapy skills.

Consultation is given to the institutions which have received grants to assist them in making the best use of training opportunities. Technical information and professional consultation is being provided to the remaining State institutions for the mentally retarded in order to enable them to qualify for similar grants.

E. Student Work Experience and Training

A program of Student Work Experience and Training (SWEAT) projects provides students with both employment and training during summer months and other vacation periods, while working directly with mentally retarded children and adults.

The program is open to high school seniors, college, and graduate students and generally offers to these young people experience in all phases of work with the mentally retarded.

Twenty-eight projects, in which approximately 298 students are participating, are being supported. It is hoped that, as a result of this experience, many of these students will be attracted to careers in mental retardation.

IV. Construction

A. Community Facilities for the Mentally Retarded

The community facilities construction program authorized under Title I, Part C of the "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963" (P.L. 88-164) provides Federal grants to States to assist in the construction of specially designed public or other nonprofit facilities for the diagnosis, treatment, education, training, or custodial care of the mentally retarded, including sheltered workshops which are part of a facility providing comprehensive services. The program is administered at the State level by an officially designated State agency. Participation in the program requires the development of a State plan for the construction of community facilities for the mentally retarded based on an inventory of needed additional services and facilities. Construction projects are approved in accordance with the provisions of the State plan.

All States are participating in the program. As of December 1968, 241 projects have been approved. Fifty-three facilities are completed and in operation, and 100 additional facilities are under construction. These facilities will provide care and treatment for approximately 27,000 additional retarded persons not now being served. The estimated total cost of these projects is over $148 million with an estimated Federal share of over $48 million.

The program is having a widespread impact on community efforts to meet the needs of the retarded. Public and voluntary agencies are demonstrating increased interest in participating in the construction program, and community leaders and professional personnel are combining efforts to stimulate sponsorship of needed facilities. Accomplishments to date, however, have only slightly touched on the need for additional services and facilities. State plans indicate that services should be provided for about one million additional retarded individuals.

B. Construction of Rehabilitation Facilities

The Vocational Rehabilitation Amendments of 1965 (P.L. 89-333) authorized a program for the construction of rehabilitation facilities and workshops; the construction of rehabilitation facilities and sheltered workshops; and initial staffing support for newly constructed rehabilitation facilities and workshops. Special provisions are made to permit the inclusion of residential facilities within projects for the construction of workshops for the mentally retarded.

State Planning grants for workshops and rehabilitation facilities encompass: (1) the development of State Workshop and Rehabilitation Facilities Plan; and (2) construction, utilization, development, and improvement of workshops and rehabilitation facilities.

Project Development grants pay part of the cost of organized, identifiable activities necessary for the planning and development of specific local construction projects for rehabilitation facilities or workshops. These projects are oriented particularly towards assisting local citizens groups with limited financial resources to engage consultants and secure other types of help to develop a sound project proposal.

During fiscal year 1968, 38 Project Development Grants, having a national average of $7,000, were made to applicants planning a specific construction project providing services to the mentally retarded.

Construction grants assist in the costs of the new construction of rehabilitation facilities and workshops; the acquisition, expansion and alteration of existing facility and workshop buildings; initial equipment for the completed projects.

Twenty-seven construction grants totaling about $3,000,000 were awarded during fiscal year 1968. These projects were for the construction of workshops, and comprehensive rehabilitation centers, and one was for the construction of a comprehensive speech and hearing rehabilitation center. Most of these projects are multidisability in nature and serve the mentally retarded as well as other disability groups. Workshops serving the retarded were constructed in Lebanon, Pennsylvania, and Casper, Wyoming.

C. University-Affiliated Facilities for the Mentally Retarded

The University-Affiliated Facilities for the Mentally Retarded program assists universities or affiliated facilities for the mentally retarded in the construction of special clinical facilities capable of demonstrating exemplary care, treatment, education and habilitation of the mentally retarded. In University-Affiliated Clinical facilities comprehensive services are provided; specialized personnel are trained; or new techniques of specialized service are demonstrated.

The primary purpose of this program is to provide facilities for the clinical training of physicians and other professional and technical personnel in the field of mental retardation. Among the professional disciplines represented in these facilities are medical personnel, dentists, nurses, speech and hearing therapists, nutritionists, physical therapists, occupational therapists, rehabilitation specialists, special educators, psychologists, social workers, recreational specialists and chaplains. Each facility is encouraged to conduct a comprehensive multidisciplinary training program so that each discipline involved in the care and rehabilitation of the mentally retarded may be fully familiar with the contributions of the other disciplines.

The Mental Retardation Amendments of 1967 (P.L. 90-170) extended the university-affiliated construction program until June 1970. The present law was also

amended to provide grants for the construction of university-affiliated facilities which include programs for persons with other neurological handicapping conditions related to mental retardation and for research incidental or related to activities conducted within the facility.

Because of the complexity of the university-affiliated program, individual planning grants are available. Such individual grants may not exceed $25,000 nor more than 75 percent of the planning costs.

Examples of approved projects for the construction of university-affiliated facilities for the mentally retarded are: Children's Rehabilitation Institute, Reisterstown, Maryland; University of Colorado, Denver, Colorado; Walter E. Fernald State School, Waltham, Massachusetts; Children's Hospital Medical Center, Boston, Massachusetts; Georgetown University, Washington, D.C.; University of California Neuropsychiatric Institute, Los Angeles, California; University of Alabama Medical Center, Birmingham and Tuscaloosa, Alabama; Indiana University Medical Center, Indianapolis and Bloomington, Indiana; University of N.C., Chapter Hill, North Carolina; University of Tennessee, Memphis, Tennessee; New York Medical College, New York, New York; Georgia Department of Public Health, Atlanta, and Athens, Georgia; University of Oregon, Portland, Oregon, and Eugene, Oregon; University of Miami, Miami, Florida; and Utah State University, Logan, Utah.

V. Initial Staffing of Community Facilities for the Mentally Retarded

The Mental Retardation Amendments of 1967 (P.L. 90-170) added a new program to stimulate and aid local communities in responding to the unmet needs of the retarded by providing grants to pay for the initial cost of professional and technical personnel in the operation of new facilities or for new services in existing facilities for the mentally retarded. Over eight million dollars was appropriated in 1969 fiscal year to implement the program.

Funds are approved for individual projects sponsored by local nonprofit community organizations or public agencies on a declining basis for 51 months. During the first 15 months, the grant may not exceed 75 percent of the cost; 60 percent for the next year; 45 percent for the third year; and 30 percent for the last 12 months.

The program is authorized for continuation through June 30, 1970, and an additional $14 million is authorized to be appropriated for new projects.

VI. Planning

A. Mental Retardation Planning and Coordination

State planning for comprehensive coordinated services to the mentally retarded was begun in 1964 under P.L. 88-156 and is now supported under P.L. 89-97 in the form of continued planning, the development of mechanisms for the coordination of programs of State agencies dealing with the mentally retarded, and the mobilization of community support.

Although the implementation programs vary greatly from State to State, progress is evident in all areas. For example, stress has been placed on community planning in Colorado, North Carolina, Florida, and Nebraska. The division of a State into regions for better assessment and projection of programming is being emphasized in Illinois, Indiana, Connecticut, and Wisconsin. Special projects with primary attention to implementation objectives have been undertaken in Texas, New York, Michigan, and Montana.

Funding of new projects terminated in the spring of 1968; however, some projects were extended through December 1968. Indications are that in a majority of the States these planning and implementation activities are continuing and will continue under State sponsorship on a permanent basis, thus providing conformity and assuring coordinated services to the mentally retarded. Consultation from the Federal level will also continue, including analysis of data coming out of the planning and implementation projects.

B. Vocational Rehabilitation Planning

The Vocational Rehabilitation Amendments of 1965 authorized a program of grants to States to plan for the orderly development of comprehensive vocational rehabilitation services, including services provided by private, nonprofit agencies. These plans, which will involve careful consideration of the rehabilitation needs of the mentally retarded have the objectives of making vocational rehabilitation services available by 1975 to all handicapped individuals who need them. Fifty-two comprehensive Statewide planning projects are now being undertaken by State vocational rehabilitation agencies and other designated agencies throughout the country. Upon completion of this special grant program, States will be conducting continuing Statewide studies of the needs of the handicapped and how these needs may be most effectively met.

State Planning Grants for Workshops and Rehabilitation Facilities provide for the coordinated and orderly development of the total State-Federal facilities effort. Initial State Workshops and Rehabilitation Facility Plans have been completed in the 49 States receiving grants. These States received continuation grants for a second year during which the plans are being updated and refined. Upon completion of the continuation grants in June 1968, this program will become a part of the State vocational rehabilitation agency operation, thus assuring a permanent program in each State agency for assessing needs and evaluating activities for establishment, construction, utilization, development, and improvement of workshops and rehabilitation facilities.

VII. Information

A. Collection and Dissemination of Information

Since September 1968, the special mental retardation review, abstracting and information activity has been operated as part of the Social and Rehabilitation Service. In previous years this service was a part of the National Clearinghouse for Mental Health Information. Because knowledge about mental retardation comes from many scientific disciplines and professions, this service will improve both research and practice and thus have a decided effect on the prevention and treatment of mental retardation.

To maintain this service, the Social and Rehabilitation Service under contract with the American Association on Mental Deficiency, collects current literature on mental retardation, writes informative abstracts, indexes the literature in depth, compiles annotated bibliographies on special topics, and prepares critical reviews. In 1964, a total of 9,300 current articles, books and monographs have been collected, abstracted, and indexed. To provide a more extensive coverage of information for retrieval purposes, an additional 3,500 indexed abstracts of documents published from 1957 through 1963 were added to this system.

Special annotated bibliographies have been prepared on: (1) Programmed Instruction with the Retarded; (2) Literature for Parents; (3) Application on the Stanford-Binet and Wechsler Intelligence Scales with the Mentally Retarded; (4) Nursing and Mental Retardation; (5) Family Care and Adoption of Retarded Children; (6) Psychotherapy with the Mentally Retarded; (7) Recreation for the Retarded; (8) Counseling Parents of the Mentally Retarded; (9) Sheltered Workshops for the Mentally Retarded; (10)Films on Mental Retardation;

(11) Psychopharmacological Therapy with the Mentally Retarded; (12) Electroencephalographic Studies Relating to Mental Retardation; (13) Hydrocephalus; (14) Mental Retardation and Religion; (15) A Selected List of Teaching Materials Regarding Mental Retardation for Faculty of Schools of Social Work; (16) Architectural Planning for the Mentally Retarded to Remove Barriers and Facilitate Programming; (17) Inservice Training in Institutions for the Mentally Retarded.

Review articles and critiques have been prepared on: (1) Mental Retardation: Definition, Classification, and Prevalence; (2) Research on Linquistic Problems of the Mentally Retarded; (3) Attendant Personnel: Their Selection, Training, and Role; (4) Research on Personality Disorders and Characteristics of the Mentally Retarded; (5) Effects of Severely Mentally Retarded Children on Family Relationships; (6) Factor Analysis and Structure of Intellect applied to Mental Retardation; (7) Counseling Parents of the Mentally Retarded; (8) Genetic Aspects of Mental Retardation; (9) Instrumental Learning in Mental Retardates; (10) Vocational Rehabilitation of the Mentally Retarded: The Sheltered Workshop; (11) Relationships between Educational Programs for the Mentally Retarded and the Culturally Deprived; (12) A Decade of Research on the Education of the Mentally Retarded; (13) Application of Operant Conditioning Techniques to Institutionalized Severely and Profoundly Retarded Children; (14) Adaptive Behavior: A New Dimension in the Classification of the Mentally Retarded.

The abstracts, annotated bibliographies, and reviews appear in the quarterly journal Mental Retardation Abstracts, which is distributed gratis to approximately 6,000 individuals engaged in research and practice in mental retardation and is also for sale by the Superintendent of Documents.

B. Films and Publications

The Rehabilitation Services Administration continues to distribute a documentary film, "Handle with Care," stressing the value of a fixed community point of referral upon which the families of the mentally retarded can depend for continuing lifetime guidance and assistance in obtaining appropriate services. The film has been placed in State health departments and medical school film libraries for wider distribution.

A second film, "Teaching the Mentally Retarded--A Positive Approach," a documentary dealing with behavior shaping, was placed in circulation during 1967. It is aimed at child-care workers and attendants as well as students who are preparing to work with the mentally retarded.

A third film was produced in 1968. This film "A Way Out of the Wilderness" depicts care, treatment, and training activities in a private institution and a large State institution for the mentally retarded. The film was developed to sharpen the awareness of the general public to today's problems and promises in institutional care for the retarded.

A package of training materials for parents of retarded children and personnel in residential and day facilities for the retarded provides information on training mentally retarded children in feeding skills and toilet use. The materials which include filmstrips, records, a discussion guide and pamphlets provide helpful directions for both individual and group training in these two basic skills which are a major step toward self-care and increased independence.

The packages of training materials "Growing Up at the Table" (individual and group) and "Diapers Away" (individual and group) are available on a free short term loan basis from:

National Medical Audiovisual Center (Annex)
Chamblee, Georgia 30005

Numerous publications have been prepared and placed in circulation. One in particular, "A Modern Plan for Modern Services," states the basic philosophy of the Division of Mental Retardation in 6 major points. Briefly stated, these points emphasize: (1) utilization of generic community agencies in lieu of establishing specialized services; (2) provision of basic training in mental retardation for every category of service personnel; (3) definition for utilization of specialized services and agencies; (4) placement of a mental retardation specialist in every generic agency; (5) development of standards for service and training; and (6) coordination within the community.

Two other publications are worthy of note: (1) Opportunity: Help for the Mentally Retarded, provides a brief description of rehabilitation services available to the retarded, eligibility requirements and a list of the State rehabilitation agencies where further information may be acquired; (2) A Mental Retardation Film List, sponsored by the Division of Mental Retardation provides a list of films of interest to both professional and to the general public. Brief descriptions of each film and the sources from which each may be borrowed, rented and/or purchased are included in the pamphlet.

SOCIAL SECURITY ADMINISTRATION

The social security program today is the basic method in the United States of assuring income to individuals and families who suffer a loss of earnings when workers retire, become disabled, or die and, since July 1, 1966, health insurance protection to persons 65 and over.

Economic Impact

Under social security's "Childhood Disability" provisions, lifetime monthly payments can be made to a person age 18 or over who has been disabled by mental retardation--or other impairments--since childhood. In many cases, the monthly benefits enable the retarded childhood disability beneficiary to be cared for at home instead of in an institution. Furthermore, as more and more retarded people outlive their parents, the program offers reassurance to fathers and mothers who know that financial help for their disabled child will be forthcoming even after their death. (About half of the childhood disability beneficiaries are over 35 and 25 percent of them are over 45.)

The problem of mental deficiency is a major factor in more than 65 percent of the beneficiary groups having disabilities which began in childhood. It is the primary diagnosis in about half of this group. In fiscal year 1968 an estimated 153,000 adult mentally retarded beneficiaries received $107,900,000 in social security benefits. The number of mentally retarded children under age 18 who receive payments as dependents of retired, disabled, or deceased workers is unknown, since their benefits are payable regardless of disability.

If the parents are dead, a relative who has demonstrated a continuing interest in the beneficiary's welfare, a welfare agency, or a legal guardian may be chosen as representative payee to handle the benefit funds and plan for using them in behalf of the beneficiary. A representative payee receives social security benefits in trust for the beneficiary and, as a trustee, is held accountable for the way in which he uses the benefits.

Health insurance benefits under the social security law are available to any individual, including a mentally retarded individual who is 65 or over and who meets certain necessary conditions. Therefore, a mentally retarded individual 65 years of age who has contracted an illness or suffered an injury is, like any other person in this age group, protected under the health insurance program. However, the health insurance for the aged program specifically prohibits reimbursement under the law for expenses incurred for personal care designed primarily to aid an individual in meeting the activities of daily living and which do not require the continuing attention of trained medical or paramedical personnel. Therefore, an aged mentally retarded person whose only deficiency is mental retardation requiring general institutional care, e.g., vocational training, help in the activities of daily living, and so forth would not be receiving the type of care covered under the Medicare program.

Activities and Achievements

All district offfices of the Social Security Administration maintain a referral service to other programs and services of both public and private agencies and organizations. Giving information about these programs and agencies is an essential part of the Social Security Administration's service to the public. The service is provided to beneficiaries as well as to non-beneficiaries and applicants who inquire about services not provided by the OASDHI program. Disabled persons applying for disability benefits under social security are promptly referred to the Rehabilitation Services Administration to the end that the maximum number may be rehabilitated into productive activity or to a level of self-care. The information and referral service is currently under study to determine what changes are indicated to make the program more responsive to the

needs of people and the multiplicity of problems they bring to district offices.

SSA has participated in the employment of the mentally retarded since the inception of the employment program in 1964. Experience has demonstrated conclusively that the retardate can perform excellent work in basically routine positions when placement is carefully selected or the job re-engineered to the level or degree of his handicap. In SSA, retardates are successfully performing in such positions as mail and file clerk, messenger, printing machine operator, and xerox machine operator.

After success on a pilot project, placements have been greatly increased in the last year at SSA headquarters and payment centers by utilizing retardates in the operation of card reader machines which control the location of claims folders. Retardates are performing in a highly successful manner and many have been promoted to a grade GS-2. One has performed so well in the Division of Personnel at headquarters, that the Maryland State Division of Vocational Rehabilitation has certified her capable for promotion to a grade GS-3 position.

A significant development at the Baltimore headquarters complex was the establishment of a training seminar, in cooperation with specialists from the Maryland State Division of Vocational Rehabilitation, for supervisors of retardate program employees.

As of September 30, 1968, a total of 126 retardates were on duty as follows: 32 in central headquarters offices, 48 in payment centers, and 46 in district offices.

In the area of public information, a number of steps were taken during fiscal year 1968 to publicize the childhood disability provisions of the social security program. All the materials produced emphasized early filing and the high incidence of mental retardation among childhood disability beneficiaries. Major activities included:

1. Articles were carried by many national medical and health publications, including KNOW Your World (Teacher's Edition, read by special education teachers), Medical World News, Physician's Management, Rehabilitation Literature, American Association of Industrial Nurses Journal, Resident Physician, and The New Physician.

2. The American Academy of Pediatrics distributed a leaflet, "Special Social Security Benefits for Persons Disabled in Childhood," to its 8000 members. The leaflet urges physicians to refer patients who may be eligible for benefits to social security.

3. A release was sent to the National Association for Retarded Children for distribution to its 1150 State and local components. Following this, in November 1967, a member of BDI's top staff addressed the annual convention of the NARC.

An exhibit, "Childhood Disability and Social Security," had its premier showing at the convention of the American Orthopsychiatric Association in Washington, D.C., in March 1967. Since then it has been shown at numerous meetings of national organizations and medical groups interested in the handicapped. In the very near future it will be revised to update statistics on the number of mentally retarded childhood disability beneficiaries and the percentage of childhood disability beneficiaries for whom mental retardation is the primary diagnosis.

A 20-minute film on mental retardation, "Where There Is Hope," will be released by the Social Security Administration about February 1969 in both 35mm and 16mm color for theatrical and general showing. Early sequences in the film deal with diagnosis and therapy at the John F. Kennedy Institute in Baltimore.

These are followed by scenes filmed at a sheltered workshop in Washington, D.C., showing the activity of teenagers and older people, and finally scenes showing rehabilitation services for a 21-year old girl just completing a trial work period in Greensboro, North Carolina. The film tells of the social security benefits available for the adult disabled child. A 14½-minute version is now in use as part of the "Social Security in America" series being shown in 184 television stations throughout the country.

The Social Security Administration has developed a pamphlet entitled, "Social Security: What It Means For The Parents Of A Mentally Retarded Child." This pamphlet describes the conditions under which a mentally retarded child may be eligible for social security benefits. It is available in both English and Spanish. The present edition includes information about the 1967 amendments. About a half million of these pamphlets have been distributed in recent months.

The Social Security Administration conducted a nationwide survey in the fall of 1967 which will supply basic information about institutionalized adults, including the mentally retarded in institutional care. The 1967 surveys of institutionalized adults examined the socio-economic characteristics of mentally retarded persons (as well as other disabled persons) over age 18 in institutions such as homes and schools for the mentally or physically handicapped, mental hospitals, chronic diseases and other long-term hospitals. This survey focused on the types of care they received, the cost of care, and sources of payment, the economic resources of the patient and his family, and his family relationships.

The 1966 survey of disabled adults (non-institutionalized) will also provide a wide range of data on financial, medical, and family arrangements of disabled adults who are mentally retarded.

Obligations for Mental Retardation Programs by Agency Designation
Fiscal Years 1968-1970
(In Thousands of Dollars)

Social Security Administration	1968	1969	1970
Estimated benefits from the trust funds...	107,900	131,300	141,700
Trust fund obligations incurred to adjudicate claims from beneficiaries....	1,900	2,400	2,600
Total-Social Security Administration	109,800	133,700	144,300

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Obligations for Mental Retardation Programs
by Agency Designation
Fiscal Years 1966-1970
(Thousands of Dollars)

AGENCY	1966	1967	1968	1969 Estimated	1970 Estimated
Health Services and Mental Health Administration					
Comprehensive Health Planning and Services	$ -0-	$ 5,485	$ 4,071	$ 3,475	$ -0-
Mental Health Research and Services	11,636	8,279	1,556	1,627	1,495
National Health Statistics	19	21	21	6	-0-
Total, Health Services and Mental Health Administration	11,655	13,785	5,648	5,108	1,495
National Institutes of Health					
Neurology and Stroke Activities	22,028	19,473	21,384	21,950	21,600
Child Health and Human Development	8,500	12,134	13,680	15,608	16,486
Grants for Construction of Health Research Facilities	6,234	6,026	-0-	-0-	-0-
Total, National Institutes of Health	36,762	37,633	35,064	37,558	38,086
Office of Education					
Elementary and Secondary Education Activities	20,963	27,512	30,589	37,218	40,438
Educational Improvement for the Handicapped	8,977	10,024	17,410	27,200	29,600
Education Professions Development	-0-	-0-	-0-	129	150
Libraries and Community Services	-0-	-0-	-0-	90	90
Research and Training	255	165	38	25	20
Vocational Education	-0-	-0-	-0-	-0-	11,500
Total, Office of Education	30,195	37,701	48,037	64,662	81,798

AGENCY	1966	1967	1968	1969 Estimated	1970 Estimated
Social and Rehabilitation Service					
Vocational Rehabilitation					
Grants to States	$13,764	$22,855	$27,800	$40,860	$61,760
Research and Demonstration Activities	3,713	3,764	2,867	2,909	3,035
Innovation and Expansion Grants	311	475	570	574	574
Facility Improvement Grants	283	1,302	3,400	3,700	3,900
Training and Traineeships	1,501	1,700	1,760	1,760	1,760
Rehabilitation Facilities and Construction Grants	325	1,000	866	828	472
Mental Retardation					
Staffing Grants	-0-	-0-	-0-	8,358	12,000
Hospital Improvement	8,909	8,790	8,610	8,972	8,972
Rehabilitation Service Projects	-0-	-0-	-0-	-0-	4,500
Research	36	32	126	126	126
Construction	20,562	32,339	16,680	27,113	13,531
Planning	2,120	1,523	1,394	-0-	-0-
Maternal and Child Health and Welfare					
Grants to States	11,220	11,843	12,740	12,990	12,990
Training and Traineeships	5,865	9,865	12,865	14,865	17,065
Research and Demonstration	2,759	2,957	3,300	3,300	3,200
Medical Assistance - Grants to States 1/	13,100	28,500	30,000	75,000	100,000
Public Assistance - Grants to States 2/	37,900	51,000	55,000	65,000	75,000
Total, Social and Rehabilitation Service	122,368	177,945	177,978	266,355	318,885
Social Security Administration					
Estimated Benefit Payments from Trust Funds	84,500	93,600	107,900	131,300	141,700
Trust Fund Obligations Incurred to Adjudicate Claims of Beneficiaries	1,800	1,600	1,900	2,400	2,600
Total, Social Security Administration	86,300	95,200	109,800	133,700	144,300

AGENCY	1966	1967	1968	1969 Estimated	1970 Estimated
Office of the Secretary					
Secretary's Committee on Mental Retardation 3/	$(238)	$ (105)	$ (128)	$ (160)	$ (160)
President's Committee on Mental Retardation 4/	-0-	(316)	577	580	605
Total, Office of Secretary	--	--	577	580	605
Total, Services and Grants	163,080	216,064	212,304	309,263	365,869
Total, Income Maintenance	124,200	146,200	164,800	198,700	219,300
GRAND TOTAL, ALL FUNDS	287,280	362,264	377,104	507,963	585,169

1/ These expenditures are based on present experience with six States claiming an average of approximately $5 million per State for a full year for the care of the retarded in State institutions. Fifteen States for 1969 and twenty States for 1970 are estimated in the amounts shown. There is presently no method available for estimating title XIX payments for the care of the retarded outside of State institutions.

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

3/ Shown as non-add items since they were derived from funds available to other agencies for mental retardation activities.

4/ Beginning in 1968 this item is included in direct funding as a line item.

ACTIVITIES IN AGING

OF

THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

1968

(Report compiled by the Administration on Aging)

The year 1968 was one of achievement and promise in programs for the aged carried on within the Department of Health, Education, and Welfare. The scope, diversity, and vitality of these programs reflect the deep commitment and dedication on the part of the American people to help the nearly 20 million older citizens in this country achieve a better standard of living and a more active, useful, and meaningful role in society.

The various activities in aging reported by the constituent HEW agencies reveal "the comprehensive approach" being taken by the Department to meet the needs of the Nation's elderly. These activities are described in the individual reports submitted by the following agencies:

1. Social and Rehabilitation Service
    a. Administration on Aging
    b. Assistance Payments Administration
    c. Medical Services Administration
    d. Rehabilitation Services Administration
    e. Office of Research, Demonstration, and Training
2. Public Health Service
    a. Consumer Protection and Environmental Health Service
    b. Health Services and Mental Health Administration
    c. National Institutes of Health
3. Office of Education
4. Social Security Administration

SOCIAL AND REHABILITATION SERVICE

The Social and Rehabilitation Service was established in August 1967 to bring together under a single leadership within the Department of Health, Education, and Welfare programs of:

- Financial and medical assistance for needy Americans
- Social and rehabilitation services for families, children, older people and the handicapped.

Within the Social and Rehabilitation Service the Administration on Aging, the Assistance Payments Administration, the Medical Services Administration, the Rehabilitation Services Administration, and the Office of Research, Demonstration and Training all have responsibility for programs serving older persons.

The Administration on Aging, while maintaining overall responsibility for giving national visibility to the public issues related to aging, joins in and works together with the other components of the Social and Rehabilitation Service in planning for, promoting,and providing services for the aged.

In the field, the activities of the Social and Rehabilitation Service are supervised by a Commissioner located in each of the nine HEW regions. Through these regional offices technical assistance is provided to States and other Federal agencies. Under this arrangement, SRS is able to provide a unified and comprehensive approach toward meeting the needs of older people in the communities, by making available to the States a broad range of technical expertise from one central source.

The program activities in aging undertaken during 1968 by the components of SRS are described separately in the reports which follow.

The Administration on Aging

The Administration on Aging was created by the Older Americans Act of 1965 to provide assistance in the development of new or improved programs to help older persons and to serve as the focal point for the Federal Government's concern for the needs and problems of the aging.

The Older Americans Act provides for three grant programs which are administered by the Administration on Aging. They include:

Title III - Grants to the States for Community, Planning, Services, and Training

Title IV - Grants for Research, Demonstration, and Development Projects

Title V - Grants for Training of Persons in the field of aging.

The Administration on Aging also operates the Foster Grandparent Program which is funded by the Office of Economic Opportunity.

At the end of 1968, after three full years of operation under the Act, the Administration on Aging can record significant progress in its efforts to help solve both the long and short range problems of older persons. This has been a period of action and accomplishment at the Federal, State and local level -- toward the goal of assuring the elderly a larger share of the Nation's economic and social well-being.

The benefits accruing to the Nation's elderly after three years of progress under the Older Americans Act are reflected in the following examples:

-- A total of 650,000 older people have directly benefited from over 900 projects funded in local communities under Title III since the program began operation in 1965. The Title III projects have achieved significant results in assisting older persons to maintain independent living in the community and to remain actively engaged in the daily social life of the community.

-- Of the Title III projects in operation during fiscal year 1968, 49% offered information and referral services; 53% provided recreation and leisure activities; 30% included transportation services; 25% offered adult education programs; and 30% provided home maintenance, friendly visiting and telephone reassurance services.

-- Over 100 Title IV research, development, and demonstration projects have been initiated to stimulate innovative approaches to new programs and services for the aging.

-- Under the Title IV nutrition program, 29 grants for over $2,000,000 have been awarded for projects designed to combat the problems underlying malnutrition in older people.

-- A total of 48 training grants have been awarded under Title V of the Act to help fill the critical need for trained manpower in the field of aging.

-- More than 3,650 persons have received or are receiving long or short term training under Title V. Priority in training has been given to the areas of broad planning and administration in aging for work at Federal, State, and local levels, and management training in the field of retirement housing, villages, and homes for the aged.

-- The Foster Grandparent Program begun as a limited demonstration program in August 1965 with 21 projects, now has 68 projects operating in 40 States and Puerto Rico. The services of 4,000 foster grandparents are being utilized to help 8,000 retarded or disadvantaged children.

The preceding illustrations and the detailed descriptions of AoA program activity in 1968 which follow, reflect the extent to which the Older Americans Act has provided services and opportunities for the Nation's elderly that were previously unavailable or non-existent. Recognizing that the needs and problems of the aged are ever-shifting in our dynamic society, the Administration on Aging in close partnership with the States, will give priority during the coming year to developing a comprehensive network of coordinated community services for all older people and to laying the groundwork for a White House Conference on Aging which will take place in 1971.

GRANT PROGRAMS AND SERVICES UNDER THE OLDER AMERICANS ACT

Title III - Grants to States for Community Planning, Services and Training

Title III of the Older Americans Act provides for allotments to the States for (1) community planning and coordination of programs in aging; (2) demonstration of new programs or activities beneficial to older people; (3) training of special personnel to carry out such programs and (4) establishment of new or expansion of existing programs including senior centers. The grants are intended to strengthen State and community services to the aging and to stimulate new interest and commitment on the part of the States and communities to their older residents.

In order to participate in the Title III programs, the Governor of each State must designate a single State agency to coordinate programs for the aging throughout the State and a State plan for the aged must be approved. The State, in turn, makes grants to local public and nonprofit, private agencies. At the end of 1968, 46 States, the District of Columbia, Puerto Rico, and the Virgin Islands had approved State plans and were actively implementing Title III programs.

In fiscal year 1968 alone, 688 community projects were operating with funds provided under Title III to help communities plan effective local programs serving the elderly. Approximately 580,784 older persons had benefited from these projects by the end of the fiscal year.

SERVICES PROVIDED THROUGH TITLE III PROJECTS

1. Independent Living

Projects funded by Title III grants have provided a variety of services to help older people maintain independent living. These services played an important part in helping older persons to remain in the community, in congenial and familiar surroundings, at considerably less cost than the more expensive alternatives of nursing home and institutional care.

Homemaker-home health aide assistance was provided by 62 projects to 6,178 persons. Through 207 projects 82,743 persons were helped with home maintenance, friendly visiting, and regular telephone reassurance calls (frequently provided by older volunteers).

Seventeen innovative projects assisted 968 older persons to find foster home care. Protective services were provided to 7,901 older individuals through 49 projects. Meals were served to 17,341 aged individuals via 44 projects. Finally, 107 projects extended health screening services to 15,330 older persons and other health services to 24,784.

One project in Missouri is delivering health related services for the aged in four small town and rural areas through the offices of a physician in each of these localities. The project is utilizing the services of medical social aides all of whom are older persons who perform tasks to supplement those of the physician and social worker. Social services are provided by graduate social work students. The project will develop community interest in providing services for the aged on a permanent basis as well as extending the plan of delivery of services from physician's offices to patients of all ages.

2. Participation in Community Life

Another category of service rendered by Title III projects provides opportunities to continue engagement in community life. These services includ-

ed placing 10,916 older persons in jobs through the auspices of 160 projects. Adult education was offered through 170 projects to 52,482 persons. A very large number of older persons, 288,545, participated in recreation and leisure type activities in 375 projects. Counseling was offered to 46,766 persons in 199 projects. Transportation for the older person is often a major obstacle to continuing activity in the community. Its lack can represent the barrier to shopping, conducting business affairs, receiving medical treatment, and participating in community life. Title III funds have been used in 206 communities to provide special transportation services for 41,472 individuals.

3. Senior Centers

Many of the above services in category 2 were provided through approximately 250 multipurpose senior centers which receive support from Title III grants. The center can become, for the community in which it operates, a focal point for planning, developing, and delivering services to the aged. It is the channel through which contact is made and maintained with the elderly and through which they in turn are integrated into and connected with the community and its broad range of resources. Multipurpose senior centers funded by Title III were utilized by over 225,000 persons during the year.

In North Dakota such a center provides a varied recreation program for its 350 members. The center has arranged for regular service from the library bookmobile, and one of its members has provided employment counseling and referral services for other members. Hearing and eye examinations are conducted, with glasses provided by a service club for those needing them but unable to afford them. Meaningful volunteer activities were developed both for the members to work at the center and in the community and for high school students interested in serving older persons. Counseling of older persons on their problems and referral to appropriate community agencies for specialized assistance is provided by the center director.

A senior center in Ohio which had been operating for several years received a Title III grant to extend its services. This permitted expansion of its program to residents of nearby housing projects and isolated older persons living in their own homes. This center has also established a new job opportunities service to help older persons find full or part-time employment

4. Volunteer Opportunities

The increasing number of volunteer opportunities available to older persons through Title III projects has been of major significance. It is noteworthy that 493 projects have made it possible for 28,974 older persons to contribute volunteer services. The tasks involved have been varied and the beneficiaries of the time, interest and skills of the older volunteers have included the aged, youth, families, and community projects.

Services include assisting in direction of leisure time activities, providing information and referral in response to questions about available programs and services, and helping the homebound. In Kentucky, volunteer efforts were effectively directed toward providing tutoring services for failing students at two junior high schools.

In Florida, 46 senior citizens volunteer as friendly visitors to provide companionship for isolated and frail aged persons. They also offer transportation to keep medical appointments, to go shopping, and to attend church. In one Massachusetts community, 184 older volunteers work with the health, educational, cultural, social, and welfare agencies in bring-

ing services to over 2,000 elderly persons.

5. Training

Training projects in 64 communities utilized Title III funds to train 5,980 persons. These project funds support short-term courses which help to prepare specialized personnel to serve the elderly. Included are projects which prepare community leaders to initiate and conduct programs for the aging, prepare nursing home personnel to better serve aged patients, and train homemakers to help the elderly in their own homes. These projects are, however, only beginning to meet acute needs for institutional and rehabilitative personnel adequately prepared to work with older persons.

In Virginia, a significant Title III training program is helping to meet the lack of qualified dieticians to fill food services positions in the increasing numbers of nursing homes. Two five-day workshops have been conducted for 30 staff members of nursing homes and homes for the aged. They have been given training in nutrition for the aged, menu planning, food buying, quantity food preparation, sanitation, and such food management subjects as buying procedures and food cost control.

6. Comprehensive Community Planning

Planning projects serve a vital purpose in the development and coordination of services for the aged. Such projects enable a community to assess the human needs of its aging population as well as its resources to meet those needs. In many areas, aged persons have participated actively in this planning process. Planning projects were operational under Title III in 133 communities.

In one Kansas community, a planning project has successfully coordinated a variety of needed programs for the aging. It has developed a plan for a geriatric clinic at a local medical center, coordinated efforts of church groups to reach older persons, involved non-profit organizations in providing special services for the aged, and provided information and referral services to the aged, including publication of a directory of services.

Information and referral services funded through 335 projects are reaching 227,000 older persons. These services constitute a vital aspect of the planning process. Through the programs both the community resources and gaps in services for the aged become more clearly known.

During 1968, the Title III program placed emphasis on obtaining adequate recognition of the needs of the aged in Model Cities Planning. Materials on the special problems and needs of older persons were prepared for inclusion in Model City Kits. There are 115 Title III projects located in the first 55 cities selected as model cities. Data available on 77 of these projects indicates that: 9 are located in Model Neighborhoods, 39 serve but are not located in Model Neighborhoods, 10 are areawide projects which encompass Model Neighborhoods, 5 do not serve Model Neighborhood residents but are likely to be expanded to serve them, and only 14 do not serve Model Neighborhood residents and are not likely to be expanded to serve them.

TITLE IV - RESEARCH & DEMONSTRATION GRANTS

The Title IV grant program of the Older Americans Act authorizes grants

for 1) research into the living conditions and patterns of older people, 2) demonstration and development of new approaches and programs to better meet the needs of the aged, and 3) the improvement and coordination of community services. During 1968, 69 new and continuation projects were funded under Title IV at a cost of approximately $4,155,000. These projects were funded through grants or contracts with public or nonprofit private agencies, organizations, institutions, or individuals.

The objectives of the Title IV program are to analyze develop and demonstrate:

-- various ways of administering and delivering a full range of services in an effective and efficient manner wherever older people live;

-- new roles and meaningful activities for older persons;

-- improved patterns of retirement and preparation for it;

-- opportunities for employment and sources of supplemental income for older persons;

-- housing and living arrangements conducive to the well-being of older persons;

-- means of preventing personal disability among older persons, and when needed, providing rehabilitative procedures.

Research grants are probing areas such as problems of adjustment after retirement, the effects of social isolation on older people's nutritional habits, and the role of senior centers in enabling the elderly to remain active in the community.

Development and demonstration grants are investigating such areas as methods of providing low-cost meal services; administrative techniques for coordinating comprehensive health and welfare services for the aging; transportation methods for the elderly; new means of delivering services to special groups of older people such as the non-English speaking, the homebound and residents of rural areas; and new volunteer service roles for the elderly in schools and other health, education, and welfare settings.

A summary of the projects under the Title IV grant program has recently been completed. The knowledge and experience from these research and demonstration projects will be used as a feed-in to the Title III program to produce more effective programs, more extensive and readily usable services, and more appropriate activities, and to make these available at reasonable cost.

The competition for Title IV funds has been severe. Only one-fourth of the applications that have been submitted for formal review have been funded. These grants have been targeted into priority areas.

I. Organization of Food and Nutrition Services

The first priority area has centered on nutrition and meal patterns. Twenty-nine grants for over $2,000,000 have been made for projects designed to attack the social problems underlying inadequate and/or poor diets among older people. These projects attack such problems as loneliness, inability to market and prepare meals on the part of the homebound, lack of motivation for eating, and inadequate knowledge of food purchasing and meal preparation. They are testing a series

of carefully selected approaches for providing older people with information and a range of nutrition services in settings conducive to sociability, education, and good eating habits. The end objective is the promotion of independent living and the avoidance of institutionalization.

A few statistics on the 29 nutrition projects serve to illustrate the dimensions of this program.

(1) 23 are demonstration grants--20 in urban areas, 3 in rural areas.

(2) 3 are research projects and 1 is a development project.

(3) 9 are totally or in part located in model neighborhoods of the Model Cities Program.

(4) projects are located in all 9 regions and in 17 States.

(5) 2 have been completed, the others are active.

The demonstration projects are testing a variety of delivery approaches.

Among the approaches being tested are the following:

. In New York City, a multipurpose senior center located in a large public housing project will serve 200 older people a hot noontime dinner 5 days a week. A consumer education program will be coordinated with the meal service.

. In the poverty-stricken Mississippi delta region, older people are being brought together to plan, prepare, serve and eat one hot meal a day, 5 days a week, at a daily cost of 25 cents per person.

. In Kentucky, elderly persons from isolated Appalachain mountain communities are coming to community centers every Saturday night by bus for a hot nutritious dinner and an old-fashioned "country gathering."

. In Nebraska, Omaha and Winnebago Indians are learning good nutrition practices and economical meal planning in their own homes and in group meal centers located in tribal housing projects.

Many different types of public and private facilities for meal services are represented: senior centers, public schools, homes for the aged, nursing homes, day care centers, recreation centers, public housing, and church social halls.

Other related elements are built on to the meal service. These include consumer and nutrition education; nutrition counseling to meet individual needs; cooperative purchasing; commercial mobile marketing service; transportation, recreational activities; health services (both medical and dental); and social and referral services.

The research projects are providing comprehensive data and knowledge related to nutritional status, nutritional principles and practices, and social interaction patterns among the elderly as well as cost and acceptance of different delivery systems.

II. Coordination of Comprehensive Community Services

The research and development program's second priority area includes

an intensive, long-range attack on the problems of coordinating comprehensive community services. This attack is being implemented at various levels of the public and private sectors. It implements priorities of the Social and Rehabilitation Service, the Department of Health, Education, and Welfare, and the Model Cities Program.

Effective coordination of services must first be preceded by a set of viable services. Therefore, the approach includes emphasis on both improving services and on the development of services to fill current gaps. The latter priority includes studies and demonstrations of special transportation services, retirement planning and counseling, services to extend independent living for those threatened with institutionalization or dependency, part-time paid and volunteer service opportunities, and the facilities, staff and other resources for conducting meal and food services projects. Some of the nation's outstanding gerontologists are becoming involved in the design and testing of coordinating mechanisms for insuring efficient administration and delivery of the services being improved and developed in various types of communities.

Illustrations of the approaches which are being taken in the communities receiving grants for coordination of services to older people are as follows:

-- In New York City, a Title IV grant is being used to establish five neighborhood offices under the new City Office for the Aging. Three of the offices will be in Model City areas, and the other two selected to provide contrasting bases of comparison in terms of living arrangements, ethnic background and population density.

-- In Kansas Mo., a City-County Office of Aging is being set up with funds provided for this purpose under Title IV. The grant will enable the new unit to design programs to meet service needs of the elderly more effectively and develop a program planning and budgeting system as a model for other communities on a metropolitan or regional basis.

-- In Minnesota, the State Agency on Aging and a statewide five-station educational television network are demonstrating an effective system supported by Title IV funds. Their efforts not only get important information to older people, but also give them a sense of common interest--a sense of being part of a larger significant population group. A weekly program especially for senior citizens has been estimated to reach eighty-five percent of the elderly within the viewership area. This is a phenomenally high percentage for any kind of programming. Both group and individual viewing is encouraged, and off the air interpretation is provided through a localized telephone answering system and a network of field representatives who work with and through local and State senior citizens' organizations.

Although the first concern of the Title IV program is to generate and test knowledge, to demonstrate applications of this knowledge, and to seek improvements in current programs and practices, the Administration on Aging is also interested in seeing successful projects continued beyond the Federal support period. One such successful example was a grant of $42,000 in FY-68 to the Dade County Schools to develop part-time service roles in retirement for older people as teacher aides. This project generated $35,000 in income for older persons. This year, the people are still serving, but with local, rather than Federal funds paying the costs. As the program continues, the social and income benefits to older people will be multiplied many times

beyond the initial Title IV investment.

TITLE V - GRANTS FOR TRAINING

Title V of the Older Americans Act authorizes grants and contracts for the specialized training of professional, technical, and lay personnel to plan for and serve older people in programs related to the broad purposes of the Act.

In 1968, 15 grants and contracts were awarded for a total of 48 grants since Title V of the Older Americans Act became operational. Approximately 3,647 persons had received short and long-term training at the end of the year.

Broad objectives of the program are: (1) to develop and maintain an adequate supply of personnel trained for meeting the demands for manpower in services to the aging and related fields, and (2) to provide currently employed professional and technical personnel in appropriate fields with better understanding of older people and of methods for working with them.

The Administration on Aging training program has maintained its focus on areas within which there is desperate need for personnel and for which existing support has been inadequate or lacking. Training is now being offered in several professions for the first time. Priority occupations upon which the program is focusing are as follows:

1. Broad planning and administration in aging for work in public and voluntary programs at Federal, State, and local levels. Career training is needed as master's and doctoral levels; short-term training for currently employed persons seeking to increase their competency for work in the field of aging.

2. Training in planning, administration, and management in the field of retirement housing, villages, and homes for the aged. Career training at the master's level and a variety of short courses for employed persons are indicated.

3. Planning, administration, and program supervision for personnel of multiservice centers for older people. This field, like the two preceding, is expanding rapidly. The need is great for both career and short-term training.

4. Training for specialists in aging within such professions as recreation, counseling, adult education, architecture, library work, home economics, and retirement preparation. There are urgent needs in both the career preparation and short course area.

5. Preparation of faculty personnel broadly trained in applied social gerontology and preparation of specialists in aging within established professions. This is really the key to the production of all other types of personnel. Hundreds of members of professional school, college, and community college faculties should have indoctrination in aging or career preparation for teaching in the field.

6. Leadership training for members of State and community committees on aging and for older adults who wish to become active in their communities.

7. Training for semi-professional and technical personnel to serve under professional direction as library and recreation aides; aides in housing projects, senior centers, homes for the aged, and institutions; in homemaking and meal services, and in a host of other ways,

when support for such training is not available under other grant programs, such as vocational education.

Nearly twice as many short-term training projects as long-term projects were funded by the Administration on Aging in 1968; these were career preparation course, curriculum development projects, seminars and conferences.

The impact of the Title V Program is growing each year. An adequate measure of this impact is the number of trained personnel becoming available from projects supported by Title V funds. Through a major practicum experience as part of the traineeships, students have been able to learn from and contribute to various programs serving the needs of older people; also, potential employers are made aware of the availability of competent, trained personnel.

The Older Americans Act Amendments of 1967 authorized the Secretary of Health, Education, and Welfare to undertake a study and evaluation of the existing and foreseeable needs for trained personnel in various programs and services related to the objectives of the Older Americans Act and to report his findings to the President.

The Administration on Aging began preparation for the study in July of 1967. Projections were made on the numbers of older people in 1970 and 1980, their incomes, life expectancies, participation in the labor force, and other aspects of the older population. Three studies were made in which these projections were used by all grantees and/or contractors for background data.

The studies have now been completed and the preliminary indicators show a great need for additional trained personnel. It is estimated that the 330,000 or so persons now working in agencies serving older people exclusively or primarily will rise to a million or more by the middle of the upcoming decade.

Foster Grandparent Program

The Foster Grandparent Program which is administered by the Administration on Aging under contract with the Office of Economic Opportunity has proven to be a most successful method to provide meaningful person to person service roles for older people. This program now provides such roles for 4,000 low income men and women over 60 years of age. The program recruits, trains, and sponsors foster grandparents to provide personal attention to deprived, dependent, neglected or mentally retarded children. Each foster grandparent spends two hours a day with each of two children, five days a week, giving the children individual attention and care. Today, these foster grandparents work with a minimum of 8,000 children on any given day in 166 institutions, day care centers, hospitals and schools, in 40 States and Puerto Rico. The projects were supported by 9.5 million in Federal funds in FY 1968 with local sources providing approximately 15% of the total project cost.

Foster grandparents have demonstrated that they have much to give as a result of their years of living and they have shown ability to adapt, to change, to be flexible and to give of themselves to children in need. Their love, compassion, warmth, tenderness, patience and calm acceptance make then invaluable to the program, bringing new life and hope to the children they serve.

With the establishment of this continuing one-to-one relationship, children are walking who never walked, children are talking who never talked.

Even the most profoundly retarded respond to the warm care of foster grandparents and, and those who before had turned their faces to the wall glow with recognition and anticipation. At the same time, the program enables the "grandparent" to remain active in the community, and to gain a sense of dignity in this service role. The program provides incentive and purpose for more meaningful living as these elderly persons seek to help others who are less fortunate. It enhances self-esteem and brings an increased sense of security as a contributor to society.

The Foster Grandparent Program recently marked its third anniversary, having been authorized in 1965. From the initial 21 projects, it has expanded to a total of 68. Two thousand five hundred and sixteen foster grandparents, over half of the total, are working with retarded children in 71 different settings.

One hundred percent of the foster grandparents are over 60 years of age and under the poverty guideline of income. Twenty-three percent are black, 77 percent are white. Eighteen percent come from cities with 250,000 or over population, 44.5 percent from other urban areas, and 37.5 percent from rural settings.

Recent research studies which affirm the viability of the Foster Grandparent Program include those of the University of Utah by Gray and Kastler; Denton, Texas Research Report by Dr. Hiram Friedson; the Northeastern State College, Tahlequah, Oklahoma; Thames Valley Council for Community Action, Inc., Norwich, Connecticut and two studies by the Merrill-Palmer Institute, Detroit, Michigan, the second of which has just been released.

Perhaps the most important finding of this latter study is "that the foster-grandparents have indeed proven able to fulfill the personalized quasi-family function for the infants and young children in their care that was the most innovative feature of the Foster Grandparent Program plan. The rich emotional interchange between the foster-grandparents and "their" children has proven to be, in fact, the most distinctive and important contribution of the foster-grandparents to the institutional routine. One of the foster-grandparents, after two years of employment at the Sarah Fisher Home, Detroit, said in reference to her foster-grandchild, "I love him and he loves me. We help each other."

The future potentials for this program are great. There are long waiting lists of potential foster grandparents over the Nation who are requesting a part in the program. There are thousands of children who need love, care and the supportive role of an adult in their lives. It is the coming together of a great need and a great resource.

Activities and Relationships with Other Agencies and Groups

As focal point for the Federal concern for the needs and problems of the aging, the Administration on Aging is charged with stimulating more effective use of existing resources and available services for the benefit of older people. In carrying out this responsibility, the Administration on Aging engages in many joint activities and programs with other agencies of Federal, State and local government and voluntary and religious organizations active in the field of aging.

Coordinated programs and cooperative activities over the past year were achieved in three major ways:

First - through the established channels and the individual staff relationship developed by the Administration on Aging in its day to day con-

tact with other organizations and groups concerned with matters related to older people;

Second - through the formal mechanism of the President's Council on Aging, on which eleven major Departments and agencies are represented;

Third - through the interest and participation of the Advisory Committee on Older Americans whose members are involved in activities in aging in many areas and with many segments of the population.

In 1968, the Administration on Aging continued its operation of the Foster Grandparent Program in cooperation with the Office of Economic Opportunity. It also continued to review applications for Model Cities and to prepare models and guidelines for programs in aging for use by Model City demonstration agencies.

A 28-page booklet "The Fitness Challenge in the Later Years" was published in cooperation with the President's Council on Physical Fitness and Sports. With the cooperation of the President's Committee on Consumer Interests, the Administration on Aging published and distributed 700,000 wallet sized Consumer Guides for Older People.

The Administration on Aging worked with the Public Health Service in the development of suitable training programs for nursing home administrators in pilot projects for home health aides, in planning a national nutritional survey, and in developing model nutritional programs.

Consultations were held with the Department of Agriculture in the development of demonstration programs in nutrition for older people, with participation on the inter-agency task force on rural health pilot projects. The Administration on Aging provided the President's Committee on Mental Retardation with information on the impact of foster grandparents in institutions, day centers, special classes and homebound programs for the mentally retarded. The Administration on Aging joined the Rehabilitation Services Administration in the issuance of a joint State Letter to State agencies on aging, Vocational Rehabilitation Agencies, and Agencies for the Blind, urging closer cooperation and the exploration of new programs. It has joined with the National Institutes of Child Health and Human Development in the development of basic concepts for the study of retirement.

Close working relationships are maintained with those groups which represent older people or have aging divisions such as The American Association of Retired Persons, the National Council of Senior Citizens, the National Council on the Aging, the American Public Welfare Association, the American Medical Association, the National Farmers Union and the Gerontological Society. The Administration on Aging and other agencies worked with the National Medical Association on integrating comprehensive health care, housing and senior center services into the District of Columbia's Pilot Program.

Special addresses, consultation, or technical assistance were provided during the past year for the National Parks and Recreation Association, the General Federation of Women's Clubs, The Kiwanis Club, the American Geriatric Society, The American Society for Public Administration, the American Optometric Association, the National Conference on Social Welfare, to name only a few.

The interest and activity of religious groups has increased. In answer to requests, the Administration on Aging has assisted in seminars, workshops and conferences held by the Methodist Division of Christian Education; The United Church of Christ; Unitarian Universalist Association; the National Conference of Catholic Charities; the National Presbyterian Church and Center, The National Catholic Women's Clubs and several workshops for the clergy sponsored by lay groups or agencies on aging.

National religious denominations are putting greater emphasis on training of the practicing clergy to understand the problems of older adults and to stimulate the development of services to enable the elderly to live independently outside institutions. The Administration on Aging is working with all denominations toward these ends.

Plans are being made to include the voluntary and religious organizations in activities relating to the proposed White House Conference on Aging in 1971.

Information Activities

Charged with responsibility to serve as Federal clearinghouse of information on matters related to the aged and aging, the information program of the Administration on Aging serves a variety of "publics" --older people themselves, professionals working with and for them, Federal and State agencies and officials, and the public in general.

The Administration's Division of Information develops publications, fact sheets, press releases, publishes a monthly newsmagazine, Aging, and works closely with media in development of radio and TV programs, magazine articles, and newspaper series.

During 1968, the Administration on Aging handled more than 22,500 inquiries from members of Congress, from public and other private organizations, other government agencies, the press and members of the public, including many older people themselves.

There were several major publications during the year. AoA published the President's Council on Aging Report, A Time of Progress for Older Americans, which reviewed the activities of Federal agencies with programs benefiting older people and progress that has been made from 1965 through 1967. In May 1968, the Administration on Aging published The Fitness Challenge in the Later Years. The booklet presents an exercise program for older people at three levels of difficulty according to the amount of stress involved.

Another major publication was Communities in Action for Older Americans, a report of progress under Title III of the Older Americans Act in developing planning, service, and training programs at the local level.

Four major speeches by AoA officials, containing basic discussions on the needs of, and services for, older people were published in booklet form to make their information widely available. A new categorical list of AoA publications also was printed during the year.

Two church programs-one concerned with housing for the elderly and the other with an interfaith center--became the fourth and fifth publications in the Designs for Action series. A one-page flyer of statistical data, It's Happening Today in Programs of the Administration on Aging was published twice, once in January and once on July 14, to mark the third anniversary of the Older Americans Act. Aging in the News, reproductions of local newspaper clippings about projects funded under the Older Americans Act, was printed five times during the year.

Seven publications in the Federal Financial Assistance for Projects in Aging series were published in 1968. They explained support available for programs in aging under the Research and Training grant programs of the National Institute of Mental Health, the Vocational Education, Continuing Education and the Adult Basic Education programs of the Office of Education, the Manpower Development and Training programs of the Office of Education and the Department of Labor, and the joint Research and Demonstration program of the Social and Rehabilitation Service and the Social Security Administration.

One of the most popular publications ever put out by the Administration on Aging is the 16-panel, folding wallet care of tips on consumer buying and avoiding frauds and swindles, the Consumer Guide for Older People. It was developed by the Administration on Aging in cooperation with the President's Committee on Consumer Interests, and the Food and Drug Administration. More than half a million of the guides were distributed in response to requests in two months and a third printing of 250,000 was ordered to fill the steadily mounting orders from older people, senior citizens organizations and State agencies.

Aging, the official magazine of the Administration on Aging continued to be a major informational medium for professionals in the field. Monthly circulation during the year was 14,600, of which 6,100 were paid subscriptions and sales. Changes in format were introduced to make it more easily readable and improve its appearance. A special two-color Senior Citizens Month issue was printed for May. Several reprints were made of major articles, including one on the University of Michigan milieu therapy project and another on Texas programs conducted under the Older Americans Act.

Senior Citizens Month

May, 1968 appears to be the most successful yet in the six-year history of a Presidentially proclaimed Senior Citizens Month to promote interest in helping older citizens and in recognition of their talents and experience as a national resource. "Meeting the Challenge of the Later Years," the 1967 theme, was selected as a continuing theme, and in 1968, special emphasis within this broad theme was placed on the contributions older people are making to their communities. Well over a million copies of informational materials were mailed out to national organizations, State and local aging units, and to individuals. Local newspaper interest in older people, their activities and their contributions, was substantially greater than in previous years and hundreds of news items, feature articles, photographs and editorials concerning older people were printed in newspapers throughout the country during May.

Publications developed for Senior Citizens Month, in addition to the wallet card, and the Physical Fitness booklet were the proclamation, the poster in two colors with a matching envelope for mailing; the What Churches Can Do housing booklet; How Communities Observed Senior Citizens Month 1967, a collection of local newspaper clippings; and To Tell the Story, A Public Information Guide for Project Directors.

Service Responsibilities to Public Assistance Recipients

Social services to eligible older persons provided under Titles I, XVI, and XIX of the Social Security Act and certain other related responsiblities are now part of the administrative functions of the Administration on Aging. Eligible persons include recipients of Old Age Assistance and medical assistance to the aged, former recipients and potential applicants who are aged persons, and the aged leaving mental institutions.

Under the provision of Title I and XVI of the 1967 Amendments to the Social Security Act, States administering the public assistance programs for the aged may elect to purchase services from other public and private agencies, as specified by the Secretary of Health, Education, and Welfare. This action by the Congress gives States the opportunity to develop more flexibility in the provision of services by public assistance agencies.

As of December 31, 1968, 36 States and other areas were providing prescribed social services to the aged under the provision of Title I and XVI of the Social Security Act (1962 Amendments). At the present time, 23 State Departments of Public Welfare have a State level Specialist on Aging, or a unit composed of such specialists who are responsible for the planning and development of social services in the public assistance program.

The following paragraphs reflect the progress which has been made to date in some specific service areas.

Homemaker Services

Homemaker services in public agencies have more than tripled since 1963. Of the 440 public welfare departments throughout the country providing homemaker services in 1968, 115 were helping the frail aged with home management, and 93 were providing personal care. Thirty-one States now have homemaker services specialists or other State staff with program responsibility for homemaker services.

Volunteer Services

Program services by volunteers are statewide in New York, Michigan, Wisconsin, and Minnesota where coordinators of volunteer program services are part of the State agency staff. The Cook County (Chicago), Cuyahoga County (Cleveland), the District of Columbia, Milwaukee, Salt Lake City, and San Francisco Departments of Public Welfare each have fully developed citizen services for the benefit of recipients. Utilization of volunteer services in other communities is often sporadic, unorganized and temporary in nature.

Hope for a greater utilization of volunteers lies in Public Law 90-248 (The Harris Amendment) which requires that by July 1, 1969, States will use "non-paid or partially paid volunteers in a social service volunteer program - and in assisting any advisory committees established by the State."

Housing

During 1968, a plan which had been developed earlier to increase cooperation between housing and public welfare agencies was put into operation. To improve housing and expand housing resources, State agency guidelines were developed for:

1) relocation adjustment payments and relocation social services required by older public assistance recipients

2) cooperation between the Farmers Home Administration of the Department of Agriculture and public welfare agencies to improve housing of aged recipients in rural areas

3) public welfare's role in Model Cities planning, particularly as it affects older recipients

4) welfare rents in public housing as they affect older public assistance recipients, and

5) State experience in programs to improve housing of older public assistance recipients

The plan will help States take direct action to increase shelter allowances in assistance payments and to cooperate with the local housing authorities and other local agencies responsible for housing standards and housing code enforcement. The end result will be increased opportunities for aged recipients to secure adequate and decent housing at rentals they can afford.

Institutional Care

Intermediate Care Institutions are non-medical institutions which provide maintenance, some care and services, and group living accommodations for older persons who do not need medical care but do need a protective environment. Standards for these institutions have been issued to the States.

In addition, the 1965 Amendments to the Social Security Act have also made possible Federal sharing in payments to needy aged persons in institutions for mental diseases and tuberculosis. As of 1968, 28 jurisdictions had adopted the provision with respect to institutions for mental illness, and 21 the provision for tuberculosis institutions.

Demonstration Projects

During Calendar Year 1968 the Demonstration Projects Program in Public Assistance under Section 1115 of the Social Security Act provided grants for at least 14 different projects concerned with serving elderly recipients of public assistance. These projects were carried out under the auspices of State public welfare agencies.

Two areas participated in model projects under a National Plan for protective services to the aged: the District of Columbia carried out its protective services program in a metropolitan area, and Colorado experimented with the delivery of protective services in three rural counties. These projects were designed to increase knowledge and skills in the provision of protective social and legal services to older adults, to demonstrate the process and value of a multi-disciplinary approach in which a local department of public welfare provided the protective services, and to develop specific criteria to identify and define protective services and the roles of the various units participating in their provision.

The Texas State Department of Public Welfare continued to carry out a demonstration in the provision of comprehensive services to aged, ill and handicapped recipients in public housing in Dallas and Houston. Through this project gaps in service to the elderly were identified; attempts were made to eliminate them; and valuable data was collected for projecting the administrative and service costs involved in extending adult services on a boarder basis.

The Mississippi Department of Public Welfare has had a project to extend services to elderly public assistance recipients from a few selected counties to a broad Statewide program. A consultant on services to the aged was employed by the State agency, and the project focused on identifying the potential for improving family and individual functions and the reduction of dependency.

The Assistance Payments Administration

The Assistance Payments Administration of the Social and Rehabilitation Service is responsible for making grants to States to finance money payment programs for needy persons. These payments were to provide for the basic necessities of food, clothing, shelter and other incidentals of daily living.

The old age assistance program served about 2,023,000 persons 65 and over in September, 1968. This is a marked decline from the all time high of 2,810,000 in September, 1950 despite the steady increase in the number of aged people in the older population. It is due to the increased number of persons receiving Old Age Survivors and Disability Insurance (OASDI). About 1.2 million older persons were receiving both Old Age Assistance and Social Security payments in June, 1968. They represent 59 percent of all Old Age Assistance recipients. The average monthly money payment to recipients of Old Age Assistance in September 1968 was slightly over $68.00. All 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have old age assistance programs.

The Aid to the Needy Blind program is administered in all jurisdictions and served about 81,000 persons in September 1968, of whom approximately 32,000 were 65 and over.

All States except Nevada have Aid to the Permanently and Totally Disabled programs, and served 684,000 persons in September, 1968, of whom over 22,600 were 65 and over. This program has gradually increased since its beginning in October, 1950.

The 1967 Amendments to the Social Security Act, effective January 1, 1968, made it possible for States to disregard up to $7.50 a month--rather than $5.00--of any income of aged, blind, or disabled recipients. As of September, 1968, nine States have adopted this provision; another 15 States have adopted the provision to disregard $5.00 of any income.

Another amendment, effective January 1, 1968, permits the Federal Government to share with the States in the cost of repairs made to homes of older persons receiving assistance. The purpose is to enable the individual to continue to live in his own home. The limit is $500 for the repair of any home.

Medical Services Administration

The Medical Services Administration of the Social and Rehabilitation Service administers grants to States for medical assistance programs serving public assistance recipients and other medically needy people.

This program began January 1, 1966, and by 1970 will be the only way for States to receive Federal funds for vendor payments for medical care for welfare recipients. In adopting a Medicaid program, a State must provide high quality medical care and services to all people receiving federally aided public assistance. By 1975, the program must be extended to certain children and adults who do not qualify for public assistance but do need help with medical expenses.

By January 1, 1969, 43 jurisdictions had approved Medicaid programs. They were: California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Guam, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virgin Islands, Washington, West Virginia, Wisconsin, and Wyoming.

During fiscal year 1968, medical vendor payments in behalf of people 65 years of age and over, totalled $867.6 million, about 97% of which was under title XIX (Medicaid).

In the 12-month period from July 1, 1967 to June 30, 1968, hospital care and nursing home costs accounted for approximately three quarters of the total expenditures for medical vendor payments. The remaining costs covered physicians care, prescribed drugs, and other services.

Jurisdictions that do not have Medicaid programs in operation, provide basic medical care for needy people over age 65, under the Old-Age Assistance Program and/or Medical Assistance for the Aged. In July 1968, payments for medical care under MAA and OAA totalled $4,670,000.

Rehabilitation Services Administration

The primary objective of the Rehabilitation Services Administration's program for the Aging is to rehabilitate as many older handicapped individuals as possible into gainful employment. This is accomplished through activities of the State-Federal rehabilitation program administered by the agency.

The Rehabilitation Services Administration is uniquely qualified, through the type of individualized services and specialized programs it offers, to meet the needs of those older Americans requiring rehabilitation. The agency endeavors to assist each individual to reach his most adequate functioning level and highest potential. This is accomplished through a diagnosis of his condition followed by various services designed to overcome his specific handicap. Throughout the process, the emphasis is on helping the individual to help himself. These services include evaluation and medical diagnosis to determine the nature and extent of the disability and to ascertain capacity for work, counseling to help in developing a good vocational plan; medical care to reduce or eliminate the disability; artificial limbs and other prosthetic devices needed to aid work ability; vocational training and job placement; and follow-up to ensure satisfactory placement.

Progress in Rehabilitation of the Aging:

There has been a steady increase in the number of individuals aged 45 and over rehabilitated into gainful employment as State agencies have placed more emphasis on the need to serve this age group.

State Rehabilitation Agencies: Rehabilitated persons 45 years of age and over at acceptance Fiscal Years 1966 - 1970.

Fiscal Year	All Rehabilitants	45 years of age and over
1966	154,279	41,300
1967	173,594	47,000
1968 1/	207,918	60,000
1969 1/	230,000	64,100
1970 1/	265,000	74,000

Training:

It is anticipated that larger numbers of older Americans will require rehabilitation services, and we have been directing more of our training resources toward increasing the skills of rehabilitation personnel and other appropriate personnel, so that they will become more proficient in serving older citizens.

The agency has conducted training courses and conferences in all sections of the country, which brought to personnel indigenous to these areas, information about modern rehabilitation concepts and methods, thereby enabling these people to keep abreast of current rehabilitation philosophy and techniques.

For example, in FY 1968 a Regional Conference on Rehabilitation of the Aged Handicapped was conducted at the University of Tennessee in Knoxville. Two short-term training courses focused on the older handicapped are planned for FY 1969.

1/ Estimated.

Rehabilitation Facilities - Projects with a Geriatric Identification:

Although most of the agencies receiving grants have a segment of client population that would qualify as Aged, the following three projects currently in operation have specific programs for this group:

Ohio - (Construction Grant)

Grant awarded to assist applicant in the purchase of land and the construction of a new vocational rehabilitation center. Project enhanced by agreement to participate in the project with the local Metropolitan Housing Authority to demonstrate the desirability of constructing a public housing development for the handicapped and senior citizens in conjunction with a vocational rehabilitation facility. The proposed new vocational rehabilitation center will be adjacent to the housing project.

Missouri - (Workshop Improvement Grant)

More than 50% of client load identified as aged or too severely handicapped to be employable in competitive employment. This grant added three staff members and leased space to develop a more meaningful program for the current clients as well as long-term chronic clients from nearby County and State Hospitals.

Nebraska (Project Development Grant)

Purpose of project is to evaluate the feasibility of introducing a vocational element into a combination nursing home and extended care facility. Client load ranges in age from 23 to 95.

Special Activities for the Aging in State Agencies:

Although State rehabilitation agencies serve older persons during the operation of their regular on-going programs, some special projects are initiated which focus on the aging. The following are presented as representative of this type of specialized service.

New Mexico:

Basic support (Sec. 2) funds have, for example, been used to establish a rehabilitation program for the aged with chronic disabilities at the Roswell Rehabilitation Center in New Mexico. Nearly a quarter of a million Federal dollars were channeled through the New Mexico Division of Vocational Rehabilitation in 1968 for the expansion of services, equipping and staffing of this facility.

New York:

The State agency has sponsored two projects which will aid blind public assistance clients residing in long-term nursing homes. Additional staff will be made available to assist in working with these individuals so that they can either return to the community or be moved into foster home settings.

Texas:

"An early referral project" involving Social Security beneficiaries was initiated by the State agency in Austin, Texas, this year. The project is modeled after successful projects in other States and is designed to serve Social Security beneficiaries as soon as possible after disability begins.

A large percent of individuals served are over 45.

Social Security Disability Applicants:

The Rehabilitation Services Administration works with the Social Security Administration in utilizing the Social Security disability applicant load as an important referral source of older disabled persons for State vocational rehabilitation services. Over the past several years, more than one-half million persons have applied annually for disability benefits and have been considered for rehabilitation services. In recent years, the median age of such beneficiaries has been 57. In fiscal year 1967, the median age of all applicants for disability benefits who were rehabilitated under a State plan was 44. The 1967 Amendments to the Social Security Act provide reduced disability benefit payments to a new group of persons age 50 and over, namely, to totally disabled widows, widowers and surviving divorced wives. It is estimated that about 100,000 such persons will apply for reduced disability benefits in Fiscal Year 1969.

To make it possible for more persons who apply for Social Security disability benefits to receive State vocational rehabilitation services, the 1965 Amendments to the Social Security Act authorized the use of certain social security trust funds to pay the cost of such services to selected disability beneficiaries. Trust Fund expenditures for Fiscal Year 1968 amounted to $16 million; for Fiscal Year 1969 an estimated $18 million will be available, and the States estimate that they will spend the entire amount.

It is estimated that during FY 1968 21,000 Social Security Disability Insurance applicants were rehabilitated, including 13,000 who were beneficiaries. Of these beneficiaries, 6,000 were rehabilitated with the aid of Social Security trust funds.

Future Plans:

Increased emphasis will be placed on RSA's program for the aging, as the 1968 Amendments to the Vocational Rehabilitation Act propose to aid individuals disadvantaged by advanced age, or other factors, through the Vocational Evaluation and Work Adjustment Program. Also, it is anticipated that RSA will work in conjunction with the Administration on Aging in the organization and development of plans for the White House Conference on Aging, legislation for which has been enacted by Congress.

Office of Research, Demonstration and Training

Research and Demonstration

One of the most difficult problems faced in working with the chronically disabled person is bridging the gap from hospitalization to return to the community. The special problems of the aging in ghetto areas need to be examined through projects that can demonstrate new techniques involving appropriate vocational activities for the group. With the great advance made in medical and surgical care of patients in the hospital, there has not been a corresponding advance in community planning to ease the transition. More programs need to be developed to help the patient shed his habits and way of life acquired from long-term hospitalization, to develop more independence, to brush-up on old skills, and to develop increased tolerance. Something akin to the "half-way house" concept of the mental health movement, needs to be tried out more. The problem of the homebound must not be overlooked, either. Removing architectural barriers can help, and the testing of the use of subprofessional personnel selected from the aging needs to be initiated.

Particular attention is being paid to rehabilitation of the aging in the multi-service centers now being initiated with support from various parts of SRS and focused on the needs of clients drawn from the culturally and socially disadvantaged. One of these, the Atlanta Evaluation and Employment Center, is making a special effort to upgrade services to the aging poor and place them in appropriate jobs.

Another project is devoted to preparation of a system for placing aging persons in industry in up to twenty locations throughout the country. This is the most massive attack which has yet been made on the neglected problem of industrial placement for the aging.

Special Foreign Currency Program

In the international research program, cross-national studies supported by U.S.-owned local currencies provide comparative and cumulative knowledge on aspects of aging which are of universal concern. Recognition of the important implications for social policy and for programs to meet the diverse needs of this age group has prompted the European Office of the United Nations to initiate plans for a special seminar to consider findings from these studies. Next steps include more intensive and longitudinal studies to assess changes in the circumstances of sub-samples of persons included in earlier or on-going studies. Experimental multipurpose service programs related to structures and patterns in different settings will test assumptions and generalizations which evolve in individual countries.

PUBLIC HEALTH SERVICE

Consumer Protection and Environmental Health Service

Food and Drug Administration

All of the activities of the Food and Drug Administration are designed to protect consumers and, therefore, have a significant impact on the health and well-being of older persons. Nearly 60 million Americans are aged 45 and over, representing about 30 percent of the Nation's population; FDA estimates that one-third of its resources are devoted in one way or another to the protection of the aging.

National Air Pollution Control Administration

The National Air Pollution Control Administration conducts a research and development program on the effects, causes, and control of air pollution, and a program for the abatement and control of air pollution. Although the NAPCA's programs are not specifically aimed at the aged, they represent a population group more likely to suffer ill effects from exposure to air pollution; hence, the aged will benefit greatly from the research, abatement, and training activities being conducted and supported by the National Air Pollution Control Administration.

Environmental Control Administration

Aging programs in the Environmental Control Administration include research conducted or supported by the Occupational Safety and Health Program which is concerned primarily with the pathophysiologic response of man to his environment. In this connection, clinical studies are being made in which age is the most important non-occupational variable. Among the projects now being supported are investigations of chronic chest diseases in bituminous coal miners, health hazards in uranium mining and milling, and the effect of a hot environment on the elderly. Other research projects supported by the program include a study of hearing loss in industry due to noise, and a study of the aging lung.

The Community Environmental Management program is supporting several research projects basic to the health and well-being of older people. Included are studies which provide for the screening of women for osteoporosis, bone disease, evaluation of a new diagnostic device used to measure osteoporotic change, and methods of maintaining bone strength and improving bone mending, all of which will contribute to improved preventive or control measures. In addition, experimental research has been programmed in the program's research laboratory on various types of motor and perceptual impairments in driving among the aged.

Consultation is also given to State health departments, other Federal agencies, and other public and voluntary groups concerned with the development of accident prevention programs for services and public education.

The program also assists the agency involved with the development of materials relating to accidents and the aged, and provides courses in the "Public Health Aspects of Accident Prevention," which includes material relevant to the problems of older people. These courses are conducted by health departments, universities, and schools of public health. Similar seminars are being developed for selected practitioners in the field of public health and for personnel in schools of nursing and public health. Close liaison is maintained with experimental groups in gerontology. The program also provides consultation to groups planning special services for the aging and aged. General consultation in housing hygiene is given to Federal, State, and local and private agencies.

A major portion of the research efforts of the Bureau of Radiological Health is concerned with the long-term effects of low levels of radiation exposure. Primary interests relate to the study of long-term effects as a function of radiation dose with the ultimate aim of providing better scientific bases for population radiation standards as well as gaining more fundamental knowledge related to the mechanisms of cause-effect relationships and methods by which radiation damage may be diagnosed early, prevented, mitigated or treated.

The primary approach is to study the relationship between radiation dose and the incidence of disease and disability in human population groups; i.e., epidemiologic studies, with supportive and complementary experimental studies using animals and various biological systems. Nonspecific life-span shortening and acceleration of aging are among the most important consequences of the long-term somatic effects of radiation exposure in population groups. Consequently, much of the research, directly or indirectly, relates to the problem of "aging" and the closely interrelated problem of radiation carcinogenesis.

The major epidemiologic study effort as related directly to aging concerns the studies of the Atomic Bomb Casualty Commission in which life-span studies are being done on the incidence of disease and disability among the survivors of Hiroshima and Nagasaki. A major study parameter is whether nonspecific life-span shortening or accelerated aging relatable to exposure from the atom bomb will be found in the survivors.

The major experimental program related to aging studies is a cooperative effort with Colorado State University and deals with the developmental and aging effects in dogs as consequence of radiation exposure at various times of life as compared to a normal unexposed population of dogs. This project, referred to as the Collaborative Radiological Health Animal Research Laboratory, involves the use of 2,000 beagles most of which will be carefully followed for their life-span and subjected to a spectrum of numerous experiments and tests.

Salaries and Expenses, Office of the Administrator

Consumer Specialists in the field are directing special attention to the problems of elderly consumers. A series of regional conferences (conducted in cooperation with the Administration on Aging) was directed at professional groups and organizations concerned with the problems of the elderly. In addition to these conferences, Consumer Specialists spoke to many senior-citizen centers and clubs throughout the country and worked as advisors to several State Committees on problems of the aging.

Health Services and Mental Health Administration

Community Health Service

The Partnership for Health legislation, enacted two years ago, broadened the emphasis of Public Health Service activities from programs of categorical nature to a broad approach encompassing the total spectrum of comprehensive health services. In the new approach, two action thrusts are being made: (1) to remove inequities and inadequacies in access to and quality of personal health care; and (2) to assure maximum protection against preventable diseases and hazards in the environment.

Full recognition is given to the fact that the unique health needs of the aged often necessitate health services specially designed to meet these needs. At the same time, with the current emphasis on planning for comprehensive health services many individual activities which formerly would have been developed as free-standing programs for the aged were now incorporated into comprehensive health programs for wider populations.

In October 1968, the Division of Medical Care Administration was merged with the Office of Comprehensive Health Planning to form the Community Health Service. It brought to the Community Health Service a significant program commitment to the health needs of the aging, especially, because of its responsibilities in the professional health aspects of Medicare. The Division was particularly active in the areas of standards development for providers, certification of health service providers, and assistance to providers to enable them to meet Medicare standards. By the end of fiscal year 1968, 6,966 hospitals, 2,181 home health agencies and 6,048 extended care facilities had been certified to participate in Medicare.

General Aging Activities in the Community Health Service

The Community Health Service carries out programs designed to meet the unique health needs of the aged through stimulation and improvement of community services, development of educational materials and through the conduct of information programs.

Health Resources

The Division of Health Resources in the Community Health Service is concerned with the development of activities to improve services provided in hospitals and in nursing homes and related facilities, and to stimulate the development of a broad range of home health services to meet the health needs of the population, including the aged living in the community.

Home Health

The Public Health Service collaborated with the Office of Economic Opportunity and with the Administration on Aging in developing a group of pilot training projects to train poor, older individuals to become home health aides. Seventeen completed community projects trained 974 persons, and all but 151 were immediately employed in a variety of health facilities. To date, 2,000 copies of an advanced version of guidelines for recruitment, selection, training, employment and utilization of home health aides have been distributed to interested programmers.

Staff activities carried a large share in providing assistance and encouragement for promoting home health services. A two-day national conference was

held in Chicago, September 14-15, 1967 as a cooperative endeavor with the Bureau of Health Insurance, Social Security Administration. The purpose of the conference was to assess the impact of Medicare on home health agencies in order to learn what was working well, what problems were encountered and what actions might be taken to consolidate and multiply gains in the program. The 26 participants represented official and voluntary service agencies, State certifying agencies, and fiscal intermediaries and, in addition, there were 20 resource persons from the Bureau of Health Insurance, Social Security Administration and the Division of Medical Care Administration. The Conference discussions have been summarized for publication as "Home Health Agencies After One Year of Medicare." Another such conference, as suggested by the conferees, is included in the work plans for FY 1969.

The year's numerous activities served to provide information on home health care and home health agency development. A new film strip on home health services was produced and copies sent to the Regional Offices for their use in promotion of home health services. An exhibit on home health aid services was developed and used for the first time at the May meeting of the National Social Welfare Conference in San Francisco. The portrait, "Tri-Hospital Home Care" which depicts how Passaic, New Jersey, developed a home care program was produced and given extensive distribution to State health, welfare and nursing departments, voluntary and professional organizations, schools of public health, and regional offices.

Long Term Care Facilities

A pilot program for using nursing homes to teach undergraduate medical students selected elements of geriatric and community medicine was implemented with the University of Vermont College of Medicine. First quarter project report shows 18 of the 44 fourth-year students elected to participate in the program and that the Director considers the project to be valuable and successful, in excess of their anticipation, and that they look forward to continuing growth.

A State-Public Health Service Cooperative Improvement Program for nursing home inspection was initiated at a national meeting in Dallas, Texas, in May 1968. This program was subsequently implemented through Regional Conferences and through the appointment of an ad hoc committee composed of State personnel responsible for licensure of health care facilities. The committees are developing a uniform nursing home survey form and model State licensure regulations. Training programs for State surveyors and consultants are also being developed.

New legislation in the form of an amendment to Title XIX of the Social Security Act requiring the licensing of nursing home administrators by July 1, 1970 has increased activity in the area of training nursing home administrators.

To assist States in preparing for the development of more extensive educational programs to improve the quality of long-term care administrators, continued emphasis was placed on university-based seminars. Eight State universities held seminars with approximately 400 participants representing 15 States. A project was developed with the Professional Examination Service of APHA to prepare examination questions and core examinations for State licensure of nursing home administrators and for the selection of qualified surveyors by State and local authorities.

Close working relationships have been maintained with the Division of Allied Health Manpower in the development of a curriculum offering more extensive educational opportunities for community-based education of long-term care facility administrators. Direct staff support is being provided to the

National Advisory Council on Nursing Home Administration to assist the Council in carrying out its functions.

A total of 39 short-term training grants were stimulated in 27 States to enhance the professional competence of personnel (i.e., administrators, pharmacists, therapists, dietitians, nurses, social workers, etc.) working in long-term care facilities.

Professional Education

The paucity of teaching programs and resources required to train health professionals oriented to comprehensive health care is of particular importance to the aging and aged in the population. For while this inadequacy adversely affects the health status of the total population, the impact is especially sharp among the aging and aged who are more vulnerable to illness and disability.

As a means of stimulating interest in developing undergraduate medical curricula that provide orientation in comprehensive patient management, the Adult Health Protection and Aging Branch last year negotiated contracts with three medical schools to develop "blueprints" for teaching programs in this area. These were the School of Medicine of the University of Missouri, the School of Medicine of Tufts University, and Mount Sinai School of Medicine of the University of New York City. This year two additional contracts for planning of model teaching programs in comprehensive patient management were negotiated with the schools of medicine of Boston University and the University of Southern California.

Supported by a contract negotiated with Community Health Service, the University of Pennsylvania School of Social Work completed the third and final year of providing its students with supervised field experience in work with the aged. This demonstration of social work within a nursing home conducted under the auspices of the Philadelphia Welfare Department was so successful that a supervisor of social work and four additional social work positions involving work with the aged were put into the City budget.

Educational Materials

The development under contract of a comprehensive body of knowledge in applied gerontology was completed by the Gerontological Society to be released by the Community Health Service as a four-volume series entitled "Working With Older People: A Guide to Practice."

Volume I, "The Practitioner and the Elderly" has received enthusiastic reception from the medical profession as well as from other health practitioners and educational institutions. More than 20,000 copies have been distributed or sold, and requests for copies continue to be received daily. Attesting to the usefulness of the volume as a training resource are the highly commendatory reports submitted to the Public Health Service by medical organizations, schools of nursing and social work, and other organizations concerned with the training or orientation of individuals who work with the aged.

Volume II, "Biological, Psychological, and Sociological Aspects of Aging," is expected to be available in the spring of 1969.

Volume III, "The Aging Person: Needs and Services," and Volume IV, "Clinical Aspects of Aging," are in advanced stages of preparation.

Hopefully with the availability of all four volumes, efforts will be directed toward the development of specially designed training programs that will

utilize this valuable resource material for continuing education in applied gerontology for physicians, nurses, therapists, social workers, and the many other professionals who work with the aged.

Particular emphasis will be placed on use of this resource material in the development of orientation programs for the practicing physician, for it is he who is the key member of the team at the primary care level. "Working With Older People: A Guide to Practice" alerts the physician to the need to consider psychological and social factors along with physical factors in the treatment of the elderly patient. Treatment of the whole person rather than the symptom is a philosophy the Community Health Service is attempting to engender among physicians for patients of all ages.

Other Activities

During 1968, two health counseling projects supported by the Public Health Service in cooperation with the Social Security Administration were completed. Located in Milwaukee, Wisconsin, and Peoria, Illinois, the projects were designed to develop and test a method of providing personal health counseling which will motivate older adults to take positive action to protect their health. One new project begun in 1968 in Fresno, California, will continue through July 1969; the New Orleans project, which was started in 1967, is nearing completion. All of these contracts are utilizing a similar population sample, individuals 62 years of age or older who are applicants for Social Security retirement benefits. Preliminary data indicate an increase in adequate health maintenance routines after counseling.

Reports from the National Audiovisual Center in Atlanta, Georgia, reveal continued high interest in the two Public Health Service films which relate to health of the aging. "The Critical Decades" focuses on the need for health protection for individuals in their forties and fifties to insure good health in the later years. "Ready for Edna" gives historical perspective on development of health services through the years, and describes the broad range of health services which ideally should be available in communities throughout the Nation. The films were loaned for showing to 1,000 organizations in 1968. Such organizations included: voluntary and governmental health agencies; a broad range of teaching institutions including schools of medicine, nursing, public health and pharmacology; hospitals; professional and voluntary medical organizations; and commercial and educational television.

Health Facilities Planning and Construction Service

A primary objective of the Health Facilities Planning and Construction Service is to stimulate the construction of facilities needed to build up an efficient, well-coordinated network of services for the acute care, long-term care, and rehabilitation of all persons, including the aged, and aging. Since the enactment of the Hill-Burton program, the Division has provided assistance for the construction of 82,000 long-term care beds in chronic disease hospitals, nursing homes, and units of general hospitals.

The need for construction of long-term care facilities continues at a high level. As the aging population continues to increase, the demand for adequate nursing home care for them must be met. In addition the enactment of the Medicare program partially removes the economic barriers to care of the aged. State agencies report that 357,500 long-term care beds, including extended care facility beds, must be constructed, remodeled, or replaced. In FY 1969, 66.8 million dollars were appropriated for the construction of long-term care facilities. This level of financial assistance will stimulate the construction of approximately 10,000 long-term care beds.

The aging and aged will benefit also from the construction or modernization of other health facilities under the Hill-Burton program. Hospitals, diagnostic and treatment centers, public health centers, and rehabilitation facilities are used extensively by the aging. Funds appropriated for these facilities totaled 200.4 million dollars in 1969

In addition, the following services provided by the Division contribute to improved health care of the aged and others throughout the Nation: (1) technical and professional consultation regarding all aspects of facility planning, design, and construction, which is available to States, public agencies, and nonprofit organizations; and (2) guideline material relating to the planning, design, equipping, and construction of health facilities, which is continually being developed and distributed.

National Institute of Mental Health

Some 20 million Americans today are more than 65 years old and about 12,000 are more than 100. By the year 2,000, it is estimated that 28 million people will be over 65. The mental health aspects of aging are, therefore, among the most important areas of inquiry and service supported by the National Institute of Mental Health. Though medical science has increased the prospects of longevity, the complexities of modern life pose problems of adaptation, especially for older persons, far greater than those of earlier times and simpler societies. Hence, the National Institute of Mental Health supports a wide range of research endeavors, clinical studies, community programs, and training efforts to enable older people to the fullest extent possible--which is certainly far larger than at present--to lead enjoyable and rewarding lives.

Besides the mental health problems they share with other age groups, older people are vulnerable to specific difficulties associated with the aging process. Some of the mental impairment of many older people is concomitant with physical aging, but the psychological reaction to the physical process makes for unnecessary impairment as evidenced by the high incidence of depression, suicide, and other maladaptive behavior among older people. Loss of status in a youth-oriented society accelerates psychopathological reactions. Although persons over 65 constitute less than 10 percent of the population, they make up 19 percent of all first admissions to State mental hospitals and they occupy 30 percent of all public mental hospital beds. In addition, large numbers of mentally disturbed older persons are found in such institutions as nursing homes and homes for the aging.

The Institute's efforts in this field are centered in the Section on the Mental Health of the Aging which is in the Office of the Director, Division of Special Mental Health Programs. The Section has two main, general concerns. First, it stimulates and encourages the incorporation of specific mental health considerations in those programs for the aging where such considerations have been neglected; similarly, it stimulates and encourages appropriate provision for older people in mental health programs where the aging have been largely ignored. Second, the Section stimulates and aids the establishment of new, usually model or exploratory, service programs and of research studies in areas where more information is needed. Ih these efforts extramural basic and applied research grants, training and manpower programs are all involved.

Institute-supported research related to the aged and the aging process includes the biological, medical, psychological, and social sciences. Some studies are investigating the impact of cultural values, minority status, ethnic backgrounds, and housing. Others are concerned with the psychological effects of different environmental situations--for example, occupying a hospital bed, living in an institution, living in a housing project for the aged, living in the community. Such research will increase the knowledge and skill with which lay and professional groups and individuals can plan a better future for the aged.

The Institute has long been interested in the importance of housing in meeting the psychological as well as the physical needs of the elderly. To get more information on this subject, investigators supported by NIMH are studying the effects of special noninstitutional housing for healthy older persons living on the west coast. In the first stage of the work, the investigators made an extensive survey of apartments, houses, and hotel units being built for elderly persons of low or middle income. The findings have been published in book form. Then a sample of individuals was drawn from six housing facilities, maintained for elderly people of all levels of income and matched with a control group of comparable individuals living in urban neighborhoods. Among areas being investigated are the emotional and physical consequences of segregating older persons and of placing them at some distance from their relatives. The findings are not all in, but the investigators conclude thus far that housing itself has very little influence upon health, under the conditions studied, and no great effect upon social pathology. The aged person in retirement housing appears to like it. There is some evidence that retirement housing presents a welcome retreat from contemporary and pressing urban problems.

Another investigation of the same general subject is studying 1700 elderly persons residing in various types of housing--some for older people only, some for people of diverse ages, some in the city, and some in the suburbs. The investigators are learning what the aged themselves feel is important in housing, the kind of housing that would best meet the expressed needs, the extent to which these needs actually influence satisfaction with their present housing, and the effect of socioeconomic variables.

Investigators elsewhere are measuring the effects of the availability of social and medical services in various housing arrangements for the aged, and identifying some of the characteristics of those aged who choose these types of group living arrangements rather than remain in a larger, more heterogeneous community. Residents of eight different group housing settings for the elderly--including public, nonprofit, and commercial developments--are being compared with one another and with people outside of such developments.

One of the major problems faced by older people in public housing in urban settings is identifying and using available resources and interpreting their needs to the managers of housing developments. The Community Service Society of New York City is attempting to meet this problem by giving special training to mature women and placing them in public housing developments as information and referral sources for elderly residents. One of these senior advisory workers has been placed in each of four housing projects, each with 300 to 500 persons aged 60 or above. A fifth project is used as a control. The elderly, readily responding to the program, use the offices of the service workers as places for meeting, discussing problems, and seeking information and help. In the first year of the project, 86 percent of the target population, 953 aged people living in the housing projects, were in some way reached and helped. Many, but not most, tenants said they had major problems. In the greatest proportion of cases (33 percent), the big problem was the inability to utilize resources independently. Other major problems were health and finances. The principal types of help given were information, facilitating the receipt of services, referral to agencies, and advice and reassurance about problems of daily living.

Adjustment to forced retirement presents many older people with a crisis which seriously interfers with their adjustment to later life. In Boston, a project is being carried out to determine social and psychological conditions and processes by which the sense of personal autonomy is produced and maintained in relation to the problems and crises of role alteration at forced retirement. One thousand persons employed in companies following the policy of forced retirement at the age of 65 are being given intensive interviews plus mail-back questionnaires - 6 months before and 6 and 18 months after leaving the job -

to determine the factors involved in successful adaptation to retirement. Major areas to be explored are: 1) adaptation, as described by knowledge and information, ability to get along with others, intelligence, energy and skills, 2) goal attainment, including independence, initiative, industry, and use of available opportunities, 3) integration, including unity of belief and value system, consistency of behavior and likes and dislikes as well as physical health, 4) pattern, including self-respect and personal integrity, keeping physically fit and putting principles and beliefs into practice.

In related work, the Department of Psychiatry at Harvard Medical School is trying to identify patterns of behavioral response to loss of occupation through retirement and to learn about the factors influencing individual response to retirement. The subjects are 500 men and women who have not been retired more than three years. Such research may contribute to our understanding of the factors which influence most the nature of individual responses to retirement. It may also provide information that will increase the effectiveness of pre-retirement education programs.

Other investigators are concerned with developing information on the role and function of the aging in our society. One group is examining the hypothesis that guidelines for behavior in old age are poorly defined in the American culture, which is one main reason the elderly face serious adaptational problems. Some of the information in this research is coming from a comparison between elderly persons living in the community and persons admitted to a psychiatric ward for the first time after they reached 60.

Another project has aimed to show how older persons in a rural community might achieve a satisfying role by becoming a participant in tasks - such as beautification projects - for bettering the community. Both older and younger adults have participated in some phases of the demonstration. Tangible community benefits resulted, and the people participating in the program gained in morale.

Changes in racial attitudes are being studied by researchers at the Senior Citizens Center of Nashville, Tennessee, which is integrated. Preliminary analysis indicates that membership in the Center reduces racial prejudice in both whites and Negroes but that older Negroes are less prejudiced than older whites. These Negroes feel that they are different from both whites and other Negores in that they value personal qualities rather than material objects or pleasure-oriented behavior. They also believe they have less personal control over their environment and are more controlled by outside forces than older whites. The attitudes and personalities of these people are being compared with those of Negores and whites who are active in non-integrated groups.

In San Francisco a major study, drawing to a close, has been analyzing psychiatric, physical, sociological and anthropological information about 600 elderly people living in the community and a similar number of elderly people admitted for the first time to a psychiatric ward. The research group so far has published three books and numerous papers. One finding deals with social isolation, which has long been thought of as a possible cause of mental illness. The investigators report that old persons who are mentally ill, whether they are hospitalized or living in the community, are indeed far more isolated than other old people. However, the researchers also find that people who have been extremely isolated all their lives run no greater risk of being hospitalized for mental illness in old age than people who have been socially active.

One of the most crucial problems in this field is how to prevent the unnecessary institutionalization of older people, and, with Institute encouragement and support, a number of research and demonstration projects have addressed themselves to it. In Houston, for example, an interdisciplinary geriatric diagnostic team is studying 100 persons, over 65, who were suspected of being mentally ill and were admitted to the Harris County Diagnostic Center. Through work by existing community resources and by members of the team, these people are treated and given rehabilitation services. The members of the group are being compared with members of a similar group processed through the same center before the current program

began. Preliminary reports show that only two out of five of the patients in the present study, in contrast to three out of four of those in the control group, have had to go to a mental hospital.

In a somewhat similar project in Philadelphia, individuals who had applied for admission to a home for the aged and been placed on the waiting list were provided with a program of medical, social and personal services. At the end of the project, 10 patients turned down offers of admission, and 13 indicated they preferred to remain on the deferred list. In contrast, out of 12 persons who were not provided with such services, 11 accepted admission when it was offered or chose to be on the active waiting list. The investigator concluded that a large number of aged persons seeking institutionalization experience considerable loneliness and alienation and that it is feasible to organize service programs for aged persons to enable them to live relatively independently.

The role of guardianship and protective services for mentally impaired older people to help them live in the community is the focus of a project carried out by the National Council on the Aging in several cities. Preliminary findings indicate that legal, medical, and psychiatric services and consultation must be available for decision-making concerning the needed care. Supportive services, including those of visiting nurses and homemaking aides, are also highly important in helping to sustain the aged person in the community and must be available from local agencies.

Specialized services for the aged as part of the program of Comprehensive Community Mental Health Centers are being developed in a number of cities and rural areas. For example, the San Luis Obispo Community Mental Health Center has an active program for the elderly that includes medical, social, rehabilitative, and financial planning. In collaboration with the Department of Public Welfare, the Center provides consultation to all nursing homes and to physicians in the County. The program's goal is to support and maintain general health at the maximum level, to prevent emotional problems, and to maintain satisfying functioning in the community. Pre-screening and alternative community services are used to prevent unnecessary admissions to the State Hospital 150 miles away. For those who do go to the hospital, the Center coordinates appropriate aftercare services; it becomes involved in the planning for the patient's return while he is still hospitalized. Home visits are made to older persons living in remote areas of the county to familiarize them with the services available at the Center and to encourage their utilization.

The Area Community Mental Health Center in Washington, D.C. also has a special program for the elderly. Proceeding on the assumption that the community is the natural habitat for the elderly, a flexible treatment program is offered including 24-hour care, daycare, semi-daycare, nightcare, and outpatient care. During the first year 168 persons 65 or older were treated; nearly half were able to continue living in the community.

For those aged who require institutional care, efforts are being made to find ways to prevent further physical and psychological deterioration. At Ypsilanti State Hospital, a group from the University of Michigan is studying the effects of several different milieu therapy programs upon older mental patients while they are hospitalized and after they have been discharged to various aftercare settings. Four different treatment programs and three types of community facilities to which patients are discharged for further care are being studied. Preliminary findings strongly support the conclusion that the difficulties associated with treating the aging mentally ill can be attacked by an active program and that the long-term debilitative effects of hospitalization can be reversed. Work therapy in a lively and colorful setting in which personal responsibility and improvement are expected, can help the patients get better.

It has been estimated that more than half of those mentally impaired individuals who are 65 years of age or over are in homes for the aging and in nursing homes

and that about 40 percent of all elderly patients discharged from State mental hospitals are placed in such facilities. Special attention must be given, therefore, to the development of suitable programs in these institutions. At the Hebrew Home for the Aged in Riverdale, New York, a workshop was established in which the participants observed scheduled hours and production standards were paid. The elderly people in this workshop showed so much improvement, in terms of functioning as well as in feelings of self-esteem and well-being, that the institution has continued the operation even though the NIMH grant has ended. Now, under another grant, the program has been expanded to include residents whose physical handicaps and brain damage do not permit them to leave that part of the institution in which they live. Separate workshops have been established in the various living quarters, and special bedside facilities have been designed for nonambulatory patients.

To determine the degree to which problems of mental impairment among residents of homes for the aged are recognized and how such problems are handled by these institutions, a psychiatrically oriented survey of such homes was conducted. As estimated by the staff of the 13 homes studied, 16 percent of the residents, on the average, were mentally impaired. By the criteria of the study staff, however, 60 percent were impaired. Interviews with the homes' administrators revealed that obviously impaired applicants were generally screened out even by homes that had policies permitting their admission. Usually, the higher the prevalence of mental impairment within the homes, the poorer the quality of programs for social interaction. Little attention seems to be given to supportive measures for mentally impaired persons until a crisis occurs. When a crisis does occur, care falls almost exclusively on the medical and nursing staff members, and these generally are not well organized or do not have the proper support to deal with it.

At Boston State Hospital, researchers from Northeastern University are studying the nursing home as a community resource for aged mental hospital patients and seeking to delineate the factors that affect the adjustment of such patients to nursing homes. Patients who are suicidal, hostile, destructive, or boisterous, or who wander excessively, smoke in bed, or have severe alcoholic or drug problems, the study indicates, are not acceptable to nursing homes. On the other hand, depressed, withdrawn, confused, disoriented, hypochondriacal, and incontinent patients are acceptable, as are those with sleeping and feeding problems. The presence or absence of psychiatric disturbance shortly after admission appears to be a key factor in the outcome of placement. The adjustment of nursing home patients was not inferior to that of patients of similar status still in the hospital. However, the question of relative outcome over a longer period of time needs to be studied further in other settings and with larger samples.

In the area of basic research related to aging, the Institute supports several promising investigations. At Duke University, researchers are attempting to isolate the normal changes of the aging process from the abnormal or pathological. The study, begun 10 years ago, originally included 267 persons. Those still living and those who have died are being compared on the basis of psychiatric, neurological, physical, and psychological factors and sex, race, and socioeconomic background. Abnormalities of the electroencephalogram and the circulatory system, the study has found, are related to senility and relatively early death.

For more information on the process of aging, the Philadelphia Geriatric Center is comparing the biological and behavioral characteristics of healthy aged men with those of the same men studied by NIMH in 1957. The original study group was composed of 47 men ranging in age between 69 and 91. About 25 of them survive.

Although numerous drugs are available to treat geriatric patients having emotional problems, no completely reliable methods for judging how a given patient will respond to a given drug are available. Therefore the Institute supports research to develop ways of predicting an individual's responses to drugs by recording key behavior patterns, responses to easily administered tasks, and responses to test doses of drugs. Future work may make such tests applicable to problems faced

every day by psychiatrists.

Even if the efforts to prevent and cure mental impairment in the elderly and to help those who do become impaired to sustain at least a reasonably satisfying life in the community are greatly increased, a large number of aged persons will still need institutional care. NIMH-supported projects have demonstrated, however, that this care can be improved, even to the point where in many cases patients can be discharged. Through its Hospital Improvement Program, the Institute continues working to raise the level of care for elderly patients in State mental hospitals. During the past fiscal year, 18 projects directed specifically toward aiding geriatric State hospital populations were being supported.

At the Mendota, Wisconsin, State Hospital, for instance, HIP funds have been used to establish a Geriatric Treatment Center to provide intensive care for all patients with a potential for independent living. During a 2-year period more than half of the newly admitted patients were accepted for treatment on the project. Of this group of 200, almost 90 percent could be discharged to alternative care facilities within 90 days after admission to the Center. The Center is now housed in a new building designed to serve as a model for geriatric care. To older programs - including rehabilitation, therapeutic recreation, family counseling, and geriatric outpatient services - a community visiting service and a daycare program have now been added. These help patients leave the hospital earlier, and in some cases prevent hospitalization. Because of the number of patients discharged, the average daily census shows a downward trend. Small group sessions - small because the elderly patient tends to become nonexpressive in large groups - have proved to be one of the most effective treatment methods.

At Western State Hospital, Fort Supply, Oklahoma, a HIP grant has been used to provide a special diagnostic and active treatment unit for all geriatric admissions. For each person, efforts are made to determine the nature and extent of existing organic, socioeconomic, family or other problems, and programs tailored to the needs of the individual are drawn upon. In the 3 years since this project was started, the average length of stay in the hospital for all geriatric patients has dropped from 8-½ years to 2 years and 8 months.

At the Western State Hospital, Hopkinsville, Kentucky, a Community Placement Center has been established to provide an intensive treatment and planning unit for geriatric patients and others eligible to return to the community but considered difficult to place because of their need for some type of care. The Center trains both the patients and the agencies or individuals who will be responsible for them. In the case of the patients, it has placed considerable emphasis on grooming, socialization, shopping and other trips to the community, and group therapy. In three years, 306 patients were transferred to the Center, and 212 of these were placed in the community, more than 60 percent of them with their families.

Another HIP project at Kerrville, Texas, is demonstrating how even a remote State hospital, lacking adequate staff and resources, can stimulate elderly patients to care for themselves and take interest in their surroundings. A group of 90 women, and in moderately good physical health, were selected for the original study. On the average they had been hospitalized more than 15 years. Most of them were completely dependent upon ward attendants and exhibited an advanced degree of "institutionalization." These patients were moved to a renovated, partitioned ward with mirrors. They were told that they were ladies and were expected to behave as such. Lessons were given in self-grooming. The patients were required to bathe themselves and to buy or make their own clothes instead of having them issued. The response was so dramatic - for example, the women became friendly and cooperative and began participating in activities - that the program has been enlarged to include a men's ward.

In dealing with the mental health problems of the aging, manpower, of course, is critical. Besides the general training programs of the Institute, a number of

programs directed entirely or in large part toward providing more and better trained personnel for working with the aged are supported. One grant finances a 2-year advanced residency training program in geriatric psychiatry. Another supports a program to increase the number of clinically skilled psychiatric nurses who are interested particularly in the geropsychiatric nurses who already have a master's degree. Most of the other training programs in this field are for social workers.

Social work schools throughout the country are increasingly responding to the need for manpower for services to the aged. Their graduate curricula include seminars and courses dealing with geriatric problems and theory, as well as training and experience in group work and casework services to the aged in a variety of settings. The 14 schools with special training programs supported by the Institute provide students with a broad range of field experience that includes recreational and group work programs, community centers, hospital, public housing development, Golden Age Clubs, homes for the aged, general hospital comprehensive care programs, nursing homes, and social service departments of medical schools. Field training also includes experience with such groups as retired workers, elderly people with physical and mental disabilities, and persons who are poor as well as old.

Various activities and techniques have been used to promote the development of mental health programs for the aging in a wide range of public and private agencies. Staff participation in conferences, meetings, institutes and workshops; consultations with grantees and prospective grantees; and liaison with other Federal agencies and with other Divisions within NIMH, have all been useful methods of stimulating increasing interest and activity in this area.

The important problem of planning for the support and care of elderly people discharged from State mental hospitals was the subject of a three-day conference sponsored by the American Public Welfare Association under an NIMH contract this past year. This conference brought together State Mental Health Authorities and State Public Welfare staff to discuss the responsibilities of the respective agencies and to establish more effective means of communication and coordination. The conference proceedings were published by the APWA and have been widely distributed.

Concern for the mental health problems of later life is being expressed by an increasing number and range of organizations. In response to invitations, staff presentations have been made to the annual meeting of Educators for the Visually Impaired, sponsored by the American Foundation for the Blind; the annual conference for Nursing Home Administrators, sponsored by the Illinois State Health Department, and the Eastern Regional Meeting of the American Association of Volunteer Service Coordinators.

The important problem of providing appropriate mental health services for residents of homes for the aging was considered at institutes held at the Drexel Home, Chicago, and the Hebrew Home for the Aged, Riverdale, New York. The Section on the Mental Health of the Aging assisted in developing these Institutes, presented papers, and participated in the discussion of the mental health principles involved in the care of older people.

The Chief of the Section served as co-director of a Workshop to Consider Strategies for Stimulating Change in Mental Health Services for the Elderly, sponsored and funded by the University of Michigan. A task force composed of outstanding authorities in the field of mental health and gerontology developed as a result of this meeting and will be influential, it is anticipated, in improving mental health services for older people.

At the request of the Regional Offices, consultation was provided to the State of Colorado concerning the total mental health service structure for older individuals, to the State of Wisconsin concerning the development of mental health services in county homes and hospitals, and to the State of North Carolina concerning

the development of a comprehensive mental health program involving a State hospital and two comprehensive community mental health centers.

Ongoing relationships have been maintained with other Federal agencies with program concerns for older people. The Chief of the Section continues to serve as Vice-Chairman of the Steering Committee for the Survey of Health Frauds Affecting the Elderly being conducted by the Food and Drug Administration. He is also a member of the Committee on Group Services of the President's Council on Aging and a member of the Task Force to Develop a Program for the Disposition of Patients at St. Elizabeth's Hospital. Staff of the Section are also members of the Ad Hoc Group on Psychiatric Hospitals on which the other NIMH representatives come from the Mental Health Care Branch, Division of Mental Health Service Programs. This committee includes staff members of the Social Security Administration, Social and Rehabilitation Service, and the Bureau of Health Services. A consultative relationship, to assist in developing plans for incorporation of appropriate facilities and services for the elderly in public housing, has been established with the Special Assistant to the Secretary of HUD responsible for the program on housing for the handicapped elderly.

National Institutes of Health

National Institute of Child Health and Human Development

Introduction

Research on the diseases that afflict the elderly has expanded at a spectacular rate since the Second World War, primarily as a result of the Federal support of research through NIH. Research on aging processes of the individual and on the relation of the age-structure of the population to societal function has increased more slowly.

A definition of "aging processes" is a difficult one, but this is no insurmountable block to research. The understanding of biology itself was advanced satisfactorily over many centuries without a satisfactory definition of life. Whatever aging processes are, they appear relatively early in life and affect the individual over much of the lifespan. Thus, the Institute is concerned not only with the aged, but also with the processes that, for example, make the 30-year-old different from the 20-year-old.

The continuation of these and similar processes eventually results in the aged person. This broad approach to defining aging processes has the advantage not only of stimulating research on more than a limited segment of the lifespan but also of bringing together research questions that logically belong together.

An informal classification of Institute-supported research contains the following categories: (1) basic biology of aging; (2) biochemical and physiological changes with age; (3) interrelationships of aging and disease; (4) neurophysiological and psychological change with age: and (5) age-structure and societal function.

Each of these categories contains a great many possible sub-categories of topics for study. For example, under age-structure and societal function could be included the problems of leisure time (including retirement), housing (especially for the elderly), the economic impact of various population age-structures, adaptation to social requirements of the various stages of life, and many other topics.

These areas probably understate the extent of the NIH research activities relevant to aging. Much of the research conducted and supported by the NIH on specific disease processes through other Institutes' programs is of importance, since it contributes to advances in medical science from which the elderly will benefit and may extend insight into underlying biological processes relevant to understanding the phenomena of aging. However, to classify this as research on aging would be misleading in reporting the extent to which NIH supports research directed specifically toward aging.

During fiscal year 1968 the NICHD supported 68 research grants on problems related to aging at a cost of $3,549,331 and 23 training grants at $1,955,880. There were 4 fellowships funded at $67,017 and 7 research career development awards at $154,594. In addition to this support of research in universities and non-profit institutions throughout the country, the NICHD conducts its own research on the problems of aging.

Last summer the Institute opened the largest research facility for studies on aging in the western world--the Gerontology Research Center building--located at the Baltimore City Hospitals. In this modern, $7.5 million structure, Institute scientists are expanding previous studies and initiating new work aimed at obtaining basic knowledge about aging that can be used to improve the capabilities and well-being of the ever growing population of aged.

The new building exemplifies the increased concern with aging that has developed since 1940, when the NIH established its first gerontology unit at the Baltimore

City Hospitals. In that year a two-man staff working in a 9' x 12' laboratory began to study age changes in kidney function. Today over 125 staff members conduct a wide range of investigations aimed at describing and interpreting age changes, including changes in performance and behavior, that occur in an individual with the passage of time.

Many disciplines are represented on the research staff, and investigations carried out deal with human performance, renal physiology, metabolism, cardiovascular physiology, nutritional biochemistry, cellular and comparative physiology, cognitive behavior, animal behavior, and physiological psychology. Other studies related to aging are carried out in intermediary metabolism, endocrinology, morphology, molecular biology, and biophysics. Human studies at the Center are augmented by basic work on the biological mechanisms of aging, using a variety of animal species ranging from fruit flies and cockroaches to rats and mice.

The opening of the Center's new building makes it possible to conduct comprehensive multidisciplinary research into the factors involved in aging and the many urgent social, psychological, and medical problems faced by our elderly population.

In the future, significant advances in our knowledge of human aging can be expected to result from the studies conducted in the Gerontology Research Center. Eventually, nearly 300 Center scientists and supportive staff will seek answers to the perennial questions of how and why the mind and body grow old, and what, if anything, can be done about it.

Training

A summer course in the biology of aging will be supported by the Institute for the first time in 1969. This undertaking is recognized as one of the most significant instruments at the disposal of the NICHD for encouraging well-qualified young scientists to enter the field of aging research.

The Institute hopes that a monograph on the Basic Biology of Aging may eventually result from this and future summer courses in the biology of aging.

New Approaches to Research Support

In the future, particular emphasis will be placed on development of new approaches to the support of research to encourage optimum use of government funds. It is anticipated that this can be accomplished, in part, by using existing funding procedures to facilitate support and growth of centers of aging research. Each center would have one or more central substantive interests and an integrated research program designed to study some aspect of aging in depth. Centers of this type would vary in size and complexity and provide an atmosphere of common purpose and commitment, an interdisciplinary structure of graduate training, and a base to attract capable scientists not heretofore intimately involved in aging research.

In August 1969, the Eighth International Congress of Gerontology will be held in Washington, D. C., and Baltimore, Maryland. The president of the Congress is

Dr. Nathan Shock, Chief of the NICHD's Gerontology Research Center. The Institute is one of the sponsors of the Congress, which will gather together outstanding professionals in geriatrics, gerontology, and allied fields to exchange ideas and knowledge relating to the study of aging and special problems of the aged around the globe. The meeting will also serve to stimulate research and training in this country and abroad in order to benefit the entire field of aging research at all levels. The Congress, held every three years, is sponsored by the International Association of Gerontology, which is composed of 34 geriatric and gerontology societies from 28 countries.

During 1965 the Institute began a series of conferences on varied aspects of retirement. In the first four conferences, emphasis was placed on the psychological impact of retirement on the individual and on the interrelations of chronic disease with retirement. Scientific papers presented at the first conference have been published as a book, The Retirement Process.

The Retirement Process represents the careful thinking of the Nation's leading experts in aging research on what is known--and more importantly, what is not known--about one of the most crucial periods of life, when the individual changes from active employment to, frequently, full-time leisure. This change may not be by choice, and the retiree does not always know how to cope with his empty hours. In addition, the retirement process may be accompanied by decreased health, loss of prestige, and a feeling of uselessness.

The fifth conference in the retirement series, held during 1968, was concerned with adult socialization and retirement. The conferees (sociologists and psychologists) outlined several research priorities, including the identification of norms and objectives of socialization (adaptation to social needs) in old age and the role of a variety of agents in meeting these objectives. Conferees also stressed the need for factual studies of existing data, analytical studies--including cross-cultural research and cohort analysis, and the need to develop new research techniques and methods.

Aids to Investigators

The Aging Information Center of the NICHD is now in full operation; the first issue of the Aging Abstract Journal is to be published in January 1969. The Center will make rapid exchange of research findings possible. Personnel of the Center scan the world literature relevant to aging, identify appropriate papers, abstract them, and present them to the scientific public through abstract journals. The abstracts are also stored on computer tapes that can easily be searched for information to guide research in aging.

The Institute's interest in aiding investigators in the study of aging and furthering research progress also takes other forms. The Institute would encourage a continuing reassessment of laboratory activities and the support of aging research in neglected areas. In addition, rapid exchange of research findings and adequate supplies of certain research materials--such as special tissues and animals--are of interest to the Institute.

The Institute's interest in effective research supplies stems partly from the long-recognized need for provision of old animals for aging research. If the aging process is to be studied across the entire lifespan then animals of all ages within the species' lifespan must be available for study.

The Gerontology Research Center in Baltimore has an excellent supply of experimental animals for the use of its scientists. Extensive animal facilities in the building allow for development of a constant supply of experimental animals needed to conduct aging research that is not possible in human subjects. A closed colony at the Center contains space where up to 24,000 small animals can be reared to senescence. A section of this colony operates as a germ-free area while the other section serves as a standard rat and mouse colony. An open colony will eventually

house rabbits, guinea pigs, cats, dogs, and primates in individual pens with outdoor runways. The Center also contains fully equipped rooms for clinical studies of animals.

Research Activities

The Institute supports research in the biology, psychology, and sociology of aging. Research in biological aging is encouraged at all levels from molecular and subcellular, through the entire organism. Studies at the subcellular and cellular levels include the use of tissue culture systems, of normal human cells that grow old and die in the culture environment. This research model provides a unique analytic approach to cellular senescence that could provide new insight into basic processes that are reflected in the overt signs of aging in the adult.

Biological research in aging also includes continued support and encouragement of research directed toward physiological and biochemical changes at the organismic level with age. Such studies involve all organ systems. For example, various biochemical studies, including the complex anzymatic reactions involved in intermediate metabolism, are being pursued. Major changes are known to occur in many organ systems with increasing age. Often these alterations are detrimental to the general health and vitality of the individual.

It is becoming increasingly evident that many of the older persons in this country do not live in a psycho-socially adequate environment. Of concern to the Institute is the lack of an adequate research base for understanding the psychological and social characteristics of the aging adult person. The factors involved appear extremely complex, and successful pursuit of this research will require recruitment of highly qualified scientists into the field. It is recognized that after the attainment of maturity, the effectiveness of certain psychological functions diminishes; however, the accumulation of experience leads to continued improvement of some complex functions until relatively late in the lifespan. Negating such positive factors may be some of the current attitudes and practices relative to intellectual challenge throughout adult years, early retirement, family structure and housing. In addition, the environment of man changes as he ages in ways that are not always favorable to continued behavioral growth.

Longitudinal Studies

Included in research programs that address questions of the biology and psychology of aging are longitudinal studies of humans.

It is important to distinguish between "age differences" and "age changes." Age differences are easily determined by comparing measurements taken on subjects of different ages. Measuring many different subjects over the age span and using modern statistical methods will give estimates as to the probability or significance of any differences in average values of a test with age. On the other hand, measurements of "age changes" require serial measurements taken on the same individual for at least two different points of time. Such a longitudinal method requires repitition of the same measurements in the same individual at standardized time intervals. Scientists use this method to study animals with relatively short lifespans but it is nearly impossible to study humans over their entire lifespan. However, much can be learned about individual patterns of aging in the human when measurements are repeated in the same individual every two or three years over a period of 20 or more years.

The most powerful methodologic approach is the combination cross-sectional, longitudinal study since it permits the most complete analysis of environmental and individual factors.

With age there are changes in function at an organ level (decrease in efficiency of cardiovascular function), at an organismic biochemical level (decrease in efficacy

of carbohydrate metabolism), at a neuro-physiological level (decrease in sensory, efficacy, decrease in speed of transmission of nerve impulses), at a psychological level (decrease in short-term memory), and at a societal level (change and eventual decrease in the contribution of individuals to society). An understanding of these changes is important not only for the maintenance of the health of the individuals who comprise society, but also for decisions that relate to society's function. The problems relating to the time for retirement are relevant here. The problems that commercial airlines face with regard to pilot efficiency as a function of age have highlighted society's need for an understanding of physiological and psychological change with age.

Large-scale cross-sectional or longitudinal studies present many difficultires. The individuals studied should be representative so that study results can be applied to a larger population. Yet the longitudinal study remains a very valuable means of looking at changes--physiological, psychological, and social--which occur with the passage of time. Such studies provide unique opportunities to view these changes within individuals as well as among individuals.

Through longitudinal studies involving healthy, community-dwelling male volunteers, investigators at the Gerontology Research Center have noted a number of age differences and are trying to determine age changes that take place in the same individual as he ages. More than 600 men ranging in age from 18-96 years participate in these studies.

In the Center's longitudinal studies, subjects enter the program at different ages. By this method a survey of the entire lifespan can be made in a relatively short period of time.

Subjects in the study come in every 19 months and spend two and one-half days undergoing an extensive series of biochemical, physiological and psychological tests. At the same time, general information on age differences can be obtained by cross-sectional analysis in which age groups within the study are compared with each other.

Such analyses show that the changes and declines in function noted do not usually occur in rapid succession once a person reaches a certain period of life. Rather they seem to be more gradual and progressive.

Glucose tolerance provides an excellent example of new concepts of normality as standardized for age. In older persons this tolerance declines drastically. Using "normal" diagnostic standards,nearly half of older individuals would be classified as diabetics. But Center scientists have worked out a system enabling them to interpret normal glucose tolerance in individuals of different ages. Their work is helping physicians prevent misdiagnosis of diabetes in aged patients.

One of the more apparent signs of aging is a decline in work ability. In Center studies the amount and rate of decline in such ability is sought through a number of tests. Cross-sectional data from these studies has confirmed that muscle strength and individual endurance do decline with aging.

At least one reason for this decline in strength and endurance is that muscles require extra oxygen during exercise. The extra oxygen supplied results in production of metabolic products that must be collected and excreted. Hearts need to work harder to exchange blood faster and the older heart has more trouble stepping up its pace quickly. This means less blood is pumped, resulting in a lowered work capacity.

A similar problem occurs in the amount of oxygen that can be transferred to the blood by the lungs of older individuals. Tests measuring the amount of air that can be moved through the lungs in 15 seconds indicate a 40 percent decline in this ability between the ages of 20 and 60.

Some Research Findings of 1968

The Biology of Aging and Tumor Development

In vitro studies of changes with age in human amnion cells (harvested from the placenta) are making important contributions to our knowledge of the biology of aging and the development of tumors, which are usually associated with older patients.

Human amnion cells may be an ideal system for investigating environmental agents which may affect the development of a transformation in shape and growth rate of normal human cells in tissue culture. Such a transformation is characteristic of tumor formation in the body. Dramatic age-dependent changes noted in the amnion cells included a decrease in cell density with age, a decrease in DNA synthesis, and an increase in incorporation of free fatty acids and cholesterol into cell lipids.

A long-term study is now in progress mainly to investigate the effect of mutagens and carcinogens on development of transformation of proliferating cells, to examine human cancer tissues for the possible factors that may stimulate the development of such transformations, and to delineate events that may be associated with the development of altered cells. Results of such an investigation, through augmentation of similar study with cells of the lower animals, may contribute substantially to our understanding of the process of tumor formation in man.

Reaction Time Changes With Age

Research at Duke University has challenged the significance of the well established theory that as adults grow older, they become increasingly slow in responding to environmental events. The data challenge theories relating to decreased central nervous system (CNS) functioning with age, using reaction time as one means with which to define aging.

The investigators found that while older subjects (ages 68-86) were significantly slower than young athletes (ages 18-27), they were not significantly slower in reaction times than young non-athletes.

The findings emphasize that just as individual differences must be controlled or evaluated in the aging persons studied, they must also be considered in the younger control subjects. Matters such as health and sickness in old age are known to determine the extent of age differences in the statistical comparisons, and the investigators suggest that a variable such as physical fitness in young subjects also must be considered. Some age-dependent differences in reaction time between young and old subjects were inherent in the data. Nevertheless, the importance of such individual variables as amount of exercise and general health of all experimental subjects was suggested by the data.

Young people in general can be expected to exercise more than elderly people, and this decrease in exercise with age may be subsequent to central nervous system deficits rather than antecedent to or causative of the slowdown in reaction time.

In another study, these investigators have also found that old subjects vary more among themselves in RT than do young adults.

Age Pigment Studies

One current theory of aging holds that over the years damaging substances accumulate in cells to the point where they interfere with normal cell function. Age pigment (lipofuscin) which accumulates in aging tissues has been suggested as one substance that might be implicated in the impairment of cellular function in older individuals. This insoluble substance has been observed in a number of human tissues examined at autopsy.

Investigators at the Gerontology Research Center have, for several years, been studying age pigment accumulation in various animal species. This year, investigators succeeded in developing a technique to maintain adult central nervous system cells of rats in tissue culture. They found that age pigment accumulates in these cells while they are in cultures originating from old rats than in those from young animals.

These findings suggest that an age-related morphological change, noted earlier in tissues of various animal species, can be brought about in an in vitro system under experimental conditions that can be rigidly controlled.

The Gerontology Research Center investigators suggest this model system could prove extremely useful in studying the biological mechanisms involved in age pigment accumulation.

Age Differences in Problem Solving and Learning

The elderly individual's performance on tasks of problem solving and learning is known to be poorer, generally, than that of younger persons. One problem under investigation at the Gerontology Research Center is the apparent decrement in reasoning ability exhibited by many older persons.

In another section of the Gerontology Research Center, an investigator is trying to analyze the effects of aging on learning in animals.

One study conducted involved using a complex maze to determine age differences in rats' abilities to learn specific cul-de-sacs. With a standard training schedule of disturbed maze learning trials (four per day) the old rats either failed to learn the maze or did so very slowly, while young rats experienced little difficulty. Trying a different approach, the investigator began giving massed training trials (12 per day). Using this method he was able to improve the performance by the slow-learning old rats.

Apparently the older rats' failure to learn was due to their tendency to persistently repeat their errors. This finding was supported by results of extinction trials in which the old rats continued to run the goal box longer than young animals even after good rewards were no longer available.

These results suggest that the age differences in learning and extinction were due to behavioral rigidity or relative lack of variability by the senescent rats.

Bureau of Health Professions Education and Manpower Training

The Division of Allied Health Manpower supports four project grants in the field of aging at Tulane, University of Michigan, Boston University, and John Hopkins University. Each of these grants provides for faculty and curriculum growth in the area of chronic disease as well as aging. At Tulane, work is being done on teaching rehabilitation of aged. The University of Michigan project emphasis is on adult health and aging, while the John Hopkins project centers on chronic disease. The grant to Boston University is for a gerontology program in the school of nursing.

Through the traineeship mechanism, the Division supports students pursuing full-time graduate training in public health with majors in adult health and aging and gerontology. Also included is support for short-term courses relating to geriatic medicine and gerontology. In addition to these courses, various long- and short-term training programs are for the training of nurses, pharmicists, physical and occupational therapists, dietary consultants, social workers, and nursing home administrators. Others provide for training of health officers and voluntary health agency officials who, for example, may serve as consultants to nursing homes and extended care facilities.

OFFICE OF EDUCATION

Under the provisions of Title I of the Library Services and Construction Act (as amended by P.L. 89-511) the Division of Library Services provides information and advice on programs oriented to the aging which are conducted by State library agencies; assists training institutions with programs designed to give librarians special skills needed to meet the special library needs of older persons; maintains liaison with other Federal agencies and organizations concerned with the aging; assists in conferences of professional and lay leaders concerned with library-sponsored activities for older people; and provides grants for the improvement of public library services. Examples or special programs supported by Federal funds to assist the aging include a grant by California to the Los Angeles Public Library for a three-year project for library services to shut-ins in the inner city. The St. Louis public library is bringing books and other library services directly to the aged living in hotels, apartments, and rooming houses.

Under the Adult Education Act of 1966 (P.L. 89-750), approximately 20 percent of the total enrollment in basic education classes in fiscal year 1966 was age 45 or older. In fiscal year 1967, approximately 26 percent was age 45 or older. It is expected that the fiscal year 1967 percentage will remain constant through fiscal year 1970.

Vocational education training programs provide training and retraining for persons of all ages in occupations in health, technical, trades and industry, office, distribution and marketing, home economics, and agriculture. These programs serve increasing numbers of older persons who need to learn basic skills, improve old skills, or develop new skills in order to advance their employment opportunities. Information is not available on the number of older persons who have been or will be trained or on the amount of Federal funds involved.

Programs under the Manpower Development and Training Act have focused attention on the older worker. Pilot projects have been developed using a multi-occupational training program which provides a greater variety of training opportunities. These programs offer basic education prevocational opportunities, counseling specifically for this age group and a variety of occupational offerings.

A manpower training program to provide basic education as an aid to upgrading steel workers offered a new outlook to many older workers. The mean age of workers in this program was 42 years and the oldest worker involved was 66 years of age.

Under Title I of the Higher Education Act of 1965 (P.L. 89-329), in fiscal year 1966 there were 12 programs in 10 States and 12 institutions of higher education dealing with the problems of the aging and focusing generally on (1) increasing the intellectual and community involvement of the older persons, (2) broadening their economic knowledge and/or employment opportunities, and (3) making available to them the best possible health information and medical treatment. In fiscal year 1967, there were 18 such programs in 12 States and 18 institutions of higher education, and in fiscal year 1968 there were 12 programs in 7 States and 12 institutions of higher education with approximately 112,000 participants.

In fiscal years 1968 through 1970, the Research and Training Appropriation will support several projects concerned with adult education. It is impossible to determine at this time which of these will specifically involve problems of the aging, but it is estimated that approximately $418,000 will be spent in this area in fiscal year 1968.

SOCIAL SECURITY ADMINISTRATION

Objective

The Social Security Administration is responsible for administering the social security program which provides old-age, survivors, and disability insurance protection for over 90 percent of the workers and their families in the United States. It also provides hospital insurance protection for virtually all individuals in the United States who are age 65 or older, as well as voluntary supplementary medical insurance coverage elected by about 95 percent of those age 65 or over.

Benefits to Older Persons

Cash Benefits: Monthly benefits are paid: (1) To insured workers between the ages of 62 and 72 who have substantially retired from gainful employment and beginning at age 72 without regard to work status; benefits are also paid to wives of beneficiaries at or after age 62 and to widows of insured workers when they reach age 60. Children of retired, deceased, or disabled workers are also eligible for benefits when they are under age 18, and after age 18 if they have a severe disability which began before that age and which has made it impossible for them to work and support themselves. For those children continuing to attend school at age 18 and above, monthly benefits are payable up to age 22. Benefits are paid to mothers (irrespective of age) when they have such children in their care, except for the students age 18 and over; (2) to insured workers up to 65 years of age who have worked a specified period of time in covered employment and have a medically determinable disability which can be expected to last for a continuous period of not less than 12 calendar months and so severe that it prevents them from engaging in any substantial gainful activity; (3) to certain individuals age 72 and over who are not insured under the social security program; and (4) to certain disabled individuals at age 50 who qualify as widows, widowers, or divorced wives of insured workers.

Of the 24.4 million beneficiaries receiving monthly old-age, survivors, and disability insurance benefits at the end of November 1968, about 18.4 million were age 62 or over. About 90 percent of all persons now 65 and over are either receiving old-age and survivors insurance benefits or would be eligible for benefits on retirement. This proportion will grow until practically all aged persons are protected. The number of disabled workers and their dependents receiving benefits at the end of November 1968 totaled 2.3 million.

The minimum monthly benefit for a retired worker who meets the regular insurance requirements is $55; and $82.50 for a retired couple. This is subject to actuarial reduction if the benefit is taken prior to age 65. For those persons age 72 and older who qualify for uninsured (Prouty) benefits the payment to a single person is $40 a month and for a couple $60.00 a month.

Monthly benefits which were being paid at the end of June 1968 for retired workers without dependents averaged $93; for a retired worker and his aged wife, the average was $163; and for an aged widow, $85. For families with benefits computed on the basis of earnings after 1950, the averages were higher. Among these families the average benefits being paid at the end of June 1968 were $100 for a retired worker with no dependents, $170 for a retired worker and his aged wife, and $96 for an aged widow.

Health Insurance Benefits: Nearly all of the 19.7 million persons aged 65 and over in the United States (as of January 1, 1969) are afforded basic protection against the costs of inpatient hospital services, post-hospital home health services and post-hospital extended care facilities under the hospital insurance program established by the 1965 Amendments to the Social Security Act. In addition, an average of about 18.8 million persons aged 65 and over are expected to be enrolled during fiscal year 1969 in the voluntary supplemental medical insurance program, which covers physicians and related services. Both programs provide for

payment of these costs subject to certain deductible and co-insurance amounts.

Payments to hospitals, extended care facilities and home health agencies under the hospital insurance program are expected to total an estimated $4.4 billion in 1969 and $4.9 billion in 1970. Supplementary medical insurance payments for 1969 and 1970 are estimated to amount to $1.7 billion and $1.8 billion, respectively.

Services to Aged Individuals and to Community Groups

The social security program is nationally administered. Local communities are serviced by 642 district offices, 117 branch offices, and 3,517 service centers, resident stations, and contact stations.

Social security district offices give information to the public and answer inquiries about the benefits available to those who meet the conditions specified under the insurance provisions of the Social Security Act. Old-age, survivors, and disability insurance claims for benefits are received, developed, and initially adjudicated in the district offices. Help is given in securing the factual information needed to determine eligibility for benefits, and persons filing claims are advised as to their rights. Information and assistance is also provided inquirers and beneficiaries under the health insurance aspects of the social security program (Title XVIII of the Social Security Act). For those adult beneficiaries determined by SSA to be incapable of management of their benefit funds, a person other than the beneficiary is selected to receive the checks and is held accountable for using the benefits in the best interests of the beneficiary.

District offices maintain current information about community resources and make referrals to other health and welfare agencies when appropriate. The Social Security Administration participates in many ways in planning with other public and voluntary agencies at the Federal, State, and local levels. The district office manager and staff are also responsible for planning with local groups for services not provided by the social security program but which are needed by SSA beneficiaries. District office managers, assistant managers, and officers in charge are currently serving as Community Liaison Representatives in most cities and communities selected for participation in the Model Cities Program. Additional managers will serve in this capacity as more cities are selected.

Community Planning involves working with other community organizations in planning for the continued development of health, vocational, and welfare services. SSA data on the numbers of aged, disabled, survivors, and health insurance beneficiaries assists communities in planning services to meet existing needs as well as for long-range planning. With the advent of Medicare and medicaid, there has been increased interest in community analysis of resources such as hospitals, extended care facilities, home care, and other health services. In this area SSA experience and data provide information on incidence and trends which are useful to community planning bodies.

The following are examples of SSA cooperation and collaboration with other agencies toward the objectives of having more services available to beneficiaries and all others in the community who need the services.

1. At the Federal level additional services are being developed through interagency planning committees directed by:

   a. Department of Agriculture for rural health projects in selected areas.

b. Public Health Service for health maintenance projects for the aged.

c. Social and Rehabilitation Service for development of protective services projects to meet the needs of incapable aged beneficiaries.

d. HUD for development of experimental information and service through the Neighborhood Service and Model Cities Programs.

2. At the State level the assistance to State health departments to fulfill Medicare requirements and to promote full potential for care of the aged in institutions, outpatient, and home care models with:

a. Participation in experimental training programs for community service personnel on the problems and needs of the aged and chronically ill.

b. Consultation to State personnel, e.g., when used for planning and promotion of health services as related to medical care.

3. At the local level interagency community planning and development of resources such as:

a. Surveys and analysis of health and welfare facilities and services.

b. Collaboration with local information and referral centers, providing a contact service for persons having questions or concern about SSA benefits.

c. Experimental centers of information or service under special arrangements, such as in the Federal Office Building, to help the public obtain information on Federal services. One of those is functioning in Atlanta and half of the public inquiries in the Federal Office Building are related to SSA.

d. Close cooperation with public welfare and voluntary agencies that provide services to the aged and handicapped.

Research on Economic Security for the Aged

The Social Security Administration research and statistical program provides information derived from the operations of the Social Security Administration system, from population surveys and from studies of related public and private income maintenance programs that is useful for continuous evaluation of the effectiveness of the social security program in providing economic security for the aged, including protection against the costs of hospital and medical care. Data are developed and published regularly in the Social Security Bulletin and its Annual Statistical Supplement, in special published reports and in various other ways to meet user requests.

Indicative of the types of information made available and of interest to officials and groups planning programs for the aged are: continuously reported data on claims and benefit payments to retired workers and their dependents; the findings of surveys of the aged population, including OASDI beneficiaries, which provide information as to the level of economic security that social security benefits support (information obtained on income includes sources of income of individuals and families, level and types of assets owned, special demands on income such as medical expenditures, etc.); special studies that show the changing share of the total national output going to the aged, what measures of income adequacy are most appropriate and meaningful, the relations between individual and family income over the life cycle; continuing statistical series that are concerned with the totality of public and private income maintenance protections and the relative weight of the social security program in that totality; and research to measure

the impacts on both public and private health and medical care, to identify and define gaps and unmet needs under the health insurance program, and to examine and evaluate the economic consequences of the health insurance program. Social Security Administration research draws heavily upon basic data in the social security system, data from the population survey program, and upon data from the Bureau of the Census, Bureau of Labor and Statistics, and other statistical sources.

Funds for Programs on Aging

(In thousands - existing legislation)

	1966	1967	1968	1969 Estimate	1970 Estimate
General fund appropriations:					
Public Health Service:					
Consumer Protection and Environmental Health Service:					
Food and Drug Control	18,512	18,370	19,881	20,833	21,509
Air Pollution Control	2,965	3,948	6,292	6,799	7,305
Environmental Control	772	1,136	925	1,052	1,056
Salaries and Expenses, Office of the Administrator	---	---	300	300	300
Total, CPEHS	22,249	23,454	27,398	28,984	30,170
Health Services and Mental Health Administration:					
Comprehensive Health	55,300	46,787	45,000	45,000	45,000
Community Health Services	4,690	7,858	8,817	9,715	5,833
Hospital Construction	49,450	49,097	60,086	61,234	66,734
Nat'l. Inst. of Mental Health	4,780	3,967	4,050	3,919	3,006
Total, HSMHA	114,220	107,709	117,953	119,868	120,573
National Institutes of Health:					
National Institute of Child Health and Human Development	5,764	7,270	7,932	8,082	8,114
Health Manpower	1,528	790	672	697	663
Total, NIH	7,292	8,060	8,604	8,779	8,777
Total, PHS	143,761	139,223	153,955	157,631	159,520
Office of Education: (vocational education, library services, research, community service, adult basic education, and administrative costs)	22,140	22,175	24,052	24,665	24,665
Social and Rehabilitation Service:					
Grants to States for Maintenance Payments:					
Age 45 to 64	352,194	411,115	477,017	548,677	644,846
Age 65 and over	1,640,685	1,730,733	1,755,397	1,943,254	2,138,104
Total	1,992,879	2,141,848	2,232,414	2,491,931	2,782,950
Grants to States for Medical Assistance:					
Age 65 and over	588,000	619,600	865,600	1,187,000	1,579,000
Social Services and Administration:					
Social Services under Titles I, XVI, and XIX of the Social Security Act	60,200	67,000	96,100	116,900	134,200
Grants for Rehabilitation Services and Facilities	39,972	60,778	81,026	101,920	142,820
Development of Programs for the Aging: (includes technical consultant services. Foster Grandparent Program shown on a comparative basis 1968-1970)	7,341	9,327	26,884	33,657	30,984
Rehabilitation Research and Training:					
Research and Demonstrations	694	654	267	450	415
Training	10	18	14	10	10
Research and Training: (Special Foreign Currency Program)	---	---	197	400	500
Total, SRS	2,689,096	2,899,225	3,302,502	3,932,268	4,670,879
Total, general fund appropriations	2,854,997	3,060,623	3,480,509	4,114,564	4,855,064

Funds for Programs on Aging (con't.)

(In thousands - existing legislation)

	1966	1967	1968	1969 Estimate	1970 Estimate
Federal Old-Age Survivors, Disability, Hospital, and Medical Insurance Trust Funds:					
Social Security Administration:					
Disability insurance payments:					
Age 45 to 64	1,202,000	1,297,000	1,460,000	1,710,000	1,841,000
Dependents age 65 and over	8,000	9,000	10,000	10,000	11,000
Retirement/Survivors insurance payments:					
Age 45 to 64	1,748,000	1,845,000	2,007,000	2,326,000	2,417,000
Age 65 and over	14,129,000	14,857,000	16,312,000	18,605,000	19,391,000
Hospital insurance payments:					
Age 65 and over	---	2,508,000	3,736,000	4,367,000	4,940,000
Supplementary medical insurance payments:					
Age 65 and over	---	664,000	1,390,000	1,567,000	1,598,000
Total, Federal Old-Age, Survivors, Disability, Hospital and Medical Insurance Trust Funds	17,087,000	21,180,000	24,915,000	28,585,000	30,198,000
Total, Department of Health, Education, and Welfare	19,941,997	24,240,623	28,395,509	32,699,564	35,053,064

JUVENILE DELINQUENCY

Juvenile delinquency continues to be one of our Nation's major unsolved problems. One out of every nine of our young people is referred to a juvenile court before the age of eighteen. The recidivism rate among young people who have been institutionalized is 48 percent. The youth population is growing. By 1970 more than one-half our population will be under age 25. The number of citizens in this age group is increasing at twice the rate as the older age group. This could mean a significant increase in the delinquency problem in the years ahead.

Obviously, the problem is not only extensive but complex. It bears on all our social institutions and public agencies, including education, employment, social and legal services, as well as our law enforcement agencies and the juvenile justice system. Within the Department of Health, Education, and Welfare, a variety of agencies and units are specifically designed to deal with these crucial problems. Some programs are testing new approaches to delinquency prevention, rehabilitation and control through research and demonstration projects. Others are funding educational and training programs. The majority of the programs are concerned with strengthening State and local efforts through consultation and dissemination of current information on activities in the field and successful programs supported by HEW.

With the initiation of a new program under the Juvenile Delinquency Prevention and Control Act of 1968, the Department is reviewing its efforts to provide support for delinquency prevention and control activities which will have a significant impact on the development of new social programs.

The agencies in the Department concerned with the problems of delinquency support a diversity of programs and strategies. There are central points of intervention that cut across all programs, and include education, youth employment, community-based programs and services, courts and corrections, youth involvement, and group services. There continues to exist inter-departmental activities and special committees that provide the kind of coordination and exchange of views that support and strengthen the on-going programs.

The attached reports describe the programs from the following agencies in the Department:

1. Social and Rehabilitation Service
   a. Office of Juvenile Delinquency and Youth Development
   b. Children's Bureau Division of Juvenile Delinquency Services
   c. Rehabilitation Services Administration
2. Office of Education
3. Health Services and Mental Health Administration

OFFICE OF JUVENILE DELINQUENCY AND YOUTH DEVELOPMENT

Grants-Contracts for Demonstration and Training Projects

Between 1961 and June 1967 the Office of Juvenile Delinquency and Youth Development supported over 180 demonstration and training projects (331 grants). As mandated by Congress, under the Juvenile Delinquency and Youth Offenses Control Act of 1961 (P.L. 87-274), the demonstration grants were designed to provide Federal assistance for projects which will demonstrate or develop techniques and practices leading to a solution of the Nation's juvenile delinquency control problems. Training grants were awarded for the purpose of training personnel employed or preparing for employment in programs for the prevention or control of juvenile delinquency or youth offenses. Under these two programs, the following types of grants received support:

Comprehensive Demonstrations: Grants were awarded to 16 communities to plan and/or to carry out comprehensive action programs for projects designed to alter those social conditions which affect delinquent and potentially delinquent youth. Concentrating on deprived inner-city areas which have the highest delinquency rates, these projects emphasized prevention as well as control.

Recognizing the multiple causes of youth problems, they involved intensive efforts toward coordination with educational, employment, health, welfare, law enforcement, corrections, neighborhood organizations and other agencies concerned with youth problems. With the exception of the District of Columbia program, for which the Office maintained statutory responsibility, these projects were transferred to the Office of Economic Opportunity by the end of fiscal year 1966.

Special Demonstrations: Over 40 short-term projects have been supported since fiscal year 1965. Focusing upon delinquent and potentially delinquent youth, especially youth who have not been served effectively by social, educational or treatment agencies, these projects capitalize upon the techniques and practices developed in the comprehensive programs. Similar to earlier activities, their objective is to develop innovative techniques with potential for wider adaptation and which deal with the social conditions that foster delinquent and anti-social behavior.

Training Centers: Thirteen long-range, university-based interdisciplinary centers, designed to offer the full resources of a university for training personnel to deal with the problems of the prevention and control of juvenile delinquency have received support. Activities of the centers include stimulating change in the teaching methods and techniques in colleges and universities; providing consultation to diverse Federal, State, local, and private institutions; developing curriculum; and training youth-serving personnel.

Curriculum Development: Forty-eight projects were supported for the development of new techniques, materials and information for use in training professional and nonprofessional youth-serving personnel. Awarded to universities, colleges, and a variety of public and private agencies, these projects were designed to provide basic information to fill previous gaps in knowledge and training. Over 1,000 different types of materials have been produced, including training manuals, syllabi, guidelines for designing programs, reference books, and visual aids.

Workshops, Institutes, Seminars, Etc: Sixty-five projects have been supported, designed to provide all levels of youth-serving personnel with training. Stressing both an interdisciplinary and an interagency orientation, the training programs were intended to assist trainees in examining the adequacy of existing services, to plan needed changes, and to initiate new services. Over 36,000 persons

directly participated in these training programs; indirectly, thousands of additional personnel have benefited through the upgrading of the quality of knowledge transmitted to them.

The Juvenile Delinquency and Youth Offenses Control Act of 1961 expired June 30, 1967, since that time no new grants have been awarded.

The impact of the experimental delinquency program can be measured on a variety of levels. Several programmatic concepts initiated and tested under the Juvenile Delinquency and Youth Offenses Control Act of 1961 have been incorporated into subsequent Federal legislation. Many of the approaches embodied by the Comprehensive Demonstration Projects are reflected in the Economic Opportunity Act of 1964, including the idea of comprehensive, coordinated action within a community to achieve social reform (Title II, Community Action Programs) the emphasis placed on the involvement of the persons to be served in the development and direction of assistance programs (maximum feasible participation of the poor), the multi-track approach to job training for youth and the creation of work experience programs (Title II, Part B, Neighborhood Youth Corps) the policy of dealing directly with community institutions State agencies, the effort to improve coordination between local and Federal agencies in coping with major social issues (Title II, Community Action Programs as well as the Model Demonstration Cities Program), the development of specialized educational programs for deprived youth (e.g., Operation Headstart), or the provision of neighborhood legal services to the poor. Similarly, the concept of neighborhood-based employment centers served as a blueprint in designing the Department of Labor's Youth Opportunity Centers; new career lines created for disadvantaged youth under both the Demonstration and Training Programs have been implemented by such other Federal agencies as the Office of Education, the National Institute of Mental Health, the Department of Labor and the Office of Economic Opportunity on a larger scale; the National Conference on Bail and Criminal Justice, conducted under a focused nationwide attention on defects in the bail system and on the ways in which it could be improved, and was largely responsible for the establishment of the Office of Criminal Justice within the Department of Justice; and, the concept of Training Centers has been replicated by other Federal agencies, including the Office of Education and the Office of Economic Opportunity.

Projects funded by the Office have pioneered in a number of significant areas. The National Conference on Bail and Criminal Justice provided impetus to States and local communities for the development of recognizance programs. It also generated widespread interest among professional associations and the mass media on the problems of bail and its effect upon indigents. An agreement reached by one Comprehensive Demonstration Project with the Bureau of Apprenticeship Training of the Department of Labor, under which on-the-job training slots were provided through subcontracts between the agency and employer thereby opening up many more such opportunities than had been practicable when the Department itself was required to contract with each employer, has been widely replicated across the country. An experimental educational program, piloted at the National Boys' Training School, designed to upgrade the general educational level of a group of adjudicated delinquents aged 15 to 17, has secured the cooperation and support of the Federal Bureau of Prisons. A program utilizing volunteers in the Juvenile Court setting has not only had an impact on public and private agencies, but also has stimulated interest in a number of juvenile courts across the country in the use of volunteers. A number of youth involvement projects, i.e., the creation of decision-making roles for youth in the comunity including youth management have served to stimulate widespread interest in this type of program endeavor, and to provide impetus for the development of similiar projects. Curriculum guides for use in training teachers, supervisors and administrators of inner-city schools, produced under a training project, have been incorporated into teacher education courses in numerous colleges and universities across the country. Another training project is

helping to bring about a recasting of social work education through the development of an entirely new community organization curriculum to be implemented in all schools of social work. Also, the National Parole Institutes, conducted under a training project, resulted in establishing the first systematic series of training institutes for parole authorities.

Additionally, a variety of innovative conferences have been conducted under grants from the Office, such as the National Conference on Bail and Criminal Justice; the First National Conference on Amphetamine Abuse, followed by a Continuing Institute on Non-Narcotic Drug Abuse; the First National Forestry Camp Conference; a national conference on the training of personnel in community action programs; and, a Conference on the Inhalation of Glue Fumes and Other Substance Abuse Practices Among Adolescents. The Office itself has also sponsored a number of significant conferences, including the first national conference on the Extension of Legal Services to the Poor.

Dissemination of Information In fiscal year 1968, the Office continued its Congressional mandate to collect, evaluate, publish and disseminate information and materials related both to the new knowledge gained from the projects it supported, and to information and findings concerning new approaches to dealing with the problem of delinquency prevention, treatment and control. Over the past six years, the Office has produced and widely disseminated some 34 publications. Titles produced during the final year of program operation include:

1. A Community Mental Health Approach to Drug Addiction
2. Education and Training for Criminal Justice: A Directory of Programs in Universities and Agencies, 1965-67
3. Analyzing Delinquent Behavior
4. Helping Youth
5. Conference Proceedings: Inhalation of Glue Fumes and Other Substance Abuse Practices Among Adolescents

Another vehicle for the dissemination of knowledge has been the production of three movies filmed on the site of projects funded by the Office: "The Quiet Summer" describes a youth-run project operated during the summer of 1965 in Hampton Beach, New Hampshire that successfully ended a pattern of annual rioting begun in 1961; "Look Further Than Tommorrow" focuses on Washington, D.C. programs emphasizing youth involvement; and, "The Image Changers" discusses relationships among the police, the community, and youth.

Additionally, materials have been made available and special reports prepared for dissemination to grantees, universities, national organizations and other Federal agencies.

Program Assessment An Assessment Unit was established by the Office during fiscal 1968 to evaluate, coordinate, and disseminate research documents evolving from the seven-year program. The purpose of this endeavor is to prepare a history of the program, to trace the evolvement of its philosophy and its operations in relation to that philosophy, and to review its contributions to the field of delinquency prevention, treatment and control, and youth development. The completed assessment endeavor will present a clear picture of the new developments, trends, problems, and gaps in particular programmatic areas related to the delinquency control field and, additionally, will serve as a guide for ongoing and developing delinquency programs.

Nineteen contracts have been awarded to individuals and/or research organizations having specialized knowledge in the fields of juvenile delinquency and youth development. Several of these contracts focus on the Office in terms of its history and philosophy; others are concerned with broad programmatic areas while others relate to various particular substantive areas in which projects have been funded. The contracts are:

The Development and Implementation of the Office of Juvenile Delinquency and Youth Development Program

The Development and Operation of Experimental Social Action Programs as Instruments of Social Change and Knowledge Development (two contracts)

Theoretical Constructs for Community Intervention in Delinquency Control

Evaluation of the Office of Juvenile Delinquency and Youth Development Training Programs

Study of Evaluation in the Office of Juvenile Delinquency and Youth Development Program

An Assessment of Education-Related Projects

Politics of Community Organization

Social Service Delivery System

Community Competence and Community Intervention Strategies

The Development and Impact of Legal Services Programs

New Careers as a Component of Youth Participation

Social Work Practice and Education

Adolescent Drug Use

Socio-Cultural Consideration in the Treatment and Rehabilitation of Delinquent Youth

Volunteers Services

Police-Community Relations

Youth Violence

The assessment plan is conceived as providing a total, cohesive statement on various aspects of the delinquency program. Each study focuses on the lessons learned (successes and failures) in terms of the operation of the program and/or the projects funded by it. An extensive bibliography was compiled by staff of all relevant documents available in the Office -- grantee applications, progress reports and related materials, final reports and publications, and staff papers, -- and copies of materials relevant to the concern of each study were sent to the contractors. Additionally, staff has continued to serve in a resource capacity to the contractors as needed.

The last of the final documents will be submitted to the Office by early Spring. It is envisioned that an editorial board, composed of persons knowledgeable about the Office and its program, will be established. The main function of the board will be to react to the content of each of the studies in

terms of the philosophy and programmatic implementation of the Office and its relationship to the overall assessment design. Additionally, in conjunction with Office staff, the board will develop recommendations concerning the dissemination of the final studies. It is anticipated that the final documents will be published for distribution to a wide audience, including Congress, related Federal agencies, persons working in the broad areas of juvenile delinquency and youth development and in related fields, and the interested public.

THE JUVENILE DELINQUENCY PREVENTION AND CONTROL ACT OF 1968 (PUBLIC LAW 90-445)

During fiscal years 1968 and 1969, the staff of the Office of Juvenile Delinquency and Youth Development has been involved in the effort to provide for a renewed and expanded Federal program to assist States and local communities to develop systematic and effective approaches to the prevention and control of juvenile delinquency. This effort culminated in the enactment of the Juvenile Delinquency Prevention and Control Act of 1968 (PL 90-445) on July 31, 1968.

Prior to enactment, Office staff has been engaged in the preparation and submission of documents designed to outline and clarify the Department's requirements for appropriate delinquency legislation. Following passage of the Act, Office staff has been performing tasks which must be accomplished in order to develop an operational program. These tasks include the creation of regulations and guidelines designed to interpret the provisions of the Act and establish program directions and priorities, the development of administrative mechanisms to facilitate the award of project funds, the development of budget requirements for the conduct of program activities, and the creation of organizational and staffing patterns to provide for proper administration of the program. It is expected that completion of all preparatory tasks during the third quarter of fiscal year 1969 will permit the award of the initial grants under this Act during the fourth quarter.

During the pre-operational period, program staff will be engaged in the establishment of contacts with a variety of State and local public agencies and national and local private organizations involved in the problems of delinquency prevention and control. The purpose of these contacts will be to create a climate of understanding and to establish lines of communication in order to achieve the program goals essential to the national effort intended under the Act. Several meetings have already been held with representatives of State and local governments as well as a variety of private organizations to solicit ideas and discuss suggestions related to the implementation of the program. In addition, various interdepartmental meetings have been held to insure coordination of activities conducted under this program with similar activities of the Departments of Labor, Justice, HUD, and the Office of Economic Opportunity.

CHILDREN'S BUREAU

The Children's Bureau was created by Act of Congress in 1912 and initiated studies in the field of juvenile delinquency in 1914. Subsequent to a Bureau review of procedures and programs on juvenile delinquency, a Juvenile Delinquency Branch was established in the Division of Social Services in 1952, to be followed by the present Division of Juvenile Delinquency Service authorized by the Secretary of Health, Education, and Welfare as the result of a supplemental appropriation by Congress in 1954 to enable an expansion of the Bureau's services in the field of delinquency.

The Division was required to provide technical assistance to public and voluntary agencies and to develop standards, guides, and methods relating to various types of services and care for delinquent children. The fields covered include police work with juveniles; court and probation services; institutional care for delinquent children, including training schools, forestry camps, and detention care; legal aspects of delinquency, including legislation; community coordination and planning for the prevention, control, and treatment of delinquency; group work with delinquent children and potential delinquent gangs; and training programs for personnel, professionals, and nonprofessionals working with delinquent youth.

The Bureau, through its Division of Research, has obtained a more precise national picture on the total volume of juvenile delinquency, from 1,800 juvenile court statistical reports utilized as the base of a representative sampling of data of 500 juvenile courts. Juvenile Court Statistics are compiled and released by the Bureau annually, The Division of Family and Child Welfare Services, through its expanded grant-in-aid program to States for child welfare services and its consultative services, continued its effort to safeguard children and young people who seemed prone to commit delinquent acts.

The mandate implicit in two decisions of the Supreme Court of the United States regarding due process in the administration of justice to juveniles has clearly motivated States to re-examine their juvenile court statutes. The critical observations of the President's Commission on the present status of juvenile courts will reinforce this examination. In the one case of Kent v. U.S., 541 (March 1966) which was not decided on constitutional grounds, the right of hearing preliminary to waiver to criminal court was upheld, while in the second case, In re Gault, 387 U.S. 1, (May 1967) Standards, and Guides promulgated by the Division over the years received recognition by citation in the decision which held that a juvenile has a constitutional right to counsel, right to confrontation of witnesses, privilege against self-incrimination and right to notice of the charges. In declaring that . . . neither the Fourteenth Amendment nor the Bill of Rights is for adults alone, the Supreme Court of the United States forced States to evaluate the procedural regularity of their juvenile hearings. That the States are doing just that is evident by recent requests for consultation to this Division.

In the courts and probation area of service of the Division, the scope of the concern and interest in juvenile delinquency and the administration of justice displayed by the decisions of the United States Supreme Court, the Report of the President's Commission, and the passage of legislation in the nature of the 1968 Juvenile Delinquency Prevention and Control Act has been reflected in increased requests for professional assistance from judges and staff. A Task Force has been appointed within the Department on the implementation of this Act, and Division Staff have developed tentative guides for new programs and services under this legislation.

The trend toward the provision of community based service, strongly recommended by the report of the President's Commission, and the development of youth

service bureaus, also recommended to provide a central value in the intake channels of the juvenile correctional system, are being developed as trial programs in some settings throughout the country.

As United States correspondent to the United Nations, the Director has been active in the international field. He was a consultant for the International Course on Criminology and Juvenile Delinquency held in Montreal, Canada, which included more than 50 nations. The Solicitor General of Canada requested and received consultation in establishing a juvenile delinquency service within his Department similar to the Juvenile Delinquency Service Division in the Children's Bureau.

During the past year the Director has had numerous international visitors seeking consultation and orientation, from Pakistan, the Philippines, El Salvador, Japan, Chile, Costa Rica, Israel, Lebanon, and Thailand. The Director also continued to represent the Children's Bureau on the Joint Commission on Correctional Manpower and Training.

The Division staff has been involved in meeting the increased requests both of a national and international nature for professional consultations, surveys, training activities, evaluations and guide materials in the field of juvenile delinquency and youth offenses. The Assistant Director served on the Special Committee of the National Conference of Commissioners on Uniform State Laws and assisted in drafting the Proposed Uniform Juvenile Court Act. A Proposed Family Court Act was drafted by the Assistant Director and Division staff. States, Bar Associations, Governors' Commissions, and Legislative Commissions sought consultation on every facet of service to delinquent children. The Assistant Director worked extensively with State legislative committees drafting new juvenile court statutes in Vermont, Maryland, and the District of Columbia. The Vermont legislation has been adopted.

Staff members participated in the training of foreign police officers for the Agency for International Development throughout the year.

An evaluative study of the Illinois delinquency prevention program administered by the Division of Community Services of the Illinois Youth Commission was completed. Work was also completed on the articles, "Volunteers in Institutions for Delinquent Children," which appeared in Children, and the publications, Group Counseling with Delinquent Youth, Post-Institutional Services for Delinquent Youth, and Guidelines for Volunteers in Institutions for Delinquent Children. An article by the Assistant Director which appeared in Indiana Law Review 1968, The Gault Decision and Probation Services, has been reprinted by the Department for distribution.

Detention consultation majored in survey work in St. Louis County, Minnesota, the Receiving Home in Washington, D. C., services in Volusia County, Florida, and Passaic County, New Jersey, as well as services in the states of Nevada, New Mexico and North Dakota, and continuing consultation to the Center for Study of Crime, Delinquency and Corrections of Southern Illinois University in its sponsorship of the National Institute for Detention Home Superintendents.

Surveys of local program for delinquent children and youth were made in Fort Worth, Texas; Arlington County, Virginia; Daytona Beach and Volusia County, Florida; and Cleveland County, Oklahoma.

State surveys of services for delinquent children requiring in some instances the total involvement of Division staff are being conducted in Missouri, Nevada, Louisiana, Alabama, and Florida. They cover the areas of legislation, courts, probation, detention, institutions, training, police, and community services. These surveys, requested by the respective Governor of each State and appointive Commissions reflect the interest and activity toward statewide planning generated by legislation such as the 1968 Juvenile Delinquency

Prevention and Control Act. The concept of statewide planning in services for delinquent children has long been promulgated by the Division.

Detention needs in the State of Minnesota also will be the subject of a survey at the request of the Governor of that State.

Educational opportunities in the new broad areas of juvenile corrections are expanding with training programs pointing the way toward increased and better community-based services for dealing with youth. Staff has become increasingly involved with other Federal agencies and with universities in such programs as law enforcement curriculum and police community relations projects.

All the States of the United States, Guam, and the District of Columbia received either field or office consultation from the Division of Juvenile Delinquency Service during the last year.

REHABILITATION SERVICES ADMINISTRATION

Continued efforts of the Rehabilitation Services Administration toward the rehabilitation of the public offender are bringing about the return of more and more disabled youthful offenders into normal productive lives within their community. The growth and development of vocational rehabilitation programs and projects designed to serve the adult and juvenile public offender have been impressive and continue to accelerate with each successive year.

For a client to be eligible to receive vocational rehabilitation services, a physical or mental disability must exist. Included within the definition of physical and mental disability are those behavior disorders characterized by deviant social behavior or impaired ability to carry out relationships with family and community. Studies have shown that within delinquent populations, a relatively small number have physical disabilities. A much greater number have mental disabilities, often in the form of mild mental retardation. There is a very sizable group, however, whose disability is essentially behavioral and the public rehabilitation program is broadly extending vocational rehabilitation services to this group of disabled young people.

Most of the services which public offenders are receiving under the vocational rehabilitation program are part of the regular activities of the State vocational rehabilitation agencies in cooperation with State and Federal correctional agencies and probation offices as well as with State training schools and municipal courts. In over 40 States cooperative agreements and/or cooperative programs have been developed for the establishment and operation of vocational rehabilitation units or programs for the rehabilitation of public offenders. Such programs have varied in scope from the assignment of part-time counselors to correctional institutions, to the installation in reformatories of comprehensive vocational rehabilitation units, including a full array of personnel, equipment, and services. The Tennessee Division of Vocational Rehabilitation, for example, through a cooperative arrangement with the Department of Corrections has developed a unit at the Jordonia Training School for Juvenile Offenders. This program offers seven prevocational training classes in the area of: (1) cooking and food service, (2) furniture refinishing and upholstery, (3) masonry, (4) general metals and welding, (5) basic electricity and small motor repair, (6) radio and television, and (7) dental technician. In addition, individual and group counseling, a behavioral modification program, and on-the-job placement and training after leaving the institution are provided. One of the most current projects under the Basic Support Program was the establishment at Mt. Lemmon, Arizona, of a facility to rehabilitate culturally disadvantaged Indian juvenile delinquents from detention centers located on reservations. The facility will be situated on a surplus installation of the Federal prison system which has a considerable amount of residential training and work experience equipment already in place. Similar institutional programs for young offenders are found or are being developed in about 25 other States throughout the country.

Many rehabilitation counselors have been assigned full-time to correctional institutions and others regularly visit them. The Texas Division of Vocational Rehabilitation, for example, has 18 counselors assigned to provide rehabilitation services for the total Department of Corrections. In addition, an approach to provide more comprehensive services to the juvenile offender is being planned through the establishment of a Family Court-Vocational Rehabilitation Team. This team will work with physically disabled or emotionally disturbed boys and girls 15 to 18 years old who are brought before the courts. This team will be the core of an extensive service program for the juvenile offender. It will stress the "preventive approach," because it is believed that early detection and treatment of emotional and physical problems can help the adolescent to avoid a life of maladjustment.

Under a Rehabilitation Services Administration Innovation Grant, utilizing the Laird Amendment provisions of the Vocational Rehabilitation Act, the New York vocational rehabilitation agency in cooperation with the U.S. Department of Labor (OMPER) has established a vocational training facility for socially disadvantaged adolescent female delinquents at the Villa Loretto School, Peekskill, New York. The girls are referred for rehabilitation by the Family Courts of New York State after having been adjudicated as being delinquent, predelinquent, or victims of neglect. Training is provided the girls in the areas of beauty culture, health aids, food service, and business training.

The Rehabilitation Services Administration's Expansion Grant Program has been particularly instrumental in the development of programs for serving the youthful offender. Colorado's rehabilitation agency, under an Expansion Grant, has established residential rehabilitation facilities for predelinquent adolescents, ages 12 to 14½, known to the Denver Juvenile Court. These young people are provided prevocational and vocational counseling, vocational training experiences in a variety of settings, and part-time work experiences. Another Expansion Project is a joint venture between the North Carolina Division of Vocational Rehabilitation and the Department of Corrections to rehabilitate the mentally retarded youthful offender. Prevocational, vocational, social and personal adjustment, group counseling, individual counseling and recreational services are offered.

Substantial grants under Section 12 allowing for the construction of facilities to provide rehabilitation services to youthful offenders have been awarded to the correctional institutions in Columbia, South Carolina and Topeka, Kansas. Eligible clients in these facilities are provided intensive vocational, academic, and social rehabilitation services.

Training

Under its training grant authority the Rehabilitation Services Administration has been supporting conferences which bring together professionals from both the correctional and rehabilitation fields to explore ways of working more closely together. Past conferences have been the "Midwest Institute of Correctional Manpower and Training," Topeka, Kansas; "Institute for Meeting Manpower Needs for Correctional Rehabilitation in the South," Atlanta, Georgia; "Rehabilitation of Clients with Behavioral Disorders," Norman, Oklahoma; "Effective Approaches to the Rehabilitation of the Disabled Public Offender," Andover, Massachusetts; and "The Juvenile Court and Vocational Rehabilitation" Boston, Massachusetts. The most recent conference was just completed at the University of Missouri on "State Agency Consultants as a Means of Developing Coordinated Patterns of Juvenile Corrections and Rehabilitation Services."

Social workers and rehabilitation counselors being trained for correctional work are also supported by the Vocational Rehabilitation Administration training grant authority. Social work programs with correctional emphasis have been established at Bryn Mawr College, University of Washington, University of Denver, State University of New York at Buffalo, University of Illinois, University of Louisville, and University of Missouri. Similarly, vocational rehabilitation counselors receive some correctional experience in the programs at University of Alabama, State University of New York at Buffalo, Columbia University, University of Georgia, University of Missouri, Southern Illinois University, Syracuse University, and University of Tennessee.

Preventive Rehabilitation Programs in Schools

Research has shown that within the youthful offender population there is a sizable proportion of young people who would qualify for special education classes. In virtually every State, special education-vocational rehabilitation cooperative programs have been developed to provide curricular and vocational

training experience appropriate for young people in special classes and to insure their securing stable and suitable employment at the termination of their schooling. Programs of this type have spread rapidly throughout the country, and the Rehabilitation Services Administration and the Office of Education are jointly encouraging the establishment of new programs and the improvement of existing ones.

It is hoped that a further expansion of this effort will present the pre-delinquent who has limited mental ability with an alternative to school dropout and delinquent behavior.

RESEARCH AND DEMONSTRATION

In the development of the vocational rehabilitation program, the trend toward closer study of emotional handicaps has led in the last few years to extension of research and demonstration to the behavioral disorders as reflected in both juvenile and adult offenders. The impact of the 1968 Amendments to the Vocational Rehabilitation Act will involve more attention to problems of delinquency as the socially and culturally disadvantaged are included in the eligible client group.

Work is necessary to determine cultural factors in the causation and treatment of delinquent behavior. This is an area in which preventive methods are also of particular importance. An important new departure connected with the general involvement of the poor in their rehabilitation is the development of roles which delinquents can play in projects studying their problems. In this connection delinquents or pre-delinquents may be employed as research or rehabilitation aides and such a position may be conceptualized as the first rung on a career ladder.

The Social and Rehabilitation Service research and demonstration program supported a variety of projects for rehabilitation of juvenile delinquents including: (1) a treatment center within a residential school in New York for emotionally disturbed youth adjudged to be juvenile delinquent; (2) a prevocational curriculum in Illinois for slow learners considered delinquency prone; (3) a study in Oklahoma of the rehabilitation needs of the juvenile delinquent; (4) a study in the State of Washington on the influence of identification opportunities on the behavior of adolescent delinquent boys; (5) a study in the District of Columbia to determine essential features of a rehabilitation program for young handicapped inmates of a correctional facility, and (6) a study in New York to evaluate the effectiveness of various types of treatment programs for the rehabilitation of emotionally handicapped and delinquent youth.

Current projects include demonstrations of the role of former delinquents in the community as participants in new business or occupations, in the reduction of rioting, and in research on poverty groups.

Mounting juvenile delinquency rates in this country have for sometime prompted interest in a comparative study of juvenile delinquency programs in other countries. International comparisons in this area have been handicapped by lack of common terminology with respect to offenses, and by insufficient information about the personal and social characteristics of the youngsters with whom the courts deal. Discussions about the variation in the character of delinquency from place to place throughout the world and about the effectiveness of various measures used with delinquent youngsters have bogged down for lack of adequate information about what sorts of behavior bring children to court, who these children are, and what dispositions are made of specific kinds of cases.

The fact that jurisdiction and operations of juvenile courts within some of the cooperating countries is more uniform than in the United States enhances the value of identical studies in Belgrade and Ljubljuna, Yugoslavia in Warsaw, Jerusalem, and (under a domestic grant from the Children's Bureau) San Juan, Puerto Rico. An essential first step in what has been called Phase I of the identical study has been to devise a system of classification in order to cut through the considerable range and variety of behavior and treatment decisions in the different countries. To promote uniformity in approach and comparability of findings, investigators have met with U.S. Children's Bureau staff in Yugoslavia and in Washington. Other countries, including Egypt, England, Belgium, and India, are interested in undertaking similar studies.

Utilization in mainland American cities of techniques developed in these pilot investigations can also be of real value to courts and correctional authorities.

An action-demonstration attack on juvenile delinquency was tested in Israel by an investigator who had worked with street-corner gangs in Harlem. Carefully documented findings have prompted the Israeli Ministry of Social Welfare to initiate similar programs in other parts of the country.

Other studies of measures to treat juvenile delinquents in India, Israel and UAR-Egypt suggest follow-up programs to test improved administration and training practices and correct deficiencies which parallel those revealed in U.S. studies. (A Yugoslavian project to overcome these problems is experimenting with multidisciplinary teams training staff in a new institution.)

OFFICE OF EDUCATION

The 1966-67 school year marked the beginning of a new grant program authorized by the 1966 amendements to Title I of the Elementary and Secondary Education Act of 1965 (P.L. 89-750) and administered by the U.S. Office of Education on behalf of children in institutions for juvenile delinquents. Under this program, grants are made available to State agencies for those institutions which operate a school program and to local educational agencies for other public and private non-profit institutions for delinquents. The grants are based on applications which describe the special educational needs of the youth in the institution and propose a project designed to meet the most crucial of these needs. While the U.S. Office of Education administers the provisions of the Act and provides program leadership, it is the State departments of education which are authorized by Title I to approve project applications.

In 1968, $9.2 million was allocated for 36,600 eligible delinquent children in 177 State institutions. Funding was increased to $12.5 million in 1969 for 41,200 eligible children in 216 State institutions. During fiscal year 1968 approximately 70 percent of the eligible delinquent children participated in this program.

Grants to local school districts in 1968 totalled $2.4 million which was allocated for 13,900 eligible delinquent children in 189 local institutions. In 1969, $2.2 million was allocated for 14,500 eligible delinquent children in 208 local institutions, who were served through grants to local school districts.

Since the inception of P.L. 89-750 in 1967, a major effort has been made to rehabilitate institutionalized children and return them to their families and communities with changed concepts about themselves and society. The emphasis in programs has been on improved, more relevant curriculums designed for the unique needs of the children, better teaching, and greater cooperation among institutions, schools, and community. Effective educational aid received by these children now is much less costly to the taxpayer in the long run. Growing relief payments and the need for ever-expanding law enforcement facilities are inevitable results if delinquent children continue unaided into adulthood as highly unproductive and disruptive products of the poverty cycle.

Actually, there are 55,700 institutionalized, neglected, and delinquent children in State and local institutions who are counted for computing an authorization under P.L. 89-750 for 1969. With continued and increased funding, the opportunities are favorable for this program to benefit the children while discovering more effective general approaches to compensatory education. The laboratory-like characteristics of education in institutions, the nation-wide scope of this relatively small and relatively easily managed program, and its involvement with agencies and activities concerned mainly with poverty, crime, and education are factors pointing to a high level of future success.

Title III of the Elementary and Secondary Education Act (P.L. 89-10) provides non-matching grants to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs to service as models for regular school programs. For 1966 and 1967 10 projects in which juvenile delinquency was a component were funded under this title. Four of these projects are still operating in 1969. In 1970, as a result of new legislation, the States will administer most Title III projects. Some of these projects will probably deal

with juvenile delinquency. It is impossible at this time to estimate how many projects.

In 1969, 356 proposals were submitted for funding under ESEA Title VIII, Dropout Prevention Program. A number of these proposals which are now being evaluated for funding, deal with juvenile delinquency.

In fiscal year 1966, there were 27 programs begun in 21 States under the provisions of Title I of the Higher Education Act of 1965 (P.L. 89-329) which focused on the problems of youth, both pre- and post-delinquency. These programs include, the counseling and training of youths if correctional institutions to rehabilitate them and help them re-enter society; training teachers and school guidance personnel to work with youths to help prevent drop-outs which can lead to delinquency; strengthening the role of probation officers, retraining law enforcement personnel; and clarifying juvenile court procedures to cope with problem of juvenile crime; identifying, counseling and training culturally disadvataged out-of-school youths to help them discover their abilities and find employment; and helping parents and society to better understand youths and their behavior patterns. In fiscal year 1967, 44 such programs were conducted in 28 States. In fiscal year 1968, 26 programs were conducted in 15 States.

Under the Library Services and Construction Act, Title IV-A funds are authorized for State institutional library services. This may include penal institutions, reformatories, and residential training schools which are operated or substantially supported by the State. Under approved State plans States may provide books and other library materials and library services to inmates of such institutions.

In fiscal year 1968 Federal funds in the amount of $1,890,500 were obligated for projects under Title IV-A. Examples of projects affecting juvenile delinquents include:

Nevada

Nevada Girls Training Center. Relocate the present library resource center in a room providing additional space and accessible to the girls both during school hours and after school. Employ a part-time librarian to provide service after the school day ends. Supplement the book and periodical resources including additional reference materials. Supplement audio-visual resources through rental of films and filmstrips. Purchase equipment including a film projector. Contract for centralized acquisition and cataloging service from the Nevada Center for Cooperative Library Service.

Maryland

Maryland State Department of Juvenile Services. The Department of Juvenile Services proposes to improve its library services to the young people in juvenile institutions in Maryland by freeing the librarian at one institution (Boys' Village) two day per week to allow her to work with the other library personnel in the four other institutions.

California

Santa Rose-Sonoma County Free Library and Los Guilucos School for Girls-Bookmobile Service. By contract, the county library would provide service through the use of a bookmobile and deposit collections of books for the inmates.

The Vocational Education Act of 1963 has stimulated activity on the part of vocational educators in the area of correctional institutions. Reports from 16 States show that in fiscal year 1968 approximately $510,900 in Federal

funds was used for equipment, instructional materials, and teachers' salaries for programs in reformatories for both boys and girls. A recent survey shows that 19 States are using approximately $608,200 in fiscal year 1969 for such programs. It is estimated that the States having such programs will number about 30 in fiscal year 1970 and will expend approximately $2,000,000 for programs in correctional institutions. Most States are giving technical assistance to correctional officials as they set up vocational programs under their own auspices and use vocational educators as advisors. For example, in Norwalk, Connecticut, the Center for Vocational Skills was established to provide vocational education to dropouts and potential dropouts. The student-teacher ratio is approximately 8:1. Students work four hours a day and attend classes for three hours. The community has given it strong support, and the Center received an award from the National Education Association.

The Richmond, California, pre-tech program as expanded into 19 schools in the Bay area. Its major feature has been a determined effort to integrate the academic and vocational subjects making them relevant to the practical aspects of the work world. The business community is closely involved in the formulation of curriculum. The Richmond Plan has been particularly effective in demonstrating that most deprived youth can compete successfully with others if given the proper education and attention and can go into more highly technical fields.

The Minneapolis, Minnesota, Work Opportunity Center provides whatever services a young dropout between 16 and 21, needs to become self-reliant. This includes vocational education, vocational guidance, work experience, testing, work attitude orientation, basic education, job development, placement and follow-up. It is in a non-school setting and the students may enroll and leave at any time they feel it necessary. The student-teacher ratio is 6:1.

Manpower Development and Training has, since its inception, provided opportunity for the training of youths under 21 and, in its redirection, 65 percent of its trainees are to be hard-core unemployed. More youth with records, of a minor or major nature, have been included as trainees. The 1968 Amendments to the Manpower Development and Training Act provide for youths participating in MDTA training to be paid training allowances in accordance with the average weekly gross unemployment compensation.

Multi-occupational training programs have offered a wide variety of training, counseling and supportive programs at one location for these youth. Implementation of the 1966 amendment to the Act provides for the development and institution of pilot programs of training and education for persons in correctional institutions, including projects which deal with youths in a variety of correctional institutions.

During fiscal year 1968, Research and Training programs have supported projects which deal with the problems of the disadvantaged, dropouts, the role and behavior of adolescents, and the effect of training on potential dropouts. Other studies which were supported were a comparison of education versus vocational training for young dropouts, motivation, and achievement factors, and the relationship these factors have toward the prevention of juvenile delinquency by the early detection of predisposition toward delinquency.

Current and planned projects include a study in which Pennsylvania State University will investigate the effectiveness of formal education versus vocational training with respect to rehabilitating high school dropouts. Two control groups and two experimental groups will be used for the study and an evaluation will be done based on the results. One group of 50 youths, who have completed at least the ninth grade, will be selected to take courses leading to a high school diploma. A second group of 50 will be given a 52 week training program for entry into specific occupations. Two control groups of

50 each will receive guidance and counseling over the period of one year, without any education or training.

A 36-month curriculum demonstration program training school at Quincy Public Schools in Illinois will be available for approximately 45 drop-out prone students. The objectives of the program are (1) to provide a prevocational work laboratory for students, (2) to provide paid work experience, (3) to use the school to encourage local employers to hire successful trainees, and (4) to provide motivation for the students to stay in school. Based on these evaluations, students will be promoted and certificates of achievement awarded to those successfully completing the training. Job placement will follow.

The University of Chicago will examine relationships between aggression toward peers and aggression toward adult authority in terms of social, culture, and psychological variables. The date will be analyzed to determine the extent to which aggressive behavior and compliance toward peers and adult authority is determinable and predicatable from variables built into the design of the study.

NATIONAL INSTITUTE OF MENTAL HEALTH

Introduction

Law-violating behavior has become a major, if not the major, domestic social concern in the United States. Public alarm about the crime rate has markedly increased. Rising delinquency and crime rates and various acts of individual and mass violence receive widespread publicity and attention. The extent of this concern has been reflected in a number of significant national developments over the last three years. In December 1966, the President's Crime Commission for the District of Columbia published its findings and recommendations concerning crime in the Nation's Capitol. Two months later, the President's Commission on Law Enforcement and Administration of Justice published the widely acclaimed report, The Challenge of Crime in a Free Society, plus nine supplemental task force reports dealing with various aspects of the crime and delinquency problem. Various recommendations made in the above reports have resulted in the enactment of the "Juvenile Delinquency Prevention and Control Act of 1968" and the "Omnibus Crime Control and Safe Streets Act of 1968." In response to rising national concern about incidents of violence, and following the assassination of Senator Robert Kennedy, the President established the National Commission on the Causes and Prevention of Violence. The subject of law and order has become a major social and political issue.

Anti-social conduct labeled crime and delinquency covers a wide range of behavior from truancy and petty larceny to multiple homicide and political assassination. The monetary cost of such deviant behavior to the Nation--not only the expense of law enforcement, administration of justice, and correctional efforts, but also the cost of damages inflicted by criminals--has been estimated at more than $20 billion a year. The emotional and psychological consequences defy measurement.

At any given time, approximately 1.3 million offenders are under some form of correctional supervision, with about a third of them in jails, prisons, and reformatories. Public expenditures for police, courts, and corrections--currently estimated at more than $4 billion annually--are borne primarily by taxpayers at the State and local level. The number of delinquency cases among youngsters between the ages of 10 and 17 has been increasing at a considerably faster rate than the number of youngsters in this age group. Recent studies have indicated that one out of five boys within this age range will at some point appear before the juvenile court. In some areas, 9 out of every 10 juveniles have had some contact with juvenile court authorities.

Although the 15 to 17 age group represents less than 6 percent of the population, it accounts for almost 13 percent of all arrests--the highest arrest rate of all age groups. Over half of all arrests for burglary and larceny and almost two-thirds of the arrests for auto theft are of persons under the age of 18. While juveniles predominate in these forms of offense against property, they are also becoming involved, to an increasing extent in an offense against people--aggravated assault. If present trends continue, the proportion of the population now 10 years old or less--almost 25 percent--is an ominous statistic.

NIMH Program in Crime and Delinquency

The National Institute of Mental Health has a specific mandate to be concerned with the prevention, control, and treatment of deviant behavior defined as mental illness. Such behavior, which is stressful to the individual and often threatening to society, may at times be manifested in law violations. Thus, the Institute's role in the area of crime and delinquency is inextricably related to its role as primarily a research organization dealing with the phenomena of human behavior, especially problem behavior.

The Center for Studies of Crime and Delinquency serves as the Institute's focal point for activities in this area. These activities are directed toward meeting some of the following needs: a better definition and conceptualization of the phenomena of crime and delinquency; development of personnel for research and service programs dealing with these phenomena; and the more effective communication and utilization of research findings.

The Center encourages and supports basic research on the nature and causes of crime and delinquency; the development and better coordination of community resources directed at delinquency prevention and control; the development of innovative and more effective programs for treating offenders; the development of newer models for training of professional and non-professional mental health, correctional, and related personnel; the provision of more effective services and improved facilities for mentally disorderd offenders, as well as research into related issues of law and mental health; research in the area of individual violent behavior; and the communication of new knowledge through publications, conferences, and direct consultation with regional, State, and local groups.

The Center for Studies of Crime and Delinquency is now functioning as a "total" operating center. This change reflects a recognition of some of the problems inherent in trying to coordinate a comprehensive and diverse program across many different Institute components. An integrated and comprehensive center permits a more systematic and effective approach to the interrelated programs of basic and applied research, training, and service.

Collaborative Program Efforts

The Center for Studies of Crime and Delinquency has continued to work closely with the Joint Commission on Correctional Manpower and Training. Staff members have served in various consultative and advisory capacities to the Commission. Consultation have been provided to the various task forces concerned with developing new approaches to the in-service training, recruitment, and retention of correctional personnel and to groups concerned with various community-based programs for the treatment and rehabilitation of offenders.

The Center staff has also collaborated with the Department of Housing and Urban Development in planning a crime and delinquency component in the Model Cities Program. Efforts have focused on developing community resources to prevent and control crime and delinquency, modifying the correctional system to enhance the rehabilitation of offenders and better integrate them into society, and changing local law-enforcement programs with respect to poor and disadvantaged residents. Other issues discussed in a series of meetings with Model Cities staff have included possible changes in local and State laws and criminal codes, the organization and administration of police, court, and probation systems, the provision of legal counsel for indigent law-violators, bail bond practices, and the development of community-based alternatives to institutionalization.

Center staff attended meetings with representatives from various Federal agencies in reference to the "Juvenile Delinquency Prevention and Control Act of 1968" and the "Omnibus Crime Control and Safe Street Act of 1968."

Other collaborative efforts have pertained to the problem of violence and the establishment of the National Commission on the Causes and Prevention of Violence. Center staff prepared a report on "The Problem of Individual Violence: A Review of Some Major Issues and Concerns," and the Center Chief was among the consultants and advisors invited by the Violence Commission for assistance in planning its work.

The Center continues to be closely interested in two new major pieces of

legislation, the "Juvenile Delinquency Prevention and Control Act of 1968," which will be administered by the Department of Health, Education, and Welfare, and the "Omnibus Crime Control and Safe Streets Act of 1968," which will be administered by the Department of Justice.

In the case of the latter act, the staff of the Center has provided assistance in formulating guidelines and program goals for the research and development component of the legislation. The law established a National Institute of Law Enforcement and Criminal Justice to provide support for research pertaining to crime prevention and control, the administration of justice, and the rehabiliation of offenders. While the new legislative mandates and the NIMH program in the area of crime and delinquency overlap to some degree, it seems likely that the Justice Department program will focus more specifically on law enforecement, administration of justice, and correctional programs. In contrast, NIMH will continue to place major emphasis on behavioral and social science research in these areas. The Center's close coordination and collaboration with this new program in the Justice Department will be maintained.

The Center has been especially active in providing technical assistance and advice to a number of State and local agencies, including, for example, the Mobile Psychiatric Clinic in Richmond, Virginia; the Utah Juvenile Court system, Department of Corrections, Department of Mental Health, and the Utah Criminal Justice Council; the Bureau of Clinical Services of the Wisconsin Department of Corrections; the Department of Mental Health and the Commissioner of Corrections, in Maine; and the Ohio Youth Commission.

Information Dissemination

The rapid increase of published material on crime and delinquency throughout the world has necessitated the compilation of bibliographical references to help those involved in research, teaching, law enforcement, and correctional work. The International Bibliography on Crime and Delinquency and the Current Projects in the Prevention, Control, and Treatment of Crime and Delinquency were both developed with NIMH support. They are now combined as the Crime and Delinquency Abstracts and are printed by the U.S. Government Printing Office.

As part of the Center's efforts to improve and expand its information services, a recent grant to the National Council on Crime and Delinquency provides for the screening of projects listed in the Abstracts and the preparation of final summaries. This material will be made available to all interested agencies and individuals. It will also form the basis for a monograph describing and assessing the national effort to prevent, control, and treat crime and delinquency.

Basic and Applied Research

More than 120 basic and applied research and training projects directly related to crime and delinquency are being supported. NIMH grants in this area during fiscal 1968 totalled approximately $8 million. Grants since 1951, when the first ones were made in this field, have amounted to about $63 million. Research projects summarized in the following sections are illustrative of present or recent Institute-supported efforts.

Nature and Scope of Delinquent-Criminal Behavior

If crime and delinquency are to be prevented and controlled, the dimensions and nature of the problem must be known. At our present level of knowledge, it is difficult to determine the extent of law-violating behavior, where and under what circumstances it occurs, who participates in it, for what reasons, and how frequently. Such data are being developed through several studies funded by NIMH.

One project has attempted to determine the incidence, frequency, and type of delinquent acts committed by an age-cohort of 10,000 boys in a large metropolitan area. The boys involved in the study were born in 1945, entered schools in a defined geographical area before the age of 10, and remained in the study area through their 18th birthday. Specific aims of this project were to determine how delinquency evolves by age and severity: to compare delinquents with non-delinquents in regard to such variables as school history, intelligence, race, and residential area: and to apply a standardized numerical scoring system to assess the severity of anti-social behavior. Preliminary findings indicate that 3,500 of the 10,000 boys have had over 10,000 police contacts.

A sequel to that study, which is nearing completion, will follow up a 5 percent sample of the non-delinquents and a 10 percent sample of the delinquents. Information derived from the two studies will be utilized in an effort to produce means of predicting delinquent behavior.

Another investigator is measuring detected and undetected delinquent activity among a representative sample of American boys and girls ranging in age from 13 to 16 years. He seeks to obtain information about the who-what-when-where-and hows of their delinquent acts, and to place these acts in a psychological, sociological, economic, and cultural context. The findings are expected to contribute much to our understanding both of delinquency and of the development of mental health in children. The results should also provide the basis for the establishment of national norms on delinquency, thus making it easier to determine local and regional needs for prevention efforts.

Two additional projects by the same investigator were recently approved for support. One, which will study the nature and extent of delinquent behavior among a sample of teenagers in rural Michigan, will seek to validate measures of such behavior, whether or not it has been officially detected. At the same time, the study should help test the widespread belief that youngsters in rural settings tend to be less frequently delinquent than urban youth. The second new study will determine the degree to which official records reflect the actual frequency and distribution of delinquent behavior. To do so, it will compare the self-report delinquency data previously collected in the representative national samples with official records in the jurisdicition in which the respondents live.

Another significant study was designed to determine the basic background factors and psycho-social correlates of classroom behavior and the extent of the relationship between classroom behavior and juvenile delinquency, and to provide a longitudinal record of the correlates of approved and disapproved classroom behavior in terms of academic achievement, personal-social adjustment, anti-social behavior, and contact with the law. In 1961, about 400 children in the third, sixth, and ninth grades of a school system in Wisconsin were described by their teachers as displaying either persistently aggressive and disruptive or socially approved classroom behavior. Follow-up data indicate that school achievement, personal-social adjustment, and involvement with the law become increasingly serious problems for children who display aggressive and disruptive behavior in school. Moreover, such problems appear to persist and worsen as the children proceed through school to adult life. In contrast, the children who display consistent socially approved behavior in the classroom were less likely to develop psychosocial difficulties.

Institutional Programs

On an average day in 1965 there were approximately 426,000 persons confined in correctional institutions. Whatever the differences in type and quality

among these institutions, there is an inherent sameness about places where people are kept against their will. Many offenders have problems of such severity that incarceration is required as a valuable prelude to community treatment. For offenders who need to be confined for society's protection and also for their own treatment and rehabilitation effective institutional programs have to be developed. The task is to develop and exploit the advantages of institutional treatment and to minimize the disadvantages.

NIMH has supported a number of research projects concerned with the improvement of institutional programs. The basic tenet of one of these, which has had considerable influence on prison rehabilitation programs throughout the Nation, is that education is the key to the released inmate's successful readjustment to society, so the investigators have developed a low-cost, self-instructional program of education and vocational training for youthful offenders. The program prepares the inmate for further education or for an occupation, or both, and helps him find a job upon release. Nearly 1000 inmates have received educational and vocational training in this program since its start in 1962. The majority have found employment in the fields for which they were trained, and 16 have entered college. Through the use of self-instructional materials, the educational level of some participants has been raised from grade to high school or better within the period of a year. In the same period, functional illiterates have achieved 6th and 8th grade education level. For inmates enrolled in this pilot project, the institution's readmission rate after a year's discharge was substantially reduced. The program has been so effective that the Department of Labor has made a substantial grant to expand it.

Another project is developing a systematic social-psychological program of environmental treatment for delinquent adolescents in institutions. As is typical in such facilities, primary responsibility for fostering change is given to non-professional and minimally training cottage "parents." The investigator is trying to specify treatment techniques for critial situtations in ways that can be readily understood and applies by cottage staff. He is also trying to develop differential intervention techniques based on a classification of individuals and treatment environments. The project is expected to increase our knowledge of environmental treatment and to provide means for cottage staff to utilize treatment opportunities more effectively. Several other projects are describing and evaluating psychotherapeutic services as utilized in correctional settings.

Community-Based Programs

With two-thirds of the total corrections case load under probation or parole supervision at any given time, the central question is no longer whether to handle offenders in the community but how to do so safely and successfully. It is necessary to confine dangerous offenders, but recent studies have demonstrated that intensive community treatment for many of the others is both effective and economical.

An Institute-supported project in community treatment has received national attention and acclaim. Begun in 1961, this project has sought (1) to determine the feasibility of intensive community treatment as an alternative to incarceration, and (2) to assess the value of a classification method (based on the level of interpersonal maturity) in determining the type of treatment likely to be most effective. Approximately 600 male and female youth wards, undergoing their first commitments from the juvenile court, were randomly assigned to the community treatment project and to the regular institutional programs. Seriously assaultive youngsters were eliminated from the eligible pool. Treatment agents had small case loads--from eight to ten persons--so they could provide intensive care. This included from two to five weekly contacts with each youngster and his family and either partial or full-day programming for the parolee. After 15 months on parole, 28 percent of those who had been treated in the community had violated parole or been unfavorably discharged from it. Among those whc

had received the regular institutional treatment and then been paroled, the comparable figure was 52 percent.

The community treatment program was shown to be more effective than the traditional institutional program in terms not only of parole success rates but also of results on psychological tests. With institutional construction costs approaching $22,000 a bed and the cost of maintaining a person in an institution about $400 a month, a community-based program has economic advantages, too.

Another community-based project supported by the Institute has had considerable impact on Municipal Court probation programs across the country. Referred to in the Report of the President's Crime Commission as an example of an innovative community service program, this study is evaluating the effectiveness of a citizen volunteer probation program for misdemeanant offenders. Utilizing professional as well as non-professional volunteers, the program currently has five full-time retired citizen counselors who assist a part-time, paid chief probation officer; 35 volunteer psychiatrists; 10 volunteer psychologists; diagnostic services from five psychological and psychiatric clinics; and approximately 200-250 volunteer citizen sponsors (from laborers to businessmen and doctors) who work in a one-to-one counseling relationship with the probationers. Various supportive community services are also available, such as Alcoholics Anonymous, employment placement, and religious programs. The project has stimulated similar programs in 58 Municipal Courts across the Nation. Preliminary results suggest that the volunteer probation services have been quite effective and the citizen-volunteer probation programs are feasible for communities which cannot afford full-time, paid professional employees. Further, such programs can provide solutions to the problems of overcrowding and understaffing which confront all probation departments.

Other projects have sought to improve the effectiveness and efficiency of probation services. One, for example, which has involved more than 850 Federal probationers, has tried to develop criteria for a more meaningful classification of offenders; to determine the effects of varying intensities of probation supervision on offenders' probation adjustment; and to determine the relationship between recommendations made by probation officers and the actual disposition of cases in court. Major findings are: (1) that a defendant's present and past criminal behavior and information about his general stability (for example, employment and marital history) have a greater effect than all other pre-sentence information upon the selection of a sentencing alternative--that, is, either probation or institutionalization; (2) that concurrence between the probation officers' recommendations and the courts' disposition was better than 90 percent (96 percent where the recommendation had been probation; 90 percent where it had been imprisonment); and (3) that the intensity of supervision, with random assignment of cases, had no effect on how a person succeeded on probation. The investigators suggest the need for a redefinition of the probation and parole officer's role vis-a-vis the offender. Such a role might be one of a catalyst or mediator between offenders and the community--a role in which the probation and parole officers would seek to activate the community to absorb the offender as a member of it.

Another study is developing more and better information for use in making parole decisions. Its work has been so successful as to constitute a breakthrough in the major problem of getting uniform statistics so that the results obtained by any given parole system can be compared with those obtained by another system, or by all systems. Fifty-one parole systems in 46 states, the Federal Government, and Puerto Rico--systems responsible for more than 90 percent of the Nation's parolees--are participating in a uniform reporting program. Each month the collaborating agencies list those persons serving a maximum sentence of one year or more who are released by discretionary action of a paroling authority to serve a portion of their sentence under supervision in the community. Information concerning the results of a parole program is c

step forward toward evaluating its effectiveness and that of other programs. The project has already demonstrated that the persons chosen for parole by one system may vary markedly from those chosen by another. This finding costs serious doubt on the validity of direct comparisons of parole outcomes.

Innovative Treatment Approaches

The problems of delinquency and crime have assumed such magnitude, and the shortage of skilled manpower has become so acute that an urgent need exists for treatment approaches that are not only effective but also efficient. It is not enough to know that certain methods are in many instances of value. We must also ascertain the cost and overall efficacy of various approaches and define the circumstances under which each is most useful. And in the training of personnel, obviously, that knowledge and those particular skills should be taught which, on the basis of objective evaluation, are found to be both useful and efficient in modifying deviant behavior.

Several studies supported by the Institute utilize a typological approach to treatment. This approach assumes that delinquents are not all alike and that they can be grouped meaningfully into types having clear-cut implications for the kind of treatment required. It seeks to answer; what kinds of treatment programs, in what kinds of settings, administered by what kinds of treatment agents, are most effective with what kinds of delinquents?

One study, mentioned earlier, has identified nine subtypes of delinquents. These subtypes have been merges into three large groupings along a developmental continuum of social maturity. The delinquents are described as of low, middle, and high maturity, and each group requires grossly different approaches to treatment and control. The very immature, somewhat infantile youngsters receive a great deal of support and guidance, while the middle-maturity subjects--those who display a conformity more oriented to the power of authority than to an internalized sense of right and wrong--receive firm management emphasizing consistency and predictability of behavior by treatment agents. High maturity subjects, on the other hand, whose behavior represented a struggle with internal values and inhibitions, receive a more insight-oriented and exploring form of therapy. This project has dealt with delinquents in a community treatment program.

Another investigator is exploring the efficacy of typology-oriented treatment within an institutional setting. The project is designed to develop institutional treatment strategies for each of six major sub-types of delinquents, as determined by level of maturity, and to evaluate the effects of these strategies. If the program proves effective, it should be an important first step in closing the gap between a hypothetically ideal program, in which treatment is individually prescribed, and the present system, in which little consideration is given to individual differences.

Other studies supported by NIMH involve a behavioral approach to treatment. Essentially, this approach views the goal of treatment as the cessation of anti-social activities and their replacement by more constructive personal and social functioning. The therapeutic methods utilize various principles and procedures derived from learning theory.

One recently funded project will study interaction patterns in the homes of pre-delinquent and non-delinquent boys and try to develop an intervention technology tailored to change deviant behaviors. The project will test the hypothesis that the more non-reciprocal the interaction among family members, the more likely that the child will learn to force relatively non-responsive persons in the social environment to respond to him. Boys aged 6 through 11 will be the focus of the study, which will involve a number of "deviant" and "normal" families. Following observations of family interaction the investigator hopes to train members of the family (or of the youngster's peer

group) to alter the reward system (reinforcing contingencies) in such a way as to influence the behavior of concern. The study is expected to contribute valuable information about familiar change processess and the efficacy of precise and replicable intervention strategies. The intervention techniques to be used can readily be taught to relatively inexperienced individuals.

Another investigator has begun developing remedial procedures for adolescents with academic, interpersonal, and social deficiencies and related problems. Employing operant psychological principles, the project seeks to utilize selected programmed material to improve academic performance; to teach study skills, to assist in the acquisition of interpersonal skills and thereby promote academic learning; to establish a system of consequences for successful completion to tasks in order to maintain improved behaviors; and to develop this program in such a way that regular school personnel can apply it in a regular school setting. Students between the ages of 12 and 18 will be drawn principally from junior and senior high schools in the study area. On the basis of academic and psychological assessments, the students will participate in social and academic learning programs tailored to their needs. The results may have considerable impact on educational systems and do much to prevent delinquent behavior.

Law and Mental Health

The fields of law and mental health are both concerned with the deviant behavior of individuals and, therefore, are mutually involved in many important areas. For example, aside from the basic social policy issues pertaining to the definition and labeling of deviant behavior (is it crime or mental illness?), mental examinations are commonly used to assist in the determination of pre-trial competency, exculpatory insanity, sexual psychopathy, civil commitments, pre-sentence evaluations, and other matters. So the development of information concerning the interactive process between law and mental health is important for the improved handling and disposition of mentally disordered offenders.

One Institute-supported investigation focuses on the major problem area of legal competence and insanity--major because of the marked lack of clear and meaningful clinical procedures and criteria for the examination of defendants in regard to their competence to stand trial and for deciding the issue of exculpatory insanity. The researchers address this problem by seeking to improve psychiatric clinical services to courts. Composed of psychiatrists, psychologists, lawyers, and supporting personnel, the study group is examining court procedures, the role of court personnel, the specific nature of problems handled, and the personalities and witnesses who appear in court concerning the issue of pre-trail competency. Since the law on this particular subject is basically similar throughout the United States, the mental health criteria and diagnostic procedures developed and demonstrated by the investigators are expected to be widely applicable.

Another investigator (supported by a grant to the American Bar Association) has addressed the somewhat broader issue of the medical, legal, and social procedures employed in the courts for the handling of the mentally disordered offender. He has gathered extensive data on how various individuals and agencies operate in the administration of procedures for determining competency to stand trial, procedures governing the defense of insanity in criminal cases, procedures employed in cases involving sexual psychopathy, and programs in mental hospitals and prisons for mentally disordered persons accused, convicted, or acquitted of criminal charges. The information should provide an excellent opportunity to analyze the interacting effects of the administration of criminal justice, psychiatric interventions, and social values. The results are expected to influence the training and philosophy of lawyers, mental health professionals, public officials, and others involved in the subject of mental illness and the law.

Another study is proceeding on the belief that traditional methods of processing

defendants have failed to properly diagnose those who are mentally disordered and to channel them into effective treatment and rehabilitative settings. Under the auspices of the Georgetown Pre-Trial Clinic, this project plans to establish a "Pre-Trial Conference" unit for the D.C. Court of General Sessions and the U.S. District Court. Through consultations with prosecuting and defense attorneys and through clinical and social evaluations, the unit will attempt to identify defendants suffering from mental illness who might be managed and treated more effectively in the community than in an institution. Once identified, these offenders will be diverted from the criminal process into community mental health treatment and rehabilitation channels. The researchers will be concerned with learning the psychological and social characteristics of the offenders who can be identified and safely and effectively diverted to community mental health resources. They will be concerned also with identifying the attitudinal, procedural, and legal factors that presently militate against diversion, and the limitations of community services that presently prevent it. The results are expected to demonstrate whether and in what way the provision of special legal-mental health consulting units can bring about the early diversion of mentally ill offenders.

Another critical area involving the interactionsof law and mental health appears in the juvenile justice system. Hence the Institute has undertaken to support an analysis of existing laws and court decisions affecting juvenile offenders. The study will attempt first to collect, tabulate, and analyze juvenile court statutes, case law, and statistical data from the 50 States and the District of Columbia. The results will be prepared for publication to make available (in one place) the various normative provisions affecting juvenile offenders. The study will then analyze the actual operation of a local juvenile justice system. Emphasis will be placed on learning the decision-making criteria employed at various levels, the characteristics of juveniles moving in and out of the system at several points, and the dispositional process invoked in those cases reaching the stage of adjudication.

Because there is remarkably little information about security hospitals and related facilities for the care of mentally ill offenders, the Center for Studies of Crime and Delinquency has undertaken a survey of such facilities and their programs in the United States.

Police Practices

Policemen have to deal with numerous problems having mental health implications. Such problems are reflected in various forms of disorder, ranging from individual acts of delinquent and criminal behavior to mob violence and riots. The manner in which police deal with these problems depends largely upon how they envision their role, particularly in cases where prescribed procedures give the police much discretion. The way in which the police carry out their duties can, and frequently does, have an immediate bearing on the peace and safety of an entire community. Likewise, it has a profound influence on the way various segments of the community perceive and respond to these officers.

One study supported by the Institute (through a grant to the International Association of Chiefs of Police) is seeking to determine the extent to which an undesirable change in the police officer's concept of his role takes place after he has been exposed to the rigors of his job. The investigator hypothesizes that the officer's exposure to depravity, irresponsibility, and resistance to authority, and especially his exposure to the ever-present threat of violence, results in an elevated and persistent level of anxiety and defensive behavior. Then may come, the hypothesis continues, the evolvement of pariah-like self-concepts, the harboring of virulent prejudices, the abuse of authority, and other unacceptable behaviors. The results are reflected in public cynicism, disrespect for law and order, social rebellion, and a general weakening of the community's moral fiber. If it can be demonstrated that changes in role perception and attitude on the part of new policemen do occur, the study will irvesti-

gate the nature and extent of the changes and attempt to correlate them with personality variables, different types of intra-departmental social and psychological climates, and changes in police behavior.

Another investigator is conducting a visual ethnographic study of police-community relations in a urban ghetto. Under the plan, the ordinary encounter of the police and the residents of one precinct will recorded on film and tape. Interactions occurring at the station house, on the beat, cruising in a police car, directing traffic, intervening in family disputes, providing emergency medical care, and similar activities will be recorded. The effort is to learn more about the dynamics of these routine activities and to discover the ways in which such encounters may contribute cumulatively to community confidence and cooperation or to tension and rioting. The final product will be a one-and-a-half hour film that can be used to train present and future members of the police force and to educate ghetto residents and police about the nature of their encounters and thereby make them more aware of alternative methods of dealing with one another.

The appointment of civilian boards of review to hear complaints of alleged abuse of police authority has been much discussed, often bitterly. The Philadelphia Police Advisory Board, one of the first such boards to be established successfully and to function over a period of years (since 1958), is being studied to determine the extent to which it has met its responsibility to serve as an avenue of redress for citizens with complaints against the police force; to ascertain whether or not the board has been an effective mechanism for changing procedures to prevent further cause for complaint; and to learn what factors have accounted for any effectiveness it may have had, and the nature of any limitations on its influence. The findings are expected to contribute much-needed information about an important subject--the effectiveness of administrative reform as a solution to problems of bureaucratic power and of the accountability of civil servants to the community.

Manpower and Training

Of the approximately 121,000 people employed in the field of corrections, only a small proportion have treatment and rehabilitation as their primary function. Twenty-four thousand, or 20 percent, are probation and parole officers working in the community or educators, social workers, psychologists, and psychiatrists working in institutional settings. The other 80 percent have major responsibility for custody and maintenance. Correctional agencies and programs across the country face heavy shortages of qualified manpower, particularly in positions charged with responsibility for treatment and rehabilitation. Many thousands of persons will be needed in the next decade to attain even minimum standards of effective treatment and rehabilitation programs.

Faced with this critical shortage of trained personnel, the Institute has provided support for the training of mental health professionals, such as psychiatrists, psychologists, and social workers, and of certain other professionals, including sociologists, juvenile court judges, prosecuting attorneys, and parole and probation officers. Support has also been provided for the training of non-professionals--including ex-offenders--to enable them to perform various roles in the correctional field.

One of the more important projects supported by NIMH involved the introduction of training programs and expanded work opportunities for ex-offenders. The inmates participating in the program were exposed to a program of rehabilitation that stressed self-understanding and social development. Following a period of training, each offender was placed in a supervised field setting to work with research and action groups in the area of crime and delinquency. A follow-up assessed the trainees' effectiveness in their jobs and in their ability to maintain themselves in the community. The study demonstrated that offenders can be trained for new kinds of roles in the field of human services and that they

can perform in these new roles effectively. It demonstrated also that training must be tied in with job development, that job experiences must become a part of the training, and that non-productive job behavior can be improved and made the focus of further development of the trainees.

Considerable variation was found among the trainees in the amount of on-the-job support required. For some, the formal training appeared to have set a learning process in motion that enabled them to "grow through" their own experiences with very little outside support. For others, a sheltered workshop type of situation seemed indicated. By expanding the range of career opportunities for ex-offenders, this study provided a model for enabling adult inmates, as well as other people with, usually, relatively little formal education, to function in research and action roles in the broad correctional field. This strategy for coping with the problems raised by the shortage of professional manpower has obvious implications for various other human service fields.

Another project in the area of training involves the ongoing in-service psychiatric education of the judiciary in Southern California. It aims to help the judiciary develop a greater awareness of psychiatric principles and issues involved in law; to demonstrate the influence of this increased awareness on court practices; and to relate, for the information of the legal system, the field of psychiatry to contemporary social values. Problem areas in law and psychiatry are explored in a series of lectures and seminars presented by authorities in the fields of law, sociology, psychiatry, and psychology. Particular areas of emphasis are the applications of psychiatric principles to the issues of mental competency, commitment procedures, and criminal responsibility.

The usefulness of tailoring the type of treatment to the type of delinquent has been reported earlier. This typological treatment approach, referred to as the Differential Treatment Model, provides the basis for one of the more innovative training programs for people working to prevent and control delinquency. The program covers Interpersonal Maturity Theory, the theoretical basis of the Differential Treatment Model; the differentiation of the nine identified delinquent subtypes by test and interview; the prescription of treatment strategies for individual cases; and the clinical techniques appropriate for implementing these strategies. Trainees include correctional administrators, planning and research personnel, treatment supervisors and line staff, delinquency prevention workers, and graduate students. An estimated 36-40 hours of training are required, plus an additional 48 hours of field experience in using the differential treatment method. Follow-up consultation will be provided both to the students and their parent agencies.

Hospital Improvement and In-Service Training Programs

The Institute provided approximately $1.2 million during fiscal year 1968 for Hospital Improvement and In-Service Training grants to mental hospitals having maximum security units with programs for mentally ill offenders. Twelve such projects are in operation, the majority of them concerned with expanding and improving existing treatment programs. In-Service Training aims mainly to increase the competence of psychiatric technicians and ward nurses.

One Hospital Improvement Program has established an intensive treatment unit for "sexual psychopaths" in the maximum security division of a State hospital. Previously the hospital had no specially designed treatment and rehabilitation program for this group of offenders, and they were distributed through the institution. Now a separate 92-bed ward has been provided. The treatment program includes group work, patient government, therapeutic milieu, recreational activities, and educational and vocational services. An attendant-counselor, working under professional supervision, is assigned to each patient. Families of patients are encouraged to participate in the treatment program

from the point of admission onward. Progress during hospitalization and while on parole in the community is measured by psychological tests, rating scales, and behavioral indices. A sponsor for a paroled patient must report monthly on his community adjustment. This program is expected to contribute considerably to our understanding of sexual deviation and to its more effective prevention, treatment, and control.

An In-Service Training grant to a State hospital for mentally disordered offenders--1600 males classified mainly as "sex offenders" or "criminally insane"--seeks to expand and improve a training program for psychiatric technicians and ward nurses. The program is designed to provide nursing personnel at the ward level with a body of skills and techniques geared to meeting the specific needs of these patients. The basic teaching method is group discussion of the didactic material, illustrated by case studies of individuals, groups, and ward programs as they occur in the hospital.

Priority Areas and Future Plans

The following are some of the critical areas for program development in the expanding program of NIMH activities in crime and delinquency.

1. More and better knowledge concerning the causes, nature, and scope of law-violating and related deviant behavior. Surveys conducted for the President's Crime Commission revealed that there is far more crime than is ever reported. If prevention, treatment, and control efforts are to be effective, it is imperative to know more about the causes and dimensions of the problem. Progress is being made in this area through studies using clinical, longitudinal, age-cohort, and survey research techniques, but more has to be learned about the numerous social forces which define certain kinds of behavior as deviant, the kinds of deviant behavior which are ultimately labelled "delinquent" or "criminal," and the effects on those who are so labelled, and the forms of deviance that can be identified as hard core delinquency as opposed to tolerable though annoying youthful behavior.

2. Research pertaining to the role of the police as key definers of deviance and "gate keepers" of the juvenile and criminal justice systems. The bulk of all juvenile court cases first pass through the hands of the police, and therefore police actions largely determine the kinds and numbers of cases that come to the attention of the courts. The police are also the first point of contact between the juvenile and formal legal authorities. Thus, the behavior of the police is a decisive element in the processing of delinquents. The Center plans to stimulate a variety of programs to determine the extent to which police practices relative to case disposition differ from one jurisdiction to another; the factors that influence police decisions in disposing of various cases; the nature and extent of the social norms and related pressures that, by being exerted on police departments, affect disposition of cases; the development of new police roles and functions related to delinquency and crime prevention and to broader peace-keeping functions in the community; and the extent to which police may more effectively utilize community agencies and services as alternatives to court referral.

3. The development and increased utilization of a variety of community-based programs as alternatives to institutionalization. It is necessary to confine dangerous offenders, but studies have demonstrated the effectiveness and economy of intensive community treatment programs for many others. Further work in this field is planned.

4. More innovative and efficient treatment programs for offenders in institutions. The President's Crime Commission recommended that "correctional institutions should upgrade educational and vocational training programs, extending them to all inmates who can profit from them." Studies to improve these programs through the use of such developments as programmed instruction

and behavior modification techniques and to develop more effective ways of bridging the gulf between the institution and the community will be undertaken.

5. More systematic research on issues pertaining to the juvenile court. Previous NIMH support for work in this area has included evaluations of juvenile court clinical services and administrative procedures. Further efforts to study juvenile court statutes, procedures, and practices are planned.

6. Newer methods for the training and use of personnel, particularly non-professional personnel, working in the overlapping areas of antisocial behavior and mental illness. Institute-supported projects have included a "new careers" program, so that ex-offenders could work in the correctional service field, and studies of the effects of different probation supervision methods. But more emphasis has to be given to the development of new training models and programs for sub-professionals--and for mental health professionals, too, if we are to make more appropriate and effective use of such scarce manpower.

7. More effective programs for mentally disordered offenders, as well as research pertaining to issues of law and mental health. A number of important research projects involving law and mental health have been stimutated and supported by NIMH and a number of others are planned.

8. More research in the area of individual violent behavior. In considering such behavior, attention should be given less to the apex offense of murder or manslaughter than to the broad range of acts that lead to varying degrees of bodily injury and may at times result in death. Research programs will attempt to develop better understanding of various types of violent individuals, the situations related to their behavior, and the purpose and motivation of such behavior; to devise means of predicting violent behavior and screening for violence-prone individuals; to study the nature and extent of the relationship among biochemical, neurological, psychological, and socio-environmental variables involved in violent behavior; to determine the effects of the communications media on attitudes, ideology, and behavior; and to study the attitudes, information, and beliefs of society regarding the prevention, control, and handling of violent behavior. The Center also plans to develop programs of information and education for key decision-makers--on the national, regional, state, and local levels--concerning various social problems related to violence.

9. Studies of how behavioral and social science findings can most effectively influence and be incorporated into new and ongoing programs and policies. Researchers often seem to assume that findings published in various professional and scientific journals will somehow find their way into social programs, but this very often is not the case. Indeed, the gap between available knowledge and current programs and practices is glaringly large. Efforts must be made to understand processes whereby findings from research are put to use--and can be put to use more rapidly and effectively. Included must be efforts to learn how new information influences broad public policy and understanding of social problems, and whether or not--and if so, how--it can be brought to bear with more speed and effectiveness. The difficulty in enacting effective gun legislation--for better control of the means whereby certain violent behaviors can occur--is one illustration of the need for such research. So is the use of outmoded methods of treatment in many correctional institutions though research has uncovered more effective ones. To be sure, the development of more effective means of disseminating and utilizing significant, and replicated, research findings is not limited to delinquency and crime but is common to most other concerns of the behavioral sciences. The Institute and many other agencies and individuals have tackled it. NIMH believes that more can be done and plans to play an important role in doing it.

OBLIGATIONS FOR PROGRAMS ON JUVENILE DELINQUENCY

AGENCY	1966	1967	1968	1969 Estimate	1970 Estimate
Office of Education	$2,237,730	$5,609,609	$26,663,794	$29,947,948	$35,445,000
National Institute of Mental Health	7,580,000	8,916,000	6,004,000	6,553,000	6,413,000
Social and Rehabilitation Service:					
Rehabilitation Services Administration.....	20,000	294,000	446,563	315,000	315,000
Research and Demonstrations....	75,000	82,000	232,000	625,000	585,000
Children's Bureau	306,000	583,400	581,400	472,000	470,000
Office of Juvenile Delinquency and Youth Development	6,552,185	8,171,868	573,000	5,000,000	15,000,000
Totals.....	16,770,915	23,656,877	34,500,757	42,912,948	58,228,000

DRUG ADDICTION

Introduction

Drug abuse is many things. It is the heroin user mainlining his bag of H, the methedrine user high on speed, the college student smoking a marihuana joint, the adolescent boy sniffing model airplane glue. It is also the suburban matron using her diet pills to get a fast start on the day, the harried executive driving himself with stimulants by day and swallowing barbiturates to sleep at night.

Most drug-abuse behavior is illegal and therefore escapes our techniques for examining social problems. Almost certainly drug abuse is growing, although the rate cannot be gauged accurately. Nor is it possible to make accurate predictions of how the drug scene will look in five years, or even one year from now. Far from being limited to our own affluent society with its permissive child-rearing practices, drug abuse is worldwide and poses difficulties in such widely different cultures as those of Sweden and Japan.

Drug use and abuse touches our deepest values, hopes, aspirations and fears. It is an emotionally charged area. For every false prophet advocating drug use there is a viewer-with-alarm prone to sensationalism and to advocating simplistic solutions.

This report describes programs carried out by the Health Services and Mental Health Administration and the Social and Rehabilitation Service of the Department of Health, Education, and Welfare. Problems as well as accomplishments are described, and some estimate is made of future needs and priorities in the area of drug abuse.

Obligations for programs in drug addiction
(In thousands of dollars)

	1966	1967	1968	1969 estimate	1970 estimate
Health Services and Mental Health Administration:					
National Institute of Mental Health.....	$10,614	$12,003	$21,469	$25,600	$29,108
Social and Rehabilitation Service:					
Grants to States.....	0	141	275	375	592
Innovation grants.....	0	177	240	250	300
Training and traineeships.....	18	3	0	0	0
Section 12--Project development.....	0	5	5	5	0
Rehabilitation research and demonstration.....	148	128	0	125	135
Subtotal, Social and Rehabilitation Service.....	166	454	520	755	1,027
Total.....	10,780	12,457	21,989	26,355	30,135

NATIONAL INSTITUTE OF MENTAL HEALTH

It is the task of the National Institute of Mental Health to mount the programs needed to deal flexibly with the many problems of drug abuse. As the problem is complex and changing, so must be the strategies designed to understand and cope with it.

The structure of NIMH has been revamped to deal with the burgeoning challenge of drug dependency. Now every unit which has a mission in the area of drug abuse has been consolidated into a single division, the newly formed Division of Narcotic Addiction and Drug Abuse. This Division includes the Addiction Research Center at Lexington, Kentucky, where basic research on the nature of the addict and his addiction are being studied by physiologists, biochemists, pharmacologists and other scientists. The two Clinical Research Centers at Lexington and Fort Worth are not only hospitals for the treatment of narcotic addiction, but also evaluators of treatment methods. The Narcotic Addict Rehabilitation Branch arranges for the legal and administrative procedures for bringing the addict into care and provides for the long term aftercare of the patient released from one of the Clinical Research Centers into the community to which he returns. The Center for Studies of Narcotic and Drug Abuse supports research on drug abuse in qualified institutions. It also grants funds to NARA Centers, of which six have already been established around the country and others are being planned. It supplies information and educational materials about all varieties of drugs that are subject to abuse to all sectors involved in the problem and trains those who wish to engage in a specialty career in the management of drug abuse. In addition, the Division is in active liaison with many other government agencies including the Department of State, the Department of Justice, the Food and Drug Administration and the Department of Defense.

This report treats the topic of drug abuse by drug categories for clarity and convenience of exposition. It should be noted, however, that many, perhaps most, heavy abusers do not restrict their drug use to one category of drug. Within drug-using groups there is much discussion about the effects of different drugs and of drugs used in combinations. Much of the current research activity recognizes that multiple drug use is a common complicating factor in analyses of drug-using behavior. The drugs used also depend in part on availability. The occasional social user of marihuana may switch to the more potent hashish to achieve a higher "high," or if the former is not available. Similarly, the heroin user who cannot get his supply may use barbiturates or codein cough syrups temporarily. Moreover, since the quality, quantity, and composition of drugs sold on the street is quite variable, the user himself may be understandably vague about what he has consumed. Nevertheless, this report's organization by drug groups is consistent with pharmacologic classifications and is the traditional framework around which treatment programs are organized.

NARCOTIC ADDICTION

The number of active narcotic addicts reported to the Bureau of Narcotics and Dangerous Drugs was over 67,000 as of December 1968. Typically, the known addict is a young ghetto dweller in a densely populated city. He is a member of a racial minority group, and he and his family are poor. These are characteristics of known addicts; that is, those known to the law-enforcing authorities. Submerged below the horizon of the law enforcement statistics are a large group who are addicted but who have not yet come to the attention of the authorities.

An unknown number of other people leading lives quite remote from the ghetto addicts also abuse narcotic drugs. While narcotic addiction appears to be epidemic in our urban slums among economically deprived young people, it is, in fact, an endemic problem afflicting people in every level of our society.

The Addiction Research Center

At the Addiction Research Center scientists are investigating many different aspects of addiction. One important area of research is evaluation of the addictive properties of new analgesics. Other studies include the pathophysiological processes associated with physical drug dependence, the biochemistry of addiction, and conditioning factors in opiate addiction.

Perhaps the ongoing research with the greatest potential for direct clinical application is the search for improved narcotic antagonists. These are drugs which will occupy the sites on the nerve cell which heroin would ordinarily occupy. If these can be blockaded by safe agents, the "high" which heroin produces can be blocked. Nalorphine and cyclazocine have already been developed and are in use, but they suffer the disadvantages of being relatively short acting and produce side effects in some addicts. The precise nature of the narcotic binding site is being intensively studied. The more we can learn about how opiates interact with the nerve cell, the better the chances for a rational approach to finding an optimal chemical deterrent.

Both at the Addiction Research Center and by extramural grants from the Center for Studies of Narcotic and Drug Abuse attempts are being made to improve and simplify the urine analysis test for opiate detection. Present methods are relatively accurate, but they are neither simple nor perfect. The urine testing procedure is important because it detects relapses early and the outpatient can be immediately faced with evidence of his return to heroin. Sometimes this is sufficient to cause the patient to stop using, in other instances it may be a reason for rehospitalization.

Another joint effort between the two Centers is the pursuit of studies of the sleep pattern of the addicted patient and the patient on methadone. In addition, brain wave tracings of the patient on these drugs while awake, as well as tests of performance, are being scrutinized.

Narcotic Substitutes

The development of methadone maintenance programs and the use of narcotic antagonists in treatment of addict patients have been both promising and controversial. Methadone maintenance, in particular, because it involves using a narcotic on a long-term basis, has been the object of much criticism. The most recent report of the Methadone Maintenance Evaluation Committee of the Columbia University School of Public Health and Administrative Medicine is therefore of particular interest. The Committee is charged with evaluating the research of Dr. Vincent Dole and Dr. Marie Nyswander of Rockefeller University, New York, N. Y. Basically, their program is for hard-core addicts who average ten or more years of addiction. Over 1,000 patients had been treated by November 1968.

The program is in two parts. During the initial six-week inpatient phase, patients are given methadone in increasing doses until they reach a stabilizing dose (80-120 mgms.). During their stay in the hospital, patients receive psychological support from the treatment team. The second phase of treatment is the

outpatient phase during which patients appear daily for the medication and for certified urine testing to detect drug use. Later, patients who appear to be making a reasonable adjustment are provided with a several-day supply of medication and return to the clinic only once or twice a week. There is considerable emphasis on job finding, completing an education, and developing advanced vocational skills.

On the whole, those who have remained in the program (4% have dropped out or are deceased) have become productive members of society. It should be pointed out that the patients involved were older volunteers who may well be considerably more motivated than the average street addict. This and other reports suggest that if abstinence from all drugs is the goal of treatment, the program has yet to be proven effective. If, however, the goal is social rehabilitation, the results (for these selected patients) are encouraging. In any event, further studies are needed to determine the kinds of treatment appropriate for different types of addicts. At this point we do not have a treatment for all addicts.

It is important to thoroughly gain an understanding of the meaning of methadone maintenance for every aspect of the individual's functioning. We must also obtain an answer to the question of whether some patients on methadone maintenance can eventually be removed from the drug. A conference, co-sponsored by NIMH, will be held during October 1969 at Rockefeller University to examine these and other issues.

Of our six NARA Centers, five have a methadone maintenance program. These five programs will help us evaluate whether supervised methadone maintenance treatment will be successful in other sections of the country.

Narcotic Antagonists

The Center for Studies of Narcotic and Drug Abuse staff have been exploring the possibilities of developing a long-acting antagonist drug, depo-cyclazocine (slow-release), which should be ready for preclinical screening in 1969. Staff have also encouraged submission of a grant proposal to develop a device consisting of a blend of narcotic antagonist and polymer plastic. The device would be implanted in such a way as to release the antagonist over an extended period of time.

Chemical and Biochemical Research

In order to increase our knowledge of the opium alkaloids with respect to their occurrence, chemistry, and biosynthesis, methods are being developed for determining the geographical origin of a given sample of opium.

Other grantees are studying the distribution of narcotic analgesics in mammals to learn how transport influences pharmacologic actions. Research is also under way to determine if chronic morphinization of rats stimulates brain nucleic acid, and if so, to see what type of nucleic acid synthesis is involved, if nucleic acid accumulates in the brain, and if these findings can be correlated to the development of morphine tolerance.

Experimental Psychopharmacological Studies

Several studies on the behavior of opiate-addicted animals seek to shed light on the behavior of human addicts. A method has been developed for inducing rats to acquire opiate-directed behavior; this behavior survives morphine abstinence for weeks, thus pointing to a certain resemblance to the sustained

drug-directed behavior of human addicts. Physiological differences among rat strains have been identified, which permits them to be classed as addiction-prone and addiction resistant animals. This suggests that inherent physiological characteristics--seemingly genetically transmitted--play a part in the animal's proneness to addiction.

A study has been conducted of the effects in monkeys of morphine self-administration on various behaviors (including social behavior). The aim is to develop a model of social factors involved in initial addiction and re-addiction. Other researchers are studying opiate addiction in animals in such a way as to parallel the situation of the human addict who gets his drugs intravenously in large doses. The variables pertaining to the reinforcement of dependence, such as the quantity of the drug injected and the delay of injection following an opiate-directed response, are also being studied.

To contribute to our understanding of the stimulus conditions relevant to human addictive processes, a grant has been awarded to examine the conditions under which a non-addicted animal acquires a morphine addiction and actively seeks the drug. Other investigators are exploring drug self-administration in animals and in particular the variables influencing acquisition, maintenance, and elimination of drug self-administration behavior.

Psychosocial Studies

The use of narcotics is especially high in the ghettos of our largest, most crowded cities. The motivation for drug involvement here is quite different from that which prevails in the suburbs and on college campus. To better understand the motivations of narcotic users, the Center for Studies of Narcotic and Drug Abuse is supporting several studies. For example, research is being conducted on a group of drug users of the lower socioeconomic classes living in their own neighborhoods. The focus is on specific individuals, with emphasis on their sequential movements toward drug use and an addict identity.

Knowledge of the extent of the narcotic addiction problem is necessary for any control program to be effective. Researchers are assisting the New York City Health Department to set up a register giving a reliable, up-to-date, unduplicated count of narcotic addiction in New York City. The potential use of such a register for obtaining estimates of incidence and prevalence of narcotic addiction in New York City and for determining how these estimates vary with demographic and other characteristics of the individuals will be explored.

Narcotic Addict Rehabilitation Act

Effective treatment of the narcotic addict continues to be a refractory problem. Results in the past, particularly if the criterion of success is total abstinence from drugs, have been discouraging. At least part of the difficulty has been that the addict is usually treated in a hospital far from his home community and there has been no adequate program of follow-up care to assist him on his return home. One of the objectives of the NARA program is to overcome this deficiency.

With the passage of the Narcotic Addict Rehabilitation Act of 1966 (Public Law 89-793) and the 1968 amendments (Public Law 90-574), the Congress established a new national policy for the treatment of narcotic addicts. The Act views narcotic addiction as symptomatic of an illness that should be treated, and not a criminal circumstance itself. NARA provides for the civil commitment and treatment of narcotic addicts, including those charged with or convicted of violating certain Federal criminal laws. Thus, for the first time, Federal law provides that narcotic addicts may apply for treatment in lieu of prosecution for certain

crimes and that addicts not charged with a criminal offense may also be committed to the Surgeon General for treatment and rehabilitation. The Act set in motion a new nationwide program for the treatment and rehabilitation of addicts in the community. In this way a patient can be treated, supervised and guided in his local environment, where the problems involved in his addiction can best be understood and their solution best sought. This long-term support and supervision should lower the high relapse rate of treated addicts.

The National Institute of Mental Health was designated by the Surgeon General to carry out his responsibilities under the Act. The NIMH Division of Narcotic Addiction and Drug Abuse, through its NARA Branch, is responsible for the examination and treatment of patients committed under Titles I and III, which includes arrangements with State and local programs and facilities.

The first NARA patient was committed under the provisions of Title I on June 29, 1967. As of December 31, 1968, 1,357 addicts had been admitted to the NIMH Clinical Research Centers in Fort Worth and Lexington. Of this number, 68 addicts charged with a criminal offense chose commitment under the provisions of Title I in lieu of prosecution; 220 addicts convicted of a crime were sentenced to treatment under Title II; and 1,069 addicts not charged with any criminal offense were committed under Title III.

Although the number of addicts committed under Titles I and III of this Act was initially small, there has been a gradual but progressive increase since its implementation, reaching an average of approximately 130 commitments per month since June 1968. We anticipate that this rate will continue to increase as the public becomes more informed about the provisions of the Act.

In the early years of this program, the examination and hospital treatment of patients committed under Titles I and III are being performed at the Clinical Research Centers in Fort Worth and Lexington. When suitable State and local facilities have been developed, these services will be contracted for as close as possible to the addict's home community.

In keeping with community mental health concepts and to insure that close follow-up and supervision of the addict will be maintained, contracts for aftercare treatment and rehabilitation services are being negotiated by our NARA Branch with appropriate agencies and facilities near the homes of the addicts. As of December 31, 1968, 32 such contracts had been made, and there were 215 patients in aftercare. NIMH professional personnel are assigned to field offices in the metropolitan areas having the largest addict populations. Six of these NARA field offices are now operating in New York, Chicago, Los Angeles, San Antonio, Atlanta and the Baltimore-Washington area. They will develop contracts, review the performance of those with whom we contract, and insure a high level of professional performance. They will also interpret the program to lay and professional community groups, and will help and stimulate communities to remedy deficiencies in needed services. The contracts will provide for a flexible treatment and rehabilitation program adapted to the needs of the individual addict, including vocational training, special and continued education, job placement, social casework, individual group and family therapy, halfway houses, and day and night hospitals. Urine testing and other examinations will be performed periodically to detect any relapse to the use of narcotics.

The primary aftercare services required are those which prevent or relieve family dysfunction, stabilize financial status, and develop the patient's ability to earn a living and cope with the stresses of daily life. The aftercare contracts will provide a continuity of treatment to implement specific recommendations of the hospital staff and to furnish rehabilitation services.

Research and evaluative procedures are built into the NARA program. The effectiveness of various types of treatments will be compared, including careful long-term follow-up studies. The development of innovative treatment approaches will be encouraged and studied. The opportunity to monitor the treatment of a large group of addicts in their communities over a prolonged time period will provide much needed information required for the understanding of the multiple forces which lead to a person's becoming a narcotic addict.

The Center for Studies of Narcotic and Drug Abuse is responsible for implementing Section 402 of Title IV of the Narcotic Addict Rehabilitation Act of 1966 and Public Law 90-574, which provides Federal funds to help communities develop comprehensive treatment and rehabilitation services for narcotic addicts.

Through this program the NIMH provides support to nonprofit private and governmental organizations for the construction, staffing, operation, and maintenance of community-based treatment programs for narcotic addicts. This legislation ties these funds into the Community Mental Health Center system. All of these programs are located in Model City areas. Treatment services are to be community-based.

Regulations incorporate the notion of essential services being available to the narcotic addict to assure comprehensiveness and continuity of care and these essential services parallel those required for Community Mental Health Center programs.

The funding structure is parallel to CMHC formula in that construction of new facilities for treatment of narcotic addicts will have the same Federal-local formula as mental health center construction; and staffing, operation, and maintenance for narcotic addict programs will be supported, with the Federal share being 90 percent during the first year and decreasing by 10 percent until the fifth year, when the Federal-local participation is 50 percent each. This 50 percent participation will continue through the eighth year of the grant.

During 1968, six community-based treatment programs were funded under NARA, for a total of $4,000,000. These are located in West Philadelphia Community Mental Health Center; University of Chicago; New York City Addiction Services Agency; University of New Mexico at Albuquerque; University of Missouri at St. Louis; and Connecticut Mental Health Center at New Haven.

Program guidelines have been developed that encourage applicants for Federal matching funds to offer a variety of treatment approaches and to innovate new treatment techniques. The initial grantees are testing a variety of treatment modalities, for example, pharmacologic treatments that view addiction in a medical framework and utilize narcotic antagonists such as cyclazocine and substitutes such as methadone; intervention approaches that view the addict as a victim of blocked opportunity and urban-social disorganization, which can be corrected by blending medical-psychiatric treatment with community action and community development techniques; and therapeutic community approaches such as that of Synanon and Daytop.

All grantees except New York are located in medical school-based community mental health centers. University medical centers offer a setting where professional leadership and technical competence is available, and where students of medical and mental health professions are exposed to training experiences in treatment, evaluation, and epidemiologic aspects of this field. Four of these

programs (Chicago, New York, Philadelphia, and St. Louis) are located in large urban areas with sizable populations of narcotic addicts, and two programs (New Mexico and Connecticut), located in medium-sized urban communities with significant numbers of narcotic addicts, have responsibility for treating all addicts in their communities.

The overall structure of these programs ties intervention systems to the notion of reduction of prevalence and incidence of addiction in a defined geographic area, thereby developing a public health framework for the nonpunitive control of narcotic addiction in the community. In this sense, these programs not only offer comprehensive treatment for the narcotic addict, but also take into account their own responsibility to ameliorate the socially disruptive manifestations of the narcotic addict subculture in their community.

The guidelines require each program to develop a community advisory board whose membership will help tie the program to local health, welfare, enforcement, employment, vocational training, community action, and urban renewal programs. The guidelines also encourage the creative use of ex-addicts as rehabilitation team members with significant program responsibilities. Ex-addicts account for from 25 to as much as 60 percent of the total staff positions requested by the applications approved in 1968.

Each program is required to develop an epidemiologic and evaluation unit. The grantees plan to compare the length of treatment and the economic cost of the various methods relative to their therapeutic outcome. They will also attempt to identify which treatment modality is most effective for which patients. The units will need to develop methods for evaluating over time the impact of their total program on prevalence of addiction in the community.

Further, these units will participate with the NIMH in an attempt to develop a national monitoring and data collection system. To this end, evaluation researchers from the major narcotic addiction treatment programs are meeting with NIMH staff to review the results of pilot testing of a uniform reporting system that includes admission and periodic status evaluation instruments. This is a pioneer effort and it is hoped that in the future data can be pooled from both Federally funded programs and the major non-Federally funded treatment programs for this uniform data collection system. The final outcome will be a data bank containing information on a wide variety of variables from treatment programs in all major urban centers of narcotic addiction.

Through NARA the Center also supports the development of demonstration projects and training programs. A grant was awarded to establish a regional center for studies in substance use at the New York Medical College. The project will encompass a comprehensive approach to drug abuse including clinical and preventive services, training, and research. A grant was also awarded for the training of social workers and nurses in the treatment of drug addicts.

Another study funded through the Center for Studies of Narcotic and Drug Abuse, and related to this area, will produce a taxonomic scheme for the ordering and comparison of drug addiction treatment programs. This is being done so that the similarities and differences on a number of significant dimensions--such as setting, philosophy, staff, and practice--may be understood in a systematic frame of reference and be of aid in evaluating these programs and establishing new ones.

Additionally, under the Hospital Improvement Program, a grant was made to the New Jersey Neuro-Psychiatric Institute to provide an intensive program of in-patient treatment and follow-up services for voluntary admitted drug addicts.

This grant, by making possible the establishment of a nucleus of experienced professionals and paraprofessionals, has been of great value in the development and training of additional staff members for this project. The Newark After-Care Clinic was inaugurated under the auspices of the grant and currently provides aftercare services to patients released from the inpatient unit. It also serves as a referral source of drug addicts to other agencies.

MARIHUANA

Of all the illegal drugs currently in use in our society, marihuana has generated the most popular concern. Next to alcohol it is the most widely abused drug. Its use was originally concentrated in limited sectors of the population, but has now come to include large numbers of junior high school to college age youth. There is sharp disagreement, even among well-informed scientists, regarding the degree of threat posed by marihuana. Adequate data, particularly on the implications of low-dosage, long-term social usage, are generally lacking. For many of our teen age youth, and in a few adults as well, marihuana has become the focus of a social protest movement, which argues against the injustice of the current severe legal penalties in the light of uncertainty about the drug's ill effects.

Much of the controversy over marihuana's possible effect and appropriate social policy with regard to its control arises out of over-interpretation or misinterpretation of what little data are presently available. Foreign studies of cannabis use in different societies, for example, lack the controls generally considered essential for scientifically valid conclusions. The absence of reliable evidence of the harmfulness of a substance does not, of course, demonstrate its harmlessness. Frequently, it requires relatively long-term chronic use of a substance before its public health implications are apparent. Cigarette smoking provides an obvious and apt example. Despite the limitations inherent in foreign studies, an up-to-date, unbiased review of the marihuana literature, with emphasis on foreign research and experience, would be useful, and a grant has been made for this purpose. This review critically examines the deficiencies of research efforts of the past as well as providing a discussion of research strategies for the future.

There remains a real need for controlled, in-depth epidemiologic studies of cannabis use in countries where its use has been widespread over long periods. The research should include investigation of the physical effects of varying levels of dosage and of the psychological and social consequences of use. Studies are also needed of the effects of both acute and chronic use upon learning, memory, coordination, performance, and other perceptual and cognitive processes. Adequate bioassay procedures and means of detecting marihuana in the body are also needed. Present research plans call for increased activity and support in all of these areas. Details of the program are outlined below.

Surveys

The drug scene is a rapidly changing one. By the time any survey is completed and analyzed, its results may already be outdated. In addition, what evidence there is suggests that college patterns of use, for example, are quite variable with the greatest incidence of use on the West and East coasts and with lesser degrees of use in the South and Midwest. Another obvious complication is that marihuana use is illegal and not readily reported.

Recent surveys of high school and college drug use suggest that 15 - 65% of students surveyed have had some experience with marihuana. Two out of three users reported having used it less than ten times, with "once or twice" the modal response. Thus some distinctions must be made between what might be termed "users" versus "triers," with the latter being by far the bigger group. Of those who have tried marihuana, about half report experiencing no effects from the drug. This finding may reflect such factors as potency of material, experience in use of the drug, and influence of social setting on use.

The Institute is currently considering a grant application for a national survey of drug use to be made at 200 colleges and universities among a sample of 20,000 students. The research proposes to make estimates of the prevalence of usage of psychoactive drugs and alcohol in the college population of the United States, to investigate the personal and social concomitants of individual drug use, and to investigate the role of institutional factors in drug use (e.g., type of college, law enforcement policies, etc.). The survey will take two years and will follow-up a sample of those questioned one year later.

Chemical and Biochemical Studies

Basic research on marihuana and related compounds has been hampered by a lack of standardized natural product. Researchers have had to utilize marihuana seized by the Federal Bureau of Narcotics and Dangerous Drugs. Frequently this material was old and nonuniform. The situation led to the development of the Center's Marihuana-THC Program, which has become the focal point of Institute and inter-departmental activities.

The synthesis in 1967 by an NIMH grantee of tetrahydrocannabinol or THC (one of the active substances found in the natural plant Cannabis sativa), has permitted for the first time a systematic pharmacologic investigation of the active principle in cannabis and provided synthetic THC for research purposes. The availability of an active substance of known potency makes it possible to perform pharmacologic, biochemical, genetic, and behavioral research necessary to understand the mode of action and toxicity of cannabis. The NIMH Marihuana-THC program was developed to secure adequate supplies of natural and synthetic materials and to develop proper analytical methods. The supplies include plant material--fully characterized and historically documented, synthetic untagged THC, and radioactive-tagged THC. Sources are described below.

The Research Institute of Pharmaceutical Sciences, University of Mississippi, has been contracted to grow five varieties of cannabis so that a supply of natural material will be available for every phase of the marihuana program. Natural material will also be provided by the Research Institute, which will extract it from cannabis supplied by the Federal Bureau of Narcotics. The extracted material, "Red Oil," will be used in analytical and biological studies.

Synthetic THC will be obtained from Arthur D. Little, Inc. They will examine the method of synthesis of THC as published by Petrzilka and compare it with the method published by Mechoulam, in order to determine the best approach to the preparation of large quantities of THC compounds. The Research Triangle Institute will also conduct an exploratory examination of the Petrzilka method of synthesizing THC, and will provide radioactive-tagged THC to be used in metabolic studies.

Finally, the Battelle Memorial Institute will develop special analytical methods to determine which compounds of the cannabinoid class are absorbed in the system of the marihuana user. A metabolic study of cannabinoid compounds in marihuana and in the smoke of marihuana will also be done here in order to illuminate the biochemical changes in biogenic amines.

This represents only the beginning--insuring an adequate supply of good material. The second step is to get the material to the research laboratories. A joint committee composed of staff from NIMH and FDA and of nongovernment researcher is now operating to supply these materials to qualified investigators. (This committee's work is described in detail in the final section of this report.)

The third step is the research program itself. Limited bioassay and methodology development must be conducted, applying the methods to body fluids as well as to biological tissues. These studies should include micro-detection, pharmacological profile, and exploratory and definitive studies. Acute and chronic toxicity studies are required before clinical studies in man can begin. Human toxicologic studies, including routine laboratory examinations of liver function, blood sugar, BUN, electrolytes, and hematologic examinations must be pursued. Also needed are genetic and chromosomal studies and studies of the effects of acute and chronic use on learning, memory, coordination, and other perceptual cognitive processes. Some of these are already under way.

The complete marihuana program proposed for 1969 is shown here:

Priority	Nature	Estimated Cost
1	Analytical control	$10,000
2	Continued supplies	175,000
3	Bioassays, Pharmacological Profile	120,000
4	Dose range findings and acute toxicity studies	15,000
5	Sub-acute and chronic toxicity	45,000
	Total estimated cost	365,000

Experimental Psychopharmacology

To understand the mechanisms of action of marihuana-related compounds, research is being conducted on the processes by which tetrahydrocannabinol derivatives produce their effects in the central nervous system of rats.

Clinical and Applied Research

The effects of marihuana on the perceptual and cognitive functioning of humans is being studied to contribute to an enhanced understanding of the drug. Investigators plan to study the way in which people organize sensory input and the manner in which the experienced intensity of sensory input is controlled. Another research group is studying the effects of heavy use of marihuana on performance on psychological tests.

Psychosocial Research

The association between marihuana use and emergent drug-use patterns is being investigated at a midwestern university. The basic research question to be answered: "What are the conditions necessary for the movement from a marihuana-use pattern to a hard-drug pattern?"

A study of 200 urban marihuana users is under way in New York. The research will focus on the initiation of the individual into marihuana use, the motivations for continued use, the degree to which users form a community, and the relationship between marihuana use and the use of other drugs.

Operating under the premise that no sensible policy regarding marihuana laws (whether penalties should be abolished, made more stringent or more lenient) can be framed without knowledge of the existing laws, the UCLA Law Review will study the marihuana laws in Los Angeles County and present a summary of their findings and recommendations.

Finally, Center staff are working with the Office of International Affairs, NIMH, to set up cross-cultural studies of cannabis use in Brazil, Jamaica and Israel. The aim is to determine the psychological and physiological sequelae of chronic marihuana usage.

LSD AND OTHER HALLUCINOGENS

Few drugs have had so profound an effect on American culture in so short a time as d-lysergic acid diethylamide, familiarly known as LSD. Its use, never great in terms of the percentage of the population who have tried it, has helped to create an entire subculture--the drug-based "hippie" groups. Unlike other illegal drugs, LSD first became popular among middle-class professionals and artists. At the same time, its profound psychological effects generated an initial optimism among scientific investigators about its potential usefulness for creating a model of psychosis and as a psychotherapeutic adjunct. These views have tempered with time.

While LSD is the most powerful and dramatic of the hallucinogens, it shares its mind-manifesting properties with such other drugs as mescaline (derived from the Peyote cactus), psilocybin (a mushroom derivative), dimethyltryptamine (DMT), and other chemicals. Mescaline and psilocybin in their naturally occurring forms have an ancient history of use as adjuncts to religious ceremonials as far back as pre-Columbian times in the New World. In addition to these hallucinogens, various others have come into popular use from time to time (STP and morning glory seeds, for example).

Extent of the Problem

The best estimates of the extent of use of LSD among college students, even in areas of relatively active use such as on the West Coast, yield modest numbers. Probably not more than five percent of students have ever tried the drug. Informed observers believe that use has sharply declined in the past year, probably in response to well-publicized evidence of possible adverse psychological and biological effects.

Clinical and Applied Research

A grant has been awarded to the University of California in Berkeley to develop a new type of mental health service and to administer and evaluate a therapy program. The service is specifically designed to meet the needs of high school teen-agers who are persistent users of LSD, methedrine, and other drugs. The program envisioned would provide a special community for these youths; this would provide a locus for their free-time activity as well as a therapeutic center.

Chemical and Biochemical Research

The peyote cactus Lophophora williamsii is probably the prototype of hallucinogens. Research with the peyote cactus will add to basic understanding of this class of drugs. Through NIMH support, investigators are studying the

rates of formation of the peyote alkaloids in the cactus. Other workers are attempting to identify the chemical components of the seed, germinate the seed, and grow the excised root in artificial culture. It is hoped that upon successful completion of this exploratory project the technique can be employed to perform definitive examination of the biogenesis of the peyote alkaloids.

In another area, a grant has been awarded for the development of methods to identify microgram quantities of psychotropic drugs by a combination of techniques. The method will then be used to examine extracts known to possess hallucinogenic properties and to investigate new extracts of potential hallucinogenic character.

Studies on Biological Effects of LSD

In order to shed light on the possible association between LSD and lasting chromosome damage, the leukocyte cultures grown from blood samples taken several years after a group of autistic children were treated with LSD-25 are being examined to determine if there has been any damage to the chromosomes.

A study is being conducted of the effects on the nervous system of fetal animals who were exposed to LSD. Mothers will be studied for abnormal maternal behavior. The offspring will be examined at different ages by a variety of tests to evaluate motor activity, learning, and social dominance.

Investigation of the effects of LSD-25 on the genetic system of the Drosophila fly is under way. In a series of controlled experiments the investigator is studying the effect of exposure to a food medium containing LSD on various embryonic stages of development, and the effect on adults of exposure to varying concentrations of LSD for varying periods of time.

Psychosocial Research

A study of 200 persons in the Los Angeles area who were given LSD by physicians prior to 1962 (for research or therapeutic reasons) is being conducted to determine patterns of nonmedical hallucinogenic drug use, its effects, and its psychological and sociological correlates. One purpose of this study is to discover what distinguishes the continuers (those who sought out illicit LSD after their initial legitimate exposure) from noncontinuers and from a control group who had never taken LSD.

Systematic social-psychological field studies are under way of small groups of people who use LSD illicitly. The groups will be selected to represent various special uses of LSD such as selftherapy, mysticism, and enhancement of sexual responsivity.

Several grants have been awarded to study the hippie subculture. One investigator is planning to define the patterns of drug use in the Haight-Ashbury subculture and relate these to social, demographic, and other variables. These data are needed to help clarify current myths about psychedelic drug cultures. The study will also develop and evaluate techniques of treatment. Another study of the hippie community of San Francisco's Haight-Ashbury neighborhood will focus on background of users and current psychological status.

A cross-sectional study of drug use among adolescent members of two YMHA centers--one in New York City and another in Long Island--and among a matched group of hippies in New York's East Village neighborhood--is being supported by NIMH. The investigator will focus on the exposure of adolescents to drugs, family background of users, and attitudes toward drugs.

The careers and role changes of a group of adolescent users of psychedelic drugs are being studied. This longitudinal study of high-school students will assess changes in values, knowledge of drug use, and behavior.

A grant has been awarded for the exploration of the legal significance of hallucinogenic drug research. The investigator, an attorney, plans to review existing knowledge about the hallucinogens and to survey the legal controls now in effect. He will recommend specific actions designed to increase the assimilation of the products of scientific research into legal decision-making.

In recognition of the concern regarding the extent of the LSD problem in the United States, a conference of leading researchers was held in September 1967, under Center auspices, to examine some of the issues. Most of those participating were concerned about popular reports exaggerating research findings or tending to draw unwarranted conclusions from preliminary data. These researchers pointed out that evidence of persisting psychological effects from long-term use of LSD was minimal. Generally, electroencephalographic findings after LSD administration were normal, although chronic users showed lower thresholds for auditory stimulation. The possibility was suggested that sensory overload may be a problem for chronic users and may in some way be related to an absence of goal-directed behavior among at least some users.

Some of the clinicians reported that in their experience, "bad trips" were seen mostly in the 15- to 25-age bracket. It was suggested that this might be the result of LSD precipitating adolescent adjustment crises into severe acute reactions. Several conference participants commented on the reduction in the number of hospital admissions due to LSD ingestion, a fact which may reflect a decline in the use of the drug.

With respect to possible biological effects of LSD, there were conflicting reports of chromosomal damage with uncertainty expressed as to the ultimate significance of these findings. An underlying concern was that chromosomal changes found by some investigators have also been observed in survivors of the atomic bombing of Hiroshima and might be related to an increased probability of developing leukemia-like disorders. The proceedings of this meeting are being edited and will soon be published.

A second conference is planned to examine again the significance of LSD-induced chromosomal changes and to gain a better understanding of the differences in data reported by various investigators. Conferees will also consider any evidence that LSD is teratogenic (i.e., leads to birth defects similar to those produced by such drugs as thalidomide) and will discuss what types of additional research are needed. At this time our evidence regarding the hazards of LSD and the other hallucinogens must be regarded as incomplete. There is, however, substantial agreement on the desirability of women in the child-bearing years avoiding exposure to LSD, particularly during pregnancy.

AMPHETAMINES AND BARBITURATES

Abuse of amphetamines and barbiturates ranges from the practice of using illicitly obtained drugs to the more hidden forms of abuse represented by inappropriate usage of medically prescribed medication. Some experts would also include as an iatrogenic abuse the prescribing of amphetamines in programs of weight reduction. Very large quantities of these drugs are manufactured; in the case of the amphetamines, it has been estimated that fully half of the production finds its way into illegal channels.

The Center is particularly concerned about a recent upsurge in the high dose, usually intravenous, abuse of methamphetamine (meth, speed, crystal). Increasing numbers of young people are using a hundred times the average dose in a single injection which may be repeated a number of times daily. Such a "speedfreak" may exhibit impulsive, paranoid, unpredictable behavior and is a danger to himself and those around him. When this severe misuse of methamphetamine is prolonged, malnutrition, hepatitis, brain cell damage and cardiac arrhythmias become possibilities. A ward at the Lexington Clinical Research Center and projects are being sponsored to study and treat this ominous condition.

Extent of the Problem

It is especially difficult to arrive at any sort of estimate of the extent of abuse of drugs. Part of the difficulty lies in just how abuse is defined. While some would argue for the inclusion of medically prescribed amphetamines for routine weight reduction, others regard this as a perfectly legitimate use of the drugs. Is the use of a sleep-inducing medication prescribed under one circumstance and used under other circumstances necessarily abuse? What college survey data have been accumulated indicate that use of amphetamines is limited and most commonly related to "cramming" for examinations. For example, one survey of a western university of high academic standing indicated that about one student in ten had used these drugs nonprescriptively. Is this abuse?

Through its Psychopharmacology Research Branch, the NIMH is supporting three surveys of patterns of drug acquisition and use within the general population. While the focus of these surveys is not on drug abuse, they will provide insight into the extent to which we have become a drug-oriented society and the ways in which such drugs are used. Preliminary data with respect to legitimate use of amphetamines indicate that college-educated persons and young adults are more likely than others to use them. The preliminary data also seem to suggest that mood-altering drugs such as tranquilizers and amphetamines tend to be used for coping with specific psychological crises rather than becoming a way of life. Results of the survey should give us a more accurate picture of how Americans view the role of mood-changing drugs and the degree of cultural acceptance they have gained.

Research Activities

There is a critical public health need for methods of investigating the abuse potential of new compounds before they are made available for human use.

The Addiction Research Center has a primary interest in determining the addiction potential of stimulants and depressants. Methods to quickly discover which new stimulants and sedatives have abuse possibilities are already developed. Comparisons of various amphetamines have revealed that the euphoria and other effects of methamphetamine and dextroamphetamine are equal, phenmetrozine is a half to a fifth as potent, methylphenidate is half as potent, and ephedrine is half as potent as dextroamphetamine.

A CNDA grant has been awarded to study physical and psychological factors of drug dependence in monkeys (particularly amphetamines and barbiturates). Another investigator plans to establish a laboratory for the study of various aspects of physical and psychological drug dependence in a colony of barbiturate-dependent dogs. A colony of monkeys, able to self-administer drugs directly into the heart, will be established to study drug preference and social effects of drug dependence.

In other areas, a grant has been awarded to study structure-function relationships of barbiturate tolerance. The investigator is interested in the fact that phenobarbital is more consistent in inducing tolerance to other barbiturates than many other barbituric acid derivatives, and that various nonbarbituric substances induce tolerance to barbiturates. He will study various substances similar in chemical structure to phenobarbital. Our intramural Center is working to develop a barbiturate antagonist.

Research is being conducted on the development of tolerance to and physical dependence on a variety of chronically administered drugs--central depressants, neurohumoral blocking agents, opiates, and barbiturates. The investigator will attempt to demonstrate that the occurence of acute abstinence phenomena is not confined to the classic drugs of addiction, opiates and barbiturates, but is characteristic of central depressants and neurohumoral blocking agents in general. He proposes that, following abrupt withdrawal of such agents, a period of "supersensitivity" of some portion of the central nervous system (e.g., cerebral cortex) ensues, the time course of which corresponds to that of the abstinence syndrome in question.

Other research is under way which will help to determine whether barbiturates produce tolerance by more than one mechanism. The objective of this project is to define a method for expressing the relative contribution of induced hepatic drug-metabolizing activity to the development of tolerance to hypnosedative agents in female rats.

Another investigator plans to record and analyze in cats the neurophysiological consequences of chronic amphetamine intoxication; in humans, this is often associated with a psychosis-like state. The focus will be the neurophysiological mechanisms that have a direct relationship with different levels of arousal; for example, cortical recovery functions, habituation, sleep patterns, and cortical EEG. A foreign grant has been awarded to a mental hospital in Denmark, where amphetamine effects in relation to brain function in mice and rats will be examined.

PREVENTION AND EDUCATION

The Task Force Report of the President's Crime Commission (1967) states that "misinformation about drugs and their effects is still prevalent . . . there is a clear need for a single agency, having a specific mandate for education, to prepare and distribute a broad range of materials, from pamphlets to films, suitable for presentation to target segments of the public . . . the materials must above all be factual." The Commission suggested that the Center for Studies of Narcotic and Drug Abuse might be the appropriate unit to charge with the major Federal responsibility for education.

The Center has now begun to take on the responsibilities of drug-abuse education and information. It is the Center's goal to develop effective educational programs for use in elementary, junior and senior high schools, and colleges, as well as with parents' groups and other concerned segments of the community. Factual materials will be disseminated to as wide an audience as possible through the media of posters, newspapers, radio, television, and films.

In this area of drug-abuse education, there is considerable disagreement as to how to go about dissuading people from using drugs. Some feel that the end of discouraging drug abuse justifies the use of scare tactics. Others argue

with equal conviction that a simple policy of providing accurate information on the pros and cons is the best approach. Knowing the behavioral consequences of differing approaches to different target groups would do much to clear away the controversy.

While a better understanding of the characteristics and motivations of the drug user will be helpful in designing effective drug-abuse prevention programs, there is also a separate need for careful evaluation of such programs. Prevention materials need to be evaluated in terms of their effectiveness in imparting information, promoting attitude change and, ultimately, influencing actual drug-using behavior. Almost certainly different types of material will have to be developed for use with different age groups, different socioeconomic groups, and for the various ethnic and racial groups. To do so requires a sensitive awareness of the motivations operating in the different groups and of the means of effective communication in the idiom of the target group. Part of the problem may be not only that of affecting the behavior of potential drug abusers themselves but of also developing programs conducive to change in the general population and in such groups as teachers, social agencies, the police, and others working with youth.

Toward this end, the Center for Studies of Narcotic and Drug Abuse has awarded a contract to a national advertising agency for the production of television and radio spot announcements to help develop public awareness of the problems of drug abuse. Present plans are to provide announcements in appropriate language and style for use with the general public and with such ethnic subgroups as Spanish-speaking Americans and Negroes. This series of television spots will be ready for distribution during March 1969.

The Center has also been instrumental in the founding of a National Coordinating Council on Drug Abuse Education, a voluntary association of national organizations with an interest in drug abuse education and information. The Council plans to stimulate regional, State and local involvement in drug abuse education by establishing interdisciplinary committees to respond to area needs, and by evaluating current drug abuse educational programs and promoting those that are effective.

The Center has also been involved in the development of another effort to disseminate factual information on drugs on a national scale. This is a cooperative project, initiated by the Chairman of the United States Civil Service Commission, which will supply the 15 Federal Executive Boards (regional offices of the Civil Service Commission) in 15 major cities with films and pamphlets dealing with drug abuse. These Boards will have the responsibility for organizing drug abuse education meetings with various segments of the community and encouraging these groups to implement educational programs.

The Center has awarded a contract to the American Association for Health, Physical Education, and Recreation of the National Education Association for the development of drug abuse education programs that can be utilized on a nationwide basis. The National Science Teachers Association is also a participant. It is felt that these two organizations can play an effective role in drug abuse education because health and science classes offer a direct channel to students in elementary, junior and senior high schools.

Based on the premise that educational materials should be evaluated by the various groups for which they are intended, several films on drug abuse were evaluated by two groups of students who were at NIMH for the summer. These were

college and high school students. Pointing up the paucity of drug abuse education in the school system, only five of the 13 high school students answered "Yes" to the question "Has drug abuse been taught in any of your classes?" Of these five, only one said that all of the drugs of abuse had been covered; the others answered that only one or two were studied. Almost all of the college students said that there were no drug abuse education programs on their campuses. A few said that there had been campuswide lectures or discussions in psychology or sociology classes. It is interesting to note that all of the high school students wanted a film utilizing the scare technique, while the college students were interested in a film discussing the philosophical questions concerned with the decision to use or not use drugs. These comments will be valuable in rating films for use with various audiences and in the future production of films on drug abuse.

Four pamphlets on marihuana, LSD, stimulants and sedatives, and heroin have been published. They tell a factual story of the nature, action, complications and reasons for avoiding the use of these drugs. Their reception has been unexpectedly gratifying with 700,000 already having been requested and distributed.

Another aspect of the Center's attempt to develop effective channels to young people is the publication of a 16-page insert for an issue of the National Education Association Journal. This Journal reaches a million teachers throughout the Nation and will make it possible for NIMH to provide authoritative information for use in the classroom.

In the area of educational materials for professionals in the drug field, the Center, in coordination with the National Clearinghouse for Mental Health Information of NIMH, is involved in the production of the proceedings of a Conference on Adverse Reactions to Hallucinogenic Drugs.

In addition to formal arrangements with various groups for the development of materials in the prevention and education sphere, Center staff have also provided consultation to a wide range of organizations to help them develop their programs. Some typical examples are meetings with concerned citizens interested in planning programs in their communities, with educators developing school programs, and with representatives of professional organizations such as State pharmacy associations.

RESEARCH DRUG DISTRIBUTION PROGRAM

The Department of Health, Education, and Welfare, after the passage of the Drug Abuse Control Amendments of 1965, launched a two-pronged attack on the growing problem of drug traffic and drug abuse, particularly in the field of psychotomimetic drugs. The FDA Bureau of Drug Abuse Control was assigned the task of regulatory efforts and the NIMH Center for Studies of Narcotic and Drug Abuse was given the responsibility of overseeing clinical and laboratory work with these drugs.

A Joint FDA-PHS Psychotomimetic Agents Advisory Committee, including leading scientists from outside the Federal government, meets six times a year to review applications for the use of the psychotomimetic drugs (primarily LSD, mescaline, psilocin, and psilocybin). An Ad Hoc Marihuana Advisory Committee, formed solely to review applications for the use of marihuana, red oil and THC, held its first meeting in June of 1968. The Joint FDA-PHS Psychotomimetic Agents Advisory Committee continues to operate, although the Bureau of Drug Abuse Control has been moved from the FDA to the Department of Justice. The Committee reviews each application for its scientific merit, in the same way that review committees do in cases of research grant applications.

In addition to the responsibilities outlined above, the Institute, through the Center, is also the distributor for psychotomimetic drugs used for research. In April of 1966, Sandoz Laboratories, which had pioneered in the development of psychotomimetic agents, discontinued all clinical work with LSD and turned over its entire supply of the drug to NIMH. Since that time CNDA has managed the storage, packaging and distribution of this drug. In June of 1968, CNDA assumed the same tasks for marihuana.

During the past year, the Joint FDA-PHS Psychotomimetic Agents Advisory Committee approved about three-quarters of the 143 applications submitted. More than one-third of the approved applications dealt with the study of chromosomal change, damage, or teratogenic effect. Other studies were concerned with the possible therapeutic uses of LSD with patients--for chronic neurotics, for therapy-resistant psychotics, for handling conversion reations of patients with strong presenting psychosomatic complaints, and for use with terminal cancer patients in an attempt to alter their attitudes toward death. Three investigators are looking into the effects of LSD on sensory, perceptual, and cognitive functioning in groups of chronic LSD users.

The Ad Hoc Marihuana Advisory Committee approved six of the nine studies submitted for review. Three of the studies approved involved human subjects. One had to do with the effect of marihuana on driving performance, one on auditory and visual systems, and one on a series of specific behaviors.

SOCIAL AND REHABILITATION SERVICE
Rehabilitation Services Administration

The drug addict continues to be one of the most challenging and difficult of the disability groups. However, State vocational rehabilitation agencies are intensifying efforts to serve this category. Numbers rehabilitated remain small but new approaches to the problem hold promise of more gratifying results in the future.

Estimated and Actual Number of Rehabilitants with Drug Addiction

Fiscal Year Ending June 30	Persons Rehabilitated 1/	
	Total	Drug Addicts
1968	207,919	200
1969	230,000	300
1970	265,000	400

1/ Data are actual for total rehabilitants in 1968; estimates are used for 1969 and 1970. Estimates are used for drug addicts for all three years.

The programs in the New York and California vocational rehabilitation agencies are responsible for most of the rehabilitants among drug addicts.

During the past year the New York Division of Vocational Rehabilitation initiated a special program for narcotic addicts with the Department of Mental Hygiene. This program has grown more rapidly than anticipated and almost 150 clients have been involved in the In-Hospital Program. In addition, the agency has now moved to pick up addicts who have been released from the hospital and who are now in After-care Units in New York City. Approximately 100 such after-care clients are now included in the case load. Many of these clients are continuing their training in regular community trade schools and some few have been placed in employment but are still followed up.

This special program, when considered in conjunction with their on-going programs for narcotic addicts with special hospitals and institutions in New York City and Buffalo, results in a case load of approximately 600 narcotic addicts, with three full-time and one half-time counselors providing counseling services in these special facilities.

The California Department of Rehabilitation supports two projects under Section 3 of the Act (Innovation). These are five year projects. In California a project was designed to provide vocational rehabilitation services to narcotics addicts who are institutionalized at the California Rehabilitation Center, a State correctional facility, and to provide a continuity of services after clients are released to the communities of South Central and East Los Angeles.

The current caseload consists of 112 clients in the institution, 40 who have been released to South Central Los Angeles, and 29 who have been released to East Los Angeles. In addition, 48 clients who did not come through the institutional program are served by the community-based counselors. Of the 69 clients who have been released from the institution, 25 are releasees at large. To date, 11 cases have been closed as rehabilitated to suitable employment.

The success of the program in the field depends to a great extent on the relationship of the rehabilitation counselor to the parole officer.

Innovation Project

This project uses Synanon techniques (use of recovered addicts as staff) to vocationally rehabilitate narcotic addicts. The present project caseload consists of 36 clients, most of whom have a history of narcotic addiction although several have histories of alcoholism or character disorders. Twenty-four clients are in on-the-job training programs at Synanon, one is ready for employment, five are in employment, and three have had service interrupted.

The total population of this Synanon location is well over 200 individuals. It is anticipated that in 1968-69 at least 150 of these people will have been served by the project in some way.

On-the-job training within Synanon has been the primary service provided during the past years of the project. The reason for this has been the reluctance of Synanon to use services of outside resources. There are indications that this attitude is changing and that it will be possible to use community resources for physical restoration, tutoring, or vocational training in the coming year.

In New Jersey the New Jersey Rehabilitation Commission, under Section 3 of the Act, continues to support a project in three counties to study methods and techniques which could improve the self-image of persons who have been addicted to narcotics.

Research and Demonstration

Rehabilitation of narcotic addicts depends on a continuum of services: early and accurate identification of problems; adequate therapeutic measures, including work training and community adjustment techniques; provision of half-way houses; and cooperation with private industry and other community resources in the development of transitional placement opportunities.

Research over the past few years has focused on follow-up of addicts after release from the institution and development of community-based graduated rehabilitation services. A half-way house project was recently completed in Houston, Texas. With the cooperation of the USPHS Hospital in Fort Worth, selected narcotic addicts were released to a social work community agency in Houston and provided with housing in a half-way house from which "underworld" friends and contacts were excluded. Group therapy, individual counseling, social work, and part-time employment were provided. Opportunities for engagement of former addicts in community affairs were encouraged. This therapeutic regimen proved effective in promoting the rehabilitation of a substantial portion of drug addicts.

ALCOHOLISM

When social historians of the future come to reflect on the significance of events in our time, they may well judge the latter half of the 1960's a critical turning point in the way the American people chose to deal with alcoholism. These years are marked by a new frankness in discussions about drinking and its consequences and by a more realistic accounting of the extent of alcohol-related problems in our society. Most important, it appears that we are finally turning away from a moralistic view of alcoholism that fosters puritanical condemnation of alcoholics and toward acceptance of a view that is both more rational and more humane. Americans are now showing a greater readiness to recognize that alcoholism is a disease and that alcoholics are not sinful degenerates doomed to a short, bitter life of fitful drunkenness, but suffering human beings who can be helped by treatment methods currently available.

The United States has one of the highest rates of alcoholism in the world. On the basis of several estimates, the number of alcoholics in the United States is placed between 4 million and 6 million, and an estimated 200,000 new cases develop each year. The effects on family members of an alcoholic relative are direct and often devastating. Thus, as many as 20 million people, many of whom are children, are adversely affected by alcoholism.

Alcoholics account for a large proportion of the patients known to health and social welfare agencies. For example, in recent years alcoholics have accounted for more than one fifth of all the men admitted to State mental hospitals and to the psychiatric wards of general hospitals. Alcohol is a significant factor in almost half of all fatal motor vehicle accidents and it now is clear that a majority of these drinking drivers are alcoholics.

In addition to the human costs, the economic losses resulting from alcoholism are great. Losses to industry from absenteeism and other problems associated with alcoholism are about $2 billion annually. The President's Commission on Law Enforcement and Administration of Justice estimates that the national cost for handling chronic drunkenness offenders is in excess of $100 million per year. Costs for hospital care and welfare costs for alcoholics and their families and dependents exceed $2 billion per year. Thus, the total annual cost of alcoholism to the country is at least $4 billion.

In the current--admittedly imperfect--understanding, alcoholism is defined as a chronic disease characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use or ordinary compliance with the drinking customs of the community, and that interferes with the drinker's health, interpersonal relations, or his job.

The consensus of informed opinion is that alcoholism results from a complex interaction of social, psychological, and biological factors. Even the most enthusiastic proponents of any specific theory regarding the causation of alcoholism agree on the necessity of an eclectic approach to the multifaceted problems of this illness. At the present time, no estimate can be made of the relative potential contributions of various disciplines to an understanding of the natural history of alcoholism. An adequate disease conceptualization of alcohol addiction must encompass a variety of factors. Clarification of the relevant significance of these factors requires that research carried out within a single discipline must have a meaningful relationship to research conducted within other disciplines.

Obligations for Programs on Alcoholism
(In thousands of dollars)

	1966	1967	1968	1969 estimate	1970 estimate
Consumer Protection and Environmental Health Service:					
Environmental Control Administration	79	75	80	100	100
Health Services and Mental Health Administration:					
National Institute of Mental Health	3,267	3,776	5,972	6,994	11,528
National Institutes of Health:					
Health Manpower	45	67	67	50	55
Social and Rehabilitation Service:					
Grants to States	1,504	3,467	6,200	8,700	13,000
Innovation grants	5	188	220	300	350
Expansion grants	450	756	333	800	1,000
Training and traineeships	8	28	38	19	35
Rehabilitation facilities	0	0	0	74	50
Rehabilitation research and demonstrations	498	254	40	205	215
Special foreign currency program	0	0	218	175	200
Subtotal, Social and Rehabilition Service	2,465	4,693	7,049	10,273	14,850
Total	5,856	8,611	13,168	17,417	26,533

CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE

The Community Environmental Management program is supporting research to determine the relationship between use of alcohol and accidental injury and death, alcohol measurement, an epidemiological study relating to traffic accidents, and a study of patients admitted to hospitals to determine whether alcoholism or excessive alcohol ingestion may be a factor.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

National Institute of Mental Health

Changes in attitudes toward alcoholism have occurred very gradually over the decades since the great social experiment of Prohibition. It is just within the last few years, however, that a new climate of public attitude has been matched

by bold new efforts to understand alcoholism and to increase facilities for caring for alcoholics. In 1966, in recognition of the magnitude and social impact of the problem, the National Institute of Mental Health established the National Center for the Prevention and Control of Alcoholism. During the years 1965-1969, the amount of funds allocated for alcoholism programs by the NIMH doubled, increasing from $3.5 million to $7.1 million.

These are signs of a vigorous new commitment to seek solutions to problems of alcoholism. They indicate that we have entered a new period in which a truly broad-fronted and sustained attack on the problems is underway. While alcoholism cannot be expected to yield overnight to these efforts, it is certain that only by giving this major public health problem the high priority it warrants--and is now beginning to receive--can we hope to begin reducing its appallingly high human and economic costs.

To meet the unique challenge thus posed, the National Center for the Prevention and Control of Alcoholism is a particularly suitable mechanism. The Center was designed to coordinate and serve as a focal point for Departmental activities in the field of alcoholism, to formulate and support research and training programs throughout the country, and to conduct research studies in its own laboratories at Saint Elizabeths Hospital in Washington, D. C. In collaboration with other Federal agencies, with national organizations, with State and local governments, and with voluntary citizen groups, the Center is providing leadership in the planning and developing of national programs. The Center's activities are guided by five major goals: (1) stimulation of RESEARCH on the control and prevention of alcoholism; (2) leadership in improving TREATMENT services for alcoholics; (3) acceleration of COMMUNICATION and APPLICATION of research findings to service programs; (4) development of TRAINING programs for scientific, professional, and nonprofessional personnel; and (5) modification of public attitudes through an expanded program of EDUCATION.

The growing national awareness and concern about alcoholism and alcohol-related problems can be illustrated by two actions at the Federal level--the United States Supreme Court decision in Powell v. Texas, and Congressional enactment of the Alcoholic Rehabilitation Amendments of 1968. The Court, in a split decision, refused to declare unconstitutional the criminal punishment of Mr. Powell for the offense of public drunkenness. In an opinion in which he was joined by Chief Justice Warren and Justices Black and Harlan, Justice Marshall declared:

> "Despite the comparatively primitive state of our knowledge on the subject, it cannot be denied that the destructive use of alcoholic beverages is one of our principal social and public health problems. The lowest current informed estimate places the number of 'alcoholics' in America (definitional problems aside) at 4,000,000 and most authorities are inclined to put the figures considerably higher. The problem is compounded by the fact that a very large percentage of the alcoholics in this country are 'invisible'...and the traditionally uncharitable attitude of our society toward alcoholics causes many of them to refrain from seeking treatment from any source. Nor can it be gainsaid that the legislative response to this enormous problem has in general been inadequate."

Justice Marshall's concerns with current social and medical alternatives to the "revolving door" system of handling chronic alcoholics is indicated in the following passage from the decision:

> ".....facilities for the attempted treatment of indigent alcoholics are woefully lacking throughout the country. It would be tragic to return large numbers of helpless, sometimes dangerous and frequently unsanitary inebriates to the streets of our cities without even the opportunity to sober up adequately which a brief jail term provides. Presumably no State or city will tolerate such a state of affairs."

The 90th Congress, in the Alcoholic Rehabilitation Amendments of 1968 declared that:

> "Alcoholism is a major health and social problem afflicting a significant proportion of the public, and much more needs to be done by public and private agencies to develop effective prevention and control.
>
> "The handling of chronic alcoholics within the system of criminal justice perpetuates and aggravates the broad problem of alcoholism, whereas treating it as a health problem permits early detection and prevention of alcoholism and effective treatment and rehabilitation, relieves police and other law enforcement agencies of an inappropriate burden that impedes their important work, and better serves the interests of the public.
>
> "Alcoholism treatment and control programs should whenever possible: (A) be community based, (B) provide a comprehensive range of services, including emergency treatment, under proper medical auspices on a coordinated basis, and (C) be integrated with and involve the active participation of a wide range of public and nongovernmental agencies."

Research Activities

The studies currently in progress seek answers to a broad range of questions about the nature of alcoholism and its biological, psychological, and sociocultural antecedents. In other areas of interests, controlled demonstration studies are pointing the way to more efficacious treatment techniques for the victims of alcoholism and their families. Still other kinds of studies are investigating methods for preventing alcohol abuse from starting. The great diversity of research activities reflects the fact that alcoholism involves man at every level of his functioning. Thus, biochemists, physiologists, neurologists, and pharmacologists are focusing on the impact of alcohol abuse at micro-levels; psychiatrists and psychologists concentrate their studies at the level of interpersonal relations; and sociologists, anthropologists, and epidemiologists study host-alcohol interactions at macro-levels of social functioning. Because of the urgent need for basic knowledge about alcoholism and alcohol-related problems, the research grants program is the largest segment, in budgetary terms, of the extramural activities of the NIMH Center for Prevention and Control of Alcoholism.

The University Centers

During the first two years of the Center's existence major grants were made to six universities for the support of multidisciplinary research programs. The centers are distributed across the Nation and all are located in areas that show a high endemic incidence of alcoholism. They are at Rutgers State University in New Jersey, Boston City Hospital and Harvard Medical School, Barnes Hospital and Washington University School of Medicine in St. Louis, Baltimore City Hospital and Johns Hopkins School of Medicine, Oklahoma Medical Research Foundation and the University of Oklahoma Medical Center, and Houston State Psychiatric Institute. Although the focus of research differs among research centers, each is involved in multidisciplinary research, integrating basic and clinical science disciplines, and each conducts a program of research training.

Research in progress at these centers is concerned with every aspect of the problem. For example, there are studies of the drinking patterns and behavior of chronic alcoholics in an experimental setting, drinking problems among ghetto residents, relationships between metabolic and behavioral changes in alcoholics, effect of alcohol on behavior and the central nervous system of animals, and pharmacological studies to determine the physiopathology of alcohol dependence.

The programs in these six settings have already begun to utilize the skills of more than 130 scientific workers--few of whom were working in the area of alcohol problems prior to the initiation of this grant program. As noted above, each center also conducts an active program of research training at the pre- and postdoctoral level in medicine and basic science disciplines. These research training programs are attracting highly qualified young scientists to work in the field of alcohol problems.

Other Laboratory and Clinical Studies

The continuing importance of physiological studies is reflected in the fact that more than one-third of the research grants awarded in the past year were in this area. These include investigation of the metabolism of alcohol and the production of fatty liver, and studies of the effects of alcohol on the circulatory system, and on the brain.

Clinical studies are also underway in a variety of areas. They are concerned with such problems as the genesis of anemia, the effect of alcohol on the stomach, and the effect of beer on the heart. Such studies will help to improve both the diagnosis and the treatment of alcoholism. One pilot study is exploring a test of chronic alcoholism; for example, the investigator is attempting to correlate vestibular aberrations with stages of chronic alcoholism.

The early hopes that LSD would provide an efficacious treatment method for alcoholics have, unfortunately, not been fulfilled. A number of clinical research reports from laboratories in the United States and abroad indicate that LSD treatment is no more effective than a variety of other drug therapies. It seems unlikely, therefore, that LSD therapy will play a significant role in the treatment of alcoholic patients.

A new mode for the action of alcohol as an addictive agent is suggested by recent work at Columbia University. The studies show that a metabolic by-product of alcohol may combine with certain crucial chemical substances in the brain to produce a substance similar to morphine-like compounds. Staff of the National Center have met to consult with the investigators conducting this work. A research application from the group will be received by the Center's Review Committee in the near future. These studies may be of significance in understanding the action of alcohol on the brain.

The Intramural Program

The Center's intramural research program, carried out in special facilities at Saint Elizabeths Hospital, is particularly concerned with this fundamental issue-- the nature of the addictive process in alcoholism. The experimental program at Saint Elizabeths is based upon the premise that the biological bases of addiction are associated with neurochemical, neurophysiological, and metabolic correlates of behavior.

Intramural scientists are working in newly constructed facilities, the first of their type in the world. Included are an 8-bed metabolic and behavioral research ward, psychological laboratories, biochemical and pharmacological laboratories, and special settings for studies of social processes. A laboratory for the study of comparative neurobehavior also has been constructed. The work here will focus on animal models of alcohol addiction and basic aspects of central nervous system functions related to the addictive process. These studies will permit development of rational drug evaluation techniques that can be applied to alcohol problems in man.

The research paradigm used on the metabolic ward allows the researchers to study both the behavior and the biochemistry of alcoholic individuals prior to, during, and following a period of experimentally induced intoxication. Alcohol administration can be programmed (given in divided doses around the clock) or the subject can be permitted to determine the volume and frequency of his alcohol ingestion.

One important reason for experimental study of the drinking patterns and behavior of chronic alcoholics is the need to examine the many untested assumptions about how and why an alcoholic drinks. These assumptions, derived for the most part from the retrospective reports of alcoholic individuals made during intervals of sobriety, have persisted virtually unchallenged and form the basis of most therapeutic approaches to the treatment of alcohol-related illnesses. For example, according to the voluminous psychiatric literature on alcoholism, behavioral effects of alcohol include anxiety reduction and transient alleviation of depression. However, data obtained in this laboratory indicate that alcohol ingestion may increase anxiety and depression in alcoholic subjects. Such findings confirm the impression that there are many myths about this illness impeding the efforts aimed at control and prevention.

Biochemical aspects of chronic alcohol ingestion are also in need of clarification. For example, it has frequently been speculated that the behavioral and pharmacological tolerance shown for alcohol by alcoholics might be accounted for by a more rapid rate of ethanol metabolism. A number of recent studies have shown that prolonged alcohol consumption may induce a significant increase in hepatic alcohol dehydrogenase activity in animals. On the other hand, other studies have failed to demonstrate any differences between blood alcohol levels of alcoholics and nonalcoholics. Since disappearance of blood ethanol may not be an adequate way of measuring all steps in the degradation of ethanol, intramural scientists have carried out a carefully controlled study on the rate of metabolism of carbon-14 ethanol in man. They found no differences between the rates of metabolism in alcoholic and nonalcoholic subjects. The data suggest that tolerance for alcohol is related to processes of adaptation in the central nervous system rather than to alterations in the rate of metabolism of ethanol.

Another series of studies has illuminated the effect of chronic consumption on electrolyte and water balance in man. The evidence showed that serum sodium increased significantly and urinary excretion of sodium, potassium and calcium

decreased markedly, even though urine volume output was normal. The researchers concluded, therefore, that the profound dehydration believed to accompany chronic alcohol intake may not in fact occur. Indeed, an increase in total body water may occur. Such data should provide clinicians with a more rational basis for instituting electrolyte and water replacement therapy.

These intensive behavioral and biochemical studies of alcoholic individuals are leading to the development of hypotheses that can be tested most appropriately in experimental animals. Staff are now working on the development of an animal preparation that exhibits tolerance for and dependence on alcohol. Only an animal preparation will permit detailed study of the sequence of neurochemical, neurophysiological, and metabolic changes which are believed to be concomitants of alcohol addiction. It is postulated that data obtained from analyses of the sequence of cellular events involved in the development of addiction will ultimately clarify the biological mechanisms of alcohol addiction and thereby suggest ways to arrest or reverse the disease process.

Improving Treatment Services for Alcoholics

Despite the widespread occurrence of alcoholism and the substantial contact that people in helping positions have with problem drinkers, alcoholics are likely to receive less adequate care than individuals with other kinds of difficulties. Medical care for alcoholics is often minimal; substantial barriers persist in the admission of alcoholic patients to general hospitals. In most mental hospitals, as well as other psychiatric agencies, the level of interest in alcoholism is still low. Nor have public welfare agencies provided the type of financial assistance for indigent alcoholics that is offered to other indigent people.

The very magnitude of the problem of alcoholism -- and the fact that virtually all alcoholics have medical, social, and psychological problems in addition to their difficulty with alcohol -- argues against the establishment of a special network of treatment services for these patients. Such specialized services could not be adequately staffed, nor could they provide the broad range of services needed by most problem drinkers. The long-term goal, therefore, is to have all helping agencies provide services to alcoholics on an equal basis with other patients. Because this goal is far from immediate attainment, it is essential that financial and other incentives be offered to communities to develop such services.

Hospital Care for Alcoholics

One major roadblock to adequate treatment for alcoholics is the continuing reluctance of many general hsopitals to admit these persons. The reluctance is based in part on the supposition that alcoholic patients require highly specialized services. This notion has now been upset by the results of a demonstration project carried out at the Massachusetts General Hospital. Investigators there have convincingly demonstrated that general hospitals can help alcoholics on an emergency basis and through followup care in appropriate outpatient settings. The excellence of the comprehensive care provided alcoholics by this general hospital challenges the idea that they need specialized detoxification centers and treatment units.

In another approach to this aspect of the problem, the American Hospital Association, whose training proposal will soon be reviewed, plans to develop a series of State and regional conferences for hospital personnel in an effort to help improve the care and treatment provided to alcoholics by general hospitals.

Staff of the Center have worked closely with the Association in the development of this program. Meetings have been held with several local hospital associations and staff have assisted the relevant committees of the American Medical Association, American Hospital Association, and American Psychiatric Association.

In many parts of the country the only substantial services for alcoholics are in the State mental hospitals. There has been a steady increase in the number of alcoholics admitted to these hospitals. In over one-third of all the States more patients are admitted to mental hospitals with a diagnosis of alcoholism than with any other diagnosis. Rates of admission of alcoholic patients have increased more rapidly than those for most other psychiatric diagnoses. In the age group 45 to 54, for example, almost half of the men now admitted are alcoholics.

Unfortunately only a minority of State hospitals currently have any special treatment programs for alcoholics. Through the National Institute of Mental Health Hospital Improvement Program, grants have been made to a number of State hospitals to expand and improve their services to alcoholics. During 1968, $350,000 in hospital improvement grants were made to seven hospitals to provide better services for alcoholics. In one case the alcoholic treatment facility established is the only one in the entire State. Another grant allowed a program serving the whole New York City area to expand its services. Three grants went to small institutions that are developing innovative approaches to the hospital-based treatment of alcoholics. One focused on the family of the alcoholic in treatment and followup services. Another concentrated on counseling the alcoholic to make constructive use of his leisure time once he is released to the community. In the third project the length of inpatient care was sharply reduced by emphasizing continuous care in the community and extensive use of other agencies. In this program special attention also is being given to younger alcoholic patients, who are among the most severe and difficult cases to treat.

Staff of the Center have taken the lead in another critical area by preparing a report on hospital and insurance company practices in relation to medical care for alcoholics. A Center consultant has visited key general hospitals in several parts of the country to obtain first-hand information on current practices in the admission of alcoholics and to stimulate interest in pilot projects that would demonstrate the role of general hospitals in providing emergency care and treatment for alcoholics. Center staff have also provided assistance to personnel from the United States Civil Service Commission who have responsibility for negotiating contracts with group medical practice plans that provide care for government employees. Largely as a result of this work, the Civil Service Commission has decided to require these groups to present plans by 1969 indicating how they will provide care for alcoholics.

Community Mental Health Centers and Services for Alcoholics

The Center has placed the highest priority during the past year on the inclusion and improvement of treatment services for alcoholics in the Community Mental Health Centers being developed throughout the country. Meetings have been held with the staffs of all regional offices as part of this effort. Consultation has been provided to a dozen State mental health agencies and to a number of communities as part of the program to encourage them to include services for alcoholics in their community-based psychiatric services. The publication, The Community Mental Health Center and Alcoholism Programs, has been widely distributed to appropriate agencies throughout the country.

To date only 14 of the 121 Community Mental Health Centers report that they have one or more personnel assigned to work in the area of alcoholism. Community Mental Health Centers that have pioneered in developing programs for alcoholics include the following: Mid-Missouri Mental Health Center (Columbia), Central State Mental Health Center (Norman, Oklahoma), and the Pennsylvania Hospital Community Mental Health Center (Philadelphia). It appears unlikely that many centers will be able to develop services for alcoholics in the absence of some special incentives. All too frequently the centers have financial difficulties in meeting the requirements under the basic Community Mental Health Centers Act. In addition, many communities find that third-party and insurance payments rarely are available for alcoholics.

It was for these reasons that amendments to the Community Mental Health Centers Act were introduced into Congress this year by the Administration. The legislation provided special incentives to communities for the development and expansion of treatment services and preventive programs as part of Community Mental Health Centers. These incentives were: (1) Federal participation in the costs of operation and maintenance, as well as in costs of construction and initial staffing; (2) a greater degree of Federal participation in costs than that mandated under the original legislation; and (3) a longer period of support by the Federal government for alcoholism services than that mandated in the original Act. The legislation as finally approved by the Congress, however, removed all three types of incentives and only slightly modified existing provisions for assisting communities to develop services for alcoholics through the Community Mental Health Centers Act.

The funds authorized for 1970 would provide the Federal share of construction costs for adding services for alcoholics in 30 Community Mental Health Centers and meet the staffing costs for 40 new programs. If all these funds are appropriated, it will be possible to establish comprehensive alcoholism programs in 58 communities. These programs will provide service to over 25,000 patients per year.

Research on Treatment

The mistaken belief that alcoholics cannot be helped has limited professional interest in providing assistance for them. The belief persists despite ample evidence that many alcoholics have been helped to control their drinking and to function again in the community. Numerous follow-up studies of the treatment of alcoholics show recovery rates, in terms of abstinence and improved social functioning, ranging from one-third to two-thirds of the patients treated. These figures compare quite favorably with results reported in the treatment of general psychiatric conditions and other behavioral problems.

Recently, there has been an encouraging increase of interest in applied research projects designed to improve diagnostic, treatment, and rehabilitation services for alcoholics. The project at the Massachusetts General Hospital provides around-the-clock diagnostic and treatment services for alcoholics within a general hospital's emergency ward service. Another important project involves the evaluation of a variety of drugs used in the clinical treatment of alcoholics. Still another approach to the problem is being taken at the University of Iowa, where a study is being made of the effectiveness of using specially trained lay counselors.

The Special Problem of Chronic Drunkenness Offenders

Arrests for public drunkenness account for nearly 40% of the five million arrests made each year for non-traffic offenses. A large proportion of the two million arrests for public drunkenness involve socially isolated and homeless

men. While these individuals, probably less than 300,000 in number, are only a fraction of all alcoholics in the country, their plight is especially harsh, and our responsibility correspondingly great.

Last year, much work was devoted to assisting various communities and other groups in their plans for dealing more effectively with this problem. Interest was vastly increased by the case of Powell v. Texas cited above. Although the Supreme Court's decision did not declare unconstitutional current procedures regarding the criminal punishment of chronic alcoholics, it is quite likely that further attempts will be made to modify the role of the courts and law enforcement agencies in the management of public drunkenness. A contract was awarded to the Legislative Drafting Research Bureau of Columbia University to examine legal aspects of alcohol problems and to prepare a model State statute. The Center staff have been collaborating with the legal experts on this project.

Materials suggesting improved ways of dealing with the problem of public drunkenness have been widely distributed. Copies of a report, Alternatives to Arrest, have been purchased and sent to key agencies in all parts of the country. Emphasis has been placed on the necessity for a wide range of health, medical care, social service, rehabilitation, and other agencies to be involved in the planning of comprehensive services for homeless alcoholics. Staff of the Center have met with officials in a number of cities, for example, Albuquerque, Denver, and Minneapolis-- to assist them in planning such services. Consultation has also been provided to several States interested in changing their laws on public drunkenness. To date, Maryland, Hawaii, and the District of Columbia have enacted new legislation in this field.

Two special projects, one supported by the Department of Justice and the other by a private foundation, have demonstrated new methods of dealing with public drunkenness offenders. The program in St. Louis, involving close cooperation with local police, has shown that the medical needs of these alcoholics can readily be dealt with by properly trained medical and nursing staff. A New York City project has substantiated the St. Louis experience by demonstrating that there are no particular medical or behavioral problems in the management of these patients. This work has also shown that the vast majority of Skid Row men are willing to avail themselves of medical and other services on a voluntary basis.

In the coming year emphasis will be placed on assisting communities to plan and develop better means of coping with the difficult problem of homeless alcoholics. Staff have become aware that some communities are tempted to rush into oversimplified solutions, such as detoxification centers, or place excessive reliance on civil commitment as an alternative to criminal incarceration.

Training Programs

On a long-range basis, the most important means of making up for past neglect of alcohol problems is through the development of training programs in medical schools, psychology departments, schools of public health, of nursing, and of social work. The past year has seen some major initial steps in this direction.

A program has been initiated in Boston to provide a year of comprehensive clinical and didactic leadership training to post-professional fellows in medicine, psychiatry, psychology, nursing and social work. This is the first program of its kind in the country. It is expected to produce a cadre of persons equipped to take on leadership positions in various treatment agencies.

Support for another highly successful research training program for predoctoral students in psychology and sociology was extended for an additional period of time. Research training is also being provided to a substantial number of young scientists by the university-based multidisciplinary centers described above.

Awaiting final approval by the National Mental Health Advisory Council is a project to develop an extensive focus on alcohol problems in a number of schools and departments of the University of Maryland. Leadership in this first effort at a university-wide training focus will be by the Schools of Medicine, Law, Nursing and Social Work. Another essential step in filling the manpower gap has been made at the Loyola University Stritch School of Medicine where the study of alcoholism is being introduced into the medical school curriculum as well as in residency training.

Public health workers potentially can make very significant contributions in identifying and assisting alcoholics and their families. Under a grant from the Center, the American Public Health Association convened a 4-day conference last year in order to review teaching materials about alcoholism to be used in schools of public health. The conference was attended by representatives from all but one of the schools of public health in the United States. The conference report should be an invaluable guide to schools of public health in furthering their educational efforts relating to alcohol problems. In the fall of 1968 the report of an earlier NIMH project was completed and distributed. This publication, A Public Health Guide for the Control of Alcoholism, is being distributed to public health workers and agencies throughout the country.

Awaiting approval by the National Mental Health Advisory Council is an alcoholism training program developed by the Department of Medicine and Public Health at Howard University in Washington, D. C. Also awaiting approval are two projects for the training of alcoholism counselors. One of these, to be conducted at the Wilmar State Hospital in Minneapolis, will train nonprofessional workers to function as counselors on teams with professional workers. The other program, at the University of North Dakota, provides for the establishment of a special masters degree program in alcoholism counseling within a well-established Department of Counseling and Guidance.

Nonprofessional workers are being trained as alcoholism counselors in a 6-month training program developed by the Baltimore City Health Department. Another project in the Baltimore Inner City area is improving the quantity of direct and indirect services to indigent alcoholics by training clergymen, physicians, nurses, social workers, policemen, and VISTA volunteers. Two projects currently are underway to train clergymen to work in the area of alcohol problems. The first of these focuses on providing clinical training to clergymen in a large alcoholism rehabilitation facility. The other, based in a theological seminary, will train students to function in a variety of roles related to alcoholism.

Substantial staff consultation has been provided to the Council on Social Work Education to assist this key group in planning a curriculum development project in the area of alcoholism. The Center's Review Committee will shortly be evaluating a proposal from the group. The project proposes the development of materials that can be used by all graduate and undergraduate schools of social work in the country. Utilization of this material would ensure that the area of alcohol problems is far better covered in these schools than it is at present.

Although beginning steps have been made to improve teaching about alcoholism in medical schools, further progress is urgently needed in this area. While several conversations have been held with key persons in the National League of Nursing and with various nursing educators, no special training programs have

yet been developed for this professional group. Also still to be established are in-service training programs for the thousands of persons who already have completed their basic training and are now working in service agencies throughout the country. Particularly important here are persons employed by social welfare and vocational rehabilitation agencies.

Prevention, Education, and Public Information

Problems of the magnitude of alcoholism can never be dealt with satisfactorily or brought under control by treatment efforts alone. It is for this reason that preventive activities receive the highest priority.

Two major studies of American drinking practices are contributing data and methods of early case finding that are essential to preventive measures. In the process of describing normal drinking practices in the United States, these investigators are attempting to identify individuals with a high risk of becoming alcoholics. One of these studies is now resurveying individuals previously interviewed to determine changes that have occurred in their drinking practices. The other project involves a national survey of drinking practices and is providing baseline data that will be invaluable for preventive purposes. A special study of drinking behavior among urban Negro men is being conducted at Washington University. These investigators have found that heavy drinking occurs twice as often among lower-class Negro men as among white men of the same urban social class origin.

The Center is negotiating a contract with the National Academy of Sciences for a collaborative study of the relationship between heavy drinking and (1) prior military delinquency, and (2) demographic variables such as education, religion, and social class. This study will utilize the extensive data available to the Academy.

Teen-age youngsters are the focus of two preventive projects. In one, the children of alcoholic fathers are being studied to discover what factors are associated with successful psychological coping by the teen-agers. In the second project, consultation services are being provided by a general hospital alcoholism program to various community agencies to assist them in evolving a coordinated treatment program for 14- to 16-year-olds who appear before the court in connection with an alcohol-associated offense. The agency's involvement in the preventive activities starts with the identification of these youngsters so that there can be appropriate intervention to reduce the likelihood of development of serious drinking problems. Preliminary findings indicate that such disruptive family factors as divorce, illness, rejection, or overindulgence appear frequently in the background of these youthful offenders.

The goals of preventive alcohol education are to modify dangerous and potentially harmful drinking patterns. The failure to make distinctions between acceptable and unacceptable drinking behavior undoubtedly is one factor contributing to the development of alcoholism. Ambivalent attitudes about drinking behavior are reflected in the general unwillingness of juries to convict persons for "drunken driving."

The most dramatic evidence of America's failure in this regard is in the area of alcohol education for youngsters. Most of this education is entirely ineffective in influencing youngsters' drinking behavior. A project in Mississippi is investigating the effectiveness of different informational techniques and materials in a junior and senior high school alcohol education program. Approximately 1,000 high school students are being interviewed as part of this evaluation program.

To help incorporate appropriate types of alcohol education activities in the school curricula, Center staff have been working with groups such as the Joint Commission of the National Education Association on Problems of Health Education, the Special Task Force on Alcoholism of the National Council of Churches, and the College Health Association.

A highlight of the Center's alcohol education activities this year has been the publication, with the cooperation of the Children's Bureau, of a pamphlet for teen-agers. Over 250,000 copies of this illustrated pamphlet, Thinking About Drinking, have been distributed to school officials, parent-teacher organizations, and youth group leaders. Center staff have developed and distributed a discussion guide to be used with the pamphlet.

Numerous radio and television appearances have been made by Center staff. Consultation was provided to the National Broadcasting Company television network for a nationwide program on alcoholism broadcast in April 1968, and to the National Educational Television network for the preparation of an hour-long program about "The Drinking American." Center staff also organized a closed-circuit television program on alcoholism as part of the annual meeting of the American Psychiatric Association. Finally, a grant has been made to the Department of Medical and Public Affairs of the George Washington University Medical School to produce a film on American drinking patterns. The film will be shown on numerous commercial TV stations during prime viewing hours.

Staff Participation in Scientific Meetings and Teaching Activities

One of the important goals of the National Center for Prevention and Control of Alcoholism is the communication of research findings and knowledge of alcoholism to as wide an audience as possible. To this end, staff have made presentations at scientific meetings of the American Psychiatric Association, the American Psychosomatic Society, the American Psychological Association, the National Association of Social Workers, the American Psychopathological Association, the New York Academy of Sciences, North American Association of Alcoholism Programs, the American Association for the Advancement of Science, and the American College of Neuropsychopharmacology. Center staff have also been involved in formal teaching sessions at many institutions, including the Schools of Medicine at Johns Hopkins, Stanford, Yale, and Harvard.

Staff of the Alcoholism Center have participated as faculty members in numerous summer schools and special institutes of alcohol studies. These have included the Rutgers Summer School of Alcohol Studies, the Southeastern School of Alcohol Studies in Athens, Georgia, the Texas Summer Institute on Alcoholism, the Colorado Summer Seminar on Alcohol Problems, the Midwest Summer School of Alcohol Studies in Madison, Wisconsin, and short-term public health training courses in St. Louis, New Orleans, and Maryland.

A flexible exhibit on alcoholism and alcohol-related problems has been developed by the National Institute of Mental Health for showing to a variety of audiences. During its first year the exhibit was displayed at meetings of the American Psychological Association, the American Hospital Association, and the American Public Health Association. It will also be used at meetings of nurses, psychiatrists, welfare workers, and educators. The exhibit will help bring alcoholism and the activities of the National Center to the attention of thousands of people in leadership roles.

The Center's commitment to accelerate communication and disseminate research findings is also evidenced by the International Congress on Alcohol and Alcoholism, which was held in Washington, D. C., September 1968. The Congress

was partially funded by a Center grant; it brought together many foreign and American professional workers and scientific investigators.

Liaison and Other Consultative Activities

The original mandate given to the National Center for Prevention and Control of Alcoholism stressed its function as coordinator of alcoholism activities throughout the Department and in the Federal Government generally. During the past year, a number of collaborative efforts of the Center have been successfully carried through.

The National Center was instrumental in bringing about a United States Civil Service Commission conference on drinking problems among Federal employees. The conference was attended by several Federal agencies. This was the first formal acknowledgment by the Civil Service Commission that problem drinking was an appropriate area of responsibility and concern for Federal agencies. A summary of the proceedings of this conference, A First Step, has been published by the Civil Service Commission and was widely distributed among Federal agencies. As a result of the conference and later consultation with NIMH staff, the Civil Service Commission has suggested to all agencies and bureaus that programs be established to help employees with drinking problems. The National Center has been designated as the focal point for guidance and consultation. A guide to program development has been written, and an in-service training program is being developed. Assistance in developing programs for employees with drinking problems has been provided to groups such as the Department of Transportation, the National Aeronautics and Space Administration, the Office of Education, the Department of Interior, and the Department of Agriculture.

The staff of the National Center have been active in providing similar assistance to private employers interested in developing alcoholism programs. In addition, Center staff members have worked with several unions in this area and have met with health personnel who are developing programs for problem drinkers among State employees in Pennsylvania and New York. A presentation on industrial alcoholism programs was made at a meeting of Community Services Representatives of the AFL-CIO.

The National Center has also been concerned with efforts to understand and control the daily tragedies associated with drinking and driving. In this area, staff collaborate with the Highway Safety Administration of the Department of Transportation. Numerous meetings have been held with the administrators of this program and Center staff assisted in the preparation of the recent report to Congress, Alcohol and Highway Safety. Consultation has also been provided to several university research workers who are undertaking studies on a contractual basis for the Department of Transportation in relation to problems of drinking and motor vehicle accidents. Staff have also collaborated with a special committee of the National Safety Council and the American Medical Association in developing materials to be used in public educational campaigns regarding the problem of drinking and driving.

A joint project is under way with the National Driver Registry of the Department of Transportation. This project is seeking to determine whether the Driver Registry can be used in conjunction with psychiatric registers to identify those drivers arrested for drunk-driving who are alcoholics. Numerous contacts have been made with national and State driver education and training programs to explore the possibilities of including appropriate information on drinking and driving in high school driver education courses. The motor vehicle departments

of several States have requested assistance in developing Statewide programs to deal with the drinking driver. Particular interest has been expressed in preventive educational approaches and in organizing appropriate treatment services to deal with drunk drivers who are alcoholics.

Last year, staff of the National Center helped to plan the Secretary's Conference on Social Welfare and Alcoholism; the Center is now distributing the Conference Proceedings. Center staff and the National Advisory Committee on Alcoholism are meeting with staff of the Social and Rehabilitation Service to continue to explore ways in which welfare and rehabilitation services can be made available to the alcoholic.

In addition to working closely with the Social and Rehabilitation Service, Office of Education, and other units of the Department of Health, Education, and Welfare, the Center provided consultation on alcohol-related problems to such diverse Federal agencies as the Bureau of Indian Affairs (Department of Interior), the Justice Department, and the Office of Economic Opportunity.

Finally, the National Center for Prevention and Control of Alcoholism has taken a leadership role in convening regular meetings of all major national groups concerned with alcoholism. Representatives of Alcoholics Anonymous, the National Council on Alcoholism, the American Medical Association, the American Public Health Association, the North American Association of Alcoholism Programs, and the Smithers Foundation have met to discuss areas of mutual interest. Discussions have focused on topics such as hospital care of alcoholics, assisting communities to cope more effectively and humanely with the problem of public drunkenness, and various strategies in overcoming manpower shortages in the field of alcoholism.

Conclusion

This special report has tried to convey a sense of the scope and range of NIMH activities in the field of alcoholism studies and services. The overall impression is one of a growing concern with these problems and a vigorous expansion of efforts to understand and deal with them. While the activities of the past year are indeed heartening, it should be emphasized once again that alcoholism presents a number of extraordinarily difficult problems. Moreover, the consequences of years of professional neglect and public attitudes ranging between indifference and animosity have yet to be completely overcome. In short, strong beginnings have now been made, but our goal is still far from attainment.

NATIONAL INSTITUTES OF HEALTH

The Bureau of Health Professions Education and Manpower Training, through its short-term public health training program, enables professional health personnel to update their knowledge and skills relating to public health problems, one of which is alcoholism.

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

There has been a dramatic increase in the number of alcoholics served by State vocational rehabilitation agencies over the past two years. This is reflected in the ever-rising number of rehabilitations for this group.

Estimated and Actual Number of Rehabilitants with Alcoholism

Fiscal Year Ending June 30	Persons Rehabilitated 1/	
	Total	Alcoholics
1968	207,918	4,500
1969	230,000	5,500
1970	265,000	7,400

1/ Data are actual for 1968. Estimates used for 1969-70

State vocational rehabilitation agencies provide services to alcoholics under various sections of the Act, cooperating with other community resources such as hospitals, clinics, treatment centers, halfway houses for the alcoholic, and Alcoholics Anonymous.

An increasing number of State rehabilitation agencies are employing special counselors to work with alcoholics. Not every counselor, even though interested in working with the disabled, can withstand the frustrations that are inevitable when working with this group.

In some State agencies, programs for the alcoholic are supported under basic support funds while others have developed specialized programs under Section 3 (Innovation) or 4(A)2(a)-(Expansion). To give some examples of this State activity:

In 1967, the Texas Division of Vocational Rehabilitation developed a program for alcoholics, purchasing services from the Houston Psychiatric Institute. This past year they embarked on a Statewide program. There is an Inter-Agency Agreement between the Texas Commission on Alcoholism and the Texas general agency whereby the Alcoholism Commission has transferred approximately $100,000 in State funds per year to the rehabilitation agency, making possible a one-half million dollar program. These funds provide for a special corps of rehabilitation counselors and case service funds for a comprehensive program throughout the State.

In California the budget for the Department of Rehabilitation has authorized an expenditure of $2,000,000 in Federal funds for services to alcoholics. State funds have been provided by direct contract between the Departments of Public Health and Rehabilitation. In addition to the Sacramento Alcoholism Center, vocational rehabilitation staff is provided to ten community alcoholism programs. All patients of the community clinics are clients of the Department of Rehabilitation.

In Arizona a program for alcoholics, including those who were public offenders, was initiated in 1967. The Alcohol and Drug Abuse Section of the Arizona Department of Health plans to transfer $10,000 to the State rehabilitation agency in 1969 to be used for the rehabilitation of this group. During 1969 the State agency will accept twenty Navajo Indians, from their reservations in Northern Arizona, whose primary disability is alcoholism. It is anticipated that the total State program will require at least $100,000 of case service funds for 1969.

These are just a few examples of the greatly accelerated activity taking place in almost every State in relation to this disability.

Training Courses for the Rehabilitation of the Alcoholics

The subject is given some attention in the two-year Training Grant Program in the various universities receiving grants for counselor training. Some of the hospital field work programs afford an opportunity for some extensive study of the problem.

Each year a number of counselors from the State vocational rehabilitation agencies attend the Rutgers School on Alcoholism and also those held locally such as in Colorado, Utah, Louisiana and the Southeastern Summer School in Georgia. Rehabilitation Services Administration has supported the summer schools at the universities of Utah and Georgia. Several short-term regional workshops were supported by the Rehabilitation Services Administration in 1968 and early 1969.

A planning grant has been made to the Association of American Indian Affairs for two planning meetings to be held in 1969 to prepare for a National Workshop on Alcoholism Among American Indians in 1970. The Tribal leaders recognize this as a problem and have asked for help with it.

There is a need for an increase in intensive training activities in this area for rehabilitation personnel in all States. This staff will need greater knowledge of the pathology of alcoholism, modification of rigid and moralistic attitudes through recognizing the alcoholic's self-depreciating image, his fundamental insecurity and dependence (especially important the welfare client). The counselor must have some understanding, too, of the needs of families of the alcoholic. Spouses and children of alcoholics have been found to benefit from group therapy, which in turn benefits the entire family.

The six months internship courses for vocational rehabilitation counselors working with psychiatric cases located at Harvard School of Medicine, Harvard University, Nebraska College of Medicine, University of Nebraska, and the University of Oregon School of Medicine, continue to include lectures on alcoholism and assignment of cases presenting the problem of alcoholism.

Research and Demonstration

As in the cases of other mental and personality disorders, rehabilitation of alcoholics is based upon development of a continuum of services including institutional programs, half-way houses, and other post-institutional facilities, transitional employment, and appropriate placement and follow-up. Utilization of significant research results in the demonstration of techniques to facilitate community adjustment, and successful employment maintenance, are given special emphasis in the program.

Projects concerned with alcoholism have (1) developed methods of counseling, placement and follow-up of members of skid row populations; (2) conducted long-term follow-up studies of rehabilitated alcoholics; (3) studied career patterns of alcoholics to identify factors in successful vocational adjustment; (4) established a half-way house for homeless alcoholic men; (5) studied problems of alcoholic offenders; (6) developed two series of films on rehabilitation of alcoholics based on research results, one intended for public showing over television, and the other series for professional training.

Special Foreign Currency Program

Evaluation and reports on progressive community and group services in Poland and Yugoslavia are of value to the United States and other countries where there is concern about the increasing number of alcoholics and problem drinkers, greater recognition that these men and women need social and psychological rehabilitation, and more interest in the socio-economic aspects and methods of treatment of alcoholism. At the 28th International Congress on Alcohol and Alcoholism prominent roles were assigned to experts working on projects in the cooperative international research program.

CYSTIC FIBROSIS

Cystic fibrosis (CF) is a grave hereditary disease of children. As a cause of death in children under 15 years it outranks many of the better known diseases such as poliomyelitis, rheumatic fever, and diabetes. Although cystic fibrosis has been recognized as a specific disease only since 1938, its increasing frequency throughout the world has made it a public health problem of no mean proportions; estimates of its incidence in the population range as high as 1 in 1,000 live births.

Cystic fibrosis is an inherited generalized metabolic disorder characterized by an abnormality in the products of the body's exocrine glands which secrete fluid to body surfaces, particularly to the skin and to the gastrointestinal and respiratory mucosal linings. Two major types of fluid are normally secreted by the exocrine glands: a watery substance produced primarily by the sweat glands of the skin and a mucous fluid intended to lubricate the gastrointestinal tract and the bronchioles in the lung. The abnormalities which occur in both types of secretions are responsible for the major symptoms and complications in cystic fibrosis.

The basic metabolic disorder of exocrine secretion results in three principal clinical problems. The first of these is the production of sweat with a high salt content. Due to this defect many patients are unable to conserve salt and are in constant danger of developing profound dehydration, or "heat exhaustion" in the summer months, which may lead to death. With the wide-spread use of the sweat test, a technique which measures the unique composition of the sweat in cystic fibrosis patients, a modality is now available for the diagnosis of this disorder.

A second, and considerably more serious facet of the disease, stems from the abnormal functioning of the mucus-secreting glands of the body. In cystic fibrosis, the mucus-producing glands fail to secrete normal, clear, free-flowing fluid. Instead, they produce an abnormally thick, viscuous mucus which tends to obstruct the ducts or openings of the glands. When the viscous mucus accumulates in the ducts of the pancreas, it interferes with the ability of this gland to supply digestive enzymes to the intestinal tract thus leading to poor digestion and mal-absorption of a number of nutrients. Depending on the severity of this complication, the patient may suffer from malnutrition - one of the major factors resulting in general under-development, poor musculature, and retarded bone growth in children with cystic fibrosis.

The third and most serious complication involves the lungs. Nearly all cystic fibrosis patients develop progressive chronic lung disease. Thick mucus obstructs the smaller air passages in the lung, causing labored breathing and a chronic productive cough. In time, bacteria multiply in the accumulated secretions, and the child may fall victim to chronic bronchitis and frequently pneumonia. The latter infection is the leading cause of death in these patients. Chronic lung changes may increase resistance to pulmonary blood flow and thus may lead to an increased blood pressure in the lung; this can result in chronic right heart strain and eventually in heart failure.

Although in the past cystic fibrosis was thought to be confined to the pediatric age group because of the high mortality in infancy and early childhood, the disease is now recognized with increasing frequency among adolescents and adults.

Recent studies have shown that the course of the disease in these older patients, because of only partial genetic endowment, is not as serious as full blown cystic fibrosis. The studies have suggested that these various expressions of cystic fibrosis may be responsible for some of the chronic lung and gastrointestinal disorders in adults often attributed to other more common disorders.

Obligations for programs in cystic fibrosis

	1966	1967	1968	1969 Estimate	1970 Estimate
National Institutes of Health:					
National Institute of Arthritis and Metabolic Diseases..	$1,152,000	$1,385,000	$2,000,396	$2,822,000	$3,321,000
Social and Rehabilitation Service:					
Children's Bureau...	1/	1/	1/	1/	1/
Total.....	1,152,000	1,385,000	2,000,396	2,822,000	3,321,000

1/ Not identifiable

NATIONAL INSTITUTES OF HEALTH

National Institute of Arthritis and Metabolic Diseases

Research Developments and Trends

At present, no one hypothesis can link all the diverse and often conflicting observations which have been made concerning the widespread malfunction of exocrine glands in cystic fibrosis. In particular, it is not yet possible to give a reasonable explanation of the abnormal behavior of mucous and sweat glands in this disorder. Recent studies, however, have helped to narrow the field for speculation and to clarify some of the mechanisms of the disease.

New Staining Technique May Pinpoint Molecular Defect

Cystic fibrosis is inherited from parents who carry the genetic trait for the disorder (both parents may be asymptomatic). When both parents carry the trait, the chances are one in four that cystic fibrosis is manifested in the severe and classical form in the offspring. If only one parent carries the trait, although the child may be asymptomatic, the trait may be passed to the offspring, who, in turn, may transmit the disease. Thus, for every overt case, there is a large reservoir of hidden carriers, recently estimated at 2-5 percent of the general population. Clearly, since the genetic character of cystic fibrosis makes the disorder particularly pernicious, a method of identifying such carriers would be a major achievement for genetic counseling.

Institute-supported scientists at the Cornell University Medical Center recently have pinpointed a cellular difference between normal persons and those in affected or carrier states of cystic fibrosis. Using a special staining technique, this newly-discovered genetic cell marker can be seen in fibroblasts, the flat elongated cells which form fibrous tissue.

Skin biopsy specimens were obtained from 7 affected children, 13 parents, 26 healthy individuals, and from 11 patients with a variety of other diseases. Cell cultures of fibroblasts from the healthy group and from the 11 patients with varied other disorders showed only an occasional cell (1 percent) with metachromasia, a condition in which portions of the cell fail to stain uniformly and in the same color as surrounding cell materials. In all 7 cultures from children with cystic fibrosis, however, cellular metachromasia appeared in an average of 56 percent of the fibroblasts. A similar staining pattern was seen in 42 percent of cells obtained from parents of children with cystic fibrosis. Thus, the test,

though still cumbersome, permits the identification of carriers of the trait for cystic fibrosis in cases where potential parents have requested genetic counseling.

One of the most important implications of this finding will lie in the results of direct investigation into the molecular defect of this metabolic disease. Up to now, clinical and chemical studies have indicated that cystic fibrosis is a generalized exocrine disorder. This new finding hints that the disease is a multicellular disorder also involving the body's connective tissue, and further biochemical analysis of the metachromatic cellular substance may prove to be a step forward in elucidating this theory.

Beyond its value as a research tool, the new test eventually may play a large role in genetic counseling to spot cystic fibrosis carriers, to facilitate studies on genetic linkage, and to determine the frequency of this detrimental gene in the normal population.

Sodium Levels and Transport

Sodium concentrations in sweat and saliva of patients with cystic fibrosis are known to be elevated. Last year Institute grantees at the University of Wisconsin demonstrated that perfusion of the rat parotid (salivary) gland with sweat and saliva from patients with cystic fibrosis caused a large increase in sodium output of the rat salivary glands. The implication of this finding is significant: the same factor in the sweat and saliva from patients with cystic fibrosis which causes salty saliva in rats may be responsible for the high salt content of the patient's own sweat and saliva. Studies continue to isolate such a factor, which, once isolated, may aid in elucidating the inherited molecular defect which causes cystic fibrosis.

More recently, Institute-supported investigators at the University of North Carolina have described a marked decrease in sodium output from red blood cells of patients with cystic fibrosis, and a similar decrease in the red blood cells of their asymptomatic parents. This defect in sodium transport should be of value in detecting cystic fibrosis carriers, and therefore, should be useful in genetic studies.

Adult Infertility

Another development which may aid genetic counseling has been reported by grant-supported investigators at Children's Hospital Medical Center, Boston, who have shown that adult males with cystic fibrosis are infertile due to a failure of the normal development in the vasa deferentia, the tubules which transport spermatozoa from the testes. By contrast, the same study pointed out that 18 women with cystic fibrosis were known to have produced nine apparently normal offspring, and thus the fertility of female patients is apparently unimpaired.

Semen specimens from 25 male patients with cystic fibrosis were studied, and a complete lack of spermatozoa was noted in every specimen. Subsequent studies revealed that while the testes were normal or diminished in size, the epididymides were rudimentary or absent, and spermatogenesis was decreased.

These investigators believe that the anatomical defect (non-patent or absent vasa deferentia) is developmental in origin, and is characteristic for cystic fibrosis. This belief is supported by another study at Children's Hospital, Los Angeles, which has shown abnormal epididymides and absent vasa deferentia in ten cystic fibrosis males between 3 days and 25 years of age.

Thus, it appears unlikely that adult males with cystic fibrosis can reproduce. On the other hand, cystic fibrosis does not impair virility or affect the external genitalia.

Lung Clearance "Jacket"

A grant-supported investigator at Children's Hospital, Boston, has reported, along with other specialists at Monticello Medical Group, Mentefiore Hospital and Van Etten Hospital, New York, that a mechanical lung percussion device clears clogging mucus from the respiratory tract of patients with cystic fibrosis six times faster than the conventional physical therapy procedures which involve hand percussion of the chest when the patient is in an inverted position.

Once the jacket-like device is buttoned and the power turned on, six rubber padded disks are forced rhythmically against the chest; when the jacket is reversed, the disks (clappers) apply equal force to the back. Since the clappers are arranged in rows, the patient can operate one row independently of another, and thus, percussion can be adjusted to avoid sensitive areas - such as post-operative sutured regions. With a simple bedside control box, which can be plugged into any household electrical outlet, the patient can adjust the strength and frequency of percussions to suit his needs.

This device has enabled the cystic fibrosis patient to be independent without relying on physical therapists for assistance in postural drainage and chest clapping. Significantly, it has eased the ordeal of eliminating mucus from pulmonary passages with much less strain on the patient.

Drug Therapy

A drug that increases the flow and concentration of digestive enzymes from the pancreas in animal models, which may indicate future possibilities in the treatment of cystic fibrosis, has been studied by an Institute grantee at Michigan State University.

The drug, called slaframine, has been isolated and purified from a fungus Rhizoctonia leguminicola which grows on clover. Slaframine has been found to stimulate the exocrine glands, especially the salivary glands, and is reported to cause the "slobbering syndrome" in cows that eat forage containing the fungus.

Intraperitoneal injection of 2 mg. of slaframine doubled pancreatic flow in experimental goats for as long as five hours. Digestive enzyme activity was increased about 10 times and remained at that level for eight hours or more.

Other experiments with animals have demonstrated the drug's capability to stimulate all exocrine glands for prolonged periods. One test revealed its specificity in stimulating exocrine glands without affecting heart rate, respiration, blood pressure, or transmission of nerve impulses.

The exocrine gland-stimulating properties of this drug raise the possibility that in cystic fibrosis patients, slaframine may spur pancreatic activity enough to clear the mucus-obstructed ducts leading to the intestinal tract. The theoretical possibility exists that with an increased production of digestive enzymes from the pancreas, the malnutrition commonly observed in young cystic fibrosis patients may be alleviated without resort to therapy with exogenous pancreatic preparations.

Incipient Heart Disease in Cystic Fibrosis

Several months ago Institute scientists reported that hypoalbuminemia, an abnormally low albumin content of the blood, in older patients with cystic fibrosis is caused by dilution of a normal albumin mass by an enlarged plasma volume.

Later clinical metabolic studies established that the abnormal increase in volume of circulating plasma in the body (hypervolemia) is secondary to cor pulmonale, an abnormal condition, ultimately leading to right-sided heart failure, brought about by abnormal resistance to pulmonary blood circulation. Since cor pulmonale is difficult to diagnose clinically in patients with cystic fibrosis, the investigators feel that a low serum albumin concentration may be of value in alerting the clinician to possible hypervolemia secondary to cor pulmonale and incipient heart disease.

Outlook

Cystic fibrosis is a disease of many disguises. Its multifaceted nature has prompted and encouraged many scientists in diverse disciplines to study its metabolic, genetic, and clinical aspects. In recent years, scientists in Bethesda and investigators supported by the Institute have contributed largely to dispelling misconceptions concerning the disease. Two major misconceptions had been that cystic fibrosis is rare and that it is invariably fatal. Neither has been shown to be true. Promising findings in basic research, as well as new methods of diagnosis and treatment, have opened up new avenues for investigating cystic fibrosis, while bringing about a more optimistic outlook for patients with this disorder. Continued progress hopefully will lead to even better means of managing and possibly eventually preventing this grave disease.

SOCIAL AND REHABILITATION SERVICE

Children's Bureau

The program of 46 State crippled children's agencies accepted children with cystic fibrosis for diagnosis, treatment and continuing care in fiscal year 1967. One additional State said they would accept children with cystic fibrosis depending on available funds; a second additional State was to initiate a program for children with cystic fibrosis in 1968. As of June 1, 1967, crippled children's agencies reported to the National Cystic Fibrosis Research Foundation that 3,299 children were treated at a cost of nearly $1.5 million during the previous year.

For every child with suspected cystic fibrosis, who is referred for diagnosis, 7-10 children with chronic pulmonary or gastrointestinal conditions (not cystic fibrosis) are found. Thus, a large group of children with unmet chronic health problems are uncovered.

CEREBRAL PALSY

The problem

The term cerebral palsy refers to symptoms of nervous system damage to the brain's centers for muscle control. The disorder, which afflicts an estimated 600,000 Americans, is not a single disease, but a condition characterized by a multitude of causes and resultant degrees of impairment. The discovery of causes and prevention for cerebral palsy (CP) damage thus remains one of the most puzzling problems in medical research.

Such damage can be limited to motor difficulties affecting a few spastic fingers or can extend throughout the body. CP can be tragically obvious in the birth of a hemiplegic baby with spastic paralysis or strangely elusive, impairing development several years later. The condition is neither contagious nor progressive. The brain lesions which produce CP damage have been shown to be associated with physiological events surrounding pregnancy and birth, events which until recently were little understood.

Prognosis for treatment and recovery ranges from excellent to extremely poor. Braces to support weak muscles, exercise to stimulate development, special coaching for patients handicapped by complications like deafness, blindness, and speech disorders, have enabled some CP children to reach a level of functioning close to normal. Even those afflicted with almost total motor involvement and mental retardation have been helped to make some progress. Although research to improve rehabilitation methods can make many CP victims more productive, the hope for the future rests with scientists working to uncover, prevent, and remedy the complications which cause the crippling damage in the first place.

Obligations for programs in cerebral palsy

	1966	1967	1968	1969 estimate	1970 estimate
Social and Rehabilitation Service:					
Grants to States.....	$936,999	$1,669,200	$1,890,000	$2,860,000	$4,245,000
Innovation grants....	73,000	54,000	---	---	---
Training and traineeships.....	25,000	---	---	---	---
Research and demonstrations.....	24,000	---	---	50,000	60,000
Research and training (special foreign currency program).	9,000	---	10,000	60,000	100,000
Subtotal, Social and Rehabilitation Service.....	1,067,999	1,723,200	1,900,000	2,970,000	4,405,000
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke.....	13,819,000	9,973,000	11,116,000	11,216,000	11,300,000
Total.....	14,886,999	11,696,200	13,016,000	14,186,000	15,705,000

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

Cerebral palsy offers many problems to the vocational rehabilitation counselor, not only because of the severity of the disability itself but also because of the broad range of handicapping conditions it presents. In virtually every case, a multidisciplinary approach is essential to the development of an approrpiate vocational rehabilitation plan for individuals with cerebral palsy. In an effort to expand and intensify rehabilitation services for this disability category, the Rehabilitation Services Administration has made extensive use of its various grant programs. Some examples of these grant activities are cited below.

Under the Basic Support (Sec. 2) Program a program of rehabilitation services has been established for adult victims of cerebral palsy at the Tidewater Rehabilitation Institute, Norfolk, Virginia. This grant resource is also being used widely across the country for the development of cooperative special education-vocational rehabilitation programs for handicapped youth, including those with cerebral palsy. Basic support funds are, for example, being utilized by the South Carolina Vocational Rehabilitation Department to implement cooperative programs for handicapped youth in the school districts of Berkeley, Florence, Greenville and Richland. Under the so-called Laird Amendment authority, Sec. 2 funds have been channeled through the Ohio Bureau of Vocational Rehabilitation to provide equipment for a rehabilitation program operated by United Cerebral Palsy of Cincinnati, Inc.

The Rehabilitation Services Administration uses its Innovation grant authority to develop new techniques for providing rehabilitation services within a State. The California Department of Rehabilitation has a grant of this kind to operate a rehabilitation program for severely disabled college students, including those with cerebral palsy, who are attending the University of California at Berkeley. Innovation grant funds assist with the cost of living in a special residential unit which is professionally staffed to provide services necessary to maintain the students' health and strength at optimum levels while they are attending college.

Through its Expansion Grant Program, the Rehabilitation Services Administration endeavors to increase substantially the number of disabled people who are restored to employment through the rehabilitation process. Individuals with cerebral palsy benefit from three Expansion Grants to the following agencies in Connecticut: The Constructive Workshop, Inc. (New Britain); the Connecticut Society for Crippled Children and Adults; and the Waterbury Area Easter Seal Society for Crippled Children and Adults. Other grants of this kind which include individuals with cerebral palsy among the clientele served have, for example, been made to the: Georgia Society for Crippled Children and Adults; Chicago Easter Seal Society; and the Fort Worth Society for Crippled Children and Adults.

In recent years the Rehabilitation Services Administration has supported short-term training courses in such areas as: (1) vocational rehabilitation methods for professional staff of local affiliates of the United Cerebral Palsy Association; (2) rehabilitation counseling techniques with the cerebral palsied client for the State rehabilitation agency counselors; and (3) executive development for administrators of cerebral palsy programs. In addition, instructional content on cerebral palsy is incorporated into the various long-term professional training courses sponsored at universities for rehabilitation counselors, nurses, psychiatrists, psychologists, physical therapists, occupational therapists, social workers, speech therapists, and recreation specialists.

Office of Research, Demonstrations, and Training

Cerebral palsy, because of its severity, varied associated disabilities and lack of acceptance by the public, presents peculiar and important problems for rehabilitation. Attitudes of employers, of parents and of the clients themselves are all fruitful areas of research, as are the special adaptation of testing methods which are necessary for the different motor and speech deficiencies involved. Because of the dependency of such clients on family help, a central problem is the training of the cerebral palsied toward independent living and eventually competitive employment.

Research and demonstration activities related to cerebral palsy have been varied. A project at the Institute for the Crippled and Disabled in New York was designed to develop methods of evaluating the potential abilities of severely disabled cerebral palsied adults by means of a wide variety of sample jobs. Under the sponsorship of the United Cerebral Palsy Association of Los Angeles County, Los Angeles, California, an intensive service workshop program for severely handicapped cerebral palsied adults was developed, aimed toward eventual job placement within industry. The social, psychological and physical problems of cerebral palsied young people in college were studied under a project at the College of Education, State University of Iowa, Iowa City, Iowa. United Cerebral Palsy of New York City, Inc., has received support to develop demonstration programs to meet the vocational rehabilitation needs of multiple handicapped cerebral palsied young adults and to evaluate the effectiveness of methods of training cerebral palsied adults in activities preparing them for employment or more independent living. Goodwill Industries of America, Inc. conducted a conference to explore how two nonprofit agencies may plan the cooperative use of their respective resources, in a single facility, to provide vocational rehabilitation to the cerebral palsied. A follow-up study is being conducted by the University of Iowa to ascertain employment satisfaction and general life adjustment to determine the efficacy of a college education for cerebral palsied persons. Work classification and evaluation centers for the cerebral palsied have been supported in centers in Milwaukee, Wisconsin; Portland, Oregon; St. Louis, Missouri; Philadelphia, Pennsylvania; Miami, Florida; Memphis, Tennessee; and Des Moines, Iowa.

Future projects will emphasize especially the adaptation of intelligence tests for cerebral-palsied individuals.

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

Program developments

From its inception in 1951, the National Institute of Neurological Diseases and Stroke has awarded CP research high priority as a major mission. The causes and complications of CP damage are being investigated through four major research avenues.

The Collaborative Perinatal Research Project

A major purpose of the Project is to ascertain causes of cerebral palsy, mental retardation, congenital blindness and deafness, and other related deficits which rob children of their fullest development.

This project, the first massive, longitudinal study of perinatal development ever attempted in American medicine, has been collecting data from 58,000 pregnant women and the development of their 55,000 offspring since 1959. The program was initiated to provide the detailed data which has been difficult or impossible to obtain in retrospective investigations of the causes and developmental course of neurological disorders. By selecting women as early in their pregnancies as possible and following them through delivery, and their offspring through age

seven, the project has made possible a prospective study to identify neurological abnormalities and their relationship to events during pregnancy.

To provide an additional safeguard for scientists wishing to use project findings, a specially appointed committee under the chairmanship of Dr. Abraham M. Lilienfeld of the School of Hygiene and Public Health, The Johns Hopkins University, has reviewed the data collected by 14 outstanding medical institutions participating in the study. After evaluating the reliability and quality of the data, the committee concluded in a report published in December 1968 that "the data can be readily used for testing relationships between perinatal factors and various pregnancy outcome characteristics." The report also recommended that "increased use of the data for this purpose by investigators in other institutions and agencies should be stimulated."

Although the last study baby was born in September 1966, it will be 1974 before this child has completed the seven-year exam and the data can be completely analyzed. Already West Germany, impressed by the value of the U.S. effort, has established a similar prospective study using NINDS protocols in which 19 universities are participating to study babies beginning with the first trimester of pregnancy.

The Institute Intramural Research Program, Surgical Neurology Branch

Scientists in this laboratory conduct intensive studies of the etiology, pathology, and prevention of cerebral injury and developmental disorders of the nervous system. Their approach extends from the examination and treatment of living patients to the study of disease processes in autopsy specimens, chromosome research, and research on the effects of radiation dosage on the human fetus.

The Laboratory of Perinatal Physiology, San Juan, Puerto Rico

Directed by Dr. Ronald E. Myers, the Laboratory serves as a valuable counterpart to the Collaborative Project's human study. Using the rhesus monkey, whose gestational physiology closely resembles that of man, Laboratory scientists attempt to replicate the various kinds of nervous system damage in the monkey which human studies have suggested are responsible for neurological disorders in man. This experimental approach is helping doctors understand the causes and results of different types of human CP. There are now more than 1,000 rhesus monkeys in caged and free-ranging colonies in which pregnancy and infant development can be studied.

Extramural Grant Program

Through its awards of funds to support qualified scientists investigating causes of CP and related disorders in both humans and animals, the Institute is able to broaden its research into specific areas and to provide fundamental data which can benefit clinicians confronted with CP cases.

Research progress

Spastic Diplegia

Spastic diplegia is a type of CP in which both arms or both legs of the body have tense, stiff muscles. Collaborative Project scientists reported earlier that spastic diplegia appears to be almost invaribly a disease of the small (under four and one-half pounds) and early-born (under 36 weeks) child that such infants suffered a postnatal weight loss of more than 10 percent. New studies this past year suggest that the cause of this type of CP may be internal hemorrhage.

Normal infants usually lose six to eight percent of their body weight after birth in the form of fluids, and the loss is associated with a rise in their red-blood-cell concentration. Spastic diplegic infants, however, show a lowering of red-cell levels, which may be explained by internal hemorrhaging. Collaborative

Project scientists have recommended further studies of newborn weight loss, protein intake, and change in red-cell levels to test this theory.

Hemiplegia

New explanations for two types of hemiplegic CP, a condition which involves spastic paralysis on one side of the body, have been reported this year. Reviews of patients' records reveal that in spastic hemiplegia complicated by epilepsy there is an association between the side on which the hemiplegia occurs and the position of the infant's head during birth. Epileptic hemiplegia sometimes appears as acquired infantile hemiplegia, a condition in which the spastic hemiplegia suddenly appears during fever-producing illness. These findings suggest that epileptic hemiplegia results from bruises suffered by the brain during birth. Small lesions may form which become more extensive during infections and which then cause spastic hemiplegia.

Records for non-epileptic hemiplegics show that many of these patients experienced postnatal collapse (an episode of circulatory failure after birth). This type of spastic hemiplegia may thus be caused by blockage of the blood flow in the arteries which supply the brain. The episode of postnatal collapse may represent the moments when such blockage, possibly caused by clots in these arteries, occurred. These studies were directed by Dr. John A. Churchill at the Lafayette Clinic in Detroit, Michigan.

In an effort to study further the relationship between head position at birth and the location of nervous system lesions, the Institute is working with scientists in Montevideo, Uruguay, where measurements of infant heartbeat, the brain's electrical pattern (electroencephalogram), and the intensity and frequency of contractions during delivery are being analyzed.

Laboratory of Perinatal Physiology: Experimental Models of Nervous System Damage

Doctors have known for some time that one of the main causes of nervous system damage results during pregnancy from compression of the umbilical cord which supplies blood carrying oxygen and nutrients from the mother to the fetus. Cord compression produces a condition called asphyxia, which means suffociation of the tissues. Studies in the rhesus monkey now show that the severity and type of damage caused by asphyxia depend upon when during gestation the injury occurs.

Thus the earlier in gestation asphyxia occurs, the less vulnerable the fetus and the longer the period of oxygen deprivation it can withstand. Fetuses at three and one-half months (pregnancy in the rhesus lasts six months) can withstand oxygen deprivation twice as long as a full-term monkey infant. Moreover, the earlier in gestation the asphyxia is introduced, the less the overall damage to the brain and, particularly, the less the damage to the higher parts of the brain.

Another important finding is the discovery this past year that it is long-term, partial oxygen deprivation during gestation, rather than sudden, total deprivation, that produces the types of CP seen in humans. Experiments which induced acute, total asphyxia produced a pattern of neuropathology which bore little resemblance to the various well recognized patterns seen in humans who are afflicted with CP or mental retardation on the basis of perinatal brain damage. Prolonged partial hypoxia, however, produced evidence of brain swelling associated with varying degrees of cortical necrosis. Under less severe insult, the damage appeared as two forms of pathology (ulegyria and status marmoratus of the basal ganglia) which represents the classically recognized and common patterns of change seen in the brains of humans damaged during gestation or at the time of birth.

Prolonged hypoxia is a naturally occurring condition for the fetus under a wide variety of circumstances consisting of depression of partial pressure of oxygen in the blood and mixed metabolic and respiratory acidosis. The scientists' ability to replicate human types of brain damage through experimental procedures in the fetus means that for the first time researchers have a long-sought animal model to aid them in developing preventive measures and treatment for humans.

The barbiturate nembutal has been shown to have a strikingly protective effect against brain damage from asphyxia during delivery by Caesarian section in the monkey. Scientists believe that the barbiturate lowers the metabolism of the brain tissue, thus reducing its need for oxygen and making it less vulnerable to asphyxia.

Another series of experiments has revealed that if the blood supply to the brain is cut off early in gestation and remains cut off, the higher part of the brain may fail to develop at all, the space filling with fluid instead of tissue, which results in a condition closely resembling hydroanencephaly in the human. At intermediate stages of pregnancy, however, the damage is more likely to take the form of localized lesions in the higher parts of the brain. After blocking blood flow in the major arteries and the vein which serve the brain by tying them off in the neck of each fetus, the scientists found that 45 percent of the fetuses were aborted.

Such experiments also have produced a new explanation for one cause of severe mental retardation in humans. The brains of some animals surviving the vascular ligation procedure showed no signs of focal brain lesions, but did exhibit varying degrees of cerebral malformation. Researchers have found that the earlier in gestation the vascular ligation is introduced, the greater the probability of cerebral malformation unassociated with evidence of discrete anoxic lesions. The particular pattern of malformation is closely similar to the pattern of pathology frequently seen in severe retardees confined to mental hospitals. Because there was no evidence for focal lesions in the brains of these patients, there had been no suspicion that the damage was related to injury involving blood-oxygen deficiencies. The present study makes it appear almost certain that the brain alterations seen in such patients results from reduced blood flow to the brain early in gestation.

Hypoglycemia and CP

Severe and prolonged hypoglycemia in childhood (a condition of low blood sugar levels) has been further confirmed as a cuase of CP and mental retardation. Scientists under Dr. Anotole Dekaban in the Institute's Surgical Neurology Branch have conducted examinations of living children and autopsy specimens in this research. Treatment methods, consisting of a special diet with feedings every three hours, have been worked out for exceptionally severe cases of hypoglycemia of unknown cause.

Studies of hypoglycemic children who are sensitive to the amino acid leucine, found in most proteins, have shown that this variety of the disease often clusters in families and that it often improves spontaneously after three to six years of age. This finding makes it possible for physicians to counsel families in which the disease tends to occur and demonstrates that if hypoglycemia can be controlled during infancy, permanent brain damage can be prevented in this not uncommon disease.

The Surgical Neurology Branch is using a three-phase investigative approach to study the pathogenesis of cerebral birth injury. In the past, neurologists have been limited by a poor conception of the causes and mechanisms behind such injuries. Under the present study, clinical findings in living patients are correlated with autopsy findings in cases of both acute and chronic lesions. This approach is providing an inventory of all types of lesions and is helping to clarify patterns of transition between acute and chronic lesions. Hopefully

the effort will enable physicians to interpret the disease process in individual cases and will eventually make possible preventive measures and treatment for certain categories of CP patients.

Toxoplasmosis

Toxoplasmosis, a disease which can cause severe neurological damage to the developing fetus, has long been a puzzler to medical science because its mode of transmission remained a mystery. Collaborative Perinatal Project investigators have now detected a human-borne parasite whose presence is closely associated with evidence of exposure to the infection in Peurto Rican children. To clarify the nature of the association, doctors from the Project's Infectious Disease Laboratory will survey 200 children from each of the two Peurto Rican villages this year, collecting and culturing parasites obtained from the children and from soil samples, and checking the children's blood for toxoplasmosis antibodies.

Although 30 percent of American women show evidence of exposure to the infection, the rate is twice as high for Negroes as for whites, and four times as high for Peurto Ricans, in whom 50 percent of children under two carry evidence of exposure, according to Project data. The Peurto Rican rate is similar to that in Western Europe where poorly cooked meat has been demonstrated to be the source of infection. Estimates are that of the 88 percent of congenital toxoplasmosis cases which survive, 85 percent are mentally retarded and more than 60 percent are spastic. Once the disease carrier is pinned down, work can begin on development of preventive treatment.

In-Utero Test for One Cause of CP

In 1968, scientists of the Division of Biologic Standards and the National Institute of Arthritis and Metabolic Diseases reported their discovery of a means of identifying the enzyme defect of Lesch-Nyhan syndrome in the developing fetus.

The disease, which causes a relatively uncommon type of CP characterized by spasticity, choreoathetosis, and psychomotor retardation, was shown earlier to be due to a defect in an enzyme of protein metabolism. The new test involves withdrawing a little of the amniotic fluid surrounding the fetus and culturing the cells. This procedure increases the possibility of satisfactory counseling of families in which this or other hereditary diseases have been detected.

Mental Deficiencies and Factors in Pregnancy

Acetonuria: Mental retardation has been found to be three times as frequent in children of mothers who had acetonuria (an excess of acetone bodies in the urine) in the last third of their pregnancies in comparison with children of acetone-free pregnancies. This finding, the result of a Collaborative Perinatal Project study by Drs. John A. Churchill, Heinz W. Berendes, and Lee Willerman, has expanded upon earlier Project surveys which showed that diabetes accompanied by acetonuria during pregnancy is associated with evidence of subnormal intellectual and neurological function in children, while non-acetonuric diabetes during pregnancy is not. The new finding supports the theory that acetonuria signifies episodes when the nutrient supply of a pregnant mother is insufficient for the fetus, since a fetus usually triples its weight in the last trimester of pregnancy and then is most in need of nutrients. Although only one percent of pregnant women are believed to have diabetes, three to five percent of pregnant women may have acetonuria alone, and Project data shows that twice as many pregnant Negroes are acetonuric as whites.

To further test whether acetonuria can be interpreted by obstetricians as a sign of inadequate maternal nutrient supply, the Project is sponsoring a study of pregnant Negro women in a Detroit clinic to check for acetonuria, assess dietary intake, and to develop simple biochemical measurements of dietary

insufficiency. In the Project's Bethesda, Maryland, laboratories pathologist Dr. Jack H. Carleton is examining brains of mice born of protein-deprived pregnancies for evidence of morphological abnormalities.

Maternal Weight and Prematurity

Studies by Collaborative Project scientists have raised questions about the advisability of a traditional American obstetric teaching: that weight gain during pregnancy should be restricted to a minimum. An investigation of factors associated with prematurity in newborns (defined as birthweight under 2500 grams) has demonstrated that both the mother's prepregnancy weight and her weight gain during pregnancy are positively associated with the birthweight of her baby. The research was based on a survey of Project data on 15,000 full-term pregnancies, which included 8,295 white and 6,909 Negro mothers whose pregnancies were considered normal (uncomplicated by such factors as diabetes, toxemia, organic heart disease, and asthma).

The data also showed that regardless of prepregnancy weight, the incidence of low birthweight babies decreases for those mothers who gain heavily during pregnancy. Project scientists have designed additional studies to determine whether or not a true cause-and-effect relationship exists between weight gain and birthweight. Assuming it does, the data suggest that if women who gained 29 pounds or less had increased their average weight gain by five pounds, the rate of premature white babies in the Project could have been reduced by 20 percent and that of Negro babies by 17 percent. The association between weight gain and birthweight diminishes markedly as prepregnancy weight increases, however according to analyses performed by Drs. Kenneth Niswander, Judith Singer, Milton Westphal, and by William Weiss.

A second study, based on separate data from Johns Hopkins Hospital on 6,675 white and 5,236 Negro mothers, and conducted by Nicholson J. Eastman of the Johns Hopkins Medical Institutions and Esther Jackson of the Office of Biometry, NINDS, has confirmed the Collaborative Project findings. This research is regarded as particularly important since prematurity (defined as low birthweight) is known to be associated with a high incidence of neurological damage and newborn mortality. Project studies have also shown that the higher the maternal weight gain, the higher the infant's birthweight and the better his growth and performance record during his first year of life. Should a definite causal relationship be proven between prepregnancy weight, maternal weight gain, and birthweight, the Project findings may be especially applicable to the low-weight woman (whose prepregnancy weight is under 120 pounds). Such a patient may need expert help to maintain an average weight gain and to counteract the effect of low prepregnancy weight in causing the birth of a low-weight baby. For other women the objective in weight control during pregnancy would be to keep weight gain reasonably close to average.

An investigation of data on 7,000 mothers who had more than one pregnancy while enrolled in the Collaborative Project will be undertaken to examine the relationships between varying prepregnancy weights, weight gains and birthweight within the same woman. Variables such as toxemia, dystocia, abnormal lengths of gestation, and cigarette smoking during pregnancy and their association with birthweight will also be studied. Although independent research has shown that any apparent relationship between maternal height and birthweight is produced through the medium of prepregnancy weight, studies of mothers belonging to different height sub-groups will be conducted to determine the possible influence of genetic factors on birthweight. To define more clearly the mechanisms which determine birthweight, further research involving the manipulation of both quantity and nutritional quality of diet will be performed on pregnant rhesus monkeys.

Much of the Institute's cerebral palsy research is conducted within the Collaborative Perinatal Research Project, where a growing body of knowledge on perinatal events give medical scientists a better understanding of some of the many factors causing cerebral palsy. Other studies are being conducted to learn more about the factors which influence the development of the neurologically handicapped. When these factors are more fully understood, it will be much easier to develop better procedures for remediation.

MULTIPLE SCLEROSIS

The problem

An estimated 250,000 Americans are afflicted by multiple sclerosis (MS), and many more by related disorders. Although the disease was recognized more than 100 years ago, its cause is still unknown, and no effective treatment is available in spite of extensive research and many approaches to the problem. Its solution presents one of the most urgent problems of basic neurology.

MS exacts a very heavy annual toll of disability among men and women throughout the world, striking them mainly in their most productive early adult years. The estimated cost of patient care in the U. S. alone is more than $250 million each year. Additional millions are spent on research while the economic loss to the Nation is incalculable.

Multiple sclerosis is a disease of the central nervous system in which myelin, the fatty, protective tissue sheathing the nerve fibers, disappears in scattered patches. The disorder, which is progressive in most cases, proceeds in a series of unpredictable attacks. In earlier stages, attacks are often followed by periods of remission. With successive episodes, resulting lesions in the brain and spinal cord become more dense and destructive, causing more severe disability.

Obligations for programs in multiple sclerosis

	1966	1967	1968	1969 estimate	1970 estimate
Social and Rehabilitation Service:					
Rehabilitation Service Administration	$259,047	$500,760	$540,000	$635,000	$965,000
Research and Demonstration	NA	NA	45,000	60,000	75,000
Subtotal, Social and Rehabilitation Service	259,047	500,760	585,000	695,000	1,040,000
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke	3,019,000	3,301,000	2,709,000	2,795,000	2,816,000
Total	3,278,047	3,801,760	3,294,000	3,490,000	3,856,000

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

Because of the nature of the disease, sometimes rapidly progressive and sometimes relatively quiescent for a period of years, multiple sclerosis has been a challenging problem for workers in the field of vocational rehabilitation. Estimating ultimate employment potential is extremely difficult, and the State-Federal program of vocational rehabilitation has had limited success in serving this disability group.

Desirous of expanding and intensifying services for the victims of multiple sclerosis, the Rehabilitation Services Administration entered into a cooperative agreement with the National Multiple Sclerosis Society in October 1968. It is expected that increased coordination between State rehabilitation agencies and local chapters of the Multiple Sclerosis Society will result from this cooperative agreement, with concomitant development of case finding, improvement of service techniques, and expansion of vocational opportunities for the multiple sclerotic.

In addition, the Rehabilitation Services Administration has recently issued a special Medical Bulletin on Multiple Sclerosis to provide the State rehabilitation agencies with current information on this disease, and to stimulate these agencies to increased efforts in rehabilitation of the multiple sclerotic, with greater use of the special program of evaluation services for a period of up to eighteen months as authorized by the 1965 Amendments to the Vocational Rehabilitation Act. The Medical Bulletin cites a study of some 1,300 people with multiple sclerosis which shows that: 70% were able to work within the first five years after onset; 50% within 10 years; and that 35% were still gainfully employed between 15 and 20 years after onset.

The basic need is that of trained personnel to treat, study, and to train patients with multiple sclerosis. These would fall in the category of physiatrists, physical therapists, occupational therapists, psychiatrists, psychologists, counselors, homemakers, nurses, speech therapists, and other related personnel.

With further advances in drug therapy, neurosurgical procedures, and rehabilitation techniques, the rehabilitation potential of those suffering with multiple sclerosis should be much greater than at present. It is our plan to encourage further research and training programs as well as the educational aspects of this disease. Since the larger proportion of persons with multiple sclerosis are women in the 20 to 40 age group, one objective should be to accept increasing numbers for services with the vocational goal of homemaker.

Rehabilitants with Multiple Sclerosis

Fiscal Year Ending June 30	Persons Rehabilitated 1/	
	Total	Multiple Sclerosis
1966	154,279	269
1967	173,594	407
1968	207,918	400
1969	230,000	400
1970	265,000	500

1/ The total number of rehabilitants is actual for 1966, 1967 and 1968, with estimates for 1969 and 1970. The number of rehabilitants with multiple sclerosis is actual for 1966 and 1967 with estimates for 1968, 1969 and 1970.

Office of Research, Demonstrations, and Training

Current work on multiple sclerosis is concerned with developing a model program for the rehabilitation of multiple sclerosis patients. Work is also being done on the determination and measurement of factors predictive of this disease.

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

Program development

The National Institute of Neurological Diseases and Stroke has developed a number of programs in the search for the etiology of multiple sclerosis. Especially significant are studies now being conducted on the epidemiology of MS, the implication of viruses in neurologic disease, and the biochemistry of the sclerosing and neuromuscular disorders.

Since MS is largely a disease of temperate climates, early studies were largely concentrated on the epidemiology of the disease. Epidemiology continues to be a major research path explored by Institute scientists in the search for answers to the riddle of MS. The fact that the incidence of multiple sclerosis is higher in colder climates is well established. Studies are under way in New York City investigating immigrants from Ireland and Italy and their first-generation descendants, to determine whether the propensity to develop MS in a common climate is altered by family background.

The Institute has continued to expand its program in "slow virus" research. Much of this research is conducted at a special virus laboratory established by the Institute at Patuxent, Maryland, in cooperation with the Fish and Wildlife Service, Department of Interior. Here, experimentally inoculated hosts are being held for a period of five to ten years. In addition to multiple sclerosis, a number of other diseases are under study.

In another program, partly supported by the National Multiple Sclerosis Society, Institute scientists are using viral antigens to detect virus antibodies. They are using these antigens to search for such antibodies in patients with MS. Although several groups have reported higher measles antibody titers among patients with multiple sclerosis than matched controls, the role of viruses in the etiology of MS is still not established. Additional studies are now in progress in which a variety of antigens and sera from different groups of patients are being examined.

Another major research effort is being directed toward understanding the biochemistry of the disease. Scientists are seeking a possible biochemical defect as the cause of demyelination, a major characteristic of MS. The Institute has developed an important program on the biochemistry of myelin to investigate this possibility.

Institute scientists are investigating the possibility that MS is due to an autoimmune disease--a process wherein the body's antibodies are being directed against its own brain tissues. The Institute is supporting a number of studies to determine the nature of the chemical which initiates the autoimmune response, the body mechanisms involved, the evidence that such a process might be operative in patients with MS, and the means to prevent such destructive processes.

One of the most potentially valuable projects in multiple sclerosis research is a double-blind cooperative study to evaluate the use of adrenocorticotrophic hormone (ACTH) in acute exacerbations of this disease. Ten university treatment centers conducting this study recently issued a preliminary report. The investigators feel that they have attained the primary purpose of the study by determining a means by which a proposed agent can be tested. In their first report, the researchers presented evidence demonstrating that adequate randomization for all testable variables can be attained. A conclusive report on the benefits or lack of benefits of short-term use of adrenal steroids and ACTH will soon be issued by the ten centers.

Research Progress - Viruses

A number of events this past year add support to the belief that infective agents may contribute to multiple sclerosis (MS). The first strong evidence that viruses may be implicated in the etiology of certain neurological disorders, including MS, was gained about three years ago by the transmission of kuru to an animal host, the chimpanzee. Kuru, a degenerative neurological disease found only in a small population of New Guinea natives, resembles MS in some respects.

Further proof was gained this past year that kuru is of infectious origin when it was transmitted to the spider monkey in the special NINDS "slow virus" laboratory. Since the study of persistent and slow virus infections in the brain requires long-term observations of animals, the discovery of another laboratory animal susceptible to the disease is of great importance to researchers. Spider monkeys are less expensive and easier to obtain in large numbers than are chimpanzees. Use of this new experimental animal should help efforts to characterize the virus and to study the pathogenesis of the disease.

The disease which in America and elsewhere throughout the world bears the closest resemblance to kuru is Creutzfeldt-Jakob disease, also called spongiform encephalopathy of gray matter. It is a nervous system disease usually fatal within several months, which occurs sporadically throughout this country. At the special NINDS virus laboratory, brain biopsy from a case with the disease has been used for successful transmission of the same neurological disease to the chimpanzee after 13 months incubation. Both this disease and kuru bear striking resemblance to scrapie, a widespread fatal brain disease of sheep.

NINDS workers last year isolated a virus from lung and brain explants of sheep dying of Montana sheep disease, which is an enzootic disease of long-standing in the United States. It has now been shown that this virus is similar to maedi and visna disease in Iceland. In the neurological form, visna, this slow virus infection causes widespread demyelination somewhat similar to that seen in multiple sclerosis. This finding among Montana sheep is of special interest because of work conducted for the past 12 years at the Institute for Experimental Pathology, University of Iceland, Reykjavik, Iceland. Scientists at the center in Iceland, supported in part by a grant from NINDS, injected brain material from different MS patients into Iceland sheep. (These sheep have existed for a thousand years in ecologic isolation.) This resulted in a central nervous system disease in some of these sheep after an incubation period of more than one year.

Subacute sclerosing panencephalitis (SSPE), a fatal disease of children, has been shown to be caused by a measles virus persisting in the body for many years after acute measles infection. The Institute was among the first to accumulate evidence for the role of measles in this disease, and called a symposium on this important subject.

Work here at the Institute and elsewhere has since further incriminated measles as the cause of SSPE, which claims the lives of several hundred American children each year. Recently, experimental work at the Wistar Institute, supported by a grant from NINDS, has produced a similar disease in ferrets from brains of human cases of SSPE. The earliest sign of this disease was an electroencephalographi (EEG) abnormality in asymptomatic animals. As the disease progressed, other signs appeared and were associated with the development of distinct histologic lesions.

MUSCULAR DYSTROPHY AND RELATED DISORDERS

The problem

The neuromuscular diseases affect primarily America's greatest assest--her children and young adults. Estimates of the number of people affected by the disorders of muscle weakness, wasting, or paralysis range between 250,000 and one million. The two most prevalent neuromuscular ailments are muscular dystrophy (MD) and myasthenia gravis, the former affecting mostly children and the latter young adults.

Obligations for programs in muscular dystrophy and related disorders

	1966	1967	1968	1969 estimate	1970 estimate
Social and Rehabilitation Service: Rehabilitation Services Administration	NA	$410,880	$552,000	$715,500	$1,061,500
National Institutes of Health: National Institute of Neurological Diseases and Stroke	$3,704,000	3,931,000	3,375,000	3,494,000	3,520,000
Total	3,704,000	4,341,880	3,927,000	4,209,500	4,581,500

SOCIAL AND REHABILITATION SERVICE

Progressive muscular dystrophy involves a gradual degeneration of the muscles, often marked by a displacement of muscle tissue with fatty and connective tissue. Etiology of the disease is unknown and there is no specific therapy. The disease may result in slow deterioration of the muscles, often with temporary periods of remission. Seldom a static disease, it usually results in death five to ten years after onset. An estimated 250,000 persons in the United States are disabled by this condition and approximately 25 percent are unable to perform activities of daily living.

Relatively few individuals handicapped by progressive muscular dystrophy have been rehabilitated under the State-Federal vocational rehabilitation program. It is hoped, however, that despite the limited vocational potential characterizing this disability group, more effective rehabilitation methods will be developed which will enable greater numbers to be served by State vocational rehabilitation agencies. The Rehabilitation Services Administration innovation grant program, which is emphasizing programs for individuals with particularly severe disabilities, may be a means of extending services to this disability group.

The Social and Rehabilitation Service supports the training of professional personnel in the fields of nursing, social work, physical therapy, occupational therapy, and physical medicine, incorporating those skills and techniques essential to the best management of persons disabled by progressive muscular dystrophy.

Rehabilitants with Muscular Dystrophy

Fiscal Year Ending June 30	Persons Rehabilitated[1/]	
	Total	Muscular Dystrophy
1967	173,594	344
1968	207,918	400
1969	230,000	450
1970	265,000	550

1/ Data on muscular dystrophy not available for Fiscal Year 1966. Data for Fiscal Year 1967 are actual; rehabilitants with muscular dystrophy are estimated for Fiscal Years 1968, 1969 and 1970.

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

Research on the neuromuscular diseases conducted and supported by the National Institute of Neurological Diseases and Stroke is concentrated in three main areas: genetic research, cell biology and chemistry, and drug treatment. Over $4 million has been spent this year on research conducted both in the Institute's Medical Neurology Branch and on over one hundred research projects at medical institutions throughout the country. Voluntary organizations such as the Muscular Dystrophy Associations of America, the Myasthenia Gravis Foundation, Inc., and the National Foundation for Neuromuscular Diseases, Inc. maintain extremely active research programs as well as supporting patient care and rehabilitation facilities.

Many basic research studies are designed to elucidate the precise biochemical or metabolic defects causing each neuromuscular disorder. Other studies are concerned with the fundamental physiological and chemical characteristics of both normal and diseased muscle cells. As these studies provide us with greater knowledge of what is normal in muscle cells, we will be better able to understand, identify, and correct disease processes. Some therapeutic trials are being conducted.

Muscular Dystrophy (MD)

Several important research findings have been reported this year in the muscular dystrophies. Investigators have been concerned with both genetic and cell abnormalities in this disorder, as well as with developing effective treatment for these diseases of progressive weakness and wasting of skeletal muscles.

Scientists in the Institute's Medical Neurology Branch have found that clinically normal carriers of Duchenne dystrophy, the most common type of MD, demonstrate atrophy and architectural derangement of scattered or slightly grouped muscle fibers. Histochemical techniques used in this study showed high RNA and oxidative enzyme stains for both types of muscle fibers and should permit researchers to identify, through chemical testing and muscle biopsy, the women who carry the gene for this X-linked disorder.

In a separate study, another group of investigators have found that carriers of the gene for MD have increased amounts of the enzyme creatine phosphokinase (CPK) in their blod serum. Physicians can detect 75 percent of the carriers by measuring this enzyme. This is important for genetic counseling.

In other studies, Institute grantees at the University of Connecticut have made an observation which may represent a significant contribution toward understanding the progressive degenerative process in muscular dystrophy. In chickens with hereditary MD, the researchers have demonstrated that a decrease in the enzyme alkaline phosphatase in the capillaries and small arterioles precedes degeneration of muscle fibers. High oxygen therapy (70 percent oxygen) has been shown to retard progress of the steps in muscle breakdown in the chickens.

Studies to establish a protocol for testing drugs which may be useful in treating muscular dystrophy are being conducted by two Institute-supported investigators. After several years of planning, the researchers--one at Case Western Reserve University and one at the University of Utah in Salt Lake City--are conducting a double-blind study.

One goal of research on muscular dystrophy is to find a biochemical defect for each form of the disease, so that physicians will be able to prescribe specific treatment for each form. Several forms of MD already have been found to be characterized by the absence of a specific enzyme. In some patients, the missing enzyme is phosphorylase, in others it is phosphohexosisomerase. Institute grantees at the College of Physicians and Surgeons, Columbia University, have recently found a third metabolic defect--an absence of phosphofructokinase.

Myasthenia Gravis (MG)

Myasthenia Gravis is a disorder characterized by widespread failure of impulse transmission at the nerve-muscle junction producing impairment of normal muscle function, fatigue, and eventually paralysis of the muscles of movement and respiration. The weakness may fluctuate from mild to severe and may affect different sets of muscles at different times.

In addition to research on the basic defect in this disorder, such as a study on the basic neurophysiology of myasthenia underway at The Johns Hopkins University, researchers are studying possible treatment methods. The value of thymectomy (removal of the thymus gland) has been studied for several years. Analysis of data on almost 300 thymectomies showed that this therapy is effective in young women who have had the disease for less than five years and who do not have a thymoma. Another form of therapy that has been used in myasthenia is ACTH.

In two studies at the Institute's Medical Neurology Branch, researchers found (1) that long-term ACTH gave marked therapeutic success in a case of atypical childhood myasthenia gravis and (2) that they could immunologically characterize and distinguish between anti-nuclear factor (an antibody seen in patients with systemic lupus erythematosus) and antimuscle factor in the serum of MG patients.

An Institute grantee at Harvard University has been stydying the action of germine diacetate on skeletal muscle in a project to develop a new type of drug for treating MG with promising results in the first group of patients. A number of researchers are investigating the possibility that myasthenia gravis and other neuromuscular disorders may be auto-immune. One such research study, being conducted at Maimonides Medical Center in New York City, is concerned with antibodies of proteinaceous substances produced in patients with myasthenia gravis.

Findings in other Neuromuscular Diseases

Laboratory techniques such as histochemistry, biochemistry, immunology, autoradiography, electron microscopy, tissue culture and electromyography are also being applied to the study of neuromuscular disorders other than muscular dystrophy and myasthenia gravis. These include such categories as peripheral neuropathies, congenital and other myopathies, and periodic paralysis. Central nervous system degenerations are also being studied. This year some research progress has been made in all of these areas.

Familial recurrent neuropathy (Tangier Disease) in two sisters has been identified as being related to a specific biochemical abnormality. Physicians from this Institute cooperated with the National Heart Institute in studying the two patients, who were found to have alpha-lipoprotein deficiency accompanied by low plasma cholesterol and neurological symptoms. This abnormality differs biochemically from similar syndromes that have been described previously and can be specifically diagnosed by careful study of plasma lipids and lipoproteins.

Two additional congenital myopathies have been identified and described by the Institute's Medical Neurology Branch. One disorder is characterized by segmental loss of cross-striations in the muscle fiber. In the second disorder, type I muscle fiber hypotrophy (selective atrophy of type I fiber) with central nuclei, an experimental model of the disorder was produced by neonatal sciatic denervation in rat gastrocnemius muscle. The researchers studying this experimental model believe it indicates that the disorder is not a myopathy but rather an alteration of the neural influence of the muscle fibers.

A functioning link-up outside the animal between nerve and muscle has been achieved by an Institute grantee at Albert Einstein College of Medicine. The characteristic transmission of signals across the neuromuscular junction develops after maturation in tissue culture. After growing pairs of isolated fetal rat cord and skeletal muscle fragments (0.5-1 mm apart) in tissue culture, electrophysiological studies demonstrated that characteristic neuromuscular transmission was present at 1 to 2 months in vitro. Studies of the ultrastructural and bioelectric properties of these tissues during critical stages of maturation in culture may provide researchers with a useful model system for studying problems of development and regeneration.

While basic research studies continue to provide information about the basic defects producing neuromuscular disorders, investigators also are developing treatment methods to alleviate the effects of the disorders. In some instances, even though the basic defect still has not been elucidated, treatment methods have been developed which provide symptomatic relief. Studies at the NINDS Medical Neurology Branch have developed therapies for three such disorders this year.

A number of patients with poorly controlled attacks of hypokalemic periodic paralysis have responded to the drug acetazolamide (Diamox). Patients suffering from severe and frequent episodes of extreme weakness to the point of quadriplegia associated with low serum potassium were often able to lead normal lives while being treated with this drug. The actual mechanism of the drug's action in this disorder remains to be clarified.

In a second study, azathiaprine (Imuran) has brought about clinical and laboratory evidence of improvement in patients with dermatomyositis (polymyositis), a collagen-vascular disorder characterized by severe muscle weakness, erythematous skin lesions, elevated serum transaminases and inflammatory myopathy on muscle biopsy. A third study, in collaboration with investigators from the National Heart Institute, has shown a liquid formula diet low in phytol and phytanic acid to be effective in reversing the nerve abnormalities in Refsum's disease (hyperphytanicacidemia).

In the course of electromyographic studies which employ hypodermic needles and muscle biopsy studies, NINDS scientists have discovered that microscopic changes can be produced in the muscle by the hypodermic needle. They strongly suggest that muscle biopsies not be taken from a site that has been needled previously because the biopsy may show the needle-produced changes which cannot be distinguished from disease-produced pathology.

Other inborn errors of Metabolism

A specific diagnostic test has been developed for detecting patients with metachromatic leucodystrophy (MLD), a progressive degenerative neurological disease characterized by a defective enzyme. Researchers in the NINDS Laboratory of Neurochemistry found that white blood cells from MLD patients show only 10 percent specific activity of arylsulfatase A compared with normal controls and patients with other neurological disorders. This new clinical technique is significantly more practical than the current screening method of urinalysis which is confused by several variables, or other earlier methods which depended upon brain or peripheral nerve biopsy.

The same laboratory two years ago developed tests to diagnose two other enzymatic disorders, Gaucher's disease and Niemann-Pick's disease. These researchers now believe they are able to diagnose both disorders in utero through the techniques of amniocentesis and growing and withdrawn fetal cells in tissue culture. Laboratory tests have shown that activity of the enzymes involved in these disorders can be seen clearly in tissue cultures. In other tissue culture studies of Gaucher's and Niemann-Pick's diseases the investigators have cultured small skin biopsies from patients and have been able to identify each disorder in culture. This same method may make it possible to identify heterozygous carriers of the disorders as well.

Tay-Sachs, another similar disorder but one which affects many more people, has until now resisted biochemical elucidation. However, Institute investigators have been successful in demonstrating for the first time the metabolism of the ganglioside which accumulates in the neurons of Tay-Sachs patients, which causes the symptoms of the disorder. They have synthesized this ganglioside and labelled it radioactively for use in experiments to study the specific abnormal enzymatic reactions producing the metabolic defect. It is only through successful studies of the basic nature of these diseases that rational therapeutic procedures can be devised. Furthermore, diagnosis of these inborn errors of metabolism during pregnancy and detection of the heterozygous carriers of these diseases now permit the important possibility of genetic counselling of families in which these diseases have appeared.

BLINDNESS

There are an estimated 420,000 people in the United States who are legally blind. The estimated annual cost for care of these people is $400 million. An additional 3.5 million people are partially sighted, one million of whom are severely visually impaired. Of these 32% (300,000) are so handicapped that they cannot work, keep house, or go to school. An estimated 12 million children in the United States require eye care.

The number of blind persons in the United States is increasing. The advances of modern medicine are largely responsible for this. New techniques and medicines are allowing more and more infants and children to survive complicated pregnancies, deliveries, and once fatal childhood diseases. Often, however, the child suffers some visual impairment. The advancements which have been made which allow people with previously fatal hereditary diseases to survive to a child-bearing age have also increased the incidence of such diseases because the off-spring of such people are often affected. At the other end of the age spectrum, the older population is increasing. As people live longer, visual impairments such as cataracts and glaucoma become more common.

Obligations for programs in blindness

	1966	1967	1968	1969 Estimate	1970 Estimate
Office of Education:					
Elementary and secondary education	$27,553	$50,000	$100,000	$150,000	$200,000
Libraries and community services	--	110,000	905,000	905,000	905,000
Education for the handicapped	1,417,927	1,600,250	2,539,933	2,924,000	3,400,000
Research and training	38,415	55,393	20,768	20,000	20,000
Subtotal, Office of Education	1,483,895	1,815,643	3,565,701	3,999,000	4,525,000
Social and Rehabilitation Service:					
Rehabilitation Services Administration:					
Grants to states	13,600,000	7,704,000	24,000,000	30,000,000	43,000,000
Innovation grants	180,000	146,000	227,000	300,000	300,000
Expansion grants	122,500	639,000	684,000	700,000	700,000
Training and traineeships	--	487,000	590,000	592,000	651,000
Project development	13,000	10,000	8,000	10,000	10,000
Construction	--	822,000	154,000	250,000	300,000
Workshop improvment	59,000	99,000	155,000	150,000	250,000
Training services	--	--	141,000	200,000	400,000

	1966	1967	1968	1969 Estimate	1970 Estimate
Office of Research, Demonstrations, and Training:					
Research and Demonstrations....	1,481,000	1,428,000	1,186,000	914,000	895,000
Special Foreign Currency Program..	174,000	293,000	276,000	250,000	200,000
Grants to states for public assistance.....	57,154,000	65,405,000	68,456,000	83,700,000	89,575,000
Subtotal, Social and Rehabilitation Service....	72,783,500	77,033,000	95,877,000	117,066,000	136,281,000
Health Services and Mental Health Administration:					
Regional Medical Programs Service..	378,000	610,000	509,000	509,000	509,000
Social Security Administration:					
Estimated benefit payments from truse funds:					
To blind persons..	38,000,000	40,000,000	43,700,000	51,500,000	51,900,000
To families of blind persons.....	7,600,000	8,100,000	8,900,000	10,400,000	10,400,000
Adjudication of claims and maintenance of beneficiary rolls.....	2,500,000	2,800,000	3,200,000	3,700,000	3,900,000
Subtotal, Social Security Administration..	48,100,000	50,900,000	55,800,000	65,600,000	66,200,000
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke.....	16,449,000	20,086,000	21,166,000	22,240,000	25,778,000
American Printing House for the Blind.	1,000,000	1,028,000	1,225,000	1,340,000	1,404,000
Total.....	140,194,395	151,472,643	178,142,701	210,754,000	234,697,000

The number of school age visually handicapped children has increased considerably in recent years. Between 1957 and 1967 there was a 73 percent increase in the number of these children registered by State and local schools with the American Printing House for the Blind. It is estimated that there are about 57,000 visually handicapped children of school age in the United States and this number is expected to rise at about the same rate as that of the general school population. Partly because of a shortage of qualified teachers many of these children are not receiving the special instruction necessitated by their handicap. More than 300 newly trained teachers are needed each year just to keep pace with the annual attrition in this area of the handicapped.

During the first four years of the program of professional preparation authorized by Public Law 88-164, awards have been made for 504 graduate fellowships, 233 senior year traineeships, 2 junior year traineeships, 746 summer traineeships, 546 institute traineeships and 10 program development grants in the area of the visually handicapped. A total of 684 persons are receiving training during school year 1968-69. It is expected that over 900 persons engaged or preparing to engage in the education of visually handicapped children will receive awards under this program during fiscal year 1969.

The leading obstacle in expanding educational opportunities for handicapped children is the lack of qualified personnel. Second is the dearth of scientifically tested knowledge relating to the education of these children.

The Research and Demonstration program for handicapped children within the U.S. Office of Education was begun during fiscal year 1964 with a modest budget. By fiscal year 1965 only about $100,000 had been invested in projects relating to blindness. This amount more than doubled in fiscal year 1966 with an investment of $136,147. A decrease in research activities the following year reduced the figure to only $92,000. Only two new projects were initiated during that year.

The very small investment in the area of blindness from the beginning of the research program through fiscal year 1968, i.e., $1,412,595 out of a total of $27.8 million, resulted in an intense effort on the part of our staff members to stimulate new activities. The expected investment in this area of the handicapped for 1968 was increased to $741,326.

In fiscal year 1968, the Bureau of Research is conducting two projects, specifically related to the blind for a total amount of $20,768. One project involves the development of an expanded reading code for the blind. The second endeavor is concerned with the blind persons comprehension of rapid speech, which would compare with the silent reading rate of the individual with sight.

Title III of the Elementary and Secondary Education Act provides for nonmatching grants directly--and, beginning in fiscal year 1969, through State Education Agencies--to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs to serve as models for regular school programs. This program gives special consideration to projects that are truly innovative as well as being of high quality and responsive to local needs. In fiscal year 1969, it is estimated that $150,000 in ESEA Title III funds will be obligated for educational projects for the blind and in fiscal year 1970, approximately $200,000 will be obligated.

Under Title I of Library Services and Construction Act there are many projects which include service for the visually handicapped and a few projects which specifically aid the visually handicapped.

Under Title IV-A, State Institutional Library Services, residential schools for the visually handicapped which are operated or substantially supported by the State are eligible for funds for library services, and Title IV-B, Library Services for the Physically Handicapped, provides for library services through public or other nonprofit libraries or agencies to the physically handicapped, including the blind and visually handicapped.

Examples of projects for the blind funded under Titles IV-A and IV-B follow:

In Nebraska, funds will be used to provide leisure reading not curriculum orientated books, for the Schools for the Deaf, for the visually impaired, and the State Home for Children, and to enable the local public library to purchase additional copies of books suitable for children at the school for the Trainable Retarded Children which does not maintain its own library.

Children-materials and training for improved library services for the blind are being funded in Kentucky.

Training for the Assistant Librarian, shelving for dormitories, and books for the library are being supported at the Florida State School for the Blind.

Native Literature Taping.--Tapes (of both indigenous literature and general works) are being prepared in various Native languages in Alaska. Taping may be done at 3 locations: (a) Mt. Edgecombe BIA Boarding School, (b) University of Alaska, and (c) Anchorage Public Library.

State Library.--Development of a collection of large print books for the partially blind, its processing, and shipment to individuals and local libraries is also in progress in Alaska.

Contracts with Out-of-State Libraries.--The Idaho State Library will contract with the "Books for the Blind" service of the Library Association of Portland, Oregon for library services to Idaho's legally blind.

Expansion and strengthening of resources and services of the Georgia Regional Library for the Blind and Physically Handicapped which is part of the Public Library Unit of the State Department of Education will be supported in Georgia.

Beginning in fiscal year 1970, the basic grant program under the appropriation Vocational Education, will provide that a minimum of each State's allotment be used for programs specifically concerned with the handicapped. Some of these funds will obviously provide for training of the blind but at this time figures are not available.

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

There are an estimated 420,000 blind persons in the United States today, with an annual increment of newly blinded persons of approximately 10 percent of the total population, or 42,000. Demographers and medically oriented scientific personnel state that small annual increases are expected due to the growth of the total population and to the fact that blindness is, for the most part, the result of difficulties usually attending the aging process. More than 50 percent of the entire blind population are above age 60. A substantial number of the remaining group suffer from multihandicapping conditions. Recent advances in surgery and medicine have substantially reduced the mortality rate prevalent in the early part of the century, but those who survive suffer multiple disabilities which must be overcome if they are to lead normal lives and make their contributions to society.

Experience has shown that with good rehabilitation techniques, through training and the current job opportunities which are available to blind persons, it is entirely possible to rehabilitate at least 25 percent of the annual increment of 42,000 persons (approximately 10,500). If the backlog waiting to be served are to be considered, as well as taking into account the increase in the total population, more than 12,000 blind persons each year should be rehabilitated into employment.

At present, there are 35 separate State agencies for the blind. In the remaining 19 States and territories, vocational rehabilitation services for blind persons are provided by a specially designated unit within the organizational structure of the general agencies for vocational rehabilitation. Where special services are clearly identifiable, the disability of blindness presents a unique opportunity to demonstrate how the total job of rehabilitation can be accomplished and all services can be provided to all blind persons who can profit from them.

As a result of the reorganization within HEW creating the new Social and Rehabilitation Service, social services to the blind became the responsibility of Rehabilitation Services Administration. The reassignment has necessitated the development of a viable program designed to provide social rehabilitation to thousands of blind persons who were not given the attention they deserved previously. The success of the expanded program depends entirely on our capacity to make available those services needed to enable a blind person to fully participate in society. While the goal for most of the clients to be served is not employment, many principles successfully used in vocational rehabilitation must be applied to make full participation a reality; e.g., adjustment services, travel training, self-help and self-care, etc.

Extent of disabling condition--

Although blindness is not the total disaster that the vast majority of the general public believe it to be, it is, nevertheless, a severe obstacle which can only be overcome through the application of much professional skill and great courage on the part of the individual receiving the service. Contrary to the opinion of many, rehabilitation is not merely finding a job that a blind person can do, but finding the right job that suits the particular individual's aptitudes, interests, and inclinations, and training him to do that job to the best of his ability so that he is thoroughly competent and is an employee that is sought after not because of his disability but because he is a high producer who can turn his skill into valuable cash for his potential employer.

Much has been learned about rehabilitation of blind persons in the last few decades. It is now recognized that in order to attain complete rehabilitation a blind person must not only be given the skills and the tools to do an adequate job but the job must be commensurate with his abilities. He must be taught the skills

which will make him socially, as well as vocationally, competent and acceptable to his sighted peers. In essence then, true rehabilitation means finding as many substitutes for sight as possible and training the blind person to utilize the substitutes to his maximum advantage. It also means the psychological evaluation of the total human being and the re-focusing of the individual's talents in the achievement of a new and full life. The ultimate goal of 12,000 rehabilitants is well within the realm of attainment. If adequate resources are available, this objective can be realized in less than a decade.

Progress to date--

At first glance it might not seem that progress has been phenomenal in the last 25 years; however, after the passage of the Barden-LaFollette Act in 1943, the law which gave impetus to rehabilitation of the severely disabled, including the blind, it is significant to note that in the first year only a few hundred were rehabilitated as compared to over 6,800 during the past fiscal year. What is of even greater significance by far, however, is the variety of vocational opportunities now open to blind persons as compared with the circumscribed opportunities less than a decade ago.

Research and training--

The expansion of job opportunities is due in large measure to the amount of research, demonstration, and training which were permitted under the amendments of Public Law 565, passed in 1954. Since that time, the Rehabilitation Services Administration has spent more than $10 million in research and training efforts demonstrating the feasibility of blind workers in such fields as computer programming, teaching in the public schools, work opportunities in numerous professions, as well as many new categories of jobs in the service, semi-skilled, and skilled occupations.

Through long-term training grants, Rehabilitation Services Administration has commenced the development of highly trained professional personnel in the field of work for the blind; e.g., mobility instructors, a discipline which is most vital to the rehabilitation of blind persons. It has been estimated that 90 percent of all blind citizens of the United States are unable to travel without the aid of a human guide. A measure of the magnitude of our dilemma in coping with this problem is clearly illustrated by the results of a cursory survey indicating that a minimum of 220 mobility instructors are needed annually. At present, we are only able to train 62 per year. It is recognized that special impetus is needed if this problem is to be overcome.

Currently there are 24 rehabilitation centers for the blind throughout the country. In order to do an adequate job, the number of facilities must be doubled, and the level of sophistication and potential of some of those already in operation increased. Research money is also being expended in the development of many electronic devices which, hopefully, will aid a blind person to travel much more efficiently than is now possible by the use of a cane. Electronic know-how is also being applied in the development of new techniques for producing Braille and for other more efficient methods of reading.

Rehabilitation facilities for the blind--

Under Section 12 of the Vocational Rehabilitation Act, funds are made available for placing, constructing, and initial staffing of specialized facilities for the blind. Since the inception of this authority in FY 1966, the program has grown from a $4,500-project development grant to a total of 11 project development and construction grants through FY 1968. During this period, grants totalling $870,413 have been awarded to organizations and agencies serving the blind.

Section 12 of the Act also provides funds for rehabilitation facility improvement. Since the beginning of this program in FY 1966 through FY 1968, $453,737 have been awarded to facilities for the blind. These grants assisted 21 facilities serving the blind in the provision of additional staff and equipment; thus, enabling these organizations to substantially improve their operations.

There is a definite need for further utilization of rehabilitation facilities in the provision of services to the multihandicapped and older blind. In order to do an adequate job for all the blind who need, desire, and could profit from these services, we must redouble our efforts in the direction of assisting agencies and organizations in improving and developing facilities for tne blind.

Optical aids--

New advances in tne field of optics have been developed. As a result, optical aid clinics for those with very limited sight have been opened in strategic locations throughout the country. These clinics are designed to fit blind persons who have some slight residual vision with microscopic and telescopic lenses to enable them to expand their vocational opportunities and in certain instances to make it possible for them to read the regular printed page. A great deal of perseverance in training is necessary in order for them to obtain maximum benefit of such lenses. However, the clinics do represent a great stride forward. There are approximately 26 clinics across the country. A substantial expansion of this effort should be implemented as soon as possible.

The following four illustrative examples of the many new occupational fields which have been opened for the blind within the last decade indicate positive progress:

(1) Data processing, in particular computer programming, is a whole new field which has developed within the past 10 to 15 years. Many professional rehabilitation workers for the blind felt that automation would pose some very serious problems for blind workers and would, in fact, reduce job opportunities drastically. If computer programming can be taken as one example of what will happen as our economy becomes more and more automated, there is reason for great optimism. Through some diligent research programs which have been conducted during the past few years, findings indicate that blind persons with the proper backgrounds and interests have an aptitude for computer programming and can be trained for very high level positions in this new field of work. About 300 blind persons are successful computer programmers employed in industry and Government, and the potential for the next 10 years, according to experts, is unlimited.

(2) Service occupations, too, will provide their fair share of opportunity for well-trained blind persons. Several million entirely new jobs in the service field are emerging. A substantial number of these will be in the many thousands of hospitals, hotels, and motels throughout the Nation. Research and training have demonstrated that many of the jobs ranging from kitchen helper and laundry worker to telephone operator, clerk, and medical transcriber are feasible for blind persons and that well-trained visually impaired workers make desirable employees.

(3) In the first decade after World War II, the majority of competitive employment opportunities for the blind were found in industry, particularly in repetitive machine operations. These opportunities were slowly eroded by the installation of highly automated machinery. This is exemplified by simple drill press operations which today have become extremely complex jobs directed and controlled by taped programs. A blind person can no longer be trained as a drill press operator within a few days or even a few weeks of vocations instruction. It is now essential to provide special trade technical training for the blind worker to prepare him to compete with his sighted colleagues and obtain his share of employment in the industrial labor market. In order to meet the challenge, funds

are necessary to implement our long-range plan to support special units within trade technical schools designed to train blind persons to qualify for the numerous opportunities in this very important area of skilled employment.

(4) Another area deriving a great deal of benefit through automation is our Randolph-Sheppard vending stand program. Potential progress in the number of employed operators, stand locations, earnings to operators, and gross volume of business is outlined in the following table:

RANDOLPH-SHEPPARD VENDING STAND PROGRAM

Fiscal year	Number of stands	Number of operators	Gross sales	Annual average earnings
1968	2,920	3,259	$78,966,000	$5,580
1969	3,175	3,500	90,000,000	5,805
1970	3,350	3,700	100,000,000	6,100

This shows steady progress and a gross volume of business of $78.9 million in FY 1968. According to a study conducted a few years ago, the potential in this field has barely been tapped. It is the opinion of the researchers that with the proper accommodation to automated equipment, the number of stand operators now employed can be trebled and the gross volume of business within the next 5 to 10 years can be doubled. However, this goal cannot be achieved unless vending stand installations are continually upgraded and blind operators and supervisors are kept abreast of new techniques. Equally important, of course, is the complete cooperation and acceptance by public and private building managements.

In the last analysis, the measure of our rehabilitation program for the blind and, indeed, the successful effort of our entire society will be measured not in terms of what we are able to do for those who were deprived of sight but endowed with innate ability but of what is attained by those for whom equality seemed impossible. Vocational success and full social participation for all blind individuals who in other societies and in former times were passed over without a second thought must be assured an integral part of this Nation's affluence. Given essential funding, the initiative, ingenuity, and imagination of the State-Federal rehabilitation partnership will enable blind citizens to assume full and productive lives so fundamental to the democratic principle which embodies the respect for the dignity of man.

Office of Research, Demonstrations, and Training

Problems of the blind continue to be concerned with appropriate industrial placement, professional placement, and the widening of opportunities hitherto not opened to the blind. Coupled with placement problems are those of mobility and a need for a precise ophthalmological measurement of residual visual ability.

Goals include the development of new inventions and intensive study of mechanical and electronic devices for blind persons mobility. Suitable demonstrations of the use of actual jobs for evaluation and occupational prediction of the blind individual's aptitude and capacity to adjust not only to a new job but to his peers within business and industry will be among the goals for 1970. These projects will place heavy emphasis upon the development of social as well as occupational skills.

Outstanding results which have been accomplished in projects serving the blind include a demonstration program to train the blind to be computer programmers. Over 25 demonstration projects have been highly successful in furnishing

optical aids to several thousand low-visioned individuals. Approximately 2,000 per year are served by these optical aid clinics throughout the United States.

The American Association of Workers for the Blind has developed a complete bibliographic reference card catalogue of literature relevant to the rehabilitation of the blind. This training device is being utilized in programs throughout the country in the preparation of workers with the blind. Two major projects provide the field of the blind with both the evaluation and the creation of new prosthetic devices as well as the eventual production design of the prototypes prior to marketing. The Hadley School for the Blind has completed the development of a Braille medical dictionary to be used primarily in the training of blind medical technicians. A conference related to use of this dictionary was held in 1968. A study of a portable, battery-operated phonograph for blind students is currently underway to determine its efficiency, durability, and value in the education and employment of the blind; college students who are blind have already found it a vast improvement over the larger, less mobile recorded books. Over 20 mobility and orientation instruction projects for the blind have been absorbed by the community in which the demonstration was supported. The regional facility for deaf-blind continues to provide innovative services for this group of individuals. It is anticipated that the National Center for Adult Deaf-Blind will become operational during FY 1970.

Major emphasis will be placed upon the functional production of sensory aids and mechanical devices to be utilized on as efficient a basis as possible. Demonstrations in new job areas will be developed through employer cooperation. New techniques and innovations in leaderless group counseling will be applied to blind students on both a college campus and in technical institutes.

One of the major problems in the field of rehabilitation is that of training the blind and visually impaired to reach the level of their capabilities. Technological advances in industry has created a job market requiring higher skills than in the past. This, in turn, has made it essential to develop new techniques for training the blind and the visually impaired as a pre-requisite to placement in modern industry and business. The problem is even more acute in countries such as India where it is estimated that there are over two million blind people in need of rehabilitation services.

International research on the blind and visually impaired will focus in the areas of prevention, improved techniques in training, investigation of new employment resources, development of assistive devices and improvement of early case finding techniques.

Grants to States for Public Assistance

Grants to States are provided under titles X (or XVI) and XIX of the Social Security Act to assist needy blind individuals by providing financial assistance for their daily maintenance needs, to make payments for needed medical care on their behalf, and to provide social services to help them deal constructively with their economic, health and social needs. All 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have the program of Aid to the Blind (AB).

Total Federal, State and local expenditures for maintenance payments under the blind program in fiscal year 1968 were $88,713,000 of which $51,668,000 represented the Federal share. In addition, total funds of $30.6 million ($15,840,000 Federal) were expended for payments to medical vendors on behalf

of the blind in 1968 (including recipients of maintenance payments and blind persons who needed help only with medical bills). Comparable figures estimated for fiscal year 1969 are: total maintenance payments $91,675,000 ($54.2 million Federal share); $35 million for medical vendor payments of which the Federal share is $21.5 million. Costs of State and local administration, services, and training was $10,543,000 in 1968, of which the Federal share was $5,950,000. The 1969 estimate for these costs is $14.6 million of which the Federal share is $8 million.

In fiscal year 1968 the average monthly number of AB recipients receiving money (maintenance) payments was 82,300 or 1,400 less than the average monthly caseload in 1967. In fiscal year 1969 the average monthly caseload receiving money payments is expected to increase by 2,400. Average monthly payments for recipients increased from 1967 to 1968 from $86.45 to $89.88. A further increase is expected in both fiscal 1969 and 1970. The estimated average monthly payment per recipient for these years are $91.70 and $96.25 respectively.

To be eligible for Aid to the Blind, Federal policy defines visual eligibility as including "persons having insufficient vision to perform task for which sight is essential, as well as persons with vision." In other words, visual limitation determined by opthalmic measurement must be severe enough to result in "economic blindness." It is not necessary to be totally blind.

The blind applicant must be a needy person but there are no age limitations in the Federal Act, although a number of States have laws excluding children. Unlike the other categories, Aid to the Blind may include the whole lifespan from infancy to old age.

In addition to providing needy blind with cash assistance for basic maintenance, public welfare assistance agencies may also provide for treatment to preserve remaining vision, for restoration of sight through surgical and medical attention whenever possible, or medically recommended optical aids to maximize use of residual vision, and for medical and dental care for other health needs.

The Federal Government will share the cost of special items related to the unique needs of the blind: a telephone, guide fees, transportation expenses, extra laundry and dry cleaning allowances, higher food expenses when the handicapped person does the cooking or must take meals in a restaurant. The food allowance for a seeing eye dog is another illustration of the flexibility that is possible.

Safe and sanitary housing is extremely important for the blind as well as safe household equipment to prevent burns and accidents. Hence, moving expenses and higher rent expenditures may be required to assure this protection for the needy blind.

In 1962 amendments encourage more comprehensive social services for the blind by providing 75 percent Federal financial participation in their costs. About four-fifths of the States are now receiving 75 percent Federal matching for these services. To obtain this additional money, a State's services must encompass the blind who are in need of protection because of physical or mental handicaps or adverse social circumstances. There must also be provision for those who require special help to remain in their own homes or elsewhere in the community of their choice, thus avoiding unnecessary institutionalization. Similar services must be given to enable clients to return to their communities following a period of institutional care. Blind recipients with potential capacity for becoming either partially or completely self-supporting will be assisted with plans to secure training opportunities. All of these service areas include not only the blind client but may be extended to relatives as well when their circumstances influence case planning.

Public welfare agencies collaborate with many other agencies toward the joint goal of restoration of blind people to the maximum level of health, employability, and personal satisfaction their capacities permit. By proper referal and provision of needed supportive services, the public assistance agency implements this goal so the handicaps of severe visual limitations may be mitigated or overcome. Illustrative of the foregoing: utilization of vocational rehabilitation services for young adults and those of middle age; special educational provisions for blind young people; casework services for parents of young blind children; encouragement of attendance at adjustment and mobility training centers; use of home teacher; sheltered work opportunities and community recreational resources and acquisition of talking book machines with the wide choice of records available from the Library of Congress. Annually, in conjunction with the annual sessions of the American Academy of Opthalmology and Otolaryngology, staff of the Department meet with State supervising opthalmologists associated with State AB programs. This has proved to be a valuable opportunity to share information and hear about operation of the State AB agencies.

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

Visual impairment and blindness constitute major health, educational, and economic problems. The Department of Health, Education, and Welfare has instituted a broad range of programs to cope with the many types of problems presented. These include programs of education, vocational rehabilitation, and income maintenance which directly assist the visually-afflicted; programs to train the health professions and associated personnel who must provide required care; programs to improve the quality and delivery of eye care service; and the long-term programs of medical research and the training of research scientists.

Among all of these Departmental efforts, the ones that have probed most deeply into the fundamental questions of cause and cure and which provide hope of ultimate prevention and control are the research and training programs which have been conducted under the National Institute of Neurological Diseases and Blindness, and hereafter will be conducted largely under the National Eye Institute, authorized by Congress in August of this past year.

Visual disability and blindness already can be reduced significantly by early detection and treatment. However, fundamental knowledge is still lacking in the understanding of causes and mechanisms of many blinding diseases. Therefore, the Institute supports a broad basic research program together with clinical research. Since not only the eye but the nerve pathways and the brain are necessary for vision, basic neurological research is involved. Also considered must be the systemic disorders that may involve the eye, such as diabetes, disorders of the blood vessels, and various diseases of the brain and central nervous system.

The Institute's program includes research at its laboratories and the Clinical Center at Bethesda, Maryland, a collaborative and field research program; research grants, fellowships, and traineeships to individual scientists in academic institutions throughout the country; and training grants to aid universities and other centers in educating more ophthalmologists and research scientists.

In addition to individual research projects, the Institute supported 9 multidisciplinary research centers in vision and 14 outpatient research centers; a Model Reporting Project in blindness in 16 States; and various collaborative and field projects relating to vision. These vision programs are currently operating at a level of $21 million.

Many of the Institute's vision programs relate to the major causes of blindness: cataract, glaucoma, retinal disorders, disorders of the optic nerve, vascular disorders, uveitis, infections, myopia, retrolental fibroplasia, neoplasms, and accidents, injuries, and poisonings.

Program Developments

A permanent Subcommittee on Vision and Its Disorders, appointed by the National Advisory Neurological Diseases and Blindness Council, has assisted the Institute in reviewing and planning vision research and training. It has conducted a continuing assessment of the status of knowledge in eye research and training, and in the identification of problem areas and special needs. A report of this subcommittee, including recommendations, developed over a 2-year period with the help of 250 of the Nation's leading scientists was published shortly before the beginning of the year. It has served as an important guideline for research efforts, particularly focusing attention on areas requiring special and immediate investigation.

Task forces, such as the ones on refractive anomalies and ocular pharmacology, served to review current research, supervise programs for the dissemination of scientific information, and organize programs of directed research and development. An ad hoc committee on visual rehabilitation made a number of recommendations including the establishment of a new review committee for rehabilitation of the blind. Plans were made also for the establishment of a diabetic retinopathy planning committee.

Information Network

A Vision Information Center (VIC), established in 1966 under a contract with Harvard University served as the focal point for the collection, storage, retrieval, and dissemination of information relating to vision, eye diseases, and blindness. The Center is located in the Francis A. Countway Library of Medicine at the Harvard Medical School.

The VIC is part of the National Information Network of specialized centers for neurological information. Its scope embraces those areas of vision and diseases of the eye which are the province of this Institute. These include: (1) all clinical aspects of ophthalmology and optometry, including eye manifestations of systemic diseases, and (2) physiological, biological, biochemical and biophysical research related to the eye and vision. The VIC scans the literature in its field for depth indexing and entry into a computer assisted retrieval system. This Center offers literature searches on eye diseases and vision, a listing of periodical publications, or abstracting of newly-published journal articles, and computer-assisted instructional services.

Vision Research Centers

In addition to the program of regular research projects, support is being provided for nine clinical research centers for blindness and eye disorders, each concentrating on special clinical problems such as glaucoma, cataract, retinal disorders, corneal disease, infections of the eye, and disturbances of eye movements. Even though highly specialized, each center maintains a broad approach to the overall problem of blindness. For example, as a basis for approaching the problem of the sensory and perceptual disorders, several centers are developing needed information about fundamental mechanisms by which light impulses are converted to nervous energy and transmitted to the brain for interpretation.

Outpatient Clinical Research Centers

The program of eye outpatient clinical research grants, initiated on a pilot basis in 1967 and 1968, has been successful and currently includes support for 14 units. These programs have made available outpatient populations with eye disorders for research study. They provide the environment to carry out clinical and epidemiological studies, drug evaluations, developmental studies, long-term follow-up, and other investigations of ocular disorders which affect only humans and cannot be duplicated in animals. They offer an opportunity for continuing research which has reached its limits in the laboratory or in animal trials.

Model Reporting Area

Through its Biometric Branch, the Institute maintains a Model Reporting Area for Blindness Statistics (MRA). Its purpose is to make available better blindness statistics and to stimulate blindness research. Ultimately the goal is a national reporting system for all States which will standardize pertinent information on severe visual impairment cases.

MRA provides uniform data by state on each blind person's visual acuity, and the blinding condition and its cause. A program of evaluation has been undertaken to assist in the future direction of this program. Almost one-third of the U.S. population is now covered. Currently, member agencies represent the

following 16 States: Connecticut, Georgia, Kansas, Louisiana, Massachusetts, New Hampshire, New York, North Carolina, New Mexico, Oregon, Rhode Island, South Dakota, Utah, Vermont, Virginia, and New Jersey.

The Training Program

The training grants program of the Institute provides support to institutions for establishing, improving, or expanding training programs to prepare clinical and laboratory scientists for careers in research and academic medicine in the biomedical and medical disciplines relating to research on the eye. The scientists trained under these programs can be expected to assume the responsibility for future advances in knowledge leading to the prevention and successful treatment of eye disorders and for training of the next generations of eye scientists. These programs have been growing steadily in number and quality, thus beginning to increase the pool of well-trained scientists available to fill the many vacant positions of leadership as researchers and teachers.

Research fellowship programs are encouraging advanced, specialized research training by providing the financial support necessary for clinical and laboratory scientists to become qualified for research on problems relating to diseases of the eye. The fellowship programs are a most effective means of providing this training and of encouraging individuals to enter research careers. Postdoctoral fellowships provide financial support during the three years of research training immediately following the doctoral degree. Career development awards assure support over 5 to 8 year periods for selected scientists who have completed formal research training, and are by this means provided with an opportunity to become established as independent investigators in a chosen line of research.

This year, a contract was entered into with the University of Minnesota for a manpower study in the visual sciences.

NINDS is supporting a training program at the University of Puerto Rico School of Medicine. This is the Western Hemisphere's first intensive course in the basic sciences for young Latin-American doctors in the field of ophthalmology. The program is being conducted in cooperation with Columbia University, New York.

Development and use of the cryoprobe for surgery has advanced far in the past year. This has facilitated the extraction of lenses in cataract surgery as well as the production of pigment in retinal detachment work. New instruments are aiding in cryo (cold) extraction, making the surgical procedure easier.

Glaucoma

Glaucoma, which causes a great deal of avoidable blindness, results from lack of control of fluid pressure within the globe of the eye. A major emphasis of Institute glaucoma research has been toward a better understanding of the processes for maintaining proper pressure within the eye, including the early use of medications that save vision by correcting pressure. Therefore, Institute researchers have studied the effects of many drugs on eye pressure and have developed diagnostic tests of intraocular pressure abnormalities.

Epidemiologists are defining the characteristics of individuals for whom special vigilance is required because they are especially prone to develop glaucoma. Efforts have been made to improve techniques for detection and testing which are highly consistent and accurate. Advances have been made in understanding the basic dynamics of intraocular pressure, in applicable diagnostic techniques, in pressure variations and aqueous humor drainage and formation, and in understanding the activity in those parts of the brain believed to serve a pressure-regulating function.

This year, the genetic determination of ocular pressure, aqueous outflow, and open-angle glaucoma by multi-factorial inheritance has been substantiated through

various studies. When investigators cannulated (inserted a tube within) the optic nerve to measure the tissue pressure and to determine its relationship to intraocular pressure, they found optic nerve pressure to be directly affected by cerebral spinal fluid (CSF) pressure. (Tissue pressure in the anterior segment of the optic nerve posterior to lamina cribosa was found, however, to be independent of acute changes in intraocular pressure). The investigators demonstrated that elevated intraocular pressure compromises the small vessel structure of the distal optic nerve segment and hypothesize that this accounts for the glaucomatous disc changes in man. Extensive clinical testing and evaluation of drugs in relation to glaucoma were made at several medical schools in the expectation that they might help in treating glaucoma or might yield information fundamental to understanding glaucoma. Drugs currently being used in this treatment were tested for their safety. A valuable contribution was made this report year in the systemic studies of the pressure in the episcleral vein with the aid of a newly designed instrument, a modified force displacement transducer with a lucite cone applantation tip.

Analysis of tonometry data, with and without drugs and before and after drugs, were made and relationships between aqueous inflow, intra-ocular pressure, and venous blood pressure in the eye were interpreted. Design and analysis of a study of correlations between eye-pressure differences (differences between blood pressure and intraocular pressure) and aqueous inflow took place. Findings made through three separate communitywide surveys suggested the need for further investigation of tonometric screening for glaucoma. Other findings suggested that the time of measurement can influence comparability of tonometry data collected for epidemiological investigation.

Corneal Disorders

Corneal scarring, caused by injury and infection, is responsible for about 10 percent of the blindness in this country. Research has led to effective treatment for one common infection, herpes simplex, before scarring occurs. Other investigators have improved methods of freezing and dehydrating corneas for transplant when this is necessary to restore vision. Institute studies have concentrated particularly on effective drugs which can be used to fight inflammation without harmful side effects; microsurgery; better understanding of mechanisms of graft rejection; improving techniques for tissue transplants; use of synthetic substances which may be used to restore sight to persons blinded by severe cases of clouded or damaged corneas. New approaches to the broader study of antiviral drugs have been made. Increased understanding of the mechanisms by which antiviral drugs accomplish their task may lead to much improved treatment of systemic virus diseases as well as eye disorders.

New knowledge gained through a recent animal study of the tensile strength of corneal wounds should aid in the management of corneal wounds by both drugs and surgery. The study provided a theoretical basis for the clinical use of flaps (tissue grafts) in corneal ulcers, with frequent beneficial results in restoration of wound healing. Scientists have demonstrated that it is possible to remove the epithelium and replace it with a membrane of plastic material having a smooth optical surface. Thus a contact lens may be bonded directly to a damaged cornea. The final evolution of favorable results necessitates long-term observation.

Reasons for graft failures were explored in a series of studies and new recommendations offered. The effectiveness of systemic steroid therapy in suppressing rejection of corneal grafts during the period of drug administration was successfully demonstrated. Prolonged follow-up after termination of drug therapy indicated that systemic corticosteroids are capable of inducing a state of tolerance or "grant adaptation" in a high percentage of recipients. Use was made in successful experiments of an artificial endothelium made of silicone rubber to be used in corneal grafts. Drs. David Paton and Miguel Martinez, Wilmer Institute, Johns Hopkins University and Hospital, has undertaken a project designed to develop improved surgical and eye bank techniques. Doctors are studying what they call "prefabricated corneal grafts"--grafts which are precut, presutured, and preserved

until used in the operating room, and "composite grafts" made up of corneal tissue with a synthetic membrane bonded to the posterior surface. Such procedures, still in early stages of development, may be expected to help in solving the problem of too few donor graft materials for transplantation.

Uveitis

Uveitis is an inflammation of the iris, ciliary body and choroid in which the cause is often unknown. Institute scientists were among the first to recognize the parasitic infection, toxoplasmosis, as a major cause. This year's research has revealed that the use of antimetabolites, such as methotrexate and cytoxan, may be beneficial in the management of some types of uveitis even after steroid treatment has become ineffective. The beneficial value of these immunosuppressive drugs in the treatment of one form of uveitis--sympathetic ophthalmia--was found due more to its anti-inflammatory properties than to the immunosuppressive action. A final evaluation of the usefulness of these properties particularly, in combination with steroids, must be postponed until the results of prolonged therapy with these drugs become available.

Reccurrence of toxoplasmosis, which accounts for 30 to 50 percent of all posterior uveitis, was beneficially treated with employment of laser energy to create scar tissue around the lesions of the retina surrounding the initial focus of infection.

Tumors

Collection of data for study of malignant tumors of the eye among residents of the United States has been completed. These data, based on the review of death certificates, provide the first description of mortality in the U.S. due to specific ocular tumors. These data will be analyzed and reported in the near future.

Far more sophisticated methods of diagnosis and detection of malignant tumors of the eye are urgently needed. Research has concentrated on a search for the origin of eye tumors and early clinical detection of malignant tumors. NINDS research has revealed some promising new methods, using fluorescence angiography and radioactive tracers. These new techniques appear to hold promise. Successful malignant transformation of ocular tissue with oncogenic DNA viruses in vitro was accomplished for the first time in a joint effort with investigators from the National Cancer Institute. Ultrasonography of the orbit has been used successfully to locate intra-orbital tumors and Institute grantees have found the method easy to perform and useful in the routine investigation of unilateral exophthalmos.

Cryosurgery was used successfully by Dr. Harvey Lincoff to destroy tumors growing on the inner surface of the eye. Treatment of malignant melanoma--generally regarded as radiation resistant--with a combination of cobalt 60 and freezing, is being tried. The combined technique may be of value in managing a number of malignant intraocular tumors formerly treatable only by removing the eye.

Retinitis Pigmentosa

Electrophysiological and psychophysical examination of patients with various forms of retinal degeneration were conducted on the offspring of families afflicted by retinitis pigmentosa before the characteristic features of the disease had developed. With the Ganzfeld technique and balanced light stimulation, deficits of the rod and cone components in the electroretinogram could be differentiated and correlated with different genetic types of the disease entity. Family studies were conducted in patients with dominant retinitis pigmentosa, sex-linked retinitis pigmentosa, a recessive cone-rod degeneration, dominant retinitis pigmentosa with incomplete penetrance and dominant cone degeneration. The combination of the tests contributed to the understanding of underlying defects in retinal degenerations.

Genetic studies of early or atypical cases of retinitis pigmentosa furthered the clarification of various types and allowed a limited prognostic evaluation.

Twin Registry for Eye Examinations

Eye examinations, perinatal medical histories, zygosity determinations, and various anthropometric measurements were completed on over 450 pairs of twins. These studies of identical and nonidentical twins will provide important information regarding the role of inheritance in glaucoma, myopia, and other eye disorders.

Oculo-motor Problems

Electromyography (EMG) is amplifying our understanding of the oculo-motor involvment in brainstem lesions. Findings support the theory that inhibitory and excitatory influences on the oculo-motor nuclei may travel along different pathways. Before electromyography, descriptions of oculo-motor involvement in the brainstem lesions were confined to clinical observations of eye movements.

Scientific data on how the eye focuses, provided through the ultrasonographic technique, have modified a century-old theory by demonstrating that it is not the lens alone, as had previously been supposed, but also the globe that changes shape as the eye shifts focus. Through ultrasonography, it may now be possible, in a matter of minutes, to determine the degree of myopia in a child.

Myopia

Advances have been made in ability to correct errors of refraction, such as myopia. Broadly based epidemiological and genetic studies are under way to assist in solving the problems of refractive anomalies. Theories have been confirmed that myopia, an inherited condition, may be influenced by environmental factors.

Color Vision

Just as our understanding of psychophysical phenomena in the visual process has come from a knowledge of electrical events and their relationship in different areas in the visual system, so may it be stated for studies of the visual pigments. The nature of the pigments, their change during various conditions, and their relationship to other known properties of the eye all contribute to a basic understanding of the psychophysics of vision. The use of various disciplines within the province of ophthalmology is especially marked in this area.

Visual Physiology

Scientists have evidence that the ability to see things in three dimensions exists because objects at different distances from the eye excite different neurons in the brain.

Animal trials are now in progress that will soon be given large-scale human testing. Some scientists now believe that hyaluronic acid, a giant molecule common to many tissues of the body, may hold the key to such eye diseases as retinal detachment, vitreous opacities, and hemorrhages, and to such joint problems as rheumatoid arthritis and osteoarthrosis.

Examination of the physiological responses of the visual system to light has been one of the major interests of physiologists in the past year. The complex responses and interactions of various areas of the visual system is far from being resolved, but an understanding of these complexities is being achieved. Nowhere is this more apparent than in studies of the receptive fields of the retina and higher pathways.

A new method of extracting rhodopsin from the retina was discovered. This may well prove to be a major assist to workers on the chemistry of visual processes.

Drugs

Medrysone, a new synthetic corticosteroid, was shown to be an effective anti-inflammatory agent for the eyes when tested through comparative studies. Useful in the treatment of certain forms of conjunctivitis, it exhibited no propensity to raise the intraocular pressure even in patients known to respond to other steroids with pressure rise, or in patients with glaucoma. Prolonged treatment with Medrysone kept symptoms under control and produced no outward side effects.

Herpes Simplex

The rate of reccurrence of herpes simplex keratitis in man is 25 percent within two years. Patients with more than one attack have a 43 percent chance of having additional episodes within two years. Chronic infection of the conjunctiva and lacrimal gland with herpes simplex virus is now believed to be a probable source of virus for recurrent corneal infection. It was an Institute grantee who just a few years ago discovered the first effective treatment for the herpes virus--IDU-- and later extended his work to testing other improved drugs for the same purpose. This year, evidence that interferon stimulation can cure an acute viral eye infection in rabbits (NIAID project) has strengthened the hope that interferon inducers may also be useful in treating viral infections in man.

Trachoma

Research on an eye ailment transmitted venereally may cause a reevaluation of mass treatment of trachoma, which is a leading cause of blindness in under-developed countries. The presence of the agent of the disease-inclusion conjunctivitis has been confirmed in both the eyes of the children and genital tracts of the mothers. Local treatment with antibiotics can suppress but not eradicate or prevent recurrence, but oral treatment with sulfa drugs usually eliminates both symptoms and the disease agent. Since the causative agent is similar to and perhaps identical with that causing trachoma, investigators believe that trachoma, too, may require treatment with systemic or chemotherapeutic agents rather than the topical drugs now employed.

Fluorescein Angiography

Technical refinements have been accomplished in methods of fluorescein angiography. Its use is becoming increasingly widespread in the investigation of both clinical and research problems. Improvements permit not only wider application of the method but also more detailed morphological and hemodynamic (blood flow) studies, and greater accuracy in interpretation of results.

Retrolental Fibroplasia

At one time retrolental fibroplasia (RLF) was the leading cause of blindness in the United States. Then it was discovered through a study supported by NINDS that the disorder was due to exposing premature infants to oxygen in excess of the usual atmospheric conditions. With this knowledge, the incidence of RLF was dramatically reduced until it was nearly an unknown disease in the U.S. Recently, however, a new problem has arisen leading to a resurgence because of the treatment of the respiratory distress syndrome which may cause the newborn to suffocate. The usual treatment for this syndrome is an increase in the incubator oxygen concentration. Thus the physician faces the difficult task of preventing the infant from suffocating and at the same time preventing RLF and blindness.

Dr Arnall Patz, Wilmer Institute, Johns Hopkins University and Hospital, reported that frequent sampling of arterial blood-oxygen could provide a means of avoiding potentially retinotoxic oxygen levels. Two serious difficulties, the investigator pointed out, are (1) the fact that the precise arterial oxygen levels that cause retinal damage are not known, and (2) few hospitals are equipped to monitor arterial oxygen tensions, for this requires expensive instrumentation and the services of highly skilled pediatricians and specially trained technicians. A standard must be established which will provide sufficient oxygen for metabolism but yet not stimulate retinal vessel proliferation. New tools must be developed which will aid the physician in maintaining this delicate standard in the premature. The approaches to this highly important problem are under evaluation and support is being planned for a series of workshops and for in-depth studies of the problem, then for development and evaluation of the required clinical tools.

Meanwhile, the oxygen treatment appears necessary until relief of the life-destroying respiratory distress syndrome becomes more adequately documented.

Effect of Light on the Retina

A series of electron microscopic studies of rat retinas has served to establish the pathogenetic mechanisms whereby exposure to very bright light (750 footcandles) damages the retina. Scientists have found that the rods and cones have regenerative capability if not too extensively damaged by continuous exposure to light. This regeneration capability is a major step forward in retinal pathophysiology.

Retinal Degeneration

Macular degeneration may result from hereditary disturbances, trauma acquired lesions, lesions secondary to other retinal abnormalities, or senile changes. Treatment is most successful in the acquired secondary type of macular lesions. New study techniques developed at several university hospitals disclose that some of these lesions are due to breaks or leaks in Bruch's membrane. Some of these may be sealed by using a photocoagulator or laser beam. New laboratory clues suggest that a person with a problem of hereditary macular degeneration should avoid prolonged exposure to bright light.

Retinal Detachment

Retinal detachment, a cause of blindness, is a separation of the retina from the underlying structure. Extensive studies relating to the cause as well as improved methods of treatment are under way. A successful innovation of the past year in retinal surgery was the use of inflatable balloons, air, and other products in vitreous surgery. These were used in an attempt to free adhesions so that the vitreous and the retina may be restored to their usual positions. Liquid silicone sometimes has been used successfully in rare cases where the retina has become "glued" in the detached position.

Diabetic Retinopathy

Diabetic retinopathy is a degenerative disorder of the retina which occurs as a complication of diabetes. The incidence of retinopathy in diabetic patients increased from less than one percent in 1930 to over 18 percent today. This increase occurred as insulin and other modern medication has lengthened the life for the diabetic patient. Vascular complications of the disease develop over a period of time and as a result are more common in the older patient.

Institute-supported research is evaluating present treatment and attempting to discover the mechanism of the disorder. Investigators have found a specific and highly significant loss of pericytes in diabetes, regardless of age. Loss of these intramural cells is associated with an increase in ghost cells, shunt vessels,

and the number of microaneurisms (ballooning of small blood vessels). A simple, semi-quantitative method of measuring tear glucose which provides the practicing physician with a new, easy, practical and readily available procedure for screening patients for diabetes, and a rapid, indirect measurement of excess of sugar in the blood, was developed. The effectiveness of currently available treatment, notably photocoagulation, was probed in a series of studies which examined the long-term visual programs for this condition and analyzed the most often used forms of therapy.

A symposium of diabetic retinopathy was held in October at which a number of the controversial views on treatment were discussed, particularly hypophysectomy as opposed to coagulation. It was agreed that rigid controls on procedures should be established. A future conference has been planned to delve deeper into these problems.

Laser Beam

A study of the possible injury to the eye resulting from scleral transmission of laser light was concluded with the evaluation of the extent and type of lesions produced in animal eyes.

Ultrasonography

Although ultrasonic energy has been used for diagnosis for only a few years, it has already proved its worth. It is an aid to diagnosing eye disorders that cannot be examined with ordinary instruments. It carries no radiation hazard, and can be used repeatedly without harm or discomfort to the patient. During the past year, experimental work has been performed in the field of ultrasonography related to breaking the lens material so that it can be successfully aspirated. The technique appears to hold promise but also some risks. So far the principle application of ultrasound has been for diagnosis. It is useful in locating tumors, retinal detachments, and foreign bodies in the eye, when cataracts and corneal scars prevent accurate examination of the eye by ordinary means. Distance within the eye can be measured electronically to within .05mm of tissue thickness.

Optic Nerve and Visual Pathway

New methods of measuring activity of the visual centers of the brain by means of electroencephalography are yielding valuabe data concerning the human visual process. Both the electrically evoked response (EER) and visually evoked response (VER) have proved useful in studying the eye. When two methods of electrical stimulation of the retina were compared, investigstors found that small stimuli moving across the visual fields are more efficient in producing VER responses to light.

Microelectrode recorded data from the visual cortex of animals has indicated that diffuse light stimulation of the retina is less efficient than target movement across the retinal fields. In normal vision, even if objects seen are perfectly still, the eye itself moves by a series of quick flicks and drifts. Dr. Christopher Evans of Middlesex, England, uses stabilized images on the retina to study what happens to the afterimage. More has been learned about the rules of the fragmentation process which occurs when pattern perception breaks down.

Model of the Eye

The development of a more accurate mathematical model of the eye, using high speed computation, opens the door to a better understanding of its optical performance. This has a great potential for the improvement not only of diagnostic and therapeutic instruments but also of optical aids to the visually handicapped.

Mechanical Aids to the Blind

In no other area are mechanical aids more greatly needed nor are the long range possibilities more promising than for the blind. Recent fundamental research has provided extensive data regarding the nature of the coded signals whereby information is transmitted from the retina to the brain. Implanted electrodes have been used extensively in animals and man. A crucial need, however, is for a precisely located array of inert stimulating devices which will provide for long-continued direct contact between an external light-sensitive device and the nervous system. To greatly oversimplify, a blind person might wear or carry a minature television camera which would transmit impulses to the brain which will be translated into vision. The first attempts, of course, will be crude. However, even the detection of rather large differences between light and darkness would be a great improvement over total blindness.

Feeding electronic information directly into the brain or optic nerve at the present time offers some serious problems. These might be temporarily circumvented by using the chest, the abdomen, or the inside of the arm as the sensory receptor. That is, a blind person might learn to use a small device with many tiny "fingers" on or near the skin so the "fingers" could be actuated by a light sensitive device. The patient could learn to interpret the pressure patterns in terms of the objects before him. The ultimate answer, of course, is the direct input of signals into the optic nerve.

The importance of the successful development of such devices is obvious. The difficulties are unusually great but some initial progress is being made though accomplishment is far off.

Television Ophthalmoscopy

Observations of the visible blood vessels and other structures in the fundus of the eye have a great value in studies of cerebral arteriosclerosis and degenerative disorders of the optic nerve and the retina. For such studies to be meaningful, precise methods of evaluating and measuring these vessels must be developed. The use of television scanning devices and advanced television technology presents a promising avenue of research and development. In collaboration with the National Center for Health Services Research and Development of the Health Services and Mental Health Administration, a workable television ophthalmoscope and techniques for its employment are being developed. A contract is now in effect to undertake an analysis of the relative merits and projects costs of specific applications of television ophthalmoscopy.

Ophthalmic Survey of Two Defined Groups in the South Pacific Isles

Institute surveys of two defined goups in the South Pacific Isles provided insight into the ocular status of people unexposed to Western civilization. Marked differences were found in the prevalence of disorders common to our society. Such conditions as hypertension and diabetes mellitus were virtually nonexistent. Even in the older subjects, there was little retinal vascular disease, no elevated determinations of intraocular tension, and almost no significant refractive error. In particular, no myopia was found, which raises the question regarding what portion of this type of refractive error might be due to environmental causes.

Summary

As can be seen from this brief review of recent activities, the causes of blindness are many and research in vision and its disorders involves lengthy, complex study. Achievements take time, but there are many hopeful elements, and a number of great strides in research have been made within the past few years. Most encouraging is the ever-increasing interest of the public in improvement in research

training, betterment of facilities for research, an increase in well-trained investigators to develop the field, and the mounting number of research projects which bring the probability of good sight for all closer to reality.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Regional Medical Programs Service

The Neurological and Sensory Disease Control Program of the Regional Medical Programs Service provides for the development of new instrumentation, methods and techniques, for prevention, early detection and diagnosis, and improved treatment of neurosensory disorders.

The methods used by the Program to control blindness and disorders of vision are the support of studies and applied research, the provision of specialized consultation to officials of State, local, academic, voluntary and related agencies and institutions; the development of public information programs; dissemination of promising research results to professionals; and technical assistance to training and service programs.

Glaucoma

Glaucoma is a disease of particular concern to the Program. Two percent of people over forty years of age are affected by this disease. Early detection, diagnosis and treatment of glaucoma ususally prevent further visual disability.

The Program is supporting a project to computerize tonography. This new instrumentation will make this diagnostic tool available to ophthalmologists who heretofore were excluded from using it because of lack of equipment, time and ability to interpret the tonographic reading.

In addition to the American Academy of Ophthalmology and Otolaryngology, the Academy of University Professors of Ophthalmology has passed a resolution which promotes the inclusion of tonometry as a routine part of a physical evaluation by non-ophthalmic physicians. Other professional groups are being encouraged to adopt similar resolutions.

The curricula of some medical schools have now been altered to include the previously neglected area of teaching tonometry to medical students. As a result, a generation of physicians is emerging which is better prepared to handle the important and voluminous task of glaucoma detection.

Instruments are being evaluated that lend themselves to use by medical students and non-ophthalmologists for glaucoma detection and for office use to aid in the diagnosis of other diseases that affect the eyes.

Pre-School Visual Disorders

Many pre-school visual disorders readily respond to treatment if diagnosed and treated early. This often prevents not only monocular blindness, but also the possibility of total blindness should something happen to the one good eye. The Program is concerned with reducing the disability resulting from pre-school visual disorders. Requests for public information material to impress upon the public the importance of having children's eyes checked before they enter school have been voluminous and are expected to continue. The Program will continue to be on the alert to improve the techniques and methodologies involved in screening for pre-school vision disorders.

Total Eye Care

In addition, the Program recognizes the importance of improving total eye care, as to both availability and quality.

Specific efforts include the evaluation of the use of the ocular fundus photograph for screening and diagnosing eye pathology and preparation for publication of the Proceedings of the International Symposium on the Treatment of Proliferative Diabetic Retinopathy.

An automatic device is being evaluated which has great potential in providing a method to screen as well as treat large numbers of people (especially children) for their refractive errors. These errors, if undetected and neglected, may lead to amblyopia and squint. Program expertise continues to be available to official and voluntary health agencies, professional organizations, institutions of higher learning, and other groups to aid their efforts to establish or improve eye care service programs.

SOCIAL SECURITY ADMINISTRATION

The purpose of the old-age, survivors, and disability insurance program is to pay benefits to insured workers and their families when they have suffered a loss of earnings due to retirement in old age, the death of the insured worker, or a severe disability. As of June 1968, 35,000 individuals for whom blindness was a significant factor in their disability were receiving an estimated $3,700,000 in monthly disability benefits. In addition, their families were receiving an estimated $700,000 monthly. It is not known how many blind persons are receiving monthly benefits as retired workers, dependents of retired workers, or survivors.

Beginning with the enactment in 1954 of the disability freeze provision of the Social Security Act, the special problems of the blind in earning a living have been given particular recognition. The disability freeze protects a worker's future benefit rights, and the benefit rights of his family, under the social security program while he is unable to work because of disability. The 1967 Amendments to the Social Security Act liberalized the definition of blindness for disability freeze purposes. Under the new definition a worker can qualify for the disability freeze based on "industrial blindness" as well as "statutory blindness". The protection is offered to those who become blind even if they are still able to work. For example, a person who experiences a severe reduction in his level of earnings because of blindness can be protected from a comparable reduction in the level of monthly benefits he will receive in the future.

The new definition of blindness also applies for benefit purposes in the case of the blind worker who is age 55 or over. If a worker over 55 becomes "industrially blind" and although not totally disabled, cannot do work requiring abilities comparable to those of his regular occupation, he will be eligible for monthly benefits.

Currently, the Social Security Administration employs 14 totally blind persons in central office positions. On an individual basis, their work performance equals or exceeds that of sighted employees.

SPEECH AND HEARING

Obligations Fiscal Year 1966 to Fiscal Year 1970

Agency and Program	1966	1967	1968	1969	1970
SOCIAL AND REHABILITATION SERVICE:					
Rehabilitation Services Administration:					
Basic support	$10,246,320	$15,665,000	$19,170,000	$24,165,000	$33,385,000
Training and traineeships	3,772,000	4,299,000	4,067,877	4,067,585	4,067,585
Innovation grants	112,000	58,000	50,000	75,000	75,000
Expansion grants	235,000	246,000	315,000	315,000	315,000
Project development	9,000	---	22,000	20,000	20,000
Construction	---	113,000	105,000	100,000	100,000
Subtotal, Rehabilitation Services	14,374,320	20,381,000	23,729,877	28,742,585	37,962,585
Office of Research Demonstrations, and Training:					
Research and demonstrations	365,000	1,754,000	2,578,000	2,444,000	2,485,000
Research and training centers	100,000	175,000	300,000	500,000	500,000
Special foreign currency program	233,000	256,000	212,000	250,000	150,000
Subtotal, Office of Research, Demonstrations, and Training	698,000	2,185,000	3,090,000	3,194,000	3,135,000
Children's Bureau:					
Special project grants	714,966	1,396,312	2,453,791	2,600,000	2,600,000
Subtotal, Social and Rehabilitation Service	15,787,286	23,962,312	29,273,668	34,536,585	43,697,585

SPEECH AND HEARING

Obligations Fiscal Year 1966 to Fiscal Year 1970
(Continued)

Agency and Program	1966	1967	1968	1969	1970
OFFICE OF EDUCATION:					
Education for the handicapped.....	$ 6,554,175	$7,930,465	$9,011,728	$10,189,000	$11,000,000
Elementary and Secondary activities	1,086,341	1,480,000	3,500,000	3,700,000	4,000,000
Research and training.....	471,562	401,172	60,000	40,000	25,000
Libraries and Community Services..	---	11,000	17,700	18,000	18,000
Subtotal, Office of Education....	8,112,078	9,822,637	12,589,428	13,947,000	15,043,000
HEALTH SERVICES AND MENTAL HEALTH ADMINSTRATION:					
Regional Medical Programs Service:	1,344,060	1,644,000	636,000	636,000	636,000
NATIONAL INSTITUTES OF HEALTH:					
National Institute of Neurological Disease and Stroke:	6,533,000	7,929,000	8,443,000	9,000,000	9,061,000
SPECIAL INSTITUTIONS:					
National Technical Institute for the Deaf.....	68,000	314,000	421,000	2,298,000	18,198,000
National Advisory Committee on Education of the Deaf	---	100,000	85,000	100,000	100,000
Model Secondary School for the Deaf	---	---	22,000	433,000	1,456,000
Subtotal, Office of the Secretary....	68,000	414,000	528,000	2,831,000	19,754,000
TOTAL, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE.....	31,844,424	43,771,949	51,470,096	60,950,585	88,191,585

PROGRAMS IN HEARING, SPEECH, AND LANGUAGE

PREFACE

It is anticipated that the facts and figures on communication disorders of the coming United States National Health Survey in 1969-1971 may differ sharply from those of the 1959-1961 Survey when it was disclosed that 8,000,000 Americans had hearing, speech, and language disabilitits. Hearing disorders then accounted for one-fourth of all impairments involving approximately 6,000,000 persons of whom 250,000 were profoundly or nearly profoundly deaf. The 1969-1971 figure is expected to be far higher due to the rubella epidemics of 1964 and 1965 when many babies were born with impaired hearing. It is certain also that speech problems which were the main handicap of 1,500,000 persons at the time of the last National Health Survey, afflict many more now due to rubella-induced aphasia and mental retardation which relate to speech disability as do cleft palate, stuttering, laryngectomy, and cerebral palsy.

On the brighter side, advances in education, medicine, and rehabilitation have increased significantly the number of communication-handicapped persons who have been aided in becoming self-sustaining and contributive members of society. Research has been particularly beneficial in devising and demonstrating special techniques that are helping more hearing, speech, and language disabled persons to overcome their handicaps completely or partially. Innovative rehabilitation techniques, new medical and surgical processes, improved prostheses, gains in language and speech therapy and other communication aids are restoring the hearing and speech of many persons and ameliorating the handicaps of others.

Challenging opportunities to mount more effective programs to meet the needs of persons with communicative disorders have been made possible through legislative authorizations and increased financial support. The Social and Rehabilitation Service, the Public Health Service, and the Office of Education are responding to this stimulation with actions of which the most outstanding are outlined here.

The Social and Rehabilitation Service continues to expand its program of training and research in speech pathology, audiology, and rehabilitation of deaf persons. Vocational training for deaf people in existing community facilities has made an auspicious start. Interpreting is providing more and better service and training outlets for deaf individuals. Newly developed training techniques are equipping severly handicapped deaf persons with work skills. The recently authorized National Technical Institute for the Deaf is now in limited early operation with a rapidly expanding program in prospect. Planning for an authorized Model Secondary School for the Deaf has been completed and the program will soon be in progress. Short-term training courses related to the rehabilitation of the adult aphasic have yielded valuable information. Approximately 1,800 former Rehabilitation Services Administration trainees in the fields of speech pathology and audiology are employed in rehabilitation settings which provide services to adults with communicative disorders.

The Children's Bureau continues to stimulate through its grants program research and demonstration projects and training programs, the development, improvement and expansion of programs in State health departments and crippled children's agencies for children with speech, hearing, and language disorders. Speech and hearing services are a basic requirement in 58 special projects for comprehensive health services for children and youth funded by the Children's Bureau. Speech services to mentally retarded children in the Iowa Crippled Children's Division are a continuing project.

The Office of Education has expanded significantly its activities related to improving and enlarging educational opportunities for hearing, speech, and language handicapped children. Training grants awarded to colleges and universities are steadily increasing the number of professionals trained to work with communication disabled children. Representatives of 22 colleges and universities attended the third conference for Program Development Grant Awardees in the summer of 1968 to discuss the implications of funding for the development of training programs. An expanding program of research and demonstration projects is determining the effectiveness of special education methods. Media Services and Captioned Films are expanding services to deaf persons through multiple distribution facilities and the improvement of techniques for captioning films. Also the expansion of visual aid services for deaf persons authorized by Public Law 85-905 is being continued. Four Regional Media Centers for the Deaf conduct intensive summer institutes on educational technology. A principal gain is the completion of a project to supply basic projection equipment to all classes for the deaf.

The Public Health Service neurological and sensory disease control program continues its activities in developing and expanding community service programs for persons with communication disorders. The program continues to make available its expertise to stimulate and aid in the implementation of long term and continuing education training programs in speech pathology and audiology for persons who plan to serve in medical environments. Studies are continuing on effective use of hearing aids, audiometric techniques to determine hearing loss in infants and mentally impaired persons and on noise control.

The National Institute of Neurological Diseases and Stroke has further expanded its comprehensive program to promote understanding of the fundamental nature of human communication and its disorders. The major emphasis continues to be training of urgently needed personnel to conduct research in this field. Significant research progress has been made in ear transplants, surgical techniques for relieving Menniere's symptoms, use of x-ray in the diagnosis of inner-ear hearing loss, the development of a better artificial larynx, and pre-school screening for rubella damage.

The Office of the Secretary continues to administer programs that promote the education of deaf persons. The National Advisory Committee on Education of the Deaf makes recommendations to the Secretary concerning the carrying out of existing programs and the development of new or modified programs for the education of the deaf. The Office of the Secretary provides support for the National Technical Institute for the Deaf. A Model Secondary School for the Deaf authorized by Public Law 89-694 is being planned.

SOCIAL AND REHABILITATION SERVICE

REHABILITATION SERVICES ADMINISTRATION

SUMMARY OF PROGRAMS FOR THE DEAF, FOR THE HARD OF HEARING, AND FOR THE SPEECH IMPAIRED

Broader legislative authorizations of the Vocational Rehabilitation Act, including amendments through 1968, and increased funding over the years together have provided means for important advances in the complex problems of helping men and women with communicative disorders to lead increasingly productive lives. These pages will highlight a number of significant developments that have their main origins in this authorizing legislation and the implementing appropriation acts.

A word of caution is necessary in order to avoid any suggestion that we have crested the challenge, that it is down hill the rest of the way. As a matter of fact, we have scarcely begun. If the extent of progress recorded herein tends to impart a glow of accomplishment, it must be equated to the practical void in effective services that existed just a few short years ago.

THE PROBLEM IN GENERAL

Americans who are vocationally handicapped by varying degrees and kinds of communication disorders exceed 8,000,000 in number. Some have disorders of the ears, the normal channels for receiving verbal messages. Some have defects in the vocal mechanisms, the main means for sending verbal messages. Some have disorders of the central nervous system which interfere with receiving and sending even though the ears and vocal apparatus are whole. Some have peripheral involvements that curb free verbalization. Some have combinations of causes.

The complexity and variety of the causes frequently obscure the fact that speech and hearing are variables that fluctuate with physical, mental and emotional conditions. Normal ears, normal mentality, normal vocal mechanisms and so on should result in normal hearing and normal speech. One abnormality or more results in abnormal communication. The person permanently affected faces formidable barriers. Fortunately, the condition for many is transitory due to the wonders of medicine and related disciplines. These are not among the above-named 8,000,000 whose disabilities are constant, who continuously search for ways to reduce the handicap of communication limitation.

Vocational rehabilitation workers share with teachers, audiologists, speech pathologists, medical workers, and others the responsibility to create, extend and improve knowledge and resources by which the communicatively handicapped can attain adjustments commensurate with their mental and residual physical capacities.

THE DEAF

Our 250,000 deaf people have very complex problems. Many of them are without useful speech despite years of training. Many have limited language skills. They receive messages principally through their eyes. They send messages by combinations of signs, gestures, speech, and writing. Most of them have normal strength, mobility and intelligence. They strive for achievement within the limitation society imposes in the face of their inadequate verbal communication. This is the handicapping base of their disability. It is primarily psycho-social. It manifests itself in many ways: underinvolvement in the main stream of community life; limited sharing with fellowmen; lack of acceptance among neighbors, employers, and fellow employees; severe underemployment. It seldom yields at all to medical intervention such as drugs, surgery or prosthesis. It does yield in approximate ratio to their availability in quality and depth, to training and adjust-

ment services that stem from comprehensive, expert diagnosis that may involve the disciplines of psychology, audiology, medicine, and education and to public relations activities that stress the deaf person's strengths.

Two deep-seated problem areas for vocational rehabilitation exist with respect to deaf people. First, the most basic and achievable need of the deaf person, specifically skill in reading and writing, is insufficiently emphasized in childhood training. Formal training has generally so heavily emphasized the development of speech skills in the deaf child that speech has erroneously assumed the position of being the equivalent of rather than a vehicle for language. To put it another way, teachers of the deaf have focused disproportionate time and energy upon an outlet (speech) for language rather than power in language itself. Language and speech are referred to interchangeably, confusing professional and lay workers alike. Hence, the handicapping aspects of deafness are often intensified by a needless wall of language deficiency.

Second, an incorrect image of the deaf person's potential in verbal communication skills stems from this heavy emphasis on speech and frequently unrealistic publicity that generates from it. These together create everywhere an expectancy in oral communication performance which very few deaf people can fulfill. Employers and others are, thus, not conditioned to look beyond the poor speech for the hidden, often rich, human resources.

The Rehabilitation Services Administration is attacking the roots of under-employment: (1) By encouraging and assisting in the establishment of rehabilitation centers to diagnose and train deaf people; (2) by extending its training operations (a) to reduce the communication barrier facing deaf people by developing standards and new procedures for speech conservation and instruction in sign language, (b) to qualify more professional workers in psychology, social work, vocational rehabilitation, speech therapy and audiology to work with the deaf, (c) to develop better understanding of the potentials of deaf people among vocational rehabilitation workers and others, including employers and community leaders, (d) to improve the understanding among professional and voluntary workers of how they can assist the State vocational rehabilitation agencies in serving the deaf, and (e) to help deaf people and their co-workers develop more productive concepts of community inter-relationships; (3) by encouraging researchers to study and resolve the many economic, social, and psychological problems associated with deafness.

THE HARD OF HEARING

The several million hard of hearing pose quite different problems from the deaf, The two groups cannot be treated as one. Whereas the deaf receive verbal communication almost solely through their eyes, the hard of hearing rely principally upon their ears, even though these are defective. The hard of hearing generally have near-normal speech and language. Their disability often had a late onset as opposed to the early affliction of the deaf. Partial hearing impairment is less a psycho-social than a medical problem and often yields significantly and quickly to medical intervention and prosthesis with speedy return to an old job or a new one.

It is known that the number of individuals with partial hearing loss is far greater than those who have lost their hearing completely. How much greater is unknown. More accurate estimates are needed before the full magnitude and vocational significance of this problem can be assessed. Deteriorating job performance, eventual loss of job, and gradual withdrawal from family and society are three of the more obvious results of gradual and progressive hearing loss. Too few of these people request help from their State divisions of vocational rehabilitation.

The problems of the hard of hearing are many; this the State vocational rehabilitation counselor knows. How best to solve them, no one yet knows. Much remains to be accomplished in helping the hard of hearing person retain the skills he had before the onset of his handicap. Better diagnostic methods need to be developed to permit earlier prediction or identification of hearing loss. Such methods would permit more successful fitting of hearing aids. Abilities which permit a person to speechread (lipread) successfully are, at present, unidentified. And yet, accurate prediction of such ability would have profound effects on the rehabilitation management of hard of hearing and deaf children as well as adults.

Further attention should also be given to ways of helping the person with progressive hearing loss retain his speech intelligibility while he is losing his major sensory pathway for judging the accuracy of his speech production.

Basic factors in meeting the vocational rehabilitation needs of our hard of hearing are people to provide the highly specialized services that they need and places to do it. The Rehabilitation Services Administration is aggressively involved in helping the States to achieve these fundamental resources.

THE SPEECH IMPAIRED

The speech impaired, including the language impaired, necessarily include many of the deaf and the hard of hearing because normal speech production depends to a great extent upon self-monitoring which in turn depends largely upon the speaker's hearing. We hear ourselves and correct as we go along. It is not the same for the hearing disabled. However, the speech impaired also number millions whose abnormal or absent output stems from organic disorders other than hearing.

The special needs of stroke victims, particularly those with language problems due to aphasia, have received nation-wide attention. Little is known about the actual incidence of the disability, particularly in its more subtle and partial forms. Also, diagnostic techniques to determine the most appropriate treatment problem and the outlook for recovery remain crude and inexact. Unavailability of crucial specialized services within the aphasic's home community, particularly language therapy, poses insurmountable problems for most aphasics living outside large metropolitan areas. New methods of extending services to those people and/or training other family members to assume the task must receive high priority. Programmed teaching machines represent one partial solution to this problem, but self-teaching programs must be developed and evaluated. The spotlight of attention given to this affliction merely highlights the problems which are as yet unsolved.

Equal attention has recently been given to cancer victims. In great need of rehabilitation are those who have lost their larynx because of cancer, thus, their ability to produce voice. Such a sudden handicap usually results in loss of job and loss of family responsibility. Training procedures now exist to help the laryngectomees learn to use esophageal speech, but too often those methods fail. Many individuals, therefore, go for the rest of their lives without the ability to speak. Reasons for this failure must be found. Better techniques for identifying those people who will be able to learn esophageal speech--and those who will not--are needed. Programmed learning methods also need to be considered as possible retraining procedures. Pre-surgery personality factors deserve investigation as probable reasons for post-surgery response to rehabilitation efforts.

Stuttering is another wide-spread speech handicap which deserves greater attention. Over 1,000,000 people in the United States suffer from this affliction. The problems of the adult stutterer are particularly damaging and cause the individual to lead a restricted and sterile life. This is true primarily because the speech defect is variable; the stutterer rarely knows when he begins to speak whether he will talk normally or will produce a spasm of muscular tension and an explosion

of distorted words. Most stutterers, therefore, remain constantly "on guard" and resort to bizarre tricks and body motions (which themselves attract attention) to avoid stuttering. Some stutterers even pose as deaf to avoid having to speak. Consequently, many stutterers of superior ability accept jobs which requires little or no talking and remain at a level of employment far below their aspirations and capacities. Underemployment, self-imposed, may sometimes be the stutterer's greatest handicap.

Usually, these problems are most resistant to change, even though most of the stutterer's speech problem has been learned and can be unlearned. The reasons for the tenacity of stuttering are unknown. What is particularly puzzling is the fact that for a few persons, long-time stuttering can be eliminated with relative ease. Clinical observation has indicated that there are different types of stutterers. We need to find ways of identifying each kind and the critical factors which determine their response to rehabilitation. Also, better ways of helping stutterers achieve and retain more normal speech must be found. To do this, better methods of judging the effectiveness of speech therapy are needed. The goal is doubly worthwhile since, if the stutterer's speech can be improved, most of the associated psychosocial and vocational problems which his stuttering creates will also be eliminated.

The State vocational rehabilitation agencies find that a major problem is the lack of guidelines that enable staff to relate speech impairment to occupational handicap. Moreover, standards of casework performance and progress in therapy are not so closely defined nor apparent in speech rehabilitation as in other areas. The resources that serve the hard of hearing can be effective for the speech handicapped if qualified staff are available. The Rehabilitation Services Administration's drive for more hearing and speech centers relates to speech rehabilitation, too. Additionally, special emphasis is being given (1) to the development of authoritative literature on the handicapping aspects of speech disorders and their treatment and (2) to the fostering of voluntary work for the speech impaired throughout the national community on a level equal to that for the hearing impaired. The development of casework standards as guidelines for vocational rehabilitation counselors serving speech impaired clients has high priority.

NUMBERS SERVED BY STATE VOCATIONAL REHABILITATION AGENCIES

The aim of the public vocational rehabilitation program is the preparation of the occupationally handicapped disabled person for suitable employment. The State vocational rehabilitation agencies actually determine eligibility and provide services using grant-in-aid funds administered by the Rehabilitation Services Administration.

All of the resources of the public vocational rehabilitation services are directed toward the occupational adjustment of the person whose disability is a vocational handicap. The media for attaining this end with each client are the case services that are patterned to individual needs. The research, training, and facility development activities of the Rehabilitation Services Administration and the State agencies are carried on for the purpose of strengthening case service techniques, developing new ones, improving the capacities of the case worker and the personnel upon whom he draws, and developing resources for better diagnostic, evaluation, training and restoration services. The dual aim of sharp increases in the quality and quantity of services and persons served permeates the whole program.

The extent to which the State agencies rehabilitated the deaf, the hard of hearing, and the speech impaired in the fiscal year 1966 and the numbers estimated to be rehabilitated in fiscal 1967 through 1970 are shown in the following table:

NUMBER OF REHABILITANTS OF THE STATE VOCATIONAL REHABILITATION AGENCIES WITH SPEECH AND HEARING IMPAIRMENTS, FISCAL YEARS ENDING JUNE 30-1965-70

	Estimated and actual Number of rehabilitants in fiscal year 1/				
	1966	1967	1968	1969	1970
All rehabilitants	154,279	173,594	207,918	230,000	265,000
Number of rehabilitants with major disability of speech or hearing.....	10,640	12,200	14,200	15,200	17,300
Deaf.....	2,731	4,900	5,400	6,600	8,300
Hard of Hearing.....	6,284	5,300	6,700	6,400	6,600
Speech.....	1,625	2,000	2,100	2,200	2,400

The effectiveness of casework rests in appreciable measure upon the joint planning of the counselor and the client. Clients who are hard of hearing or who have serious speech problems of other than hearing origin tax even the most skilled caseworker. Even so, counselor and client do have a line of verbal communication which encourages rapport. They can develop a good rehabilitation plan together. The profoundly deaf client, however, especially that large majority who have serious language deficiencies, are not able to communicate by normal means. This is the crux. There must be communication between counselor and client for effective casework.

The State agencies have recognized this basic factor and are moving to rectify it as qualified workers become available or through special training or current counselors. Forty States2/ now have or are actively recruiting staff who may be classified as expert vocational rehabilitation workers for the deaf since

1/ Data are actual for fiscal year 1966 and totals of all rehabilitants for 1967-68. Estimates are used for other data for fiscal years 1967-1970.

2/ Alabama, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Guam, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

they are trained as professional counselors and are also able to communicate by sign language with deaf clients. Several of the States are searching for and others have already secured additional qualified counselors because their caseloads of deaf clients have rapidly grown beyond the capacities of the special staff as their deaf citizens have become aware that the vocational rehabilitation agency is now able to work more effectively with them. The Rehabilitation Services Administration urges that each State have at least one highly skilled vocational rehabilitation counselor for the deaf and preferably that there be one in each metropolitan area.

A continuing problem in the area of the hard of hearing through the years has been developing and maintaining adequate channels of referral of hard of hearing persons needing vocational rehabilitation services. Major efforts have focused on encouraging the professional, the medical, and the voluntary worker to refer persons with hearing impairment to State vocational rehabilitation agencies for evaluation and consideration of possible services. The results have been disappointing as witnessed by the relatively small number of hard of hearing clients rehabilitated each year as compared to the many thousands needing or able to benefit from our services. The persistence of this problem has encouraged us to look to other channels by which more persons may become knowledgeable of their entitlements under the vocational rehabilitation service. Accordingly, we have now established formal working relationships with the National Hearing Aid Society, a principal feature of which encourages referrals by hearing aid dealers of persons coming to their attention who may be eligible for the services of our State agencies. If this move is as effective as we expect, the number of hard of hearing rehabilitants each year should increase rapidly into the tens of thousands.

SERVICE CENTERS

Most of the many hearing and speech centers that have been established in the past twenty years have come into being in universities as training and research facilities, in large hospitals as service units, and in metropolitan areas. They fill vital rehabilitation needs in diagnosis, in evaluation, in training in lipreading, speech, and listening, and in selection of hearing aids. We may have as many as 900 of widely varying levels of effectiveness and uneven distribution. Many thousands of people with communication problems are just too far away from even the least of these service centers and even further from the more technical assistance that they may need. For example, a hard of hearing person who is 50 miles away from lipreading instruction, auditory training, hearing aid evaluation, is not likely to be able to travel this distance several times per week for instruction and service. The Rehabilitation Services Administration is attacking this problem directly through encouragement of projects that bring the basic hearing and speech services that the majority of these disabled people need into the local community at a cost that it can afford to maintain, leaving for the more comprehensive center the intricate services needed by more difficult hearing or speech cases.

In this respect the State vocational rehabilitation agencies are making important contributions to the availability of hearing and speech evaluation services through grants to extend and improve vocational rehabilitation services for the communicatively impaired. In 1968 alone, at least eighteen State divisions of vocational rehabilitation established facilities or special programs to improve services to the communicatively impaired. Authorizations under Sections 2, 3, and 4(a)(2)(A) were all used in the creation of 29 projects at a total cost of over one and one-half million dollars.

The practical needs of deaf people are little related to speech and hearing centers. Almost all of them have had several years of intensive, expert training in speech and use of residual sound perception in their special schools. The deaf need the same vocational rehabilitation services as other clients, specifically diagnosis, evaluation, training, counseling, and placement, but in language that they understand. There are very few persons in rehabilitation centers or vocational schools who can communicate with deaf people to the point where a good learning situation may be said to exist. Consequently, the Rehabilitation Services Administration has had to concentrate on developing centers where there are expert professional workers for the deaf. Usually, these have proven to be the residential schools for the deaf. Diagnostic, evaluation, prevocational, and adjustment centers have been established or are planned at the State schools for the deaf in twenty-four[1] States, an increase of eight over the previous year.

Encouraging by-products of this activity is the interest in other States and the growing efforts by established rehabilitation centers to qualify themselves to serve the deaf. Community service centers for deaf people that are relieving residential schools for the deaf of counseling responsibility of deaf adults are located in three metropolitan areas and being planned in others.

Justification - The most pervasive, persistent yet reducible problem of deaf people is their underemployment. It has always been so. The normal strength, mobility, and intelligence of deaf people do not help them find satisfactory employment, that is jobs that are appropriately challenging. Much manpower is wasted. Underemployment is increasing as job demands become more complex and preparation therefore less available.

The experience of the Rehabilitation Services Administration emphasizes that a principal cause of underemployment is inadequate training. Appropriate resources for deaf people of employable age simply do not exist. By appropriate resources we mean training situations which fully compensate for the handicapping aspects of the disability, that is by providing for the special communication needs of deaf people so that transfer of ideas, exchange of thinking really takes place at more than a superficial, fragmentary level.

It is widely recognized that formal training for most deaf people terminates at the elementary level or slightly above. The average age of departure of the mass of deaf students from this level of training is about 18 years. Moreover, recent reports suggest the average age of departure is dropping. This is disastrous, except for the small percentage who qualify for and go on to secondary and higher educational opportunities, because there is no permanent school or other fixed training situation which the young deaf person may consider and toward which he may aspire. There is an utter vacuum of opportunity aside from an occasional local situation, such as on-the-job training or a receptive

1/ Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Louisiana, Mississippi, Missouri, Nebraska, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Vermont, and Wisconsin.

vocational school for normally hearing people, which may rise and fall in accordance with attending circumstances. Moreover, apprenticeships are seldom available to deaf people for age or other reasons. None of these latter provides the rich depth in training experience by which a permanent institution with its highly skilled staff reaches and motivates the deaf person to be somebody.

The tragedy of these failures of our society to meet its responsibilities is that a large portion of deaf people can benefit very much from more training. However, when their formal schooling is terminated, there is no place for them to go for more at the time or when they are motivated to want more training.

Of continuing concern to the Rehabilitation Services Administration is the decline in the vocational training of deaf clients. The accelerating inroads of automation seem to have sharply reduced the number of entry level jobs by which the deaf have gained their footholds in industry. Consequently, more vocational training has been necessary for deaf people who frequently are being pushed aside by overcrowded vocational schools. This intensifies the training void for deaf people that exists between the special school system which generally terminates at 9th grade or less and Gallaudet College, a void which has nurtured and partially perpetuated their serious underemployment.

Accomplishments - The establishment of the National Technical Institute for the Deaf authorized by Public Law 89-36 is a very important step toward reducing the underemployment of deaf people. It will contribute vital new concepts in the training of deaf people and through its special job development and placement program open employment that has not had many or even any deaf practitioners. The State vocational rehabilitation agencies will naturally be directly involved with every student.

The most promising accomplishments for that large fraction of deaf people who are the most severely handicapped because of limited or no formal education, emotional problems, mental deficiency, or other difficult-to-manage circumstances, have been the successful transfer to State operations of three pioneering Rehabilitation Services Administration conceived and sponsored research projects. These are glowing examples of research results being incorporated in regular operations.

At long last regional vocational schools for deaf people are a reality. The Delgado Institute in New Orleans is the site of the first. Two more are developing in the Northwest and upper Midwest.

The RSA project at Lapeer (Michigan) State Home and Training School to demonstrate rehabilitation of the hospitalized deaf-retarded has been made a part of regular State operations. It is essentially a training operation to make retarded deaf individuals more effective, varying from greater individual contribution to in-institutional life to discharge to independent living of those who have been patients because of improper diagnosis. It is being developed as an innovation project for adoption in other States. It has unusual economic significance in view of the larger ratio of deaf persons in institutions for the mentally retarded. It is important that this project be replicated in all States.

The State of New York has absorbed the RSA supported demonstration mental health project for the deaf in the New York State Psychiatric Institute. It is expected that other large population States will emulate this project experience as mental health workers who are able to communicate with the deaf (the crux of the project) become available.

REHABILITATION SERVICES ADMINISTRATION TRAINING IN GRANTS IN SPEECH AND HEARING (SPEECH PATHOLOGY AND AUDIOLOGY AND REHABILITATION OF THE DEAF)

Training and Traineeships	Fiscal Year		
	1968	1969 (Est)	1970 (Est)
SPA: Total	$3,330,292	$3,330,000	$3,330,000
Long-Term	3,267,000	3,267,000	3,267,000
Short-Term	63,292	63,000	63,000
Deaf: Total	737,585	737,585	737,585
Long-Term	551,000	551,000	551,000
Short-Term	186,585	186,585	186,585
Total	$4,067,877	$4,067,585	$4,067,585

Accomplishments--Some progress is being made in the effort to alleviate the shortages of qualified personnel in the diagnosis and treatment of individuals with communicative disorders. Serious shortages, however, continue to exist Since Rehabilitation Services Administration support of graduate training in the field began in 1958, the number of colleges and universities with teaching grants (to strengthen their instructional programs) has grown from seven to 79 in 1969, and the number of traineeships has increased from 23 to an estimated 678 in 1969. About 2,100 Rehabilitation Services Administration trainees have completed their graduate study in speech pathology and audiology; of this number, over 1,800 are employed in rehabilitation settings which provide services to adults with communicative disorders.

The number of speech pathologists and audiologists who have met the requirements for the certificate of clinical competence established by the American Speech and Hearing Association has increased in the past few years, from about 1,000 in 1958 to over 5,600 in 1969.

Of major importance in rehabilitation is skilled personnel to provide services to laryngectomees, including the teaching of esophageal speech. Less than 500 are currently considered qualified for such service in the post-laryngectomy period, but short-term training courses supported by Rehabilitation Services Administration are adding to this number each year.

Another highly significant area in rehabilitation in communicative disorders is aphasia. A conservative estimate of the number of trained speech therapists who are providing diagnostic and treatment services on a full-time basis to aphasics is 250. In addition, a number of speech clinicians, some with limited training and skills in this difficult area, are providing minimal services. It is important that every speech clinician receive specialized training in working with both the aphasic and the laryngectomee. Such competence is important to every clinician working in a rehabilitation center, a community hospital, private practice or in any of the work environments employing speech pathologists.

Needs - Precise figures of the number of speech pathologists and audiologists now employed are lacking. The membership of the American Speech and Hearing Association, the professional organization in the field, is now over 12,000. There are about 5,000 more working in the field who are not members. It is estimated that about 25,000 clinicians are required to provide the necessary services to those in the United States who have defective speech or hearing that is serious enough to handicap them in their social relations or vocational adjustment. The growing population requires many more to provide services than can be rendered by the 11,600 active professional personnel and the 1,000 new graduates each year.

In 1969 the number of clinicians estimated as needed for replacement or to fill new positions is 2,750. About 1,660 are estimated as enrolled in master's or doctoral programs. Of these, about 650 are receiving Rehabilitation Services Administration traineeships. About 1,355 are expected to graduate in 1969.

New health, educational and welfare programs have recently increased the demand for a larger supply of personnel. Operation Head Start, the Job Corps, the heart disease, cancer and stroke programs and others have materially added to the patient load requiring speech and hearing services. Other factors, such as casualties in the Vietnam war and highway accidents, have increased traumatic brain injuries with resultant aphasias and the need for more qualified personnel for rehabilitation services.

In rehabilitation of the deaf, trained personnel are in short supply. Special skills are required to work with this group of people who have been severely handicapped by their isolation resulting from problems of communication. Skills in manual communication are most important in working with deaf people who have not mastered the art of speech reading.

By the end of 1969 eight graduate training programs offering specialized preparation for work with totally deaf persons are expected to be in operation, so that speech pathologists, audiologists, social workers, rehabilitation counselors, psychologists, physicians, clergymen and others who work with the deaf can secure special training. About 72 students are expected to receive Rehabilitation Services Administration traineeships for master's or doctoral study.

The needs are still very great and largely unmet. State vocational rehabilitation agencies need more counselors with adequate preparation for serving deaf people. Only 35 of the 90 agencies now have even one rehabilitation counselor with special competence in serving deaf persons. Only eight State agencies employ more than one such specialized counselor.

In addition, counselors are needed in residential schools for the deaf, in public employment services, in rehabilitation centers in vocational and technical schools and in mental hospitals and schools for the retarded.

Skilled audiologists, too, are needed in the schools for the deaf to assist in assessing the level of residual hearing and ways in which it can be utilized in enabling deaf persons to become employed and live independent lives.

From a quantitative standpoint, it is estimated that in 1969, 230 counselors and other personnel will be needed to fill positions in expanding programs of services of deaf persons; in 1970, at least 275 will be needed; and by 1973 about 500 a year will be required for replacements or to fill new positions.

Although some university rehabilitation counselor education programs arrange for field experience for selected students in agencies serving deaf persons, most of them have great difficulty in locating facilities that can provide adequately supervised learning experiences for their students.

SOCIAL AND REHABILITATION SERVICE

OFFICE OF RESEARCH, DEMONSTRATIONS, AND TRAINING

SPEECH AND HEARING

(thousands)	1966	1967	1968	1969	1970
Rehabilitation research and demonstrations	$ 365	$ 1,754	$2,578	$2,444	$2,485
Research and Training Centers	100	175	300	500	500
Special Foreign Currency Program	233	256	212	250	150

Research and Demonstrations

Speech, Hearing, and Language Disorders

Persons with speech, hearing, and language problems comprise one of the largest disability groups in the country. Since they are not immediately apparent to the observer nor as dramatically handicapping as problems of blindness and deafness, the vocational ramifications of speech, hearing, and language problems are often overlooked. While continued research is needed to provide accurate statements regarding the extent of the effect on vocational achievement of the varying types of speech, hearing, or language disorders, sufficient data is available to indicate that this relatively large portion of the handicapped population presents a significant challenge to those concerned with vocational rehabilitation. Basic rehabilitative research is needed in the physical and psychological correlates of the various disorders along with basic clinical procedures for the modification of language and speech behavior leading to vocational rehabilitation. Goals for this group include the development of test instruments to assess the speech, hearing, and language behavior so as to facilitate rehabilitation oriented therapeutic goals.

Projects with both the professional organization and the service organization are under way to study man-power needs and to stimulate the recruitment of students in speech pathology and audiology training programs. The development and utilization of programmed materials for clinical rehabilitation use of speech and hearing handicapped persons and development of auditory perception tests to assist in the diagnosis of language disorders by the rehabilitation team are on-going projects. Several projects were undertaken to stimulate the evaluation and development of behavior therapy techniques for the clinical team management of the various speech and language disorders. Behavior therapy projects with stutterers have been completed with results to be soon published for purposes of utilization. A conference on aphasia will soon be conducted, focusing on the communicative rehabilitation needs and services for aphasics.

Major emphasis will be placed on the continued development of clinical procedures to assist the victim of stroke (aphasic patients), the stutterer, and the laryngectomized (cancer) person especially as projects relate to the social adjustment of the individual as he returns to work and family. Projects concerned with the rehabilitation of the hard-of-hearing will be encouraged. Projects concerned with how the various speech, hearing, and language disorders affect vocational potential need to be stimulated.

Research and Demonstrations

Deafness

Problem areas for members of the deaf community have been found to include (1) basic language disorders underlying the communication handicap, (2) social and cultural deprivation, and (3) a lack of awareness of the vocational opportunities which do exist. Our goals include the stimulation of projects concerned with basic rehabilitative procedures in language, with community efforts on behalf of the deaf, and with the expansion of vocational opportunities.

Within the past year, projects have been initiated to expand vocational and technical education opportunities for deaf persons at the post-secondary education level. There are projects in operation concerned with the development of mechanical aids to assist the teaching of language to the deaf. Several projects were begun which deal with the integration of deaf persons into the hearing community; projects concerned with providing mental health services; and projects involved in opening new job opportunities for the under-employed deaf. There is continued support of a Council of Organizations Serving the Deaf, which has as its goals the coordination of rehabilitative services to the deaf and the dissemination of information concerning deafness, problems of deafness, and suggested solutions to these problems. One of the most dramatic projects is that of the development of a theatre for the deaf through the Eugene O'Neill Theater Foundation. During the past year, the first International Seminar on research on deafness was held. A pilot project is presently under way which involves the planning and sampling for a major national census of the deaf.

A major thrust will be projects focusing on social interactivities of the deaf in hearing settings. Continued emphasis will be placed on the assessment of the potential of multi-purpose rehabilitation settings to serve the deaf community. A further emphasis will be placed demonstrating the use of counselor aids in providing service to deaf welfare recipients.

REHABILITATION RESEARCH AND TRAINING CENTERS
SPEECH AND HEARING ACTIVITIES

1966	1967	1968	1969	1970
$100,000	$175,000	$300,000	$500,000	$500,000

The New York University Rehabilitation Research and Training Center in Deafness provides a continuing framework for research and training in the problems of communication as related to the disabilities associated with the totally deaf. This Center's budget for FY 1969 is $250,000. Also, it is anticipated that the eighteen other Research and Training Centers (12 Medical, 3 Vocational Rehabilitation, and 3 Mental Retardation) will conduct research and training amounting to $250,000 in the evaluation and diagnosis, treatment, counseling, training, and placement of individuals with a wide range of speech and hearing disabilities in addition to their major rehabilitation specialties.

In all, there are 31 speech and hearing-related research projects being conducted by the Centers in such areas as technological sensory aids for the deaf, evaluation of speech intelligibility of stroke patients, and the assessment of treatment processes for aphasic children.

In the area of training, the Research and Training Centers during FY 1969 will provide 43 short-term courses in speech and hearing to approximately 4,000 professionals and sub-professionals in the rehabilitation-related disciplines. Examples of such training include a course in speech pathophysiology for medical residents, interns, and graduate students; a clinical practicum for speech pathologists in a rehabilitation center; and a course in communication disorders for graduate nursing students, rehabilitation counselors, and social workers.

In FY 1969, 44 Speech Pathologists and Audiologists are employed by the nineteen Research and Training Centers, giving 1325 man-hours per week to research, training, and service programs.

SPECIAL FOREIGN CURRENCY PROGRAM

1966	1967	1968	1969	1970
$233,000	$256,000	$212,000	$250,000	$150,000

Several projects on speech and hearing are included in the international program dealing with methods of detecting hearing defects in young infants to methods of rehabilitating and providing vocational training for adolescents and adults. Because of the heavy emphasis on this area in the past, the support in this field will be redirected in 1969 and 1970, but will include several new projects in countries where none are now supported, for example, Tunisia and Ceylon.

SOCIAL AND REHABILITATION SERVICE
CHILDREN'S BUREAU

STATEMENT DESCRIBING CHILDREN'S BUREAU
PROGRAM IN SPEECH AND HEARING, 1968

	Actual Obligations			Estimated	
	1966	1967	1968	1969	1970
Special Project Grants	$714,966	1,396,312	2,453,791	$2,600,000	2,600,000

(Excludes obligations for speech and hearing services under state formula grants.)

Objectives

The objectives of the Children's Bureau program for children with hearing, speech and language disorders are to:

1. Extend to early childhood and infancy programs for identification of children with communicative disorders of hearing, speech and language.

2. Increase the number and improve the quality of centers which provide comprehensive, multidisciplinary diagnostic evaluations of communicative handicaps.

3. Establish and expand services for preventive and remedial medical and surgical treatment, hearing aids and non-medical treatment and management, including audiological and speech therapy services.

4. Initiate and support programs for training personnel to provide services to children and youth with communicative disorders of hearing, speech and language.

Assistance to State Programs

Almost every State, using funds appropriated under Title V of the Social Security Act for maternal and child health and crippled children's services, conducts programs for the discovery, diagnosis and treatment of children with communicative disorders. Treatment includes medical and surgical care, hearing aids, auditory training and speech therapy.

In 1967, State Crippled Children's Services reported giving services to 40,744 children with hearing impairments and to 21,050 children with cleft lip or palate.

All but eleven States now employ in their State health department or Crippled Children's agencies, speech pathologists or audiologists who have the responsibility for developing services for children with hearing, speech and language handicaps. Technical assistance is provided to the States by two specialists on the Children's Bureau staff.

Regional conferences for staff development for speech and hearing specialists in state programs were held, or planned, for five regions in fiscal year 1969. Two other conferences concerned with the improvement of services for children with hearing impairment were developed and supported by the Children's Bureau. The conference at Stanford University focussed on "Electronystagmography as a Diagnostic Tool", and the conference at the University of Oklahoma considered the pediatric, otolaryngological and audiologic aspects of hearing disorders in children.

Under the leadership of the Children's Bureau speech and hearing specialists, a group of representatives of Federal agencies, voluntary agencies and the professional association, the American Speech and Hearing Association, have undertaken to encourage and guide statewide planning for speech and hearing services. The group expects the composite results of such planning to be of use in the White House Conference of 1970.

Special Projects

From 1964 to 1968 Children's Bureau grants for special projects for speech and hearing services increased from about $350,000 to $2,450,000. The estimated obligations for 1969 are $2,600,000 and for 1970, $2,600,000.

These amounts include moderate increases for support of the training programs in speech pathology and audiology, and for support of demonstration projects for speech and hearing in state programs. The major increases in the obligations are speech and hearing services within projects for comprehensive health services for children and youth, and for training as part of the grants made to University Affiliated Centers for Mental Retardation.

Support has been continued for the professional training of speech pathologists and audiologists at six medical schools: Johns Hopkins University, Vanderbilt University, University of Iowa, University of Kansas, Stanford University, and the University of Oklahoma. The amount of these grants totals to $487,461.

Support has been continued for advanced professional training at the Iowa State Services for Crippled Children and at the New York University Medical School. Total amount of these grants is $59,693.

The training program in speech and hearing as a part of the grants made to University Affiliated Centers for Mental Retardation has been expanded rapidly. The focus of these projects is to provide training in an interdisciplinary program for multiple handicapped and mentally retarded children. Speech and hearing training has been established in all 12 of the presently approved centers. Obligations increased from $27,853 in 1969 to $458,292 in 1969.

The Children's Bureau continued to support demonstration projects for speech services to mentally retarded children in the Iowa Crippled Children's Division and for hearing conservation in the State departments of health in Colorado, Hawaii, and Utah.

Services for children with hearing, speech and language disorders are a basic requirement in the special projects for comprehensive health services for children and youth. Approximately $1,030,000 has been obligated in FY 1969 for speech and hearing services in the 58 projects. Regional meetings of the speech and hearing personnel in these projects have been held in six Regions during the past two years.

A study concerning the utilization of subprofessional personnel in hearing conservation programs was undertaken by the Division of Maternal and Child Health in the Ohio Department of Health with support from the Children's Bureau in the amount of $20,000. The final report suggests that the range of tasks which are appropriate for subprofessional personnel is wider than has been previously demonstrated.

Publications

A bibliography entitled "Speech, Hearing and Language in Mental Retardation" is in the process of publication.

The Children's Bureau publications, "Choosing a Hearing Aid," "Services for the Child Who Is Hard of Hearing," "The Child with a Speech Problem," "The Child with a Hearing Impairment," continue to be in demand.

OFFICE OF EDUCATION

Obligations for Programs on Speech and Hearing

	1966	1967	1968	1969	1970
Education for the handicapped.....	$6,554,175	$7,930,465	$9,011,728	$10,189,000	$11,000,000
Elementary and Secondary Activities.....	1,086,341	1,480,000	3,500,000	3,700,000	4,000,000
Research and Training.....	471,562	401,172	60,000	40,000	25,000
Libraries and Community Services.....	---	11,000	17,700	18,000	18,000
Total, Office of Education..	8,112,078	9,822,637	12,589,428	13,947,000	15,043,000

OFFICE OF EDUCATION

PROGRAMS IN HEARING, SPEECH, AND LANGUAGE

Grants for Training of Professional Personnel

According to the most recent estimates of the American Speech and Hearing Association, speech and hearing disorders account for more than 8 million handicapped individuals. Of this number approximately 3.1 million possess hearing difficulties severe enough to interfere with communication and the development of normal speech and language. 125,000 of these are considered totally deaf, and thereby incapable of receiving any speech through the auditory mechanism. The remaining 5 million represent children and adults with significant speech and language difficulties generally unrelated or only in part related to hearing disorders. Among the types of speech and language problems found are those related to stuttering, aphasia, laryngectomy, cleft palate, cerebral palsy, or mental retardation.

The Office of Education activities related to improving and enlarging educational opportunities for handicapped children has expanded significantly during the past year. A number of training grants have been awarded to colleges and universities to help increase the number of professionals trained to work with children with communication disorders. Grants have also been awarded to training institutions for the purpose of developing graduate programs in the area of speech pathology and audiology. Research and demonstration projects are being carried out in several areas, such as determining the effectiveness of instruction in the classroom and other learning situations for communicatively handicapped children and youth.

To encourage State departments of education to expand their services to the communicatively handicapped in the schools, a National major conference was held by OE in the fall of 1966 for State supervisors in speech and hearing. Problems in the development of school programs with and without Federal assistance were identified and discussed by participants. A study of the recipients of OE trainint grants in Speech and Hearing under P.L. 85-926, as amended, revealed that almost all trainees and fellows have indicated the vocational goal of providing speech and hearing services in the schools.

Representatives of 22 colleges and universities attended the third conference for Program Development Grant Awardees in the summer of 1968. The purpose of these meetings was to discuss the implications of funding for the development of training programs as well as the details of the policies and procedures concerning program development grants.

For academic year 1968-69 $3,152,160 was obligated for awards for speech and hearing in the following categories:

	Number	Amount
Post Masters fellowship.....	27	$ 186,300
Masters followships.....	481	2,549,300
Senior year traineeships.....	44	123,200
Summer traineeships.....	56	65,850
Program Development Grants.....	13	227,510

An additional $600,000 was available to State agencies.

For academic year 1969-70, about $3,500,000 will be available for awards for speech and hearing. A categorical breakdown is not yet available, however. For academic year 1970-71 about the same level of funding is anticipated. Additional funding will be available to State agencies for academic years 1969-1970 and 1970-1971.

Although the school-age population of deaf children has remained relatively constant in the past few years, the downward extension of educational services to very young preschoolers has increased the total number. It is estimated that there are over 60,000 deaf pupils in the United States. Due to a shortage of teachers and other obstacles, and additional 14 percent are not receiving the specialized help necessary from schools and classes appropriately equipped to serve these children. A recent survey has identified an annual need for 500 new teachers of the deaf plus 500 more to overcome existing shortage and annual attrition.

Public Law 87-276, approved September 22, 1961, authorized a grant program of $1.5 million for each of 2 years to accredited public and non-profit institutions of higher learning for the training of teachers of the deaf. This program was extended for an additional year in fiscal year 1964. In the three-year tenure of the act, 1,376 scholarships have been awarded to train teachers of the deaf.

The program was expanded in academic year 1965-66 to include, in addition to the training of teachers, the preparation of college instructors, supervisors, administrators, and research personnel as authorized by section 301 of Public Law 88-164. A total of $2,068,350 was utilized in support of the program in the area of education of the deaf.

The program, incorporated by Public Law 85-926, as amended, was extended by Public Law 89-105 in 1965. Further support of the program activities in academic year 1966-67 and 1967-68 was $2,552,180 and $2,832,839, respectively.

For academic year 1968-69, $2,559,157 was awarded for the following categories:

	Number	Amount
Senior year traineeships.....	141	$ 394,800
Masters fellowships.....	312	1,653,600
Post Masters fellowships.....	11	75,900
Summer Traineeships.....	176	189,300
Special Study Institutes.....	96	55,168
Program Development Grants....	7	138,045
Special Projects.....	--	52,344

An additional $196,000 was obligated for awards to States.

It is anticipated that in 1969-70, a total of $2,844,000 will be available for the preparation of professionals to work in the area of the deaf. A categorical breakdown is not yet available. Academic year 1970-1971 will be funded at about the same level. Here, too, additional funds are awarded to State agencies.

RESEARCH

The research and demonstration program for handicapped children established under Public Law 88-164 has become the principal source of funds within the Office of Education relating to speech and hearing problems. During recent years, research has been supported which focused upon a wide variety of problems in this critical area. The largest and most complicated project currently in progress is a national survey of speech and hearing problems in school children. This study will test more than 25,000 school children in order to establish the prevalence of a variety of speech and hearing problems.

Table I - Types of Research and Demonstration Projects in the area of Speech and Hearing supported by the Bureau of Education for the Handicapped: 1964-68

Category	Research and Demonstration Projects		
	Number of Projects	% of Total Projects Supported	Amount
Screening and Longitudinal Studies.....	12	30.0	$2,118,561
Evaluation: Tests and Measurements.....	11	27.5	490,699
Automated and Programmed Instruction.....	6	15.0	230,914
Model Programs and Materials.	11	27.5	692,501
Totals.....	40	100.0	3,532,675

Table 2 - Annual Awards in Speech and Hearing Research and Demonstration Projects

Year	Number of New Grants	Funds for S&H *	Funds for R&D	% of Total Funds for S&H
1964	2	$ 46,363	$ 999,739	5
1965	6	192,681	2,000,000	10
1966	7	533,995	5,994,231	9
1967	8	803,879	8,049,041	10
1968	8	1,535,198	10,794,113	14
Totals	31**	3,112,116**	27,837,124	11

* Includes new grants and continuation grants.
** Does not include 9 Cooperative Research grants.

Other studies in this area include the development of curricula for the deaf, the development of auto-instructional aids for lipreading, the development of other teaching aids for both deaf and speech impaired children, the development of new signs to enrich the sign language of the deaf, and the development of instructional methods to reduce stuttering.

One study of particular merit is attempting to make the telephone available to the deaf. This project will develop an easily portable device which will permit the deaf to communicate over the telephone by use of specially constructed portable typewriters which act very much like teletype machines.

A number of investigators are studying testing procedures, both for identification purposes and for suggestions regarding treatment. An investigator at Gallaudet College is experimenting with a variety of electronic aids which can be useful for helping the deaf to speak. He held a conference during 1967 which brought to Gallaudet College researchers and technicians from around the world to demonstrate the various new devices now available. As a result of this work many new devices should soon become available to help teachers with the speech problems of deaf youngsters. Many new projects were initiated during 1968 which complement those previously funded. The work will continue through 1969.

Educational research relating to speech and hearing during Fiscal Year 1970 will continue to focus on two major problems: (1) communication problems of the deaf, and (2) effective use of speech therapists. The communication problems of the deaf still stand out as the greatest single deterrent to a reasonable academic education for these youngsters. Additional research and development activities will be sought in this area. It is expected that significant steps will be taken during Fiscal Year 1970 in the solution of how speech therapists can best allocate their resources and time. It has long been known that speech therapists spend a great deal of their time and efforts working with children whose problems would disappear without help anyway sometime in the future. By the end of 1970, it should be possible for therapists to determine just which children would self-correct and which would need special help.

Media Services and Captioned Films

In fiscal year 1968 Media Services and Captioned Films reached more than 1800 groups of hearing impaired persons. Of these, 700 were schools or classes for the deaf. The total audience for recreational films numbered over one million with a monthly average of 1,152 showings. Users received the films on free loan and were only required to pay return postage. Three regional libraries located in New York, Indiana and Colorado circulate these films.

The program maintains sixty film depositories which circulate captioned educational films to meet educational needs. More than 400 titles are available. In addition, schools receive extended loan of other educational media, including filmstrips, transparencies, slides, overhead and filmstrip projectors, projection tables, screens and miscellaneous instructional materials.

An extensive training program designed to instruct teachers in the use of new media is closely coordinated with the loan service. Four Regional Media Centers for the Deaf conduct intensive summer institutes on educational technology. One of these centers concentrates on programmed instruction and one is serving as an advanced institute for persons who will supervise media programs in schools for the deaf. Demonstration teams from the Regional Media Centers provide on-the-job training by conducting two and three-day workshops in schools during the regular academic year. A national symposium on educational technology for administrators of schools for the deaf is an annual event conducted by the center at the University of Nebraska. Other centers are located at the Universities of Massachusetts, Tennessee and New Mexico.

Film production, carried on under contracts with private companies and with Regional Media Centers include 8mm loop films for training in lip-reading and fingerspelling, teacher training films, vocational training films, and classroom instructional filmstrips, transparencies and slides. These are reproduced in quantity and loaned to schools.

Research is designed to find practical solutions to problems of the deaf. Examples of these problems include difficulties in acquiring normal use of the English language and abnormalities in visual perception. Programmed instruction, individualization of teaching, and multi-media presentations are among the techniques being explored to meet these problems.

The principal gain is the completion of a project to supply basic projection equipment to all classes for the deaf. Addition of 1,100 overhead projectors, 2,300 filmstrip projectors, and 4,300 projection tables and 4,000 screens equip every listed class of deaf children with these aids. In addition, 300 motion picture projectors for 8mm single concept films were put out on loan.

The name of the program has been changed to Media Services and Captioned Films Branch to more clearly reflect the expansion of activities. Because of the expanded role authorized by P.L. 90-247 over five million children are potential users of special media services. Limitations on funding however, suggest that the program for the deaf will continue to operate as described, with new funds being used to support demonstrations of the applicability of new media to other areas of the handicapped.

Centers and Services for Deaf-Blind Children

The Secretary of Health, Education, and Welfare is authorized to make grants or contracts with public, non-profit, private agencies, organizations, or institutions to finance part or all of the cost of establishment or operation, or both, of centers for deaf-blind children. This may include some construction, when necessary. Such centers must provide: Comprehensive diagnostic and evaluative services for deaf-blind children; A program for the adjustment, orientation, and education of deaf-blind children which integrates all of the professional and allied services necessary therefore; and effective consultative services for parents, teachers and others who play a direct role in the lives of deaf-blind children to enable them to understand the special problems of these children and to assist in the process of their adjustment, orientation, and education. One million dollars has been appropriated for this program for fiscal year 1969.

Title VI-A Amendment to ESEA

Title VI-A provides special education and related services to those handicapped children in public and private schools, or not enrolled in schools, who are not receiving these services from any other Federal program.

In fiscal year 1968 Congress appropriated $14,250,000, which was allocated to the 50 States and the District of Columbia according to a formula based on the number of children age 3 to 21 in each State. Funds were also allocated to Puerto Rico, Guam, Virgin Islands, the Trust Territory of the Pacific Islands, and the Bureau of Indian Affairs. In the plans submitted, States and the outlying areas reflected the needs of these unserved children within their borders, and established priorities according to specific needs which should be met. Highest

priority was accorded to the initiation and expansion of basic services in all disability areas and the development of new programs, particularly those in the area of preschool activities, multiple handicapped, learning disabilities and work-study programs. Also included are programs for the development of leadership personnel, diagnostic services; staff improvement and training; innovative and demonstration programs; curricula, and instructional materials. The States expect that approximately 84,000 handicapped children will receive some type of special education or related services under Title VI-A in the 1967-68 school year, provided by approximately 4,000 teachers and other essential personnel. It is expected that program expansion and additional basic instruction and services will be increased in 1969.

P.L. 89-313 Amendment to Title I of ESEA

The versatile provisions of this legislation support the development and expansion of many educational services. Funds may be obtained to strengthen the instructional program by adding specialized teachers, consultants, evaluation specialists, speech pathologists, teacher aides and to provide in-service training of the staff. Programs may be expanded by the development of diagnostic centers, preschool programs, language development laboratories, occupational training centers, summer camp programs and teacher exchange projects. Additional services which can be made available include parent counseling, curriculum enrichment activities, orientation and mobility instruction, transportation assistance, mobile unit services and special afternoon or evening classes.

Funds are made available to State agencies which are responsible for the administration of educationally oriented services for handicapped children in schools which they operate or support. Grants are established by the U.S. Commissioner on a formula, based on an annual survey of the number of children in average daily attendance.

Projects are designed and submitted through the State agency to the State Department of Education for review and approval. The States review the projects to determine whether the projects are of sufficient size, scope, and quality, and to assure their compliance with the Federal law governing the program including provisions for evaluation and annual reporting.

Early Education Assistance

This Act, P.L. 90-538, enables the Commissioner of Education to make grants or contracts to public and private, non-profit agencies for the development and implementation of model and demonstration programs. These grants will be distributed on a broad geographical basis throughout the Nation. Projects will also be established in both rural and urban areas. In some large metropolitan communities more than one project may be deemed appropriate.

Support will be given to many lines of attack on the problems of handicapped children that possess professional credibility and recognized expertise. It is intended that there be great diversity among projects so that models will be developed which are applicable to many different handicapping areas and particular environmental areas.

The Act directs that each program be coordinated with the local school system in the community being served. Dissemination of information, in-service training and other aspects of the model programs will be designed to encourage the development of successful early education programs throughout the State and neighboring areas. The Act provides for a Federal share of up to 90 percent of the cost of a project.

Title III of the Elementary and Secondary Education Act (P.L. 89-10) provides nonmatching grants to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs to serve as models for regular school programs. This program gives special consideration to projects that are truly innovative as well as being of high quality and responsibile to local needs. In fiscal year 1969, it is estimated that $3,700,000 in ESEA Title III funds will be obligated for speech, hearing and language projects and in fiscal year 1970 approximately $4,000,000 will be obligated. In accordance with the Elementary and Secondary Education Amendments of 1967, local educational agencies' applications for these projects will be made to the State education agencies of the Office of Education in fiscal year 1969. In fiscal year 1970, the applications will be made to the State education agencies only.

Funds under the Library Services and Construction Act, Title IV-A, (P.L. 89-511), are for the purpose of establishing and improving State institutional library services. Residential schools for the handicapped, including hard of hearing, deaf, and speech impaired, may be included in a State plan if these schools are operated or substantially supported by the State. Funds may be used for providing books and other library materials as well as other library services to students in such residential schools under an approved State plan. In fiscal year 1968 Federal funds in the amount of $1,890,500 were obligated to 50 of the 56 States and Territories. These funds supported a variety of activities.

In Delavan, Wisconsin, funds were used to provide a library assistant for the Wisconsin School for the Deaf. In Alabama, funds strengthened library service for the deaf in the Alabama Institute for the Deaf and Blind at Talladega. In the Florida School for the Deaf, funds were used to build up the operational materials of the library.

In fiscal year 1968 one project was activated under Title I of the Higher Education Act of 1965 (P.L. 89-329) which was concerned with speech activities. This project coordinated efforts between families and medical personnel in rehabilitating speech impaired individuals.

In fiscal year 1968, the Office of Education supported research projects funded under the Cooperative Research Act, Public Law 89-10, Title IV in such areas as research and instructional development in speech communication; learning of aurally received verbal materials; speech and language therapy under an automated stimulus control system, as well as, studies of speech dialects in various areas of the country.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

REGIONAL MEDICAL PROGRAMS SERVICE

SPEECH AND HEARING

The Neurological and Sensory Disease Control Program is concerned with developing and applying new techniques, methodologies, and instruments for the prevention, early detection, and diagnosis and improved treatment of communicative disorders and their handicapping effects. Hearing loss, alone, is the most prevalent chronic condition affecting man; virtually every adult has some loss of hearing acuity. Six million adult Americans are known to have significant impairment, with four million of these having a loss in both ears. The number of children with pathologic middle ear conditions is not actually known, largely because recent research indicates that present-day screening procedures are not sufficiently refined to find more than about one half the children who would be classified as "otologically abnormal." Improved systems and instruments for detection of the child with a severe hearing loss are gaining wider acceptance, but the lack of fully trained personnel and adequately equipped facilities for follow-up care are lagging behind the demand.

While most communicative disorders have their origin in childhood, from such varied causes as birth defect or injury, cultural deprivation, untreated diseases, etc., there are sufficient hazards in our technological society that many of them can occur at any age. While the effects of noise on hearing in industry are well-documented, the total effect of rising noise levels in everyday life are not satisfactorily established. Automobile and other accidents take a daily toll in adults who, through brain injury, have lost their ability to communicate. Man's efforts to prolong his own longevity have also resulted in increased prevalence of communicative disorders. The effects of aging on the auditory system as well as the cerebral cortex, with resultant loss of language facility, are two conditions common to the elderly.

Over the past several years, some gains have been clearly made. Stuttering, which once was estimated to be a problem for 1% of our population, has been reduced substantially, due in large part to massive efforts in parental education. The gains in speech and language of pre-school children which have been measured in recent years show the importance of early language and speech stimulation in the home. (Similarly, increased numbers of children from deprived backgounds show the absence of such gains in the absence of similar stimulation.)

Unfortunately, there are increased problems in other areas. Otitis media (disease of the middle ear), once felt to have been substantially reduced through antibiotic treatment, is still the largest single cause of hearing disability. It is made all the more critical since it appears to be most prevalent in groups in which language and educational problems already exist, which are furthered by the addition of a hearing loss. The chronic form of this disease, while quiescent, may go unnoticed by the child since it causes no pain. Since one half of all adult hearing problems have their origin in childhood, poor detection of such problems may affect a person's entire lifetime.

In keeping with its view that loss of hearing is primarily a health problem and that the medical and allied medical specialists most concerned with the ear and hearing should be involved in the diagnosis and treatment of the disorder, the Program is investigating ways to increase the effective use of hearing aids. A study to evaluate the effect of early hearing aid utilization on the language development of infants born with hearing defects and to explore neurophysiological implications will be supported. The largest group of hearing aid users is the older population. A study of their hearing aid need and utilization will also be supported. Additionally, the Program will continue its liaison

with the Senate Subcommittee on Consumer Interests of the elderly with regard to hearing aids. A project to develop guidelines for hearing aid use will continue.

The increasing demands for services for the communicatively impaired cannot be met by fully-trained professionals using present-day instruments and procedures. Technological advances have been such, however, that to make possible the development of new instruments and automated procedures will require less than professional competence in their operation. A recent Program study that revealed gross inadequacies in audiometric calibration in the field has led to the development of ideal characteristics for a self-calibrating audiometer, which are being evaluated. Further plans call for the development of semi-automated procedures for speech audiometry and hearing aid selection. The Program will evaluate a new device for hearing screening of pre-schoolers. Discussions are also being held to determine the efficacy of developing an automated pneumatic otoscope, a device which will detect middle ear pathology in the absence of hearing loss. Investigation will continue into the clinical usefulness of evoked response audiometry, a technique which permits the audiologist, by observing brain waves, to determine hearing loss in people too young or too physically or mentally impaired to offer verbal response.

A definition of the noise hazard problem and specific recommendations for the control and minimization of this hazard pertaining to the effects of noise on man, industrial noise and the worker, noise in the community and special problems of recent technological development, e.g. sonic boom, and community control, will be published as a result of the Program-sponsored National Conference on Noise as a Public Health Hazard.

Another study being continued will determine selected speech and neurological characteristics of dysarthria (imperfect articulation in speech due to neurological legions). Data resulting from this study will be used to determine the feasibility of applying speech physiology and analysis techniques to the problems of early diagnosis of neurological dysfunctions. A project will continue the evaluation of pitch perturbation as a diagnostic and screening tool for laryngeal pathology, both benign and malignant. An electronic device is being developed and assembled which will have the capability of analyzing speech data through the use of a specialized computer in order to determine the presence or absence of abnormalities. The Program will continue to make available its expertise to stimulate and aid in the implementation of training programs for persons who provide services to those with communicative disorders. These programs are both long-term training and continuing education.

Consultation is also available to official and voluntary health agencies, professional organizations, institutions of higher learning, and other groups to aid their efforts to establish or improve service programs for persons with communicative disorders.

The amounts obligated by this Program are:

FY 1966	$1,344,060
FY 1967	$1,644,000
FY 1968	$ 636,000
FY 1969	$ 636,000
FY 1970	$ 636,000

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE OF NEUROLOGICAL DISEASES AND STROKE

HEARING, SPEECH, AND LANGUAGE

THE PROBLEM

A recent review and analysis of available data more than doubles previous estimates of the prevalence and cost of hearing, language, and speech disorders in the United States. As a part of its report on a two-year study of the field, the Subcommittee on Human Communications and Its Disorders, of the National Advisory Neurological Diseases and Stroke Council, states: "about 8,500,000 Americans have either bilateral or unilateral hearing impairments of handicapping magnitude; another 2,000,000 have central communicative disorders; and 10,000,000 have speech disorders. We probably should assume modest overlap in these totals, but we must still recognize that approximately 20,000,000 persons in this country have communicative handicaps worthy of our concern. Moreover, at least a third (about 7,000,000) suffer either substantial or severe educational, social, and economic disadvantage. Finally, approximately one-fifth of the grand total (about 4,000,000) consist of persons under 21 years of age."

Further on, the report adds: "the direct costs of coping with communicative disorders (special education, vocational rehabilitation, hearing aids, speech therapy, training of professional personnel, etc.) totals at least $400,000,000. The annual deficit in earning power among the communicatively impaired approximates $1,750,000,000. No price tag can be assigned to the personal tragedies and social misunderstandings which communicative disorders impose on their possessors."

THE PROGRAM

Since its establishment in 1950, the National Institute of Neurological Diseases and Stroke (formerly Blindness) has been deeply concerned with communicative disorders. This category comprises deafness resulting from malformations or malfunctions of the ear, the auditory nerve, and sound-receiving centers of the brain; late speech acquisition or failure to talk; defects of articulation, including those caused by cleft palate, facial malformations, and other speech-affecting organic disorders; and inability to receive, interpret, retain, and express language, including aphasia and central disorders of perception.

Major emphasis continues on training of urgently needed personnel to conduct research in this field which has high priority in NINDS's overall effort. Currently, 389 postdoctoral students are studying with Institute support through 78 grants to institutions for advanced research training in otolaryngology, audiology, sensory physiology, and other related disciplines.

The Institute conducts the largest of all Federal programs of research into the mechanisms of human communications and the disorders which afflict them. Currently, NINDS supports:

Prepared January 1969 by the National Institute of Neurological Diseases and Stroke, Public Health Service, U. S. Department of Health, Education, and Welfare in connection with 1970 appropriations hearings.

- 174 separate research projects at 82 U.S. medical centers;
- Five multidisciplinary clinical research centers--at Princeton, Central Institute for the Deaf in St. Louis, the University of Chicago, the Kresge Hearing Research Institute of Ann Arbor, Michigan, and the University of Florida;
- Three Human Communications out-patient clinics--at Stanford, the University of Pittsburgh, and Northwestern;
- Four temporal bone banks for the long-term study of structural and pathological changes relating to functional disorders of hearing--at the University of Chicago, Johns Hopkins, the San Francisco Medical Center of UCLA, and Baylor University in Houston;
- An Information Center for Hearing, Speech, and Disorders of Human Communication at Johns Hopkins to speed the interchange of scientific information between researchers; and
- A long-term collaborative study of some 50,000 children which includes evaluating their hearing and speech.

The Institute also publishes reviews and other documents of professional interest. Three monographs published this past year have made available to many physicians, educators, and therapists new information relating to communicative disorders.

The Subcommittee on Human Communications and Its Disorders of the National Advisory Neurological Diseases and Stroke Council provides guidance to the Institute in its present programs and its planning for the future. This committee, organized in 1965 to review the state or research relating to problems of communicative disorders has completed its assignment and submitted an extensive report, which will be published in 1969.

RESEARCH PROGRESS

The Subcommittee on Human Communications and Its Disorders, after thorough review and analysis of current knowledge about hearing, language, and speech functions and dysfunctions, has identified gap areas and made specific recommendations for research concentration. Unquestionably, this impetus will speed the Institute's research program in preventing communicative handicaps and improving the lives of persons who are afflicted by them.

Ear Transplants

Successful homograft transplants of complete middle ear structures were reported by several investigators. The transplants were made from cadavers to patients whose hearing had been destroyed by chronic otitis media. Transplants of part of the middle ear had been made previously, but the recent work involves the complete middle ear which includes the eardrum and the three tiny middle-ear bones. Of 16 cases reported by Drs. Michael Glasscock, William F. House, and James L. Sheeby, of the Los Angeles Foundation of Otology, the hearing results were very good in three cases, improved in two cases, and six cases will require a second-stage procedure to obtain good results. Dr. Glasscock said, "There are many problems inherent in the use of this homograft technique which have not been solved, such as tissue preservation and prevention of adhesions in the middle ear. Dramatic results have been achieved in a few patients, and this has encouraged us to continue using this technique in selected cases."

Implanted Tack Relieves Meniere's Symptoms Automatically

Meniere's disease, resulting from increased pressure of fluid in the membranous labyrinth of the inner ear, is the most common of the inner-ear disorders and usually presents three symptoms at the same time--ringing in the ear, dizziness, and deafness on one side. While its cause is still unknown, various means have been developed to treat it, medically and surgically.

Among the new surgical techniques for managing the affliction is an operation conducted under local anesthesia, in which a stainless steel tack is implanted through the footplate of the stapes--the tiny stirrup-shaped bone of the three middle ear bones--in such a position that it will puncture a swelling membranous labyrinth before dizziness occurs. This procedure affords Meniere's disease patients, who otherwise would suffer frequent severe attacks of dizziness, an excellent chance of automatically controlling the symptoms with minimal morbidity and no serious complications.

In 57 cases the tack operation reduced dizziness in 95 percent of the patients, improved hearing by 20 decibels or more in 18 percent, reduced the sensation of ear fullness in 92 percent, and lessened ringing of the ears in 42 percent.

Antibiotic Found Destructive to Hearing

Because of the increasing use of drugs by otologists in treating ear diseases, the Institute has emphasized studies of the relation of chemical agents to hearing disorders. An NINDS-supported study suggests that topical application of the broad-spectrum antibiotic chloramphenicol succinate may actually cause deafness. The drug has been used widely following surgery, and in cases of chronic refractory otitis media because of its effectiveness against infection. Topical application of the drug to the middle ears of a large number of guinea pigs showed significant damage to the hair and supporting cells in the organ of Corti, vital to hearing processes. The findings have alerted otologists to the possible danger of using chloramphenicol topically in the middle ears of human patients.

Electrodermal Auditory Technique Used

Involuntary (electrodermal) audiometry was used by an NINDS grantee to help to resolve the controversial question about the site of the damage responsible for hearing impairment associated with Rh incompatibility. Results of a study using the technique strongly indicate that damage in Rh deafness is localized low in the central auditory nervous system (cochlear nuclei) or in the peripheral sensorineural mechanism (cochlea), not at high levels in the central auditory system.

This localization of damage is an important step in understanding the nature of the impairment and in facilitating more effective aid to afflicted individuals.

X-ray as a Diagnostic Tool

An advance in the diagnosis of inner-ear hearing loss was made this year through research conducted at a temporal bone laboratory. The bony changes which radiologists have observed and diagnosed as cochlear otosclerosis have now been confirmed histologically.

In the past, some persons with a severe hearing loss have been diagnosed, through use of X-ray, as having cochlear, or inner-ear otosclerosis. However, questions existed concerning the interpretation of the X-ray findings of inner-ear hearing loss. Some of these persons have willed their temporal bones to research and now, after death, the inner ears have been studied

histologically and the X-ray diagnosis confirmed. This recent advance concerning inner-ear diagnosis gives further support to the value of Temporal Bone Banks.

Much of our knowledge of the causes of hearing loss has been gained through the study of middle- and inner-ear structures after death. There are now many temporal bone laboratories and four regional Temporal Bone Banks. These are sponsored by the Deafness Research Foundation and the American Academy of Opthalmology and Otolaryngology and supported by NINDS.

Surgery Relieves One Type of Hearing Loss

A surgical procedure has been developed this year to relieve the blocking of the eustachian tube which sometimes causes hearing loss. Air is necessary for effective hearing and the new procedure, conducted from above the tube, removes the block, provides air, and prevents the tube from filling with fluid.

Evoked Response Audiometry Used In Diagnosis

Early diagnosis of auditory nerve lesions, such as neuromas, is most important because they threaten life when ear tumors grow into brain tumors. Symptoms of such lesions are so similar to those of Meniere's disease (a non-fatal affliction characterized by fluid-accumulation swelling of the inner ear) that even the best audiometric tests so far devised cannot always positively distinguish which is which.

Evoked response audiometry, a valuable new research tool reported last year, which uses EEG (electroencephalograph) tracings to accurately evaluate hearing ability in patients too young, too retarded, or unwilling to cooperate, was applied experimentally this year by a Johns Hopkins University scientist to the problem of differentiating between VIII nerve lesions and Meniere's disease.

Results of the experiments on a limited number of patients suggest that evoked response techniques may prove valuable for diagnosis in this important area.

Unit Simulates Patient, Speeds Training

Bioengineering made a significant contribution to audiometry education. At the Johns Hopkins Medical Institutions, a physician and an electrical engineer teamed up to develop a valuable training tool called an Audiometry Training Unit.

The machine simulates test procedures in air conduction, bone conduction, and speech audiometry to speed the training of audiologists, speech pathologists, audiometric technicians, and resident physicians. It consists of a conventional audiometer console linked to a pre-programmed simulated test subject and can be set for an infinite variety of test patterns--simulated hearing loss cases. Additionally it replaces expensive audiometers and sound-treated rooms, takes only two persons to operate it, is reasonably mobile, and may be operated by battery.

Fiber-optics Improves Laryngoscopic Techniques

NINDS grantees at the University of Tokyo devised a thin, flexible, fiber-optics cable which can be inserted through the nasal passage to provide clear observation of laryngeal conditions in the course of normal speech. Glottal conditions during articulations of consonants, not visible in ordinary laryngoscopic techniques, and during various other phonations, can now be observed and photographed. A significant recent accomplishment in speech

research, this technique will hasten the acquisition of knowledge about the ways that our speech is produced in the different registers and the fundamental frequencies.

A Better Artificial Larynx

In the area of artificial organ development, efforts continue to improve artificial larynxes. During 1968, Dr. Richard L. Goode, a Los Altos, California surgeon, developed such a device to provide speech for those postlaryngectomy patients who fail to learn esophageal speech and cannot use a conventional artificial larynx. He reports that only minor surgery is required to place this inconspicuous artificial larynx. He also indicates that the unit remains in place for spontaneous speech, produces a loud intelligible voice, with minimal external sound radiation.

Pre-school Screening for Rubella Damage

Rubella (German measles), a mild disease of children and young adults has been a vicious destroyer and crippler of unborn babies when contracted by mothers in the first weeks of pregnancy. It is hoped that new vaccine will drastically reduce the prevalence of the disease in the future, but in 1964-65 one of the worst epidemics in our history affected almost two million persons and damaged 20,000 to 40,000 babies before birth. At least half of those children have impaired hearing, the most common and persistent defect found in rubella babies.

In August, 1967, in Montgomery County, Maryland, NINDS sponsored a four-day pre-school communications screening program which was conducted by the County Health Department and the Easter Seal Treatment Center. This program was one of the early efforts to find children having hearing, language, speech, and memory abnormalities and to determine, where possible, those who had been damaged by the rubella epidemic. In response to radio and newspaper advertising, 136 children between six months and five years of age whose parents or physicians suspected communications disorders, were brought in for examination.

Study results, completed in 1968, revealed that 79 children had definite abnormalities, and that 7 were suspect. Of the overall total, 17 were found to have rubella antibodies. Additionally, of 5 children born shortly after the epidemic, 4 (3 of them previously undetected) had congenital damage like that known to be caused by rubella. The report concluded that there probably are many more children in the county who have congenital rubella damage resulting from the epidemic which is as yet undetected but will be found later.

Since this typical program was conducted, many others have been held throughout the country. However, much more needs to be done to find all the rubella-affected children so that they may be helped early. Failure to do so may prevent the full development of their speech capabilities and mark them for life as handicapped.

NINDS Research Support for Hearing, Speech, and Language

1966	1967	1968	1969	1969
$6,533,000	$7,929,000	$8,443,000	$9,000,000	$9,061,000

SPECIAL INSTITUTIONS

NATIONAL TECHNICAL INSTITUTE FOR THE DEAF

Public Law 89-36 authorized the Secretary of the Department of Health, Education, and Welfare to enter into an agreement with an institute of higher education for the establishment and operation of the National Technical Institute for the Deaf (NTID). The Rochester Institute of Technology (RIT) Rochester, New York, was selected as the sponsoring institution. The NTID will be a residential facility offering post-secondary vocational and technical training and education to deaf persons in order to prepare them for successful employment.

The facilities for NTID, which will be completed by September 1973, will consist of an academic complex, two dormitories, and a dining hall-commons. Full enrollment will be 750 students. The first interim class of 70 students entered in September 1968, using existing RIT facilities.

The NTID program includes courses of study designed to: correct deficiencies in the educational backgrounds of incoming students; provide counseling to help students select appropriate technical courses; offer special supportive services (such as interpreting and notetaking) to students; establish liaison with industry for cooperative educational and inservice programs. Audiological evaluations and speech and hearing therapy are major components of the program. Computer technology and instructional television will be used extensively in the development of curricula.

The obligations for fiscal years 1966-70 are as follows:

	Obligations				
	1966 Actual	1967 Actual	1968 Actual	1969 Estimate	1970 Estimate
Salaries and expenses	$68,000	$314,000	$421,000	$1,558,000	$3,208,000
Construction 1/	---	---	---	740,000 2/	14,990,000
Total	$68,000	$314,000	$421,000	$2,298,000	$18,198,000

1/ New account in FY 1970
2/ Comparative transfer from Salaries and expenses

NATIONAL ADVISORY COMMITTEE ON EDUCATION OF THE DEAF

The National Advisory Committee on Education of the Deaf is a statutory Committee, authorized by Section 5 of Public Law 89-258, and composed of educators of the deaf, persons interested in education of the deaf, educators of the hearing, and deaf individuals. The functions of the Advisory Committee are to make recommendations to the Secretary of Health, Education, and Welfare concerning the carrying out of existing programs and the development of new or modified programs for the education of the deaf.

NACED held a National Conference on Education of the Deaf in April 1967 in Colorado Springs, Colorado. The 150 conferees considered methods to encourage the development of State plans for the coordination of comprehensive educational and corollary services for the deaf. For the past year, the Advisory Committee has been involved in the planning for the new Model Secondary School for the Deaf which is to be located in Washington, D. C. It has also made recommendations regarding the National Technical Institute for the Deaf, Gallaudet College and the Bureau of Education for the Handicapped.

The obligations for fiscal years 1966-1970 are as follows:

1966 Actual	1967 Actual	1968 Actual	1969 Estimate	1970 Estimate
---	$100,000	$85,000	$100,000	$100,000

MODEL SECONDARY SCHOOL FOR THE DEAF

Public Law 89-694 provides for the establishment of day and residential facilities for persons who are deaf in order to prepare them for college or other advanced training. The Public Law authorizes the Secretary, after consultation with the National Advisory Committee on Education of the Deaf, to enter into an agreement with Gallaudet College for the establishment and operation, including construction, of such a school. The agreement will be signed in January, 1969.

The Model Secondary School for the Deaf (MSSD), which will be built on the campus of Gallaudet College, will serve residents of the District of Columbia and nearby states of Virginia, West Virginia, Maryland, Pennsylvania, and Delaware. It is expected that the MSSD will provide an exemplary secondary school program to stimulate the development of similarly excellent programs throughout the nation.

It is expected that the first group of approximately 50 students, bussed in from the Washington metropolitan area, and housed in temporary facilities, will begin work in late 1969 in some areas of the proposed Model Secondary School for the Deaf curriculum.

The FY 1966-70 obligations are as follows:

	1966 Actual	1967 Actual	1968 Actual	1969 Estimate	1970 Estimate
Salaries and expenses	---	---	$22,000	$333,000	$485,000
Construction	---	---	---	100,000	971,000
Total	---	---	$22,000	$433,000	$1,456,000

MONDAY, APRIL 21, 1969.

REVISED BUDGET

WITNESSES

HON. ROBERT H. FINCH, SECRETARY
CREED C. BLACK, ASSISTANT SECRETARY FOR LEGISLATION
LEWIS H. BUTLER, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
JAMES F. KELLY, ASSISTANT SECRETARY, COMPTROLLER
JAMES B. CARDWELL, DEPUTY ASSISTANT SECRETARY, BUDGET

Mr. FLOOD. Now, we have the Secretary for Health, Education, and Welfare who is here again because of the change in administration and because our President has submitted numerous budget revisions. The Secretary has been good enough to come and tell us why.

You may proceed with whatever statement you would like to make.

Secretary FINCH. I am here to discuss the revised budget for the Department of Health, Education, and Welfare. The process of review and revision has been long and difficult. We have a chart presentation following my preliminary remarks in order to provide you with a graphic presentation of the changes. I think it will be helpful, especially in the context of my earlier testimony.

I would like to point out the major changes.

HEALTH PROGRAMS

This budget seeks to—

Constrain the rising cost of medicaid and medicare;

Maintain progress in programs of consumer protection and environmental control;

Expand the production of health manpower;

Give States and localities greater flexibility to provide public health services;

Broaden the nutrition survey and begin some health and education demonstrations to overcome malnutrition;

Maintain basic health research at essentially the 1969 level;

Reduce hospital construction grants in line with recently submitted legislation to finance such construction through the private sector, backed by Federal guarantees.

The actions we are proposing to take in medicaid will undoubtedly have far-reaching effects. We intend to revise the regulations governing reimbursement so that lower rates will be charged to the program by hospitals and physicians. We also propose to limit Federal payments for State and local mental health care and discontinue reimbursements for cosmetic orthodontistry. In this way essential health services for the poor can be maintained and expanded while reducing unit costs. The medicare reimbursement formula will also be revised to cut down payments to hospitals. In sum, I believe that these new proposals are a very positive step to constrain medical costs in this country.

EDUCATION PROGRAMS

The new budget for education programs represents a more rigorous ordering of priorities in a very tight budget. Low priority programs, such as impacted area aid and grants for the purchase of equipment and library books have been significantly reduced or eliminated altogether. However, increases proposed for high priority programs to aid the disadvantaged, in particular funds budgeted for title I of the Elementary and Secondary Education Act, have been maintained.

In addition, money has been put in the budget for a new program of elementary and secondary school experimentation. As I indicated during my earlier appearance before this committee, the focus of this program will be on the community school and how it can be adapted to respond more effectively to the contemporary crisis in eduation. The immediate objective of the experiments will be to identify alternative methods of coping with educational and community problems and offer the best of these as options to local school systems.

The new budget also places a very high priority on community college construction. It contains more money for subsidizing construction loans to community colleges and retains the January request for community college construction grants. Funds for other higher education construction grants have been taken out of the budget altogether. For these facilities, subsidized loans will be the sole Federal support.

INCOME MAINTENANCE

The most significant amendment in the budget has to do with the proposed social security benefit increase. We are now proposing a 7-percent across-the-board increase to be effective February 1, 1970. This will allow social security beneficiaries to catch up with the rise in the cost-of-living since the last benefit increase in March 1968. It will not, in my opinion, contribute excessively to inflation.

During my previous appearance before this committee, I indicated that the AFDC freeze would impose an intolerable financial burden on the States. The new budget proposes to postpone the effective date of the freeze at least for another year and includes enough money to provide all the Federal matching payments needed by the States in 1970.

The revised budget also reflects the very latest State estimates of cost. A new survey of the States was completed 2 weeks ago. The survey covered not only public assistance, but medicaid as well. I feel that we now have as accurate an estimate for these programs as it is possible to make at this time. Although the new estimates show shifts between medicaid and maintenance payments, in the aggregate they support the January budget estimate.

In my previous testimony I also underlined the importance of conducting more income maintenance experiments. Although the total amount will still be limited, the new budget more than doubles the previous request for this purpose. I feel that this will be a significant step toward reducing perpetual dependency.

REHABILITATION PROGRAMS

The revised budget will continue to support expanded rehabilitation services. However, the rate of expansion of basic State rehabilitation services will be slowed somewhat. This is normally regarded as a noncontrollable program. We propose to bring this program under control by specifying a new allotment base for the States. This will allow the program to grow but not as fast as it would have if left outside administrative control.

This concludes my prepared remarks. I would now like to ask Bruce Cardwell to take you through a set of charts which I believe will give you a complete picture of the amendments to the 1970 budget. We will be glad to answer any questions you may have.

Let me just note, in passing, that the review of education was particularly difficult. We have tried to come to grips with the impacted area aid program. The position there is essentially the same as before. We have tried to maintain the increases for title I in the Elementary and Secondary Education Act. We have increased the amount for community colleges in the form of subsidized loans for these 2-year urban institutes.

LOCATION OF COMMUNITY COLLEGES

Mr. FLOOD. What about these schools? Are you still enthusiastic about them?

Secretary FINCH. Yes, sir. If anything, more so. What we hope to do is give them visibility now—that is, through a slight increase, in planning money particularly——

Mr. FLOOD. What about real estate in small towns?

Secretary FINCH. It has quite an effect, of course, on the value.

Mr. FLOOD. A small town like mine, 50,000 people, where am I going to put it? In the middle of the city; downtown?

Secretary FINCH. It might be. It might be nothing like the traditional type of campus that you and I think about. It might be an old office building. But it will be the place to do the job of teaching trades and vocational skills.

Mr. FLOOD. A class C school?

Secretary FINCH. That would depend on the State community college board.

Mr. FLOOD. I come from a town of 50,000 people. Where am I going to put it?

Secretary FINCH. The State board is going to have to make that decision, it seems to me. If the community has enough interest, they could make their case to their State board as to whether or not they had the resources, or what form of college they wanted.

Mr. FLOOD. Would you put it in the suburbs?

Secretary FINCH. Possibly they should be in both places. Again, we can't tell the States. We simply want to encourage them to begin to think about it. Very few States have statewide community college boards which we think are a necessary component of a sound community college program. I, for one, feel it would be wrong to try to lock them in under the higher educational boards in most States because then these boards would tend to dominate them and tend to push them into the liberal arts area.

Mr. FLOOD. There is plenty of land around there. Do I go out of town?

Secretary FINCH. I know so little about your district that——

Mr. FLOOD. A small town; 50,000. Lots of land around for miles and miles. What do I do?

Secretary FINCH. Well, you have to relate it to whatever passes for your statewide or Federal transportation system. The college has to be related to that. If you are going to put it out of town, then it must be accessible.

Again, this is something, it seems to me, that each State, each locality really, has to decide for itself. When I talk about an office building, I am thinking of a larger town where it has been a——

Mr. FLOOD. Now, I must have the school. This is a must. You are right. What do I do?

Secretary FINCH. Well, if we can begin this year and next to hold out hope that there will be Federal funds that would stimulate the formation of a community college, then presumably your local people could get together and start talking about those very problems. Whether they should have it located downtown in a building——

STATE BOARDS FOR COMMUNITY COLLEGES

Mr. FLOOD. What is this State thing?

Secretary FINCH. This is not a matter of legislation; it is a suggestion at this point. We have found that in those States where there are separate statewide boards for community colleges alone, where they don't get trapped into being a part of the higher educational board of regents or whatever, that——

Mr. FLOOD. We have a State Department of Public Instruction. We have a cabinet member there. He has been there for years and years and is very good. Should we create something else?

Secretary FINCH. Do you have separate governing boards for each of your institutions of higher education?

Mr. FLOOD. Yes.

Secretary FINCH. Well, you see, it varies from State to State. Some have a single person—in your case, the cabinet member—and in others there are statewide boards which govern their higher educational institutions——

Mr. FLOOD. Govern or advise?

Secretary FINCH. It varies. In some cases they are simply advisers, but in most cases they govern. In California the State regents govern the University of California. A separate board governs the 18 State colleges. A third board . . .

Mr. FLOOD. In my district the county commissioners, a board of three men, govern the county. They and they alone must give birth to this thing. What do they do? Any place in the country? Do you care about distance?

Secretary FINCH. I just wouldn't be presumptuous enough to try to tell them. They would have to come forward with a program and we would respond within the limits of this year's and next year's budget. We hope it would be a greater inducement for them to build——

Mr. FLOOD. This is a very, very, very serious problem nationwide. Here are my three county commissioners sitting in a courthouse, a small town. This is going to cost millions of dollars. The target date is many years from now. Now, suppose it is going to cost $10 million. Do I buy the land? What do I do? I am a commissioner, just a local guy. Do I buy the land or what do I do?

Secretary FINCH. Well, I hope that when we prepare the legislation we could build in a requirement for a State board which would try to rationalize which areas——

Mr. FLOOD. Do you recommend that Pennsylvania create a State board? What is a State board? A State board of what? What do you call it?

Secretary FINCH. It would be a community college board. Now, what you are suggesting would be for each community to deal directly with Washington, district by district. In terms of the use of our resources, I would tend to oppose that, but that is something——

Mr. FLOOD. Do you recommend Pennsylvania create a special commission, a special board or bureau for community colleges outside of the Department of Public Construction, or what?

Secretary FINCH. That would be my tentative recommendation, but I am not advocating specific legislation at this point. That is something we would want to work with you on, but this has been my present thinking.

Mr. FLOOD. We have a Department of Public Instruction. Do you suggest this creature separate from that department?

Secretary FINCH. That office might very well suffice to decide what these——

Mr. FLOOD. What do you suggest?

Secretary FINCH. If you are going to give the program the visibility it deserves and really excite communities in having a community college, you need a separate board. Otherwise they may get caught up and lost in the fight for dollars with the other higher educational institutions.

Mr. FLOOD. A separate bureau of community colleges?

Secretary FINCH. I would call it a board and get as prestigious a group of citizens as I could to serve on it.

Mr. FLOOD. An independent agency?

Secretary FINCH. Yes, sir.

ORGANIZATION FOR COMMUNITY COLLEGES

Mr. KELLY. There are about three kinds of prevailing practices now, Mr. Chairman. There are those which, as you suggest, use their elementary and secondary education program commission and extend it beyond high school to cover this. Then there are others who use their higher education commissions.

Then the third, of course, and the newer course of action is developing separate and independent commissions for technical and junior colleges.

Mr. FLOOD. For just this thing?

Secretary FINCH. Yes

Mr. KELLY. Well, it is a very large establishment. I think there are almost what——

Secretary FINCH. Four thousand.

Mr. KELLY. Four thousand.

Secretary FINCH. In one form or another.

Mr. MICHEL. Mr. Chairman, if I might make an observation, our legislature in Illinois has enacted a junior college law and now we have over 30 established at least in temporary buildings. The State puts up 75 percent of construction cost which will total $170 million this year alone and then the State also provides 50 percent of the operational cost at $11.50 per semester hour. What we are talking about here is five or six counties getting together to form a charter district and its working out very well in Illinois.

You were talking about where you put the buildings. Right now most of ours are still in temporary buildings but I will tell you they have a real fancy-Dan architect for the Central Illinois College just outside of Peoria. This is going to be one of the classiest junior colleges you have ever seen if it really is brought to fruition like the architects think it ought to be.

Mr. FLOOD. It is downtown?

Mr. MICHEL. No; it is outside on a beautiful spot overlooking the river on some high ground, but close to the interstate highway network.

Mr. SMITH. Are they high-rise?

Mr. MICHEL. No; they are all temporary buildings at present, but the new buildings contemplated are of a low, sprawled-out nature.

Mr. SMITH. We have 16 of them going up in Iowa and they are so spread all over the map that they can't get from class to class on a 10-minute break especially in bad weather and some of those boards told me that nobody had encouraged them to consider the benefits of high-rise. High-rises have many advantages over spreading them out.

Mr. FLOOD. In the year 2000 what have I got? I am giving birth to a community school.

Secretary FINCH. This is why we would like to see a State mechanism that will make a rational plan. First of all, you are going to have to rely on State legislatures to provide a good portion of this money. Of course, we are dealing wtih 50 different States that attack it in 50 different ways. Some rely more on the property tax than on State appropriations.

Mr. FLOOD. I don't understand this State approach. What do you mean? The State capital does what? The general assembly creates what? What do we create by law?

Secretary FINCH. The State legislature may or may not want to have its own plan, as Illinois did. But if you are going to make a community college program work, you are going to have to have a substantial infusion of money from the State general funds.

How it works in most States—and this is a broad generalization—it that a district is created and the fundamental source of income is the property tax. Then the State comes in with construction money—starter money. What we are proposing is that each State work out its own plan and then come to us so that we can help in whatever way our resources will allow. That is our interim proposal.

Mr. FLOOD. What do you do in California?

Secretary FINCH. California is very excited about community colleges because there were such high standards in universities and State

colleges that a lot of children simply couldn't get into them. The State has 90 community colleges now and many of them are fantastic plants. They look like——

Mr. FLOOD. Who owns the real estate? Who buys the real estate?

Secretary FINCH. A district is created. People assess themselves through bonds and through property taxes and there are local governing boards. The legislature ratifies a plan which the community proposes. It usually involves three, four, or five high school districts. In California, the community colleges sprang up pretty much on their own. Then 2 years ago the State responded to that development. For example, there are a lot of them along the coast, and they wanted to get in on the "sea grant" money. Suddenly there was a flow of about 30 applications to do oceanographic work. Just from that alone it was obvious we had to bring this confusion under control. So we created a community college board of very prestigious citizens appointed by the Governor. It has helped rationalize the whole system.

Mr. FLOOD. What does the State board do? What is their jurisdiction? Why do they exist?

Secretary FINCH. First, to try to even out some of the great disparities between one school and another. Also it sets patterns for their curricula and particularly sets patterns for faculty recruitment—there are great variances there—and provides a common resource for architects and prototypes.

Mr. FLOOD. Will the conditions vary because of local conditions?

Secretary FINCH. It varies for a lot of reasons: funding, faculty availability——

Mr. SMITH. They help recruit football players.

Secretary FINCH. They provide a great farm system for the State colleges and universities. They take the big guys and season them for 2 years, and then they come in with 2 years of eligibility.

PLANNING OF COMMUNITY COLLEGE CAMPUSES AND FACILITIES

Mr. FLOOD. I am really concerned because my people are going through this thing. Why can't we have a high-rise building? Must we go out into the suburban area because we have always done it—because we have always had a campus?

Mr. Michel had x acres with buildings here and there. In my country it gets very cold with snow and sleet and ice and what not. I must leave building A, I have an 8:30 class in math, and I must put up my galoshes and coat and parka and I must go a quarter of a mile to building C for history, because—why? Traditionally you must have a campus. You can't have a college without a campus. Is that it?

Secretary FINCH. Mr. Chairman, there is very little literature on this, but we tend to think, and I expect Mr. Butler will want to respond, that in a high rise there is a better exchange and mix among the students. You do not have great distances between classes. Again I want to make clear that we are talking about some initial approaches. Hopefully, we can come back next year with some concrete legislation.

Mr. FLOOD. This is the big new thing.

Secretary FINCH. That is right. I do not want to pretend we are trying to solve it all. I think in terms of the dollars we have in this budget, particularly for grants, that much of it should be for planning material that we can disseminate to areas such as the one you are describing, so that the thing is molded correctly from the beginning.

Mr. Butler, would you talk specifically on it?

Mr. BUTLER. Mr. Chairman, don't let me take a lot of time about this other than to say your suggestion is an excellent one.

Mr. FLOOD. You take all the time you want. We want information.

Mr. BUTLER. I am afraid we don't have as much information as we should. The point about the high-rise buildings is very well taken. In the urban buildings that I am familiar with, and we have talked to the Office of Education about it——

Mr. FLOOD. What do you mean by urban?

Mr. BUTLER. Oakland, Calif.

Mr. FLOOD. How big is that?

Mr. BUTLER. 500,000.

Mr. FLOOD. To us that is a great big place.

Mr. BUTLER. In our experimental school project we are going to try to encourage colleges to look at whole new systems of instruction. This could include the high-rise building idea where you get a much better mix of students in the community college.

What we would try to do is to let the community make its own decision. For example, do you want the traditional campus? We are encouraging them to take a whole new look at it.

Mr. FLOOD. I am from Wilkes-Barre, Pa. Today they are talking about this. Nobody is telling my county commissioners about this.

Mr. BUTLER. I think we ought to offer information to them.

Secretary FINCH. We will get in touch with them with whatever material we have.

Mr. FLOOD. There must be many, many places going through the throes of this thing.

Mrs. REID. If the chairman will yield a moment. Is it less expensive, and I presume it would be, to have a small amount of land and build a high rise than to have more land and build small buildings?

Secretary FINCH. It varies from area to area. One of the things we found in California was that in some cities, as people began to move out into suburbs and no longer wanted to come in and do their shopping, a hollow core developed downtown. Using existing buildings, modifying them, and putting a community college there, really brought to life the center of town again.

Mr. KELLY. I think the economics will depend on land values.

Secretary FINCH. The land values make all the difference.

Mr. BUTLER. Some places have successfully combined the community college with new county office buildings and other buildings—so instead of it becoming only a college, it becomes an integral part of the community that is used by the city government, students, and some industry.

It is a better educational environment.

Mr. FLOOD. This is a very practical thing. This is a tremendous idea. I am enthusiastic. But must there be ivy on the walls?

Secretary FINCH. We don't think so.

Mr. MICHEL. If I might make an observation at this point. This past week I was called on by a representative group from the University of Illinois, representing all the Big Ten schools. These are students who were saying we ought to provide more money for needy students to go to the University of Illinois because it is such a prestigious university, has all these goodies, and cheesecake and the things that we can't provide in our junior colleges. How do you respond to them? Shouldn't we tell them there is a limit to our ability to provide all these things, but a good education is nevertheless still available?

Secretary FINCH. This is another reason why I think we must have a State commitment. The States are going to have to continue to materially assist the community colleges in whatever form they take, whether it is an operating grant or whatever. When we come in with a full package of legislation, we are going to ask the States to make a commitment to help.

Mr. FLOOD. Mr. Secretary, you are doing a wonderful thing, in my opinion, in this community college business. I have seen it in Europe for years. I remember at the Sorbonne, there is a place about two blocks away, I had never heard of this place before. They give a 2-year certificate. This is 30 years ago. It is a very fine school. But it is right smack in the middle of Paris. It is very old. I don't know how old. I hope we are not going to simply buy real estate and set up campuses with the freshman peak caps and the striped tie for alumni and so on

Secretary FINCH. On that point, one of the very practical aspects, particularly if you can keep them downtown, is the convenient proximity to the people you are trying to reach. For example, the man who is working during the day and wants to take an evening class. You don't have to worry about residential construction. We do not have many streetcars any more, but these are what they used to call a streetcar campus. This saves a great deal of money. In the traditional campus, the residential part is expensive.

Mr. FLOOD. That is the town-and-gown department. I am concerned only about the town and not the gown people.

Secretary FINCH. I think the best we will be able to do within the constraints of this budget is to try to show some various prototypes.

Mr. FLOOD. I hope so.

Secretary FINCH. Then, in terms of the legislation we want to introduce next year, we will try to get a State response, which will make this a comprehensive program with workable components.

Mr. FLOOD. I am so afraid of the architects and planners. Not the local people, but they must hire people. These are businessmen. They know no more about setting up a school than I do. So they go to New York and Philadelphia and they hire professional architects to plan and build a community college. Of course, the first thing they do is get away from the central city and go out into my beautiful countryside, acres and acres of real estate. Beautiful country. They are going to build a community college there. Why? This is not what I thought. This is not what your predecessors told me, I don't think.

Secretary FINCH. There is no single answer to that. As I say, I think the best we can do now is to develop specific alternatives that we can afford.

FINANCING OF COLLEGE CONSTRUCTION IN 1970 BUDGET

Mr. SMITH. Before we leave the community college, what about construction? Are you visualizing a different method of financing the construction?

Secretary FINCH. This is why we would like to get the State component in there. We are not sure yet, and we have a lot more work to do on this. Just taking basically the old Hill-Burton formula may be the right way to go. We think there might be a variation of that to get them started.

Mr. KELLY. The budget plan conceives of a combination both of grants for the construction of community colleges, a continuation of the budget plan of $43 million in grants, and an increase in the amount of subsidized loans that are available.

Mr. CARDWELL. From $30 to $70 million in subsidized loans.

Mr. KELLY. Yes; which will provide for $70 million. So it gives you a total construction program of $113 million.

Mr. SMITH. What about nonjunior college higher education?

Mr. KELLY. There we eliminated the funds for the construction grants.

Mr. SMITH. Completely?

Mr. KELLY. That is right. But we held the subsidized loans at $220 million. It was only $138 million in fiscal year 1969. In the aggregate, we have $220 million available in the new 1970 budget for noncommunity college construction assistance as against $327 million in the January budget.

Mr. SMITH. They will be required to rely on loans instead of grants.

Mr. KELLY. To a greater degree. But we did hold the grants on community colleges.

The data that is available indicates that the greatest expansion in enrollment during the next 5 to 10 years in higher educational institutions will be at the junior college and the technical institute. That is where the emphasis is.

Secretary FINCH. There will be some leveling off on the higher educational side in the mid-70's as far as our information indicates. The most significant part of the budget is in the social security benefit increase, a 7-percent across-the-board increase effective February 1, 1970.

POSTPONEMENT OF AFDC FREEZE

Then probably the next critical item is the proposal to postpone the effective date of the freeze of the AFDC for at least another year. That is $321 million.

Mr. FLOOD You better say something about that because that is a glaring standout in the presentation.

Secretary FINCH. Particularly with what has happened in the Supreme Court this morning, it just seems to us that we must help these States.

Mr. FLOOD. You are very timely.

Secretary FINCH. I had nothing to do with the decision. We just felt, and this has been universal as far as the States are concerned, that we had to ask for a postponement of the effective date of the freeze and pick up the tab ourselves.

ESTIMATING PUBLIC ASSISTANCE COSTS

We have made a very, very grueling effort to avoid our mistakes of the past and get up-to-date State estimates of caseloads. Our last survey was completed just 2 weeks ago. I think we have come close to being accurate—probably far closer than any time in the past.

I wish you would speak to that, Mr. Kelly.

Mr. KELLY. I think that is right. I met with the State Budget Officers Conference on Friday and we discussed this. We are introducing, as we said, a completely new budgetary procedure which utilizes the States. As an interim measure we have been to the States three times during this fiscal year. They understood our need for their estimates and our concept that we were placing reliance upon their estimates as the way of determining Federal appropriations.

It is very clear now that they are seriously trying to make good estimates. They are beginning to stabilize, and the estimates from one period to another are not showing the fluctuations they have shown in the past. They are more refined estimates. For example, the total estimate this time was within $30 million of the estimate we got 2½ or 3 months ago. It did vary in its components. It varied in its components because they moved a substantial amount of funds.

Mr. FLOOD. They?

Mr. KELLY. The States moved substantial amount of funds from medicaid to public assistance because they concluded that people could properly be taken care of in the intermediary care facilities and did not require skilled nursing home care. They shifted a considerable amount of their patient load from one kind of facility to another with a resultant savings in cost.

Mr. HULL. Is that the concensus of all the States?

Mr. KELLY. Yes, sir.

INCOME MAINTENANCE EXPERIMENTS

Secretary FINCH. The other increase goes to tackle the income maintenance problem. This doubles the previous request. We feel that we have to find out more about this continuing dependency cycle.

Mr. Butler can tell you very briefly what is involved in these experimental programs.

Mr. BUTLER. Mr. Chairman, these programs will be designed to test alternative systems, and new approaches within the present system—for example, to eliminate the incentive for the breakup of families with the father leaving home.

Mr. FLOOD. How long have you been on board?

Mr. BUTLER. About 2 months. I guess I am still not officially confirmed.

Secretary FINCH. He is the Assistant Secretary-designee for Planning and Evaluation.

Mr. BUTLER. We will be testing what can be done to eliminate incentives that now exist for the breakup of homes, incentives that exist to get people out of work and on welfare. For example, in California if a woman working at the minimum wage were to quit work and go on to welfare and go back to work about 3 months later in the same job she would come out perhaps a thousand dollars a year ahead of where she was.

Mr. FLOOD. You have not seen the text of the Supreme Court opinion this morning?

Mr. BUTLER. No, sir. I think the tremendous inequities and even some absurdities in the present system are well known to most of you. These experiments are designed to test how those might be removed by various alternatives.

Mr. FLOOD. Various? What would be one?

Mr. BUTLER. One would be a work incentive provision whereby a person going to work retains 50 percent of his earnings. Under present systems he may lose up to 100 percent.

Mr. FLOOD. Can you explain how that would work?

Mr. BUTLER. Let us say under the present welfare plan you go to work and for every dollar earned you lose a dollar of welfare assistance. We are looking into the question of incentives in order to get more people off the rolls and into work, if they can retain half of the welfare payment, let us say, while they work. Over a period of time that would be phased out.

Mr. FLOOD. Mr. Secretary.

Secretary FINCH. If the chairman would agree, we might try just to run through this quickly.

SUMMARY OF REVISED BUDGET PROPOSALS

Mr. CARDWELL. We gave a very quick rundown of the amendments we are proposing. I know we are pressed for time.

Mr. FLOOD. No, we are not, with the Secretary.

Mr. CARDWELL. We want to make maximum use of the Secretary's time and yours as well. I will try to run through this as quickly as I can.

Mr. FLOOD. We have a copy of these figures.

Mr. CARDWELL. In terms of overall effect, you will find that there is a net adjustment of $592 million in appropriations that are being requested from the Congress for 1970. That excludes the request, that might affect the Social Security Trust Fund.

In terms of expenditures from the Treasury the net effect would be a reduction of $178 million. Adding the Federal funds and the trust funds together the total expenditure change for HEW, is a minus one billion, 227 million.

Mr. FLOOD. One billion, 227 million.

Mr. CARDWELL. $1,227,000,000. We are going to go through these changes with you. You will see that this net figure of $592 million is made up of a lot of pluses and minuses. Keep that in mind, if you will, as we go through. This is a summary of the changes by operating agency of HEW.

HEW
1970 BUDGET IN BRIEF
(In Millions)

	JANUARY BUDGET	REVISED BUDGET	CHANGE
FEDERAL FUNDS			
Budget Authority	$ 17,481	$16,889	$ -592
Outlays	17,421	17,243	-178
TRUST FUNDS			
Outlays	34,358	33,309	-1,049
TOTAL OUTLAYS	51,779	50,552	-1,227

SUMMARY OF CHANGES BY AGENCY

(Budget Authority In Millions)

	JANUARY BUDGET	INCREASES	DECREASES	REVISED BUDGET
Consumer Protection And Environmental Health Service	$233	$---	$-3	$229
Health Services And Mental Health Administration	1,306	+24	-160	1,169
National Institutes Of Health	1,499	+5	-52	1,452
Office Of Education	3,589	+32	-402	3,220
Social And Rehabilitation Service	8,712	+609	-620	8,701
Social Security Administration	43,553	---	---	43,553*
Special Institutions	76	---	-14	62
Departmental Management	55	---	-10	45
Total	59,024	+671	-1,262	58,432

*Amendment May Be Offered Later.

Mr. CARDWELL. For example, Consumer Protection and Environmental Health Service.

Mr. FLOOD. This is what we now call a realinement of priorities.

Mr. CALDWELL. Yes, sir. It shows a very small reduction, a minus $3 million. We will be talking about that in a little while. In the Health Services Mental Health Administration, by contrast, you will find a rather large reduction, minus $160 million. But there is one large item, the proposed reduction in Hill-Burton, that accounts for most of that decrease. The National Institutes of Health show a minus $52 million. The Office of Education shows a large——

Mr. FLOOD. You are certainly flying in the face of the gods on Hill-Burton, are you not?

Secretary FINCH. Yes. The Office of Education shows a large decrease, minus $402 million. There is a plus $32 million, and a minus $402 million. You will find that is accounted for in the main by four items: the proposed reduction in construction grants, the reduction in impacted area aid, reductions proposed in library resources, and in title III of the Elementary and Secondary Education Act. Those items combine to account for most of the reduction.

Mr. FLOOD. I wish you could read my mail on that.

Secretary FINCH. Social and Rehabilitation Service has a plus $609 million and a minus $620 million. The plus side includes two large items; the increase due to the AFDC freeze proposal, and then the increased requirements by the States.

Mr. FLOOD. That one item just about washes out the cut.

Secretary FINCH. Yes, sir.

Mr. CARDWELL. The States also showed an increase in their requirement for maintenance payments. But they proposed a decrease in their medicaid costs and we are also proposing additional decreases in medicaid.

In the Social Security Administration, in terms of budget authority, and the budget shows budget authority for social security trust funds in terms of revenues, we are not proposing any change at this time.

However, a review of overall Federal receipts from all sources, including taxes of all sources, may well end up in a proposal which would reduce the income from social security taxes as proposed by the Johnson budget. In the special institutions we show a minus $14 million. It affects the National Technical Institute for the Deaf.

Mr. FLOOD. You cut out the Deaf Institute.

Mr. CARDWELL. We have deferred the new construction.

Mr. KELLY. The construction.

Mr. FLOOD. The bricks and mortar.

Mr. KELLY. Yes, because they won't be ready. The plans and specifications are not scheduled to be ready until the very later part of the fiscal year 1970.

Mr. FLOOD. That is not well known. I didn't know that.

Mr. KELLY. As a part of this review we tested all of the facilities as to how far along in design they were and what their latest schedule was.

Mr. FLOOD. I didn't know that.

Mr. KELLY. All the evidence is that this facility will not be available to start construction until the early part of fiscal year 1971.

Secretary FINCH. I think we should send a letter to the chairman on that.

Mr. FLOOD. Yes; I didn't know that.

Mr. CARDWELL. They are aware of the problem.

In departmental management we show a minus $10 million. You will find that is related to a change in the legislative proposal for the Public Broadcasting Corporation.

Mr. FLOOD. How much is it cut?

Mr. CARDWELL. Minus 10.

Mr. FLOOD. How much is it cut?

Mr. CARDWELL. From 20 to 10. This is the Public Broadcasting Corporation.

Mr. FLOOD. What is the change by law?

Mr. CARDWELL. It takes law to fund the program this year. There was a $5 million one-time grant authorized for 1968. That authorization was funded and we have made a one-time payment to the Corporation. The Johnson budget proposed an additional $20 million in 1970. This would require authorizing legislation, but the budget contained a request of $20 million for another basic financing grant. We have taken a look at it and are proposing 10 as an interim arrangement.

Mr. FLOOD. Do you have law?

Mr. CARDWELL. Not yet.

Mr. KELLY. It requires an enactment before it can be funded.

Mr. CARDWELL. In some. We have increases adding to $671 million and we have decreases amounting to $1,262,000,000.

Mr. KELLY. What was the first figure?

Mr. CARDWELL. Increases of $671 million, decreases of a minus $1,262,000,000. Here are the changes as compared in 1969. In other words, this is the budget as it is now in place for this year. It adds up to almost $52 billion for HEW, including $37.9 billion worth of trust funds. We thought it would be interesting to prepare the Johnson change over 1969 with the revised budget change over 1969.

Mr. CARDWELL. Because of our net reduction there is a difference. The Johnson budget would have been greater than 1969 by $7 billion and we raise it about six and a half billion.

Mr. FLOOD. Your reduction is in one area.

Mr. CARDWELL. We have reductions, as I mentioned earlier, in the Consumer Protection and Environmental Health Service.

Mr. FLOOD. It is bookkeeping on social security.

Secretary FINCH. Yes, sir.

Mr. CARDWELL. In terms of budget authority it is a bookkeeping item.

Mr. FLOOD. Of course it is.

CHANGES OVER 1969

(Budget Authority In Millions)

AGENCY	1969	JANUARY BUDGET	REVISED BUDGET
Consumer Protection And Environmental Health Service	$227	$+6	$+2
Health Services And Mental Health Administration	1,173	+132	-4
National Institutes Of Health	1,410	+90	+43
Total, Health Agencies	2,810	+228	+41
Office Of Education	3,677	-87	-457
Social And Rehabilitation Service	7,409	+1,303	+1,292
Social Security Administration	37,909	+5,644	+5,644 *
Special Institutions	36	+40	+26
Departmental Management	36	+19	+9
Total	51,877	+7,147	+6,555

*Amendment May Be Offered Later

MAJOR INCREASES

(budget authority in millions)

	1969	1970 JANUARY BUDGET	1970 REVISED BUDGET	CHANGES FROM JANUARY
Maintenance Payments	$3,425	$3,638	$4,240	$+602
Experimental Schools	---	---	25	+25
Community Colleges Interest Subsidy	4	11	12	+1
Nutrition	1	1	5	+4
Aid To Medical Schools	66	96	101	+5

PUBLIC ASSISTANCE

Mr. CARDWELL. On the next chart are the major increases in the budget. The most significant is the maintenance payments requirement.

Mr. FLOOD. What is that?

Mr. CARDWELL. That is public assistance.

Going up by plus $602 million. That is made up of three items. The State estimates in January——

Mr. FLOOD. Off the top of your head, how many hundred thousand people are affected by the decision of this morning, two or three hundred thousand?

Mr. KELLY. I do not really know, but I don't think it is anywhere near that.

Mr. CARDWELL. We will remind Mary Switzer to talk to that subject tomorrow.

Mr. FLOOD. Tell her I would like to know about the number and about the dollars.

Mr. CARDWELL. In their March review the States identified that maintenance payments would go up by $229 million in terms of Federal matching. We added in the proposal to fund the deferral of the freeze, adding $220 million and then when we get to the discussion of the change in the social security increase——

Mr. FLOOD. That deferral is a year-by-year thing.

Mr. CARDWELL. At this point it is. The legislation itself has not been drafted. We are describing it at least as a postponement. It may end up in the form of a rescission. But that would add $321 million. The difference in the effect of the social security benefit legislation, the Johnson administration proposed a 10-percent increase, we are now proposing a 7-percent increase effective in 1970, the Johnson proposal would have reduced the cost of public assistance by $81 million, because it would have taken people off the rolls. We estimated that as a savings of $81 million.

By going to 7 percent that savings drops down to $30 million. So we had to increase the January estimate by $51 million, the difference. In sum this is made up of three items; $229 million additional State requirements; $321 million cost of the freeze, and a $51 million increase.

Mr. FLOOD. Is there any way of improving the budget estimates for these public assistance programs?

Mr. KELLY. Last year you did make an inquiry into this. Partly as a result of that there was a medicaid task force set up which included State health people, State health welfare people, State budget officers, and HEW people. They recommended a reformed system of both estimating and of being currently apprised of trends and progress in reports. That medicaid task force report was commended by the State budget officers group, by the Inter-Governmental Relations Council. The Department adopted it.

Mr. FLOOD. When?

Mr. KELLY. The report was filed last fall. The original findings were presented in a meeting held this past summer.

Mr. FLOOD. Are you satisfied?

Mr. KELLY. I am satisfied. As a result of that study a keen interest has developed at all levels: the welfare level, the health level, and the State budget officer's level, and with the Bureau of the Budget and HEW.

Mr. FLOOD. I indict nobody but there is something badly wrong.

Mr. KELLY. I think this year we have improved. The new procedure will actually go into effect on August 15 of this year, at which time they will present under the new procedure their total budget estimates. Every quarter they will update those estimates on the basis of transient experience.

Mr. FLOOD. This amounts to hundreds of millions of dollars.

Mr. KELLY. Yes.

I believe we are more nearly at the point at which you are asking that we be, that we have an organized budget procedure which produces reliable estimates than we have ever been in the past.

Mr. FLOOD. I hope so.

Mr. CARDWELL. Mr. Chairman, we will break this maintenance payments down for you in a later chart.

Mr. MICHEL. Mr. Cardwell, before you leave that, you mentioned that the $602 million was made up of the $322 million for the deferral of the freeze, and $229 million for additional State payments. What is the $51 million?

Mr. CARDWELL. The Johnson budget assumed legislation that would increase social security benefits by 10 percent. That actually reduces your maintenance payments requirements. That budget estimated re-

duction of $81 million. We have revised that estimate and it is now estimated at $30 million.

Mr. FLOOD. The 7 percent.

Mr. KELLY. As a result of the 7-percent increase.

Mr. CARDWELL. That actually gives you an increase. We had to increase the estimate because the decrease was not going to be as great as we thought. The Secretary already mentioned the experimental schools, the plus $25 million.

EXPERIMENTAL SCHOOLS

Mr. FLOOD. What is an experimental school, Mr. Secretary?

Secretary FINCH. It can take many forms. What we are trying to work toward, Mr. Chairman, is greater year-round use of the present bricks and mortar.

Mr. FLOOD. You mean 12 months a year, day and night?

Secretary FINCH. Yes, sir. We are trying to develop modular ideas.

Mr. FLOOD. I think that is a great idea.

Secretary FINCH. We cannot rush in and club these local districts over the head, nor do we want to. They have encrusted systems that we have to change by persuasion.

Mr. FLOOD. You have in mind adults as well as children?

Secretary FINCH. Yes. In many cases we might even combine both.

Mr. FLOOD. Not a dance hall?

Secretary FINCH. No, sir. Particularly in the teaching discipline, we might combine the community college concept with this so-called experimental school or community schools as somebody has described them here in the District, because there you can have a real teaching experience. Those who are being trained as teachers can also work with some of the children. We have had a number of proposals.

Mr. FLOOD. Where will you get your faculty?

Mr. BUTLER. In these new schools we want to experiment with whole new approaches to faculties.

Mr. FLOOD. Where would you get your faculty?

Mr. BUTLER. We want to look at the possibility of using community college students as faculty in high schools. We want to look at 10-year-old children, who are having difficulty, teaching 6-year-old children.

Statistics show that perhaps the best teachers are kids 4 years older than the ones being taught. The result is teaching and learning back and forth between the two of them.

Mr. FLOOD. Who will work at night?

Mr. BUTLER. Again we want to look at all different variations. If we are using community college students they would be working at night. Instead of washing dishes in a cafeteria they are working teaching kids at night. We might have day-care centers combined with them.

Mr. FLOOD. Sort of on-the-job training?

Mr. BUTLER. Yes.

Secretary FINCH. We tend to find that the best way to improve teaching is to do more teaching. The only way you learn to be a better teacher is to teach.

Mr. FLOOD. That is very logical.

Secretary FINCH. There were a lot of people for a long time who thought that was not the way to go about it

Mr. FLOOD. Yes, I know.

INTEREST SUBSIDY GRANTS

Mr. CARDWELL. The next item is the community college interest subsidy. It is only a million dollar increase going from $11 to $12 million. It would take us to the maximum authorization for community college subsidized interest. It will buy us an additional $40 million worth of financing from the private sector for construction of community colleges. There is already $30 million in the budget.

Mr. FLOOD. The colleges would borrow directly from a local bank.

Mr. CARDWELL. Yes, sir.

NUTRITION

The next item is an increase of $4 million in nutrition. We will have spent about $950,000 this year on the surveys of the five States. We hope to extend that to 10 States before the year is out. We would add $4 million under our new proposals.

Mr. FLOOD. Who would examine nutrition?

Mr. CARDWELL. It would assentially be the local health department. One of the plans we are thinking about would be to actually finance physicians in about 50 localities to evaluate the status of both children and adults in the community as to their nutrition and their health. The whole thrust is to add to our knowledge about the problem of nutrition, where it is, what its real impact is, and to give us some ideas where we should go from there.

Mr. FLOOD. Is this a job for a physician or a sociologist?

Mr. CARDWELL. I would say a physician and a statistician.

Mr. BUTLER. We have a national nutrition survey going on now under Dr. Arnold Schaefer who is one of the leading authorities in the field. He is operating under the Health Services and Mental Health Administration. That survey is going on now. The Secretary requested the Governors of a number of States to assist us in the survey. Now six or eight States we had not previously anticipated surveying have asked us to broaden our survey and include them. This money would assist us to do that, as well as the things Mr. Cardwell was talking about.

Secretary FINCH. There has been a great deal of rhetoric about this nutrition problem. I think it is important to point out that we are not just talking about the poor and the disadvantaged. They are making some heroic steps with the food stamps. But there is an awful lot we do not know about soft drinks, and potato chips—what is malnutrition and not just subnutrition. We want to find out a lot more than we know now as to what constitutes a proper diet, and the dietary impact during the first 5 years. We have some startling preliminary information that shows that the child can never catch up if he has not gotten a proper nutritional balance during his earliest years. The mother may think she is feeding the child because he has something in his stomach, but the child gets 2 or 3 or 4 years behind in terms of his capabilities.

Mr. MICHEL. We have made the comment to several previous witnesses that there seems to be three pretty sacro-sanct words, nutrition, family planning and rubella. I have seen that word nutrition everywhere. Granted it is a politically sexy thing for now, but I would like to see it someplace all put together. Before we actually get to marking up, I will have someone go through the hearings and pick

out these various spots where everybody seems to be zeroing in on nutrition. Granted what you say ought to be done and we ought to know about it but I want to make sure that we're not duplicating the effort a hundred times over.

Mr. FLOOD. I used to think I knew what the word "nutrition" meant. Now I'm not so sure.

Mr. CARDWELL. As we mentioned in the earlier hearings when the subject came up, we used the word loosely. We are talking about something much more profound than malnutrtion as you normally visualize it. We are talking about the effect on learning, the effect on future health, the whole range of things that the Secretary pointed out. Forgive us for having over-used this word, but it is something we are taking very seriously.

Mr. FLOOD. So are we. You heard Mr. Michel and you heard me. So are we.

AID TO MEDICAL SCHOOLS

Mr. CARDWELL. On aid to medical schools, the Johnson budget has $96 million for health professions development generally. This would include doctors, dentists, podiatrists.

Mr. FLOOD. Nurses?

Mr. CARDWELL. No, it does not include nurses in this particular appropriation. We are adding $5 million to the total to go directly to medical schools to be used exclusively to enlarge enrollment of physicians. Then we are directing that of the $96 million in the Johnson budget another $5 million be reprogramed away from other disciplines and directed toward physician training. Our hope is that——

Mr. FLOOD. From your budget?

Mr. CARDWELL. That is right. We are asking you for another 5, and we are saying we will re-program 5 within the total for an increase of 10. Our goal is to get 1,000 new students.

Mr. FLOOD. I would rather that statement come from the Secretary. Do you know about that?

Secretary FINCH. Yes, sir.

Mr. FLOOD. You are going to reprogram 5?

Secretary FINCH. Yes.

Mr. FLOOD. We never heard this before.

Mr. CARDWELL. No, sir; this is part of the new review.

Secretary FINCH. This is a change.

Mr. FLOOD. What are you going to do?

Secretary FINCH. In a very real sense there are a number of these institutions that are marginal right now. We have had two dental schools close in St. Louis alone in the last 3 weeks.

I will ask Mr. Kelly to give you the specifics, but I feel very keenly that the main thing is not only to increase the number of doctors we were producing, but to make sure we keep these schools operating. They are really marginal.

Mr. FLOOD. By the way, Mr. Kelly, is there any trouble getting students?

Mr. KELLY. No, the number of qualified students that apply for medical schools still substantially exceeds the number that can get in.

Mr. FLOOD. What about dental schools?

Mr. KELLY. The same is true of dental schools.

TRAINING OF NURSES

Mr. FLOOD. What about nurses?

Mr. KELLY. The nursing school situation is somewhat different. The nursing schools have, as you know, four programs: the practical nurses program; the junior college program——

Mr. FLOOD. You are stressing that?

Mr. KELLY. Yes. Then there is the old diploma school, the 3-year hospital school; and the fourth, the degree nursing school.

Mr. FLOOD. Why are you mad at these people?

Mr. KELLY. We are not. We actually have a larger school capacity for nurses than we have students.

Mr. FLOOD. You intend to do a hatchet job on them.

Mr. KELLY. No, sir. As a matter of fact, every one of these systems of teaching nurses is being supported. But it is true that the capacity to train nurses today is greater than the number of students enrolling in nursing schools. Within the present system you could increase the enrollment quite significantly without further construction. There is still a serious shortage of nurses and a great deal of attention being given to bring back trained nurses that are not now working.

Mr. FLOOD. Are you calling older women back?

Mr. KELLY. There is a very concerted effort to try and bring them back into the market.

Mr. FLOOD. You know, I have been in the hospital a number of times in the past 10 years. There is nothing in the world more satisfying, encouraging or helpful than to have one of those older women who has come back, walk in that room. She is near her middle fifties, and has been away for years but very, very considerate and efficient. They are something marvelous.

Mr. KELLY. If you would just make your example a little younger and very attractive, I can tell my wife how you feel because she is one of them.

INCREASING MEDICAL SCHOOL ENROLLMENTS

Now, to return to the aid to medical schools, the result of that $10 million budget adjustment for medical schools will make the freshman enrollment 1,600 larger in 1970 than it was in 1969.

Mr. FLOOD. Is that good?

Mr. KELLY. Yes, sir; and it is 1,000 first year students more than was in the budget originally presented to you.

The amendment proposes that an additional $5 million be added to special improvement grants specifically to accelerate enrollments in medical schools and that another $5 million of the current request of $49,900,000 for special project grants in 1970 to assist schools of medicine, dentistry, osteopathy, optometry, podiatry, pharmacy, and veterinary medicine, be used to aid schools in their enrollment increases.

Mr. FLOOD. Why do I detect there is not the rush to go to medical college that there was 10 years ago?

Mr. KELLY. I think in terms of 10 years ago you are right. I think at one time we were at a point where we had something like 7.5 students approved for entrance for every seat there was in medical school. Today I think that figure is closer to 3.5 or 4. But there is still a very much larger number of students approved for entrance than the

schools can take. I am not sure how much overlap there is because a student will apply to more than one school.

Secretary FINCH. Our basic problem is still the problem of the distribution of doctors after they are licensed to practice.

AID TO NURSING SCHOOLS

Mr. CARDWELL. Mr. Chairman, could I interject a point on your question to Mr. Kelly about our attitude and approach to assistants and nurses? I think that question may well stem from one of our earlier hearings in which there was some criticism from the committee about the fact that there was only $7 million institutional support for nursing schools. The question was raised as to whether that should not be larger. The answer that was given was similar to the one Mr. Kelly gave us and that was——

Mr. FLOOD. You mean bricks and mortar now?

Mr. CARDWELL. Yes. Secretary Finch has left that budget item intact. He did not propose any reduction in the budget as it affects nursing.

Mr. FLOOD. Mr. Secretary, I wish you would write every member of the subcommittee a memo on just that point. We are getting lots of mail on this, just that one thing.

DECREASE IN HILL-BURTON PROGRAM

Mr. CARDWELL. Now we start talking about some of the major decreases in the budget. We have, as the chairman stated, "challenged the gods" by proposing a $104 million decrease in the Hill-Burton program. That is a net figure. We proposed a minus $113 million in grants for general hospital construction and an offsetting increase of $9 million in extended care and community ambulatory facilities.

Mr. FLOOD. Well, Mr. Secretary, what about that? This is exhibit A. You are cutting Hill-Burton?

Secretary FINCH. That is correct, sir.

Mr. FLOOD. Did you cut it, Mr. Secretary, or the Bureau of the Budget?

Secretary FINCH. This was worked out with the Bureau of the Budget, along with the general scheme of——

Mr. FLOOD. You are not in favor of it; are you?

Secretary FINCH. Let's put it this way——

Mr. FLOOD. That is a leading question.

Secretary FINCH. The Hill-Burton program in my opinion, and in the opinion of the Department, has largely done what it was intended to do in terms of the number and types of physical plants that have been built. What we are confronted with now is the need to update, upgrade, and improve these existing facilities.

Mr. FLOOD. This is not retroactive, of course?

Mr. CARDWELL. No, sir. It is proposed to be effective in 1970, and is tied to a legislative proposal.

Mr. FLOOD. What about applications not acted upon as of this morning?

Mr. CARDWELL. It could affect them if they were approved for 1970. It would not affect those approved for 1969.

MAJOR DECREASES

(budget authority in millions)

	1969	1970 JANUARY BUDGET	1970 REVISED BUDGET	CHANGES FROM JANUARY
HEALTH:				
Hill-Burton	$258	$258	$154	$-104
Regional Medical Program Grants	56	96	74	-22
NIH Research And Training	1,094	1,093	1,065	-28
EDUCATION:				
Impacted Area Aid	521	315	202	-113
Supplementary Education Centers	165	173	116	-57
Higher Education Construction Grants	91	150	43	-107
Library Assistance:				
Services And Grants	79	81	44	-37
Construction	9	9	---	-9
Schools	75	67	12	-55

Mr. CARDWELL. Mr. Chairman, could I make one point on this? This is related to a legislative proposal which the new administration has suggested to the Congress. This would shift the grant portion of the existing program more to ambulatory and extended care facilities, and would finance the acute-care hospital construction by means of interest guarantees of loans from the private sector. Now that would become effective——

Mr. FLOOD. This is not responsive. I am talking about a Hill-Burton cut, period.

Mr. CARDWELL. I just wanted you to have that background. This is a part of the new look.

Mr. FLOOD. I would think that the committee would be concerned about this one cut very much.

Mr. MICHEL. We know it is a very sensitive one, true, and I think if we are going to sustain this kind of a figure, we have got to have very clearly spelled out how it is supplemented. Out in the hustings there are still all these applications that are going to be coming in for Hill-Burton money. Frankly, if we want to reorient the method of financing by subsidizing interest rates in the private sector, then I think we have got to have that pretty well spelled out. What do the prognostication and estimates show we can do? Hill-Burton is a very popular program. We can all make ourselves heroes by going in with amendments for an increase of $100 million.

Secretary FINCH. By way of general background, the general statement we have prepared——

Mr. FLOOD. And, of course, Mr. Secretary, Mr. Michel may be questioned about this on the floor.

PROPOSED CHANGES IN HILL-BURTON LEGISLATION

Mr. BLACK. We have a bill before the Congress now, Mr. Chairman, that gives the details of the new Hill-Burton program.

Mr. KELLY. The legislative plan would shift the construction of acute care patient facilities from grants to loans. At the time the Hill-Burton program was initiated over 20 years ago, the concept was not only to develop facilities where they are needed, where there was an unmet patient care need——

Mr. FLOOD. We are not talking about intensive care. We are talking about bricks and mortar, a wing on a building.

Mr. KELLY. This is entirely in terms of general hospital bed needs. The construction of the hospital.

When the Hill-Burton bill was originally written, and over the years since, there has been a concept that we should keep the cost of the depreciation of facilities out of the hospital patient's bill. The advent of prepayment plans—Blue Cross and others—then medicare, and then medicaid, has reversed this concept. Today, irrespective of who paid for the construction of the building, the patient is paying for the depreciation and the potential replacement of the facility as a part of his patient care expenses. Therefore, this concept that you should subsidize the construction has lost its original purpose. You now are paying depreciation, generally speaking, as a part of the hospital bill you receive. So it seemed appropriate to modify the method of financing to go to loans. These loans would then be repaid by the patient. Now, patients who are unable to pay are probably covered by medicare or medicaid, and those programs do include depreciation costs in their payments.

At the time the original Hill-Burton law was written, small towns and rural areas had a substantial unmet need in hospitals. That need has very largely been met. But in the interim period the hospital systems of the big cities—the places that had adequate hospitals—now have deteriorated facilities.

Mr. FLOOD. There are architects who specialize in building hospitals. All they do, Mr. Michel, is dust off the design from the time my grandfather was chairman of the board. They are obsolete the day construction is completed.

Mr. KELLY. One of the responsibilities that has gone to the new National Center for Health Services Research and Development is to find ways to improve the delivery of health services by having better designed hospitals. That depends in part on automation and places greater emphasis on ambulatory care and a lesser emphasis on the in-patient care.

Mr. MICHEL. When we add to an existing facility, we are inhibited as to what we can do in upgrading or modernizing by the very fact that we are tying it to an outmoded building.

Mr. FLOOD. That is a good point. We build wing A on the existing facilities built in 1903.

Mr. MICHEL. I remember the Secretary making an observation earlier in answer to one of my questions for expediency's sake, and with our present limitations, we enlarge the medical schools we have rather than going out in the middle of nowhere, anew, starting from the grassroots with a new facility. We just can't do that.

Mr. KELLY. A very substantial part of the modernization program will be replacement. Very frequently you are better off to——

Mr. FLOOD. You are going to tear down a building and build it someplace else?

Mr. KELLY. That is correct. The cost of modernizing an existing plant is very great and it may not produce satisfactory results. In addition, there is the problem of caring for the patients while the facility is being modernized.

Mr. SMITH. The cost-per-patient day without depreciation may be more in the old building than it is with depreciation in a new building.

Secretary FINCH. That is true. What is happening in many, many of these cases is that the existing plant acquires property next door and places an extended care facility there. This cuts down on the number of patient days in acute care. I have seen it in city after city, just in the short time I have been in this office.

Mr. FLOOD. Mr. Michel, we are still on Hill-Burton, and I think we should examine this now because of its great interest and wide concern nationwide at this point rather than waiting until the Secretary finishes his statement.

EFFECT OF BUDGET AMENDMENTS ON NUMBER OF HILL-BURTON PROJECTS

Mr. MICHEL. Do we have any indication what the volume of applications for Hill-Burton might be and how they might be affected by this change in these budget amendments?

Mr. CARDWELL. There are some data that suggest a total unmet need of many billions of dollars worth of new hospital construction and and modernization.

Mr. FLOOD. How do you know that?

Mr. CARDWELL. This is an estimate that the Division of Hospitals of the Health Services and Mental Health Administration made. We

can give you very finite estimates of potentially approvable projects for this year or next year.

Mr. FLOOD. Suppose you do?

Mr. CARDWELL. This is looking at the whole spectrum.

Mr. FLOOD. Suppose you do.

Mr. CARDWELL. We will be glad to insert it in the record.

(The information follows:)

EFFECT OF NIXON AMENDMENTS ON THE HILL-BURTON PROGRAM—NUMBER OF PROJECTS[1]

Type of project	1969	1970		
		Original	Amended	Difference
Hospitals, public health centers, and clinics:				
Hospitals	172	137	42	−95
Public health centers and laboratories	42	30	10	−20
Subtotal	214	167	52	−115
Long-term care facilities	184	158	174	+16
Diagnostic or treatment centers	75	63	70	+7
Rehabilitation facilities	32	26	29	+3
Subtotal	291	247	273	+26
Modernization	118	101	31	−70
Grand total	623	515	356	−159
Beds provided:				
Hospitals, public health centers, and clinics: Hospitals	11,545	9,695	2,965	−6,730
Long-term care facilities	10,880	8,920	9,820	+900
Modernization	8,455	6,575	2,010	−4,565
Grand total	30,880	25,190	14,795	−10,395

[1] States do not establish their priorities based on the need for individual projects in the State as a whole. Instead, health facility service areas are constituted on the basis of population concentrations. The States then develop priorities reflecting the needs of these separate service areas. If a high-priority service area has one or more approvable construction grant applications, it will be funded first. Whether a lower priority service area can be reached at all during a specific fiscal year depends upon whether the high-priority areas come up with approvable applications. This arrangement makes it impossible to predict with any accuracy on a State-by-State basis the number of projects that will be funded at alternative Hill-Burton appropriation levels.

GUARANTEED LOANS FOR HOSPITAL CONSTRUCTION

Mr. CARDWELL. The point I was going to make is based on the history of Hill-Burton over the last several years. We are not going to solve the problem with direct Federal appropriations. This is all the more reason to move to some form of federally guaranteed loans. In the proposal which HEW testified on about 3 weeks ago, we were talking about financing in 1970 about half a billion dollars worth of construction with guaranteed loans.

Mr. MICHEL. Talking in those terms the objective really is providing more—substantially more—by way of guaranteed loans construction.

Mr. BLACK. Under the old proposal there was a quarter of a million dollars, $258 million. Under our new proposal there could be $650 million available.

Mr. MICHEL. Because there would be a half billion dollars under the guaranteed loans.

Mr. BLACK. Yes; that would go for this backlog of modernization cost which is estimated by the States at about $11 billion.

Mr. FLOOD. Mr. Black, how long have you been around?

Mr. BLACK. A little longer than Mr. Butler. Since about the first of February, sir.

Mr. CARDWELL. He appeared before the committee when we were here last with the Secretary.

Mr. BLACK. You would have a total of about $650 million available. Of the present $250 million, about $150 million is going for acute care facilities in the hospitals.

ACUTE CARE FACILITIES

Mr. FLOOD. Is this what we call intensive care sections?

Mr. BLACK. No, general beds; other than out-patient facilities.

Mr. FLOOD. Why do you say acute?

Mr. KELLY. That refers to short-term patients.

The acute patient care is the general hospital where patients spend a few days rather than a few weeks. It is in-patient but it is short term as distinguished from the nursing home type care.

Mr. CARDWELL. The bed you occupied at Georgetown last fall was an acute care bed.

Mr. FLOOD. I was there only 3 days. I should not have taken up this bed. In other words, I took up a bed I should not have been in.

Mr. CARDWELL. No. The Georgetown Hospital is a general hospital and most of its facilities are for acute care. I think if you were to stay at Georgetown for 6 months we might suggest you go to another building.

Mr. KELLY. Or 6 weeks.

Mr. CARDWELL. I did not know where to draw the line. At the committee's pleasure we can discuss Hill-Burton or as the Secretary suggested give you a paper.

Mr. MICHEL. As for me there are various approaches of realineing your objective, and I think there is a good deal of soundness to taking the loan approach. That satisfies me for the moment although I will be waiting for the statement that will deal with this in depth.

EXTENDED CARE FACILITIES

Mr. FINCH. The balance of the money goes to the extended care facility and would provide a great deal of flexibility there.

Mr. BLACK. That is about a 100 million out of the present grant program. This is the kind of facility that our proposed grant program would be directed toward. We would be putting about $150 million into that.

So we are in effect increasing the portion of it by about 50 percent in the hope that we will make other types of facilities available, so that the patients will not have to use the more expensive general care facilities.

COST OF GUARANTEED LOAN PROGRAM

Mr. MICHEL. I have one final question.

Could we have a ballpark figure of what ultimately this guaranteed loan program will cost us in dollars?

Mr. BLACK. Not very much, we hope. The authorization would be a half billion dollars in loans for each of the 3 years we are proposing for the program, subject to approval by the committee.

Mr. MICHEL. Half a billion.

Mr. BLACK. Half a billion in loans that we would guarantee.

We have a charge in there of a half percent. We would hope to insure this.

Mr. KELLY. It is a self-supporting program.

Mr. FLOOD. Mr. Shriver?

Mr. SHRIVER. I do not think I have any questions at this time. I think the people of the country are going to be writing us a great number of letters.

Mr. CARDWELL. There is no question about it.

Mr. FLOOD. I want you to know, Mr. Secretary, Mr. Shriver and Mr. Michel are quite right. As you can imagine, we are getting from the provinces a tremendous amount of mail. You realize I am on the board of two hospitals, and as you know hospital boards are made up of the so-called establishment and they are very difficult people. They want the budget balanced, they want taxes reduced, but——

Secretary FINCH. They want that hospital.

Mr. FLOOD. You may proceed with the presentation, Mr. Secretary.

Secretary FINCH. Mr. Cardwell.

Mr. FLOOD. We do not intend to rush on this. Under the circumstances this is extremely important.

Secretary FINCH. I understand very well.

REGIONAL MEDICAL PROGRAM

Mr. CARDWELL. The next item is the regional medical program, and I wish Mr. Natcher were here because he raised serious questions regarding 1969 on how we would obligate the balances.

Mr. FLOOD. I might say this: Mr. Natcher, who is concerned about this particular item, is not here today because he is chairman of the Appropriations Subcommittee for the District of Columbia. They have important hearings started today. I am sure otherwise he would examine this.

Mr. CARDWELL. We will go out of our way to be certain that he understands what we are proposing.

Mr. FLOOD. I am sure you would.

Mr. CARDWELL. I think it is somewhat in keeping with an idea which he suggested to this committee. In 1969 there were appropriations of $56 million, to which we have added $36 million worth of prior year appropriations that continue to be available.

The budget assumed $92 million worth of operational planning grants this year. Mr. Natcher then raised the question: Can the committee be assured that all of those moneys—the $92 million, consisting of $56 million worth of appropriations and $36 million worth of carryover balances—will be obligated this year?

We are going to try to smooth the program out with this amendment. We will freeze in place $20 million worth of grants in 1969, and we are proposing a reduction of $22 million in appropriation requests for 1970. Using the $20 million we carry over into 1970 and adding it to the $74 million we are asking you for, we would have about the same program level we were proposing originally—$94 million. We will go out of our way to be certain that Mr. Natcher receives a presentation on this and we can also discuss it with him when he comes back.

NATIONAL INSTITUTES OF HEALTH

For NIH research and training, we show a reduction of $28 million. We will give you another breakdown of that in a couple of charts.

The FLOOD. I am personally unhappy about this.

Mr. CARDWELL. NIH?

Mr. FLOOD. Yes.

Mr. CARDWELL. You will find that NIH fares fairly well in the context of a very tight budget. I hope you will have that impression when you see the detail.

Mr. FLOOD. I hope you are right.

IMPACTED AREA AID

Mr. CARDWELL. The next most controversial item is clearly the impacted area aid reduction. The Johnson budget cut this from $521 to $325 million. We are proposing to take it even further down to $202 million. We would specify——

Mr. FLOOD. We are going to have a hard time with this one. A lot of Members who are usually in favor of economy won't go along with this. You are going to lose this finally.

Secretary FINCH. I recall the discussion of our last testimony, Mr. Chairman. I am well aware of the problems involved.

Mr. FLOOD. It is no reflection upon you or your administration.

Secretary FINCH. No; this has been a continuing problem.

Mr. CARDWELL. Under this $202 million proposal we would propose appropriation language similar to the language proposed by this subcommittee last year. Support should be available only to support school districts having an impact from families who both live and work on Federal property.

SUPPLEMENTARY EDUCATION CENTERS, TITLE III ESEA

The next reduction is a proposal to reduce supplementary education centers under title III of the Elementary and Secondary Education Act.

Mr. FLOOD. What is a supplementary education center?

Mr. CARDWELL. The original concept of the law as enacted in 1965 was that these centers would be innovative experiments in new approaches to elementary and secondary education. In the measure of many, this has not really come off as well as it had been expected. The program still seems to be struggling to find its place in elementary and secondary education.

We are proposing to pull the program back down to the 1969 level.

Mr. FLOOD. You were not against the idea? You just simply want to mark time?

Mr. CARDWELL. This would finance the continuation in 1970 of projects that would be funded in 1969. What we are really saying to you——

Mr. FLOOD. This is no hatchet job now? You are not going to phase this out?

Mr. CARDWELL. No. We would favor holding this program in check while we move ahead with the experimental school program we described earlier.

Mr. FLOOD. You are realining your priorities?

Mr. CARDWELL. Absolutely.

Mr. BUTLER. Mr. Chairman, one of our thoughts this year was while we are holding——

Mr. FLOOD. By the way, what is your background?

Mr. BUTLER. I cannot say I was a newspaperman, Mr. Chairman. I am a lawyer and spent most of the last 8 years working on education and health programs.

Mr. FLOOD. Have you ever practiced law?

Mr. BUTLER. For 10 years. I tried many cases. I did nothing but practice law for 10 years.

Mr. CARDWELL. You were about to say?

Mr. BUTLER. I was going to say we are going to try to do a very thorough evaluation of this program. I hope next year we can give you a report saying what is good and what is not.

HIGHER EDUCATION FACILITIES GRANTS

Mr. CARDWELL. The next item is higher education construction grants. We are proposing to eliminate all construction grants, except for $43 million in grants for community colleges.

Mr. FLOOD. How do you make the exception for community colleges?

Mr. CARDWELL. The law actually has a separate authorization for community colleges.

Mr. FLOOD. A separate chapter in the act?

Mr. CARDWELL. Yes, sir. The other authorization covers graduate and undergraduate.

Mr. FLOOD. In the one act?

Mr. KELLY. Yes, sir. The Congress earmarks for the community colleges.

Mr. CARDWELL. The $43 million represents the maximum level authorized for community colleges in 1970.

We are proposing that this reduction of $170 million be offset by the use of the subsidized loan program.

Mr. FLOOD. What do you mean by higher education?

Mr. CARDWELL. We mean colleges and universities, community colleges, graduate schools, and undergraduate schools.

Mr. FLOOD. This does not mean secondary and prep schools?

Mr. CARDWELL. That is right.

Mr. SMITH. Are you withholding the $153 million in construction funds in this fiscal year?

Mr. KELLY. The only ones we are withholding this fiscal year are the loan funds.

Mr. SMITH. You were withholding $153 million.

Mr. KELLY. That was the loan funds.

Mr. CARDWELL. The higher education subsidized interest loan program would operate at a level of $290 million. The January budget proposed $250 million.

Mr. KELLY. The initiation of the program this fiscal year is dependent on your action on the pending supplemental.

Mr. CARDWELL. That is right.

LIBRARY ASSISTANCE

The next item is library assistance. We have three reductions directed to libraries. Here, again, I think this might be an unpopular item, at least with the supporters of libraries. I am afraid we may be characterized as being against librarians. This is not true. We restructured our priorities.

Mr. FLOOD. Realined is the current word.

Mr. CARDWELL. Realined, within the context of a very tight budget. We feel it is better at this time to support other aspects of education rather than libraries. We would propose a total reduction of $101 million in library assistance.

MAJOR DECREASES (Cont.)

(budget authority in millions)

		1970		
	1969	JANUARY BUDGET	REVISED BUDGET	CHANGES FROM JANUARY
WELFARE:				
Medicaid	$2,396	$3,057	$2,552	$-505
Vocational Rehabilitation Services	346	524	471	-53
Work Incentives Program	118	165	130	-35
OTHER:				
NTID Construction	---	14	---	-14
Payment To The Corporation For Public Broadcasting	5	20	10	-10

Mr. CARDWELL. This next chart is a continuation of the last one. The first item here is the medicaid program.

We are proposing a decrease of $505 million.

EFFECT OF SUPREME COURT DECISION ON RESIDENCY REQUIREMENTS FOR PUBLIC ASSISTANCE

Mr. FLOOD. Mr. Secretary, do you have any idea of the dollar effect of the Supreme Court decision, which we read about this morning in the press?

Secretary FINCH. To be perfectly honest, I do not know yet. It depends on how the States react, and how they use their own resources.

Mr. FLOOD. Will you examine that and place a statement in the record?

Secretary FINCH. We will provide that for you, sir.

(The information follows:)

The Supreme Court decision removing State residence requirements for public assistance may increase by $13.5 million the fiscal year 1970 Federal share of State and local expenditures for medical assistance. In March 1969 only eight States estimated medical assistance expenditures other than for medicaid which by law prohibits State residence requirements. SRS weighed the following factors in the process of arriving at the $13.5 million estimate: (1) the length of residency now required, (2) the dollar size of the State program, and (3) the immigration potential or probability in the eight States not now under title XIX.

The effect of the Supreme Court decision on the appropriation "Grants to States for maintenance payments" is estimated to be between $70 and $100 million. This estimate was arrived at by SRS and was based on the size of the medical assistance program in States which have had long residency requirements.

Only the $13.5 million and not the $70 to $100 million affects the $505 million reduction in "Grants to States for medical assistance."

MEDICAID ESTIMATES

Mr. CARDWELL. The $505 million reduction has two parts to it. First is a reduction of $238 million in Federal matching proposed by the States as a result of their March review of their program requirements.

When Secretary Finch took office one of the first things he did was to instruct the Administrator of the Social and Rehabilitation Service to make a new canvass of the States. They were asked to report back in March on their requirements for 1969 and 1970 Federal funds for public assistance, including medicaid.

Mr. FLOOD. That is an excellent idea.

Secretary FINCH. We recognized that inaccurate projections were a real problem. We have gone through three rounds of surveys now in order to have the estimates as precise as possible.

Mr. FLOOD. An excellent idea.

Mr. CARDWELL. Our revised budget is based on data obtained from the States since the 25th of March.

Mr. KELLY. A large part of this decrease in medicaid is related to shifting patient care from nursing homes to domiciliary intermediate facilities. These are now covered by maintenance payments.

Mr. FLOOD. What is the effect of shifting from a nursing home to a domiciliary?

Mr. KELLY. The Congress enacted a law last year which authorized us to provide care for people that do not need skilled nursing homes,

but could receive adequate care in domiciliary facilities. These are people who do not have a home to go to, and are in need of care. This is somewhat like a home for the aged. They are often called nursing homes, but they do not qualify as nursing homes because they do not have around-the-clock, skilled nursing available.

Mr. CARDWELL. That produced an offsetting increase in the maintenance payments requirements.

JULIUS HOBSON

Mr. SMITH. When we reach this social security appropriation in the House, we may get some questions about one Julius Hobson.

Under the law a person is prohibited from Federal employment if they advocate the overthrow of the Government and according to the press he made some strong statements.

Have you looked into this?

Secretary FINCH. To my knowledge Mr. Hobson is now on a leave of absence. He is not on the payroll. Apparently he is entitled for reinstatement under the civil service laws and regulations.

Mr. SMITH. Title V, section 118, P, Q, and R. It is an outright prohibition against employment.

Secretary FINCH. I will have to make a decision if and when he decides he wants to come back to the Department.

Mr. SMITH. This has been discussed several times in the last few days.

I assume it will be answered before this bill reaches the House.

Secretary FINCH. We are looking into it. I have not gotten a full reading yet.

PROPOSALS TO REDUCE MEDICAID COSTS

Mr. CARDWELL. The other items that make up the $505 million decrease is a series of proposed steps to reduce the cost of medicaid to the Federal Government.

I will describe these for you in some detail, but I would like to skip over them for a few minutes.

Mr. FLOOD. Don't skip over this because this is very important.

Mr. CARDWELL. I can do it now, if you like.

Mr. FLOOD. The cost of the medicaid program is one of the things we are worried about the most.

Mr. CARDWELL. The 1970 January estimate of medicaid requirements was $3,057 million. The States, in their March review, reduced this amount by $238 million. This left a Federal matching requirement of $2,819 million.

We are proposing to this committee the consideration of the following specific budget amendments.

CONTROLLING THE NONCONTROLLABLES

(Budget Authority In Millions)

MEDICAID

1969 Estimate		$2,396
1970:		
January Estimate	$3,057	
Less: Revised State Estimates	-238	$2,819
Amendments:		
Establish Payment Plans Based On Blue Shield	-60	
Limit Federal Payment For Mentally Ill In Public Institutions To 120 Days	-126	
Eliminate 2% Unallocated Allowance For Hospitals	-25	
Improve Utilization Of Nursing Homes	-54	
Discontinue Federal Matching For Cosmetic Orthodontistry	-2	-267
Revised 1970 Appropriation Estimate		2,552

ONE HUNDRED AND TWENTY DAY LIMITATION ON PAYMENT FOR HOSPITALIZATION OF THE MENTALLY ILL

Mr. CARDWELL. One of these amendments is dependent on legislation amending the Social Security Act. This would place a limit of 120 days on the duration of care for the mentally ill that can be financed by medicaid. On the average, mental patients now financed by medicaid are being financed on a 1-year basis. We are proposing to reduce that to 120 days effective in 1970.

Mr. SMITH. Would that make mentally ill patients treated differently than other patients?

Mr. CARDWELL. No.

Mr. SMITH. Would it give them the same number of days of benefit? If they changed this as regards to mentally ill patients how would their benefits be compared with persons that were sick from other causes?

Mr. KELLY. Until a year ago the law did not authorize any assistance for those persons who were in a mental institution or tuberculosis institution. An amendment to the law, passed a little over a year ago, authorized their inclusion. This amendment we are proposing is designed to put a restriction on the amount of that benefit. It does not return to the old status of excluding these people, but it is designed to prevent medicaid from being the vehicle for financing mental institutions.

Mr. SMITH. How does that compare with somebody with a broken back in a public hospital?

Mr. CARDWELL. It is longer than the average stay in a general hospital by a significant amount.

Secretary FINCH. I would like to respond to that, too, Mr. Congressman. With the advent of new drugs——

Mr. FLOOD. It is a very important question.

Secretary FINCH. It is a very important question. We have gotten away from the philosophy of just warehousing the mentally ill. We think 120 days is a realistic figure. It relates to the amount of time they are in the institution. The whole thrust is to get them back out in the real world. The therapy they can receive in 120 days is, by and large, sufficient to get them back into the regular world. Then they can be treated on an outpatient basis. We think this conforms with newly developed techniques made possible largely through the utilization of new kinds of drugs.

Mr. SMITH. It does separate out and treat differently mentally ill patients from other kinds of illness, does it not?

Secretary FINCH. Put in one context it does. In another, it is an approach that is consistent with therapy given to any particular kind of ailment.

Mr. CARDWELL. Shall I proceed?

Mr. FLOOD. Yes.

CHANGES IN MEDICAID REGULATIONS ON PAYMENT OF PHYSICIANS AND DENTISTS

Mr. CARDWELL. The next largest item will be handled through the issuance of administrative regulations. These regulations will require that State welfare agencies adopt payment plans for physicians and dentists. The payment plans for physicians are to be based on prevailing Blue Shield plans in effect in the State.

Mr. FLOOD. How will this be put into effect fees?

Mr. KELLY. It will be done by a Department regulation. The budget amendment is based on the issuance of that regulation.

Mr. FLOOD. If that is done in time to do so, we will have it at this point in the record?

Secretary FINCH. Yes.

(The information follows:)

DESCRIPTION OF PROPOSED REGULATION RELATING TO ESTABLISHMENT OF UPPER LIMITS IN REIMBURSEMENT OF PHYSICIAN, DENTISTS, AND OTHER INDIVIDUAL PRACTITIONERS

The Department is in the process of reviewing methods States are using for reimbursement of physicians, dentists, and other individual practitioners under title XIX (medicaid). This will result in a change in Federal regulations.

A number of alternative criteria are now being considered by an HEW task force, in consultation with the concerned sectors of the professional community. These criteria include the schedule of payments made by various substantial third party purchasers as well as private patients, and relative value adjustments for services not covered by schedules.

Mr. FLOOD. This will be controversial.

Mr. CARDWELL. We think it is a very important step to bring the cost of medicaid under control.

Mr. KELLY. This only applies to medicaid. It does not apply to supplementary medical insurance under medicare.

There are a number of States, I think 23, that already use a prescribed set of fees. This will require that all States do so. The fee that is being proposed is one worked out for low-income families.

Mr. FLOOD. Mr. Secretary, you will be the mouthpiece for this?

Secretary FINCH. Yes, sir.

Mr. CARDWELL. He will be the one to issue the regulations to implement this.

Secretary FINCH. That is right.

ELIMINATION OF 2 PERCENT UNALLOCATED ALLOWANCE FOR HOSPITALS UNDER MEDICARE AND MEDICAID

Mr. CARDWELL. In the next item, we propose to eliminate the 2 percent unallocated allowance now given to hospitals in addition to their basic payment. That would save $25 million in 1970. This also would be done by the issuance of regulations.

Mr. SMITH. Is there a provision in the law on that?

Mr. KELLY. No; the provision in the law relates to proprietary nursing homes. In the development of the Medicare cost reimbursement principles, we negotiated out a number of items. But we left in an item providing an unallocated 2 percent in addition to the basic payment.

Mr. FLOOD. I did not know that.

Mr. KELLY. The provision in the law Mr. Smith referred to is a specific provision related to proprietary nursing homes.

Mr. MICHEL. Isn't that one and a half percent?

Mr. CARDWELL. Yes.

Mr. KELLY. This is in the reimbursement formula that we issued under medicare. We have applied the same thing to medicaid. By and large the States have been very critical of the fact that we included this 2 percent in a formula for their raise.

Mr. FLOOD. That is earmraked for the State.

Mr. KELLY. No. It goes to the institution. The States have to pay it under the present reimbursement formula. So the formula will be modified so that it no longer calls for this either in medicaid or medicare.

Mr. FLOOD. That is not as much as I thought it would be, $25 million.

Mr. KELLY. The application of the same policy in medicare will result in a lowering of hospital reimbursements by $65 million.

Mr. FLOOD. I see. The $25 million is just one part.

NURSING HOME UTILIZATION

Mr. CARDWELL. Next is another item that would require State agencies to improve their utilization of nursing homes.

Mr. FLOOD. What is a nursing home?

Mr. KELLY. The Social and Rehabilitation Services has defined nursing homes and has prescribed that they must have round-the-clock skilled nursing care, among other things. It is prescribed by published regulations and there is an accreditation arrangement for it.

Mr. FLOOD. By law?

Secretary FINCH. State law.

Mr. FLOOD. It is the several States that determine the conditions.

Secretary FINCH. That is right.

Mr. KELLY. They have to accredit them.

Mr. CARDWELL. The idea is not to have medicaid finance the care involved in round-the-clock nursing services for those who do not necessarily have to be in nursing homes. It is an attempt to weed out the patients who are abusing the system.

PAYMENT FOR COSMETIC ORTHODONTISTRY

The final item would be done by regulation also. We would discontinue Federal matching for cosmetic orthodontistry which is designed only to enhance the individual's appearance. This now costs about $2 million a year. This would not affect support for regular or functional orthodontistry which is concerned with correction of handicapping dental deformities.

Mr. FLOOD. I have had the impression down through the years, Mr. Secretary, that I have served on this committee that dentistry in this whole spectrum—this is merely one phase—has been subjected to an appalling discrimination throughout the Federal Government.

Secretary FINCH. I was somewhat shocked to find, after coming into office, that we have not really had a national dental policy, particularly with respect to youngsters.

Mr. FLOOD. Why? This worries me.

Secretary FINCH. I cannot give you the answer to that yet. I do know that we could do a lot more in terms of training and teaching children. Also, we would save an awful lot of money that is spent now for dentures for older people because we do not get to them early enough.

Mr. FLOOD. Mr. Secretary, will you find someplace, if you can, the figures on rejections by Selective Service related entirely and solely to this problem of teeth and the gums?

(The information follows:)

The Department of Defense informs us that recruits are not rejected because of dental disease. However, they do report that based on a study of a sample of the 96,000 recruits inducted in January and February 1969, that for every 100 recruits, 543 fillings, 113 extractions, 25 bridges, and 17 dentures are required. The average treatment time is 6.4 hours per recruit.

Mr. KELLY. If the military service, the Veterans' Administration, the Indian health program, and the medicaid program were to provide all of the dental care that people need, we would run short of dentists to provide the service. There are just not enough dentists to provide full care for everybody.

Mr. FLOOD. And there are not enough doctors.

Mr. KELLY. The shortage of doctors is not nearly as great as the shortage of dentists.

Mr. MICHEL. I know what an orthodontist is, but what is cosmetic orthodontistry?

Mr. KELLY. This would be elective orthodontistry. It isn't essential to the health and well-being of the person. It is aesthetics and appearance.

Mr. MICHEL. I just wondered about it. Here is only a $2 million item although many small items add up quickly to $100 million. It seems to me that there should be provision for these orthodontic cases.

Mr. CARDWELL. We are not talking about those. We are not talking about malocclusion where it would affect the capacity of the patient to digest his food. We are talking about correction of malocclusion that would be done only to improve the appearance of the individual.

Mr. KELLY. It only occurs in a few jurisdictions. The cost per case is around $1,500.

Mr. FLOOD. I never saw the phrase before.

Mr. MICHEL. I have a personal case of a woman at home who up to recently had very little education. She has a physically and mentally handicapped child, as a result of an automobile accident and this mother is just doing a fantastic job in providing for and caring for this child. She has had a problem in getting work at several places where she is qualified except for the fact that she can't hardly talk because she has lost all her teeth. I wanted to be sure the very deserving cases would not be overlooked.

Mr. CARDWELL. They certainly won't be.

These five proposed actions shown on the chart add up to a $267 million reduction. When added to the $238 million reduction attributable to the new State estimates it gives a total reduction of $505 million. The revised 1970 estimate then becomes $2,552 million.

Mr. SMITH. Has the legislation been submitted yet?

Mr. CARDWELL. No. This would be made a part of the proposed Social Security Act amendments.

MEDICARE PAYMENTS FOR CONTINUED STAY IN NURSING HOME

Mr. SMITH. While you are working on that I wish you would consider one other thing. I have no reason to believe they are violating the law and it is under the law, but when the time a patient is in a nursing home as a result of an accident has expired, their family may choose to keep them there. They like it there and they get the money together and keep him there. Then while there, they may have another accident and they find that because they stayed in that same nursing home—even though the second accident is not related to the first one at all——

Mr. FLOOD. How could the patient have an accident in the home? Could he fall out of the bed or what?

Mr. SMITH. Or he could just get the flu or be ill for any reason. But his new illness then is not covered because he stayed in the same nursing home.

Mr. CARDWELL. We can look into that and give you some information on it.

Mr. SMITH. I would appreciate it.

(The information follows:)

BENEFIT PERIODS UNDER MEDICARE

The days of coverage for which hospital insurance benefits are paid under medicare are related to what is termed in the law a "spell of illness"; a "spell of ilness" as defined in the law could be more accurately referred to as a "benefit period," since it does not relate to any particular illness. Under the law, a benefit period begins when a beneficiary is furnished inpatient hospital services or extended care services in a qualified hospital or extended care facility and ends when he has been out of any hospital or skilled nursing facility for 60 consecutive days. During a benefit period, payment may be made up to 90 days of inpatient hospital services and up to 100 days of extended care services. Once a beneficiary has used up these benefit days he cannot begin a new benefit period and thereby renew his eligibility for benefits, even if he develops a new illness, until he has not been an inpatient of any hospital or skilled nursing home for 60 consecutive days. A person who continues to remain in such an institution after he has used up his benefit days is considered to be an inpatient of the institution and his benefit period continues.

These provisions are designed to provide an objective means of determining when a person may renew a benefit period, and to help limit payment under the hospital insurance plan to persons who require hospital and related health care services for acute, relatively short-term illnesses rather than to persons who are chronically ill and require continuous institutionalization. If the renewal of a benefit period were to be determined on the basis of a person's particular illness or condition, it would be necessary to make individual medical judgments in all cases as to whether a person's condition during the 60-day period after he had used up his benefit days was related to his current illness or condition.

The requirements for renewing a benefit period may create problems for persons who require long-term institutional care and who cannot begin a new benefit period because they remain inpatients of skilled nursing homes. This situation was brought to the attention of the Congress, and as a result of provision was included in the Social Security Amendments of 1967 which provides some relief for persons in this situation. Under this provision, each beneficary was provided a lifetime reserve of 60 days of additional inpatient hospital benefits which can be used after the 90-day usual benefit period has ended. This provision will benefit many people who, while still confined to a nursing home, become ill enough to require hospitalization. It assures each beneficiary that he will have at least 150 days of coverage of hospital care even if he has only one benefit period.

HIGHER EDUCATION

Construction Loans VS. Grants

(Dollars In Millions)

	1969	1970 January	1970 Revised	Change From January
GRANTS:				
Budget Authority	$ 91	$ 150	$ 43	$ -107
Program Level	(242)	(150)	(43)	(-107)
LOANS:				
Budget Authority	9	11	12	+1
Program Level	(150)	(250)	(290)	(+40)
TOTAL:				
Budget Authority	100	161	55	-106
Program Level	(393)	(400)	(333)	(-67)

Amounts Included Above For Community Colleges

GRANTS:				
Budget Authority	50	43	43	---
Program Level	(83)	(43)	(43)	---
LOANS:				
Budget Authority	0.3	1	2	+1
Program Level	(12)	(30)	(70)	(+40)
TOTALS:				
Budget Authority	50	44	45	+1
Program Level	(95)	(73)	(113)	(+40)

HIGHER EDUCATION FACILITIES GRANTS AND LOANS

Mr. CARDWELL. You may want to skip over this chart.

Mr. FLOOD. We want to skip over nothing.

Mr. CARDWELL. Very well. It was prepared because of the interest evidenced by this committee in the subject. We wanted to display the relationship between higher education construction grants and loans and the difference between appropriation requests and program levels.

Mr. FLOOD. Mr. Smith is very much concerned about this.

Mr. CARDWELL. The program level figures shown here are the obligation levels in the grant programs. In the loan programs it is the value of the loan.

Mr. FLOOD. Why the parentheses?

Mr. CARDWELL. To distinguish it as being different from budget authority or appropriation.

For example, in 1969 the Congress appropriated $100 million. We obligated $130 million in the form of additional grants or loans, plus $293 million worth of prior year appropriations that had not as of that time been committed.

In the January budget, the figure would be $400 million and in the revised budget it would be $333 million. We wanted you to have these facts.

Mr. FLOOD. Mr. Smith, you may want to examine him on this.

Mr. SMITH. It is pretty clear. I may not agree with some of the revisions, but it is pretty clear.

EDUCATION PROGRAMS FOR THE DISADVANTAGED

(dollars in millions)

	1969	1970 JANUARY BUDGET	1970 REVISED BUDGET	CHANGE FROM JANUARY
Educationally Deprived Children, Title I. ESEA	*1,123	*1,226	*1,226	---
Teacher Corps	21	31	31	---
Dropout Prevention	5	24	24	---
Bilingual Education	8	10	10	---
Handicapped	80	86	86	---
Student Aid	506	538	538	---
Adult Education	45	50	50	---
Total	1,787	1,965	1,965	---

Mr. CARDWELL. We have talked about gross increases and given you a whole list of decreases. We wanted to emphasize the education program particularly, where we have a net reduction of almost $400 million in the budget that we have preserved—$1,965 million for high priority education programs directed to the disadvantaged. The most significant is $1,226 million for title I, ESEA.

Mr. FLOOD. This is elementary and secondary.

Mr. CARDWELL. They receive high priority within the revised budget.

Mr. FLOOD. In the ghettos of the great metropolitan cities?

Secretary FINCH. This is not limited to just the ghettos. Part of this money, for example, is used for bilingual education in the southwest. Title I funds go to thousands of rural and urban school districts all across the Nation.

Mr. KELLY. That $1,226 million under title I of the Elementary and Secondary Education Act goes to 17,000 school districts. The distribution formula is related to the income of the parent.

Mr. FLOOD. In all areas?

Mr. KELLY. That is right.

Mr. FLOOD. This is not parochial?

Mr. KELLY. No.

Mr. FLOOD. This is not ghetto again?

Secretary FINCH. No, sir.

Mr. CARDWELL. We would emphasize that the January budget contained an increase of $103 million for title I, and we are preserving that increase. The Teacher Corps proposed a $10 million increase over 1969. We are recommending to you also that it be increased $10 million.

TEACHER CORPS

Mr. FLOOD. Mr. Secretary, is there any fallout from the country about the Teacher Corps? Does the country know what the Teacher Corps is? Do they know in Kansas, in New Mexico, and Pennsylvania and the mountain regions?

Secretary FINCH. It doesn't have the publicity that it deserves, but I think it is a program with great promise.

Mr. FLOOD. What is the Teacher Corps?

Mr. BUTLER. I can give you an example of some of the reasons we think it ought to be increased.

Mr. FLOOD. Suppose someone stops me on Main Street and says, "Flood, what is the Teacher Corps?" What do I say?

Mr. BUTLER. You can say it is an effort to attract young people into the teaching of disadvantaged children. It is a wholly different kind of a teaching problem than we have faced before.

Mr. FLOODD. Are these teachers' aides or what?

Mr. BUTLER. They operate in a number of roles. Some of the Teacher Corps programs have taken college students and let them teach in high schools and elementary schools in disadvantaged areas and in demonstration projects.

Mr. FLOOD. Is it a tutor program?

Mr. BUTLER. In some cases they are tutoring, but it is really teaching.

Mr. FLOOD. During the school hours, do you mean?

Mr. BUTLER. Yes, both during the school hours and after hours. Many of them are actual teachers in the classroom.

Mr. FLOOD. Do they take off the shoulders of the overburdened teachers paperwork in the classrooms? Do they mark papers and so forth?

Mr. BUTLER. That is not the principal role. The principal role is to develop teachers, as you and I would understand a teacher—someone in charge of a class.

Mr. CARDWELL. I think one of the distinctions in this program is that it is really designed to take advantage of and use the idealistic interests of the many young people who want to do something. Young people who want to help other people. Well, here is a program they can go to. The Government will give them special training, finance their education, train them in——

Mr. FLOOD. What about the State laws? Uncle Sam thinks this is a good idea so can I just walk into a high school in Wilkes-Barre and hang up my hat and be a teacher under the laws of Pennsylvania because you say so?

Mr. KELLY. No. First, the school district must apply in order to participate. Secondly, the student must meet State qualifications by the time he has finished the program.

Mr. FLOOD. What student?

Mr. KELLY. The person who applies as a volunteer under the Teacher Corps will be in effect a practice teacher while he is going to school during this program.

Mr. FLOOD. But must conform with the laws of the State?

Mr. KELLY. When they are finished. If they are going to be fully qualified teachers that are desirous of working with disadvantaged children.

Mr. CARDWELL. And will become a regular teacher.

RECRUITMENT OF TEACHERS

Secretary FINCH. We are confronted in every major school district that I know anything about with a shortage of good teachers. I was in Los Angeles yesterday. They have about 6,000 teachers who could retire tomorrow if they wanted to. I think we should consider recruiting those people returning from the Vietnam war for teaching careers. We are desperately short of good teachers all across the board. In particular I think we need to get more male Negroes teaching in——

Mr. FLOOD. Mr. Secretary, Mr. Smith has suggested that you examine the proposition that, if and when this teacher finishes your program under the Teacher Corps, and thereby increases his earning power, that this person might pay back some part of the cost to the Government of giving him this education and training. How about that?

Secretary FINCH. I am perfectly willing to examine the proposition with him. I would not want to do anything that makes it harder to get good people teaching. I suspect this kind of proposal might tend to do that, but I also think it is worth serious thought and consideration.

Mr. MICHEL. When this came up several of us raised the question that it seemed to be more of an inducement for those with undergraduate degrees to get a graduate degree by way of Federal assistance by teaching part time. If that was the emphasis, then I couldn't see it. I think I may have changed my mind a little bit about the program. You say they are learning to teach the underprivileged or the handicapped, and then here again in these research educational laboratories

where we originally had 20—now cut back to 15—about every one of them has a specialized area where they are exploring the best means of teaching the underprivileged. I don't know what all they are doing that these people in the Teacher Corps aren't doing. Is there a mix of the information, or are we duplicating the effort again. This is one of those popular things, how best to teach the disadvantaged.

Mr. SMITH. There are many more applicants than there are positions open, aren't there?

Mr. KELLY. We have every reason to believe that we could recruit many more participants than we have funds to support.

Mr. FLOOD. Do you bring back retreads on this?

Mr. CARDWELL. Yes. If you mean by "retreads," a former teacher who left the field for some time.

Mr. FLOOD. Yes.

Mr. CARDWELL. Very much; yes.

PAYMENT OF TEACHER CORPS MEMBERS

Mr. SHRIVER. Aren't they paid more than the ordinary teacher?

Mr. CARDWELL. No, sir. Once they leave the program as trainees and go into the local school district as regular employees, they are paid at whatever the standard salary is for a teacher with their qualifications. The Teacher Corps people are paid stipends when they are in training.

Mr. SHRIVER. Are they paid more when they go into the program?

Mr. CARDWELL. They are paid a subsistence stipend while they are in training. Their education is paid for entirely by the Government. They do not receive a fixed salary while in school. I think on the average you will find that their stipend is considerably less than the pay of people alongside whom they are working.

Mr. FLOOD. I had the impression Mr. Shriver had, that these were sort of a hand-picked crowd who were getting a bonus of some sort.

Mr. KELLY. There is a supervisory group that is salaried.

Mr. CARDWELL. And they do get paid more than average. They are paid at about the middle of the average supervisors' salary.

Mr. KELLY. They are paid at the level, though, of that school district salary range. In the first year of the program that was not true and it was criticized and modified.

Mr. FLOOD. What is the reaction from the professional teachers generally?

Secretary FINCH. I have talked to a limited number of them, Mr. Chairman, and their reaction has been good.

GENERAL COMMENTS ON BUDGET AMENDMENTS

Mr. FLOOD. Mr. Secretary, it is late in the day and we will have to work out a mutually satisfactory time to complete the review of these budget amendments.

Secretary FINCH. Mr. Chairman, I would like to make a general comment which I think is important. We are absolutely convinced——

Mr. FLOOD. Who do you mean by "we"?

Secretary FINCH. This administration I am not just speaking departmentally. We had to pull in our belt if we are going to halt this inflationary cycle. We have examined some very sensitive areas here.

The rhetoric is going to get very strong, and we are well aware of this. There are some who thought we should have cut deeper, including your colleague, Mr. Mills.

Mr. FLOOD. Remember, you are talking about some of the most important domestic problems in the United States of America. This is the most sensitive budget and bill that will be before this House, touching every man, woman, and child in the country.

Secretary FINCH. We have tried to recognize the programs that work, and we have tried to discard some of those we don't think work so well. A great deal of labor has gone into this.

Mr. FLOOD. Did you fight for your programs item by item? Did you come out punching before the President and before the Bureau of the Budget, or did you sit back as the new Secretary for HEW from California and just say, "Yes, sir!"

Secretary FINCH. I would first like to compliment the staff who fought hard on the points we felt very strongly about. I raised some of those points with the President and we think we achieved them. My basic concern here, and the overall administration's concern, was the future costs of these programs. We are caught up in this inflationary cycle. Coming in with this kind of budget is just one step in trying to control it.

Mr. FLOOD. In the brief time you have been Secretary, the committee has developed a very high regard for you.

Secretary FINCH. I appreciate the preliminary verdict, Mr. Chairman. I simply wanted to inject that note as reference to what you have seen thus far and what you will see later on.

Mr. FLOOD. Thank you, gentlemen.

April 29, 1969.

AFTERNOON SESSION

Mr. FLOOD. I think you were in the middle of your charts the last time the Secretary was here.

Mr. CARDWELL. Yes.

Mr. FLOOD. Chart No. 10.

Mr. CARDWELL. I believe we had just finished that one.

Mr. FLOOD. Yes.

EDUCATION PROGRAMS FOR THE DISADVANTAGED

Mr. CARDWELL. The last item we discussed last Tuesday was a review of high priority items that had been left in the budget unchanged. They represent significant increases over 1969 proposed by the last administration. In effect, these increases are being confirmed by this administration. The common denominator of the items is that they all focus attention on assistance to disadvantaged. We talked quite a bit about the Teacher Corps at that time.

Secretary FINCH. And the bilingual education program.

Mr. CARDWELL. Would it be better, Mr. Chairman, to start back and thumb quickly through the charts we covered last week or pick up from here?

Mr. FLOOD. We may as well go ahead from here.

EDUCATION PROGRAMS FOR THE DISADVANTAGED

(dollars in millions)

	1969	1970 JANUARY BUDGET	1970 REVISED BUDGET	CHANGE FROM JANUARY
Educationally Deprived Children, Title I. ESEA	$1,123	$1,226	$1,226	---
Teacher Corps	21	31	31	---
Dropout Prevention	5	24	24	---
Bilingual Education	8	10	10	---
Handicapped	80	86	86	---
Student Aid	506	538	538	---
Adult Education	45	50	50	---
Total	1,787	1,965	1,965	---

Mr. CARDWELL. As we were explaining there are a number of significant increases over the 1969 budget that were proposed last January by the previous administration. We are leaving these increases in the budge, in the new budget. These are programs that are designed to assist the disadvantaged. They are all centered in the educational area. They include an increase of $203 million for the education of deprived children under title I of ESEA. This is the largest single increase in the budget.

It includes the Teacher Corps; the program of dropout prevention; special program of bilingual education; and the special education program for the handicapped. The budget provides a significant increase in assistance to students. The adult basic education program in the Office of Education is also enlarged in 1970.

Secretary FINCH. I want to point out to the committee that programs such as adult basic education, handicapped education, and bilingual education, are the types of programs that we hope could supplement the community college effort.

NATIONAL INSTITUTES OF HEALTH

(budget authority in millions)

	1969	1970 JANUARY BUDGET	1970 REVISED BUDGET	CHANGE FROM JANUARY
Research Grants:				
Traditional Research Projects:				
Continuation of Awards Made In Prior Years	+ 328	+ 331	+ 331	+---
New Awards	144	133	131	-2
Special Research Programs	162	170	164	-6
Research Training Grants And Fellowships	198	190	179	-11
Intramural Research	86	89	88	-1
Collaborative Research And Development	126	127	121	-6
Health Manpower	276	358	356	-2
National Library of Medicine	18	22	20	-2
Other (*Program Administration, Direct Construction*)	57	64	59	-5
TOTAL	1,395	1,484	1,449	-35
Scientific Activities Overseas	15	15	4	-11

Mr. CARDWELL. Last week we skipped over momentarily the budget revisions for the National Institutes of Health. The chairman expressed an interest in this particular item. We told him we thought when we got to NIH he would find it had not received any unduly harsh treatment. Of course it is a matter of opinion. The reductions for the National Institutes of Health total $35 million.

As you see, $2 million of it comes from the traditional research project grants new awards. Six million dollars in special research programs supported by NIH. There is an $11 million reduction in research training grants, and fellowships. This $11 million affects research manpower development, as contrasted to the development sup-

port of manpower to provide direct medical service to patients. We are reducing our past emphasis on the development of research manpower.

There is a minus $1 million item in the intramural research conducted on the NIH campus. Also, a $6 million cut against the collaborative research and development program. This is essentially a contract research activity directed by NIH from Bethesda.

There is a $2 million reduction in other health manpower. A $2 million reduction in the National Library of Medicine is against the biomedical communications network proposal which was in the January budget.

If you take NIH and put it all together, including the National Library of Medicine, you will find that the January budget represented a total of $1,499 million. Under the revised budget it is $1,452 million, a gross net reduction of $47 million.

CONTROLLING THE NONCONTROLLABLES (Cont.)

(Dollars in Millions)

VOCATIONAL REHABILITATION BASIC GRANTS

	1969	1970 January Budget	1970 Revised Budget	Change From January
Federal Contributions:				
Amount	$346	$524	$471	$-53
Percent	75%	80%	79%	
State Matching:				
Amount	115	131	126	-5
Percent	25%	20%	21%	
Total	461	655	597	-58

VOCATIONAL REHABILITATION GRANTS

We did not review this chart last week. Miss Switzer discussed in her testimony the effect of the budget revisions on the vocational rehabilitation program. We are proposing a reduction of $53 million in basic grants to States. This we think makes a lot of sense at this point in time.

The Johnson budget jumped from $346 million to $524 million in 1 year, a very significant increase. That increase occurred under the Johnson budget for two reasons. The 1968 amendments increased the Federal matching level from an average of 75 percent to 80 percent. That in itself would have enlarged the budget even if the States held their matching constant.

At that time we also estimated that the States would increase the amount of their funds for the program.

What we have now done is propose a plan to allot $500 million among the States by the formula in the basic law. $500 million happens to be the same allotment level authorized for 1969. In order to make that possible this year, it will require special appropriation language. This is because the basic authorizing statute would increase the allotment level up to $600 million. So we are proposing to hold the allotment level constant, but take advantage of the higher matching rate authorized by the law.

This gives us a Federal fund requirement of $471 million, still a considerable increase over the $345 million appropriated last year. The States would put up roughly the same level of dollars. Their share goes from $115 million to $126 million. The Federal funds would account for 79 percent of the total, whereas in 1969 they accounted for 75 percent.

In summary, with about the same level of State money as last year, and with the higher matching rate authorized by the law, we reduce the budget by $53 million and still provide a significant increase in a high payoff program.

PUBLIC ASSISTANCE

This next chart is on maintenance payments.

You remember that we talked earlier about Secretary Finch's request for new State estimates for public assistance funds. We received the updated estimates from the States at the end of March. In the case of maintenance payments, those revised estimates added $229 million to the January budget.

These same new State estimates produced a $238 million offsetting decrease in medicaid. So, on maintenance payments, we started out with the January estimate of $3.719 billion, and if we take into account the States' own estimates, we have to increase the budget by $229 million.

As was also explained last week, the administration is proposing that the AFDC freeze be postponed. That adds another $322 million to the maintenance payments estimates.

CHANGE IN MAINTENANCE PAYMENTS
(Budget Authority In Millions)

1969 Estimate		$3,425
1970:		
January Estimate		3,719
New State Estimates	$+229	
Increases Requiring New Legislation:		
Postpone AFDC Freeze	$+322	
Increase In Social Security Benefits	-30	+292
Change From January Estimate		+521
Revised 1970 Appropriation Estimate		$4,240

It so happens that the proposal to increase the social security benefits in effect takes some people out of the poverty level and thus no longer eligible for maintenance payments, and we estimate that would reduce the requirements for old-age assistance by $30 million. So the combination of the increased State estimate, the postponed AFDC freeze, and the decrease in maintenance payments due to the increased social security benefits has the net effect of adding $521 million to the Federal appropriation request for maintenance payments in 1970. This yields a new estimate of $4.240 billion compared to $3.045 billion appropriated in 1969, including the supplemental. The next chart is very complicated, but let me give it a try.

END OF YEAR EMPLOYMENT
(In Thousands)

		1970 ESTIMATE		
	1969	January	Revised	Change From January
Consumer Protection And Environmental Health Service	8.0	8.3	8.0	-.3
Health Services And Mental Health Administration	25.0	25.7	24.5	-1.2
National Institutes of Health	11.5	11.9	11.6	-.3
Office Of Education	2.9	3.1	3.2	+.1
Social And Rehabilitation Service	1.8	1.9	2.0	+.1
Social Security Administration	50.2	53.0	53.0	---
Departmental Management	3.2	3.6	3.6	---
Total DHEW	102.6	107.5	105.9	-1.6

We estimate that HEW will have on its rolls about 103,000 employees by this coming June 30. That is about 5,000 below the level that the Congress authorized for this next fiscal year. In other words, we were authorized for this fiscal year a level of 107,000 employees.

The January budget assumed repeal of the Revenue and Expenditure Control Act, at least as it affects employment. It reinstated those 5,000 employees would have taken the 1970 estimate of end of year employment up to 107,500.

The President has indicated to Congress that he will establish a 1970 policy to hold overall Federal employment to the June 30, 1969 level. He is, in effect, saying to the Congress, give me a chance to control executive branch employment. I will control it at that level, but I ask you in return to repeal the Revenue Expenditure Control Act.

The amendments that are coming up will show adjustments in HEW employment which would reduce employment by 1,600, giving us a 1970 total of 105,900.

The question, it seems to me, you might want to ask is whether this is consistent with the announced policy of the President to hold Federal employment to the 1969 level. It is not.

We have said to the Bureau of the Budget and the White House that we believe HEW should be made an exception to this policy for three reasons:

First, there is a proposal under consideration which would transfer St. Elizabeths Hospital from the Federal budget to the District of Columbia budget. The 3,900 employees at St. Elizabeths Hospital would no longer be counted as Federal employees and no longer be subject to the Revenue and Expenditure Control Act. And we have, in effect, said to the Bureau of the Budget that HEW should be allowed to make up part of that difference.

The second reason is this: We are deeply concerned about the capacity of the Social Security Administration to perform their job under the staffing limitations. They are becoming badly handicapped. We have asked that the January request of 2,800 additional jobs for Social Security be left in the budget.

The third element of consideration involves the direct patient care activities of the Department.

We have proposed in these amendments the closure of the two PHS hospitals at Savannah and Detroit. We would gain some benefit against total direct medical care workloads by reason of those closures, but it still would not give us enough, and we would not be able to hold that program constant. We want at least to be able to say to the beneficiaries whom we serve that we are holding our medical staff at the level it was at in January.

The Bureau of the Budget has reserved the right to lower that level during the year and the Secretary has at the same time said to them that if he can lower the employment through increased manpower utilization efforts, he will do so.

That covers the charts that we had prepared.

Mr. FLOOD. It is a first-class presentation. Charts are not my favorite food, but these have been pretty good. Of course you had a great deal to do with it, too.

Secretary FINCH. Thank you, but we must give credit to Mr. Cardwell and Mr. Kelly.

Mr. FLOOD. They know their business.

I do not imagine you have anything more to say than has been said, have you, on the charts?

Secretary FINCH. No, sir; not on the charts. I will be happy to respond to questions.

RESPONSIBILITY FOR DECISIONS ON BUDGET AMENDMENTS

Mr. FLOOD. Do these individual increases and decreases represent your views? Are they the views of you, the Bureau of the Budget, the President, or a combination?

What I mean is this: I would like to know how the decisions were made. Did you get a lump sum thrown on the table for you?

Secretary FINCH. No, sir.

Mr. FLOOD. Or did you fight this out item by item?

Secretary FINCH. We developed these amendments by a combination of processes.

As I indicated before, I had a series of task forces examine the budget—and the programs—in great detail. We were under a general instruction to reduce the budget where possible because of a strong desire of this administration to cool the economy. But we were given no lump sum figures at all.

This represents a combination of efforts of the Department to respond to that admonition from the White House and reflects our own priorities. I stand behind this fully.

Mr. FLOOD. To what extent did you as the Secretary personally engage in this review?

Secretary FINCH. I sat through meetings with every task force, and had full reports from each of them. I personally made a couple of changes myself. I feel as though I personally was involved in the entire process.

Mr. FLOOD. To what extent was the President himself involved, personally?

Secretary FINCH. I discussed with him what I would call the major changes. I discussed with him the modification of the Hill-Burton approach, which we have discussed already.

I discussed with the President the community college initiative, and the experimental school initiative. There were others, also.

Mr. FLOOD. Are you personally dissatisfied with any of these individual items that were decided upon and you are bringing us?

Secretary FINCH. Mr. Chairman, obviously there are some areas I am not happy about.

I am not happy about the employment restrictions of the Revenue and Expenditure Control Act. It constrains us very badly.

If you are talking about individual budget items, I think they represent a happy compromise between what was required and what we wanted and what we are attempting to do.

Mr. FLOOD. Are there any specific line items that you yourself are dissatisfied with today, now that you are here with them?

Secretary FINCH. No. I will stand on these figures as presented.

REDUCTIONS IN HEW COMPARED WITH OTHER AGENCIES

Mr. FLOOD. HEW is bearing a pretty large chunk of the total cut in the entire civilian budget?

Secretary FINCH. Yes.

Mr. FLOOD. Do you feel that your department's share of the cut is equitable compared to that of Agriculture, Labor, Commerce, and all of these other civilian agencies? What do you think?

Secretary FINCH. I think I would like Mr. Kelly to respond to that because I have not made this kind of comparison myself.

Mr. KELLY. One of the problems of being a very large agency is that when reductions are taken, you take very large reductions. Proportionately I do not think you will find it is out of line with our total budget. I think it is noteworthy that the largest reduction affecting HEW is a modification of a legislative proposal reducing a proposed social security benefit increase from 10 to 7 percent.

This is a legislative change involving the trust funds. In the general funds, the net change in the HEW budget is a reduction of $178 million in outlays. However, the impact is greater than $178 million

since we had to add $322 million to cover the cost of deferring the AFDC freeze, as well as a few other increases.

So in the aggregate we had to make $592 million reduction in budget authority against a $17 billion proposal before you. This is commensurate with what occurred in other agencies.

Mr. FLOOD. What I am saying in effect, did you leave whatever room you left feeling there had been discrimination against HEW vis-a-vis Agriculture and Commerce and Labor and the other civilian agencies?

Secretary FINCH. No, sir, I did not. I will let Mr. Kelly speak for himself. He had to fight it out with the Bureau of the Budget.

Mr. KELLY. The total reduction in HEW amounted to 2.4 percent, including trust funds. The total reduction in the whole Federal Government averaged 2 percent on Federal funds, and the HEW reduction was 1.2 percent in Federal funds. So I think it is equitable.

CHANGES IN FINANCING MECHANISMS

Mr. FLOOD. How much of the total cut in budgetary authority and expenditures is nothing more than a shift in financing such as shifting grants and direct loans to guaranteed loans?

Secretary FINCH. We will be happy to provide a detailed response.

Mr. FLOOD. We want something in the record on that.

(The information follows:)

CHANGES IN FINANCING

[In thousands of dollars]

	Original, 1970	Revised, 1970	Change	Explanation
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION				
Hospital construction:				
Grants for construction and modernization of hospitals.	$163,500	$50,000	−$113,500	The decrease in the revised budget for Hill-Burton grants anticipates the enactment of new legislation. The administration's proposed bill substitutes a $500,000,000 guaranteed loan program for the current formula grant program.
Loan volume in proposed legislation.	.....	(500,000)	(+500,000)	
OFFICE OF EDUCATION				
Higher education:				
Construction:				
Grants	150,000	43,000	−107,000	The revised budget requests the full amount for annual interest grants authorized by the 1968 Higher Education Amendments. These grants will subsidize the interest costs of borrowing construction funds from private financial institutions. Combined with a reduction in direct construction grants, the revised budget will result in an overall decrease in program level of about 15 percent.
(Program level)	(150,000)	(43,000)	(−107,000)	
Subsidized loans	10,670	11,750	+1,080	
(Program level)	(250,000)	(290,000)	(+40,000)	
Total, construction	160,670	54,750	−105,920	
(Program level)	(400,000)	(333,000)	(−67,000)	

DELAY IN FORMAL SUBMISSION OF BUDGET AMENDMENTS TO CONGRESS

Mr. FLOOD. Here is something that baffles me.

These amendments were announced on April 15 and the Department even had a press conference on that very day to make these dramatic details available to the public. Here it is April 29, and still nothing has been formally delivered to the Congress.

I am sure this is not just hocus-pocus or playing games with us. What is the matter? What is the problem?

Mr. KELLY. We have completed all of our work and it has all been cleared by the Bureau of the Budget, Mr. Chairman. It is part of a larger package where, apparently, there are some problems.

Mr. FLOOD. I do not say you fellows are doing any sleight of hand.

Mr. KELLY. We know of no problems with any of the amendments to the HEW budget. Apparently there are problems in other agencies included in the package that are delaying the submission.

As a matter of fact, we were expecting that the submission would be made yesterday.

Mr. CARDWELL. I talked to the Bureau of the Budget on Thursday evening and was assured the message would come up early this week. They estimated then that it would be Monday. I think on Monday the District of Columbia message was placed before it. As Mr. Kelly says, it is just a matter of time.

REDUCTIONS IN EDUCATION PROGRAMS

Mr. FLOOD. Members of Congress, including members of this subcommittee, have received personal visits, stacks of mails, and telephone calls about the Johnson budget in which education programs were cut $87 million. While every other major component in the Department went up, education went down. The total increase for the Department was over $7 billion. Now along comes the Nixon budget and it cuts education another $376 million.

How can you or we or anybody explain to these educators that this budget does not deliberately and grossly discriminate against education as contrasted with health and welfare?

Mr. KELLY. I think there are two elements of consideration worth noting there. In one it is that the Congress authorized the guaranteed student law program. We are emphasizing the use of this method for assisting students instead of direct Federal grants and loans. This reduces our Federal outlays, but still assists students to go to school equally as well.

The other thing is in connection with higher education construction. For the first time—this fiscal year—we will implement a program of interest subsidization of loans for construction of higher education facilities. Thus, we have a very substantial construction program, yet have reduced the amount for grants in the budget.

One other item that greatly influences the total education budget is the decision made by the previous administration and strengthened by this administration to reduce and restructure the impacted area aid program.

IMPACTED AREA AID

Mr. FLOOD. Right at that point, as Mr. Kelly knows and as you, Mr. Secretary, will find out in a couple of months, let me assure you, there is going to be terrific pressure on Congress to increase the budget for the impacted schools.

Why do you think this revised budget is fair? Are you fellows personally behind this a hundred percent?

Secretary FINCH. We discussed this item at considerable length, Mr. Chairman. I think the program itself has evolved in many ways as model cities evolved, as kind of a political reaction.

I think there is some question about the validity of the formula which is essentially tied to a census that is many years old. I think it is time we took another hard look at what we can do to make every dollar that is spent in this program be spent in the most effective way. I think that by striking the "B" category and funding only the "A" category, this is the only way we can come to grips with it.

That is what is behind our thinking on it.

BUDGET FOR EDUCATION PROGRAMS

Mr. FLOOD. Anything further on the first question?

Mr. KELLY. Mr. Chairman, we left in the budget a large increase of more than $100 million for title I of the Elementary and Secondary Education Act. This increase and the decrease in impacted area aid represents a choice. I think all of the people in HEW who examined these programs—the planning and evaluation staff, the Office of Education, the Secretary and his advisers—all believe that the distribution of funds under the Elementary and Secondary Education Act title I formula is a more intelligent and more effective method of helping children than making the same funds available for distribution on the basis of a count of children whose parents work, but do not live on Federal property.

This is an area in which there have been disagreements, but it is a thoughtful and studied recommendation that comes before you.

Mr. FLOOD. You are talking about the impacted schools. My original question was, you have reduced the Johnson budget for education by $375 million. Is this planned discrimination against education in favor of health and welfare programs? Is it the policy?

Mr. KELLY. I think not.

In some cases in the education programs the use of loan guarantees and interest subsidization results in a greater program level, but requires fewer Federal dollars to do so. There is greater support than is readily apparent in this budget. The same opportunities for augmenting private resources were not available to us in the Social and Rehabilitation Service or in the health programs to the extent they were in the educational programs.

Mr. CARDWELL. I would like to emphasize one thing here.

The cut against impacted area aid of $113 million, a $50 million-plus cut in title III of the Elementary and Secondard Education Act, and the cut in library resources, were in effect made so we could retain $178 million of educational increases in the budget that were already there.

They represent significant increases in the educational budget. In the case of the construction grant reduction, we feel we are offsetting that with the use of private loan interest subsidization.

LIBRARY PROGRAMS

Mr. FLOOD. Do you want to add anything specifically with reference to the library situation? That is going to cause a major uprising.

Secretary FINCH. Because of the growing pressures of inflation and

the rising costs of a number of uncontrollable programs, it was necessary to reduce the budget for many of our programs and to realine budget priorities. Within the revised budget, we have tried to give the highest priority to educational programs for the disadvantaged. Under this approach, we cut back funds for library programs from the budget in favor of education programs that are more targeted to the poor and disadvantaged. I hope this situation will be temporary. Within the next several years, it is my strong wish that we resume a full-scale effort to broaden educational opportunities and to move in bold new directions.

Mr. FLOOD. I am sure you are getting a lot of mail on this.

Secretary FINCH. Yes, definitely.

IMPACTED AREA AID

If I may at this point, I would like to offer for the record a summary evolved out of our task forces as to why we thought we should justify the change in the impacted area aid program.

(The information follows:)

PUBLIC LAWS 874 AND 815 (IMPACTED AREAS)

The previous administration transmitted to the Congress draft legislation substantially modifying the entitlement formula and making other substantive changes in Public Law 874. It is important, however, at this point to note that a major study of the Federal impacted area programs is being conducted by the Battelle Institute under authority and funds granted by the last Congress. This study will be completed by the end of the year and, after an evaluation of their recommendations, the Department may wish to submit proposals for modification of the Public Laws 874 and 815 programs.

In the meantime, and in the light of proposed budgetary levels for these programs, the Department urges an amendment to section 5(c) of Public Law 874, so that, whenever appropriations are insufficient to meet all entitlements in full, the funds would be applied toward satisfying entitlements under section 3(a), involving so-called "A" children whose parents live and work on Federal property, before funds are applied to entitlements under section 3(b) with respect to "B" children whose parents do not live on, but work on Federal property. This amendment would protect the school districts receiving a large proportion of their school budget from this program. (Of the 138 districts where impacted areas grants equal 25 percent or more of school revenues, 130 received the vast majority of such grants under section 3(a).) Under the amendment, any reduced appropriations would only affect districts which receive a relatively small proportion of their revenues from impacted grants, largely under section 3(b).

INCREASES AND DECREASES IN EDUCATION PROGRAMS

Mr. SMITH. I wonder if Mr. Cardwell could expand his answer, which is very good except that it should be itemized. The following items were deleted and the following increases would be 1, 2, 3, 4.

Mr. CARDWELL. Here are the major deletions.

Impacted area aid, minus $113 million; supplementary educational centers, minus $57 million; higher education construction grants, minus $107 million; library services and grants and construction, minus $46 million.

These items account largely for the 300-plus million we were talking about. These items listed here on the chart: educationally deprived children, title I, plus $103 million; Teacher Corps, plus $10 million; dropout prevention, plus $19 million; bilingual education, plus $2 mil-

lion; handicapped, plus $6 million; student aid, plus $32 million; adult education, plus $5 million.

And then we have increased higher education construction loans an additional $40 million, going from a loan level in 1969 of $145 million to a level of $250 million under the January budget to a higher level of $290 million under the revised budget.

Mr. FLOOD. These questions that I ask you are hard questions because I am sure you realize this is the second biggest budget that is before the Congress, and we cannot deal with it casually.

PROPOSED CHANGES IN MEDICAID AND MEDICARE REGULATIONS

You are proposing some mighty significant changes in law and in regulations to hold down the cost of medicaid. And we have heard a lot of testimony about medicaid and we have all read stories in the press and other news media about the costs of medicaid.

I am particularly interested in your proposal to establish fee schedules for doctors and dentists based on prevailing Blue Shield rates. What makes you think you are going to get away with that?

Secretary FINCH. This evolved after long discussions. We felt that the disparity in the State and local systems demanded some rational template against which we could relate these schedules. It seemed that "the blues"—the Blue Shield formula was the best way. We went through this in California. We had the "usual and customary" formula and after comparing that with other States where these same usual and customary——

Mr. FLOOD. And the glaring situation in New York.

Secretary FINCH. We thought this was a more rational way to keep the situation under control, because obviously we had to bring some constraint into play.

Mr. FLOOD. Now you delete the 2 percent add-on which you have been allowing on hospital bills.

You will run into trouble on this one, too.

Secretary FINCH. Yes; we have. I am not sure I have the latest information on that. The Under Secretary was meeting a few hours ago with some of our friends in the American Hospital Association.

Mr. FLOOD. When you get it, we would certainly like to know it.

Secretary FINCH. We are struggling with that one right now, Mr. Chairman.

Mr. FLOOD. What about medicare? Are these changes applicable there, too?

Mr. KELLY. Medicare has a $65 million reduction related to that policy. One of the elements of consideration that entered into that was that we required that the States use the same hospital reimbursement formula for medicaid as is used by medicare. This was done to try to get uniformity.

The States have exercised some pressure to be exempted from that so that they could negotiate below cost arrangements for hospitals. And one of the elements that they particularly criticized was the 2 percent.

So it was an attempt to avoid a reduction in services and to avoid departing from the uniform cost reimbursement system for both medicare and medicaid, that led to this conclusion.

Mr. FLOOD. I serve on a hospital board. It is a worrisome problem.

Secretary FINCH. We felt that the original rationale for the 2 percent had just disappeared as the programs evolved.

Mr. FLOOD. When are you going to publish the new regulations?

Secretary FINCH. I do not think we have made any decision on that.

Mr. KELLY. The one that deals with the increased utilization of nursing homes has actually now been published. The others are in process of development.

REDUCTION IN HILL-BURTON GRANTS

Mr. FLOOD. You cut the Johnson budget for the Hill-Burton hospital construction program $104 million on the basis of legislation which hasn't yet been enacted. Did you do that with tongue-in-cheek figuring that Congress of course would restore it anyhow, or are you really serious? Did you think we would put that back or are you serious about it?

Mr. KELLY. In 1946 when the Hill-Burton program was adopted, the country had less than 60 percent of the general hospital beds that were needed. The situation was particularly acute in the rural areas. That situation has dramatically changed. Today, 90 percent of the national requirement for hospital beds has been filled.

There have been instances where small towns have built small hospitals, but over time has lost their physicians. So now they have a facility but no doctors. This reflects the very grave problem of the maldistribution of physicians.

We felt that the greatest need is to modernize, replace, and expand existing facilities as opposed starting new hospitals. We think times have changed. This program was a good program, but it has largely fulfilled its purpose, and now we need to modify it to respond to a changed situation.

PROPOSED CHANGES IN HILL-BURTON LEGISLATION

Mr. FLOOD. What is the status of the bill and the chances that it will be passed in substantially the form you proposed?

Mr. BLACK. The bill has been introduced in both Houses. The committee in this House is going to be marking up soon. We are hopeful our proposal will be reflected in this markup.

Mr. CARDWELL. I think we ought to add, Mr. Chairman, even though the budget amendment is conceptually designed to fit the new legislative proposal, that amendment could be effected in 1970 without the legislation.

In other words, it does not depend on the legislation for actual implementation by the executive branch.

Mr. SMITH. If you can do it without a change in the law, what do you have a bill for?

Mr. KELLY. If the legislation were enacted, we would gain $500 million worth of loan authority in addition to the $154 million now in the budget. If the bill is enacted, the $154 million will all go for ambulatory and long-term patient care facilities. If the bill is not enacted, then only $100 million of the $154 million recommendation before you could be used for ambulatory and long-term patient care. The other $50 million would be for general hospital beds.

Mr. SMITH. Is it not true that you do not need legislation for the proposal in the budget?

Mr. KELLY. If the legislation is not passed, then the budget request now before you will still stand. I was trying to explain that the funds will be used more productively if the bill is passed.

Mr. CARDWELL. We do see it as a transition to the new concept of Hill-Burton.

Mr. FLOOD. Under the proposed law, would this cut of $104 million be replaced by an equal amount of loans for hospital construction?

Mr. KELLY. If the bill were enacted, a larger program of hospital construction could be developed than under existing law, despite the reduction.

DISTRICT OF COLUMBIA MEDICAL FACILITIES

Mr. FLOOD. There is some rather strange language in the material you submitted concerning the District of Columbia medical facilities program. I direct your attention to page 6 of your justifications. [Reads:]

All budget authority for this new program has been eliminated on the assumption that Congress will consider this item as a part of the 1969 supplemental appropriation bill.

In the event the item is not made a part of the 1969 supplemental appropriation bill, the executive branch would expect the item to be funded in 1970.

On the surface that looks as if you are trying to pull a fast one on us. You are taking credit for a cut of $15 million, but you want the $15 million. Is there something here that does not meet my very bad eyes?

Mr. CARDWELL. Yes, sir.

Mr. FLOOD. What is it?

Mr. CARDWELL. The Bureau of the Budget was aware that this committee was considering this item as a 1969 supplemental. Of course, they do not know what your final action will be. On that basis we did discuss this change with them at one point and agreed that there would be a budget amendment offered to reduce the 1970 request by $15 million as the materials that were presented to you so indicated. However, based on subsequent conversations with the Bureau of the Budget the decision was made to withdraw the idea of that amendment at this time. The package that comes to you from the White House will not propose a minus $15 million. It will be silent on this point.

Mr. FLOOD. You do not intend to send it up as a supplemental for 1969?

Mr. KELLY. No, sir. But no objection is being made to make it a supplemental.

The only point was we would not want the funds appropriated in 1970 and in 1969. Appropriate them once, in one or the other of the 2 years.

Mr. FLOOD. I would take for granted the administration would exercise its good offices with any officials in the District of Columbia who might have ideas with regard to the use of these funds contrary to the legislative intent of the authorization and, by the way, more especially, any of your minions in the Public Health Service, if you know what I mean.

Secretary FINCH. We are concerned about that also, and will endeavor to respond appropriately, Mr. Chairman.

Mr. FLOOD. I am sure you will.

Percentagewise, the NIH cut, as you said, Mr. Cardwell, is small but we have been getting a lot of complaints about the crippling effect of the Johnson budget. Now you cut the Johnson budget.

What is the answer to all of these people?

Secretary FINCH. Let me say by way of general response, we found that NIH was one of the areas that was most difficult to evaluate. We found a great deal of criticism about the utilization of money in NIH. We have tried to take a harder look at the value of what we are getting for our money there. It has grown very rapidly and we have carefully tried to evaluate that growth.

Mr. KELLY. I think that is exactly right, Mr. Chairman.

As you know, the medical research program grew at a very rapid rate, but during the last 3 years it has somewhat leveled and plateaued. And thus the expectation of large increases is not being realized. Although there has been no reduction in the National Institutes of Health, and it has in fact continued to grow at a very modest rate, the expectation of very large increases no longer being realized gives them this effect.

Both in the Johnson budget and in the revisions made by this administration the priority has been centered on the health manpower area.

As you know, during the years of growth of the National Institutes of Health, there really was no legislation or funds for aid to medical education. Medical research, therefore, had as its side effect the assistance to the institution.

Now under the Health Manpower Act, we have the authority to give direct assistance to both the institution and the students. This budget reflects that priority.

Mr. FLOOD. Mr. Secretary, for the purpose of emphasis again, are you personally satisfied with this NIH budget under all the circumstances? Would you oppose an increase?

Secretary FINCH. I am satisfied with the budget, Mr. Chairman, for the reason Mr. Kelly gave.

Mr. FLOOD. Suppose, because of my concern about this problem. that I would propose an increase. Would you oppose it?

Secretary FINCH. In any particular area you want to designate?

Mr. FLOOD. NIH.

Secretary FINCH. Are you talking about specific research programs?

Mr. FLOOD. No, just the NIH budget as such.

Secretary FINCH. Obviously we would have to defer to the wisdom of Congress, Mr. Chairman.

INCREASE FOR NUTRITION ACTIVITIES

Mr. FLOOD. You are proposing further increases in funds for work on nutrition, $4.5 million?

Secretary FINCH. Yes.

Mr. FLOOD. Every year there are certain projects and activities that are red hot. We have listened to a long line of witnesses here for a couple of months on these various health programs, and we definitely have the impression that nutrition is one of this year's fads. Everyone in HEW is certainly trying to get into the act. Have you looked into this question?

Secretary FINCH. We have, with considerable attention, Mr. Chairman.

As you know, there has been a lot of discussion about whether or not HEW should become involved in the food delivery system. Some have suggested that we should have something to do with food stamps and all the rest of it.

We have, in part, resisted that. We felt our responsibility was on the research side. Under the prior Administration studies were initiated that led to the present high visibility of the problem. It was in direct response to your colleagues on the Senate side——

Mr. FLOOD. High visibility. That is not bad.

Secretary FINCH. In response to your colleagues on the Senate side we expanded that survey from the original five States to 10 States. With this additional money we would hope we could expand it nationwide.

I must say, when we met with the Governors, many of them requested this. They made pledges of using States facilities, and in some cases State funds, because they are aware of the impact that this issue has had nationally. We would utilize their resources in carrying out the further research if you grant the increase.

AID TO MEDICAL SCHOOLS

Mr. FLOOD. You are requesting an increase of $5 million over the Johnson budget for aid to medical schools to help expand enrollment in medical schools. A statement was put out by the department that also says the initial budget request for aid to medical schools will be restructured. What does that mean?

Mr. KELLY. The budget we are submitting to you now takes $5 million of the health professions educational improvement special project grants from schools of podiatry, pharmacy, and veterinary medicine and and uses it for schools of medicine. This, added to the request for an additional $5 million makes a total increase of $10 million available for medical schools.

The Johnson budget had already met the formula distribution requirements to all of the health professional schools. So it is now possible to zero in with $10 million for expansion of first-year enrollment in the medical schools. It will have the effect of increasing the enrollment by 1,000 new medical students. The enrollment will go from 600 to 1,600 first-year medical students.

This is a large increase and one which is believed attainable with the existing institutions.

REDISTRIBUTION OF PARTNERSHIP FOR HEALTH GRANTS

Mr. FLOOD. You are asking for a cut of $18 million in the Johnson budget estimate for "partnership for health" project grants, which will reduce this program below the 1969 level.

Mr. KELLY. This is not really a proposed reduction, but a redistribution of the money to formula grants.

Mr. FLOOD. There is another part to this.

What effect will this have on the German measles vaccination program, and the rat control program? How much do you have budgeted for these two programs in 1970?

The question is in two parts?

Mr. KELLY. It will not affect them.

Let me tell you what we did. We increased the formula grants to States by $18 million and decreased the project grants by $18 million. We had several reasons for wanting to do this.

One was, the authorization for project grant support is temporarily at $98 million this fiscal year, but drops down to $80 million unless the Congress takes some action to extend it. We concluded we did not have to ask for action by the Congress to extend it, but could achieve the objectives by taking the older programs that have already had their opportunity to perform the research and demonstration program developments and move those over to the formula grants. They would then become a part of the State's comprehensive plan.

With the $80 million, we will be able to support fully the level of the rat control program as financed in fiscal year 1969, which I think is $16 million. And we will be able to carry on the rubella vaccination program presented to you originally in the 1969 supplemental. I think it has $9.6 million in 1969 and $16 million in 1970.

Mr. FLOOD. Do not touch the rubella vaccination program or you will feel the full majesty of our wrath.

CLOSING OF PHS HOSPITALS AT SAVANNAH, DETROIT, AND FORT WORTH

From what I hear, you have been doing a lot of thinking and talking in your department about closing down two marine hospitals. What decision have you made?

Mr. CARDWELL. First, I think the chairman ought to be aware that the proposed shift from project grants to formula grants could have an impact on some of the traditional chronic disease programs that have been operated by the States, TB being an example. This may come to your attention. I wanted to be sure we mentioned it to you.

Mr. FLOOD. Right now I am asking you about the marine hospital.

Mr. CARDWELL. I am sorry.

Mr. FLOOD. What has been done on this?

Secretary FINCH. We made the decision with respect to three hospitals, not just the two. We felt the same characteristics applied in each of the three cases. This had been urged by the previous administration.

Mr. FLOOD. Name the three.

Secretary FINCH. Detroit, Savannah, and Fort Worth.

First, the utilization of the hospitals was very low. In view of new state of the art of treatment for drug addiction we felt the Fort Worth facility was not responsive to the clientele that was available. So this was a carefully thought-out conversion. In the Fort Worth case, when Senator Yarborough thought it should be subject to public hearings, I advised him, while it was our intention also to close that facility, we would postpone any final judgment for the time being.

So we are talking really about the three facilities and not just the two, Mr. Chairman.

VOCATIONAL REHABILITATION GRANTS

Mr. FLOOD. One of the biggest surprises in this whole package was your cut in vocational rehabilitation.

Mr. Secretary, I am sure you know, even though you were not around here, that this program was promoted with the greatest vigor by

every Secretary that sat in your chair since Mrs. Hobby, without exception. It has been promoted with equal vigor and even more enthusiasm by every Congress. Everybody has repeatedly pointed out that for ever dollar spent in this program the program returns several dollars to the economy. And you cut it $64.3 million.

Are you just looking for trouble?

Secretary FINCH. No. The budget proposals here may be a little confusing. I would like Mr. Kelly to go over what has been done.

Mr. KELLY. Mr. Chairman, I had a wonderful experience just before I came here today. I met with the State directors of vocational rehabilitation in the auditorium at 1 o'clock and talked with them before coming up here for this hearing.

My job was to tell them what we did with the budget, and to tell them I needed their support. I can only tell you when I left the room they applauded.

Mr. SMITH. Perhaps they were glad to see you go.

Mr. KELLY. Mr. Chairman, the budget does contain an increase of $116 million over 1969 for basic grants, although it has decreased from the January budget. The appeal I made to them is that if you do not constrain the total level of expenditures and make each of the programs participate, this quickly erodes the value of the dollars through inflation.

If by making some constraint in this program you assist in constraining inflation, you will make that $116 million buy additional services for the disadvantaged. If you do not make inflation subside, the inflationary impact on this program will make that $116 million worth very little.

Mr. SMITH. If you cut back vocational rehabilitation another $116 million, would we have complete stabilization of the economy then?

Mr. KELLY. I think what you would do in that case is actually reduce the total program. The reason for the large expansion in the program is because of the change in the law Congress made last year which modified the matching formula to increase the percentage of the Federal participation.

Therefore, if you take the Federal amount back to the 1969 level without reducing the matching rate to the old level, you would be cutting the program back.

JUVENILE DELINQUENCY

Mr. FLOOD. Speaking of surprises, here is a surprise on top of a surprise. Only I was surprised the other way this time.

No increase in the budget for juvenile delinquency. The President has increased the budget for crime-fighting activities in the District of Columbia, the Department of Justice, and even the Department of Labor. Your juvenile delinquency program must be pretty well down the priority list on the war against crime. Why is that?

Secretary FINCH. The Johnson budget asked $15 million for juvenile delinquency, which is an increase of $10 million over 1969. We simply sustained that large increase without adding any more to the program.

Mr. FLOOD. Then you are no more excited about it than Mr. Johnson was.

Secretary FINCH. He recognized that crime is a problem. We had to

make a judgment as to what we can effectively do with the dollars we have in hand. In our judgment, that increase of $10 million was all we could use effectively.

Mr. FLOOD. You agree with Mr. Johnson the problem is bad, but not bad enough to increase the budget as was done in several other anti-crime areas.

Secretary FINCH. There is still a great deal we have to learn about how to combat it more effectively.

Mr. CARDWELL. The readiness is a serious problem. The $5 million available in 1969 has not been used. Miss Switzer pointed this out when she was here. You are going almost from zero to $15 million in 1970. That is a basic problem either administration would have had to face.

Secretary FINCH. We cannot tell you honestly we have a lot of good ideas for what to do with $15 million right now.

OFFICE OF CHILD DEVELOPMENT

Mr. FLOOD. President Nixon announced the establishment of an Office of Child Development in HEW. As we understand it, this organization will be located in the Office of the Secretary.

Secretary FINCH. Yes.

Mr. FLOOD. And it will handle the Headstart program. That is clear.

Secretary FINCH. Yes, sir.

Mr. FLOOD. What other programs will be shifted to the new Office of Child Development?

Secretary FINCH. We have not made any final or hard determination in that regard. We want first to make sure we can do with Headstart what should be done. This administration recognizes the importance of the first 5 years of life. A great deal of rather striking data that has come to our attention about what happens in those first 5 years in terms of language structuring and linguistic capability. There are studies that compare the premature child with the full-term child, and those that examine the effects of the Headstart program and the orthodox school situation.

It is possible that we might take over some of the other Federal programs and phase them in on an as-ready basis. I think we need this emphasis, but I am not prepared to say we are going to be denuding or dismantling the Children's Bureau and thrusting a lot of programs into the new Office at this time.

Mr. FLOOD. What was your rationale in giving birth to this new organization? There are so many already that deal with various programs for children. There is the Children's Bureau, there is the Office of Education, the National Institute of Child Health and Human Development. There is the National Institute of Mental Health, even, that has programs for children.

What did you have in mind in creating another office for children?

Secretary FINCH. A very good group, headed by former Director of the Budget Charles Schultz, which included Headstart mothers, educators, behaviorists, and others worked this out.

In the first discussion, the Children's Bureau people felt Headstart should go there, and Office of Education felt it should go there. After they had 2 days of violent discussion, the decision of that committee, which I supported and the President supported, was to place the program in a separate office reporting directly to the Secretary. This would protect the integrity of the program, protect the parental in-

volvement, and protect the nutritional input, and would make sure we were not going to lose the program somewhere in the bowels of HEW.

The reason the panel felt it should not go into the Office of Education at this point, to be perfectly candid, was a fear of locking it into the public school system. Then all of the constituencies running down to that age level, the near poor and the poor white and so on, would feel they were entitled to and should have the same kind of preschool education.

We had very grave apprehension about local school districts undertaking the additional burden this would require. Also, we were reluctant to do this because in some school districts there would just not be the proper stimulation of the children. We have seen frustrations in some school districts when the Headstart children enter the regular school.

We were satisfied, as we looked at the Children's Bureau, with the present structure they have. They were not able to absorb it and there was great apprehension on the part of the Headstart people that they would be lost administratively and psychologically if they were put into the Children's Bureau. That is the reason we made the decision we did.

Mr. FLOOD. How will the new organization be funded?

Secretary FINCH. We will take the moneys that have already been appropriated to Headstart and pick those up now. We will have to come in and justify a separate office for the next fiscal year.

REFORM OF THE WELFARE SYSTEM

Mr. FLOOD. President Nixon also announced on April 14 in his message on domestic programs and policies that he will be submitting to Congress a program providing for the reform of the welfare system.

Can you tell us anything about that at this time?

Secretary FINCH. I wish I could tell you in precise detail.

Mr. FLOOD. So do I. What can you tell us?

Secretary FINCH. All I can tell you, Mr. Chairman, is we have——

Mr. FLOOD. This is a very dramatic thing.

Secretary FINCH. We have several dramatic proposals, but they are not all worked out in complete detail yet.

Mr. FLOOD. I thought the drama was being played now.

Secretary FINCH. In any event, none of these programs anticipate anything before fiscal year 1971.

Mr. FLOOD. Not before 1971?

Secretary FINCH. As I say, we do not have our blueprint ready to submit yet.

INCOME MAINTENANCE EXPERIMENTS

Mr. FLOOD. Along the very same line, you are putting in an additional $5 million over the Johnson budget for a total of $9.7 million for "Demonstrations of new approaches to income maintenance and social services in actual operational settings."

What do you have in mind?

According to an article I have here "HEW has asked for $9.7 million in 1970 to experiment with guaranteed annual income, children's allowances in several model city neighborhoods. About 800 families will be involved."

Do you want to comment on that? That is more drama.

Secretary FINCH. And it is loaded with considerable political dynamite. I have a detailed statement outlining our plans for these experiments which I would like to insert in the record before I go on.

(The information follows:)

PLAN FOR CONDUCTING INCOME MAINTENANCE EXPERIMENTS

Over the last few years there has been a growing interest in the study of different methods for providing income supplementation to families for whom the normal working of our economic system does not, for a variety of reasons, provide an adequate level of subsistence.

Although reform of systems of income maintenance in the U.S. has been and is a continuous process, the administration and Congress have recognized that now is the time for a major reevaluation of programs in the area of income maintenance. The formation of the President's commission on income maintenance programs, the initiation of the model cities program and the various income maintenance related projects of the Office of Economic Opportunity are all evidence of this concern.

This interest has come partly from the widespread acknowledgement of the defects and limitations of current public assistance programs; partly from a growing recognition that the economic marketplace does not necessarily assure adequate income for all persons even if they are willing and able to work; and partly from the awareness that there is too little information available that can be used to predict the likely impact of major innovations in income maintenance policies.

Turning first to the defects of the present system—the most salient problems are those of inadequate payments, incomplete coverage and inequity. For example, although the costs of public assistance are high and are projected to rise steeply, in 1965 only 20 percent of poor persons received public assistance payments. Of these 82 percent remained poor after payment. Payment levels are erratic with wide State-by-State differences; in New York, for example, the average payment for a family of four on AFDC is almost $250 compared to $115 in Ohio and $35 in Mississippi. Moreover, the determination of eligibility has frequently been undignified and the recipient stigmatized as the beneficiary of a welfare handout. Finally, the program has provided very weak incentives to work and has come under attack for promoting family breakups because of the absence in many States of a program of aid to needy families where the male head of the household is unemployed. Furthermore, no Federal program provides help to families headed by a male who works but is still unable to provide sufficiently for his family.

To remedy these defects, a variety of different programs and approaches have been widely publicized. These range from relatively modest proposals such as establishing federally supported minimum payment levels in all States, to the adoption of totally new systems such as a negative income tax or a system of children or family allowances.

The fact remains, however, that all these suggested changes raise a number of key questions on which information is essential if a sensible long-term program of reform is to be undertaken. Answers to these questions will remain important even if the current system is modified during the next year or so, for without these answers it will be difficult to evaluate the usefulness of what changes are made; to improve methods for estimating caseloads and overall costs and most importantly, to assess the desirable direction of further long-term change. In any case, as yet no one has proposed a system which will solve all the problems of the current system and, given current national budget constraints it is not likely that such a system will be achieved during the next few years.

Key among the questions needing answers are the following:

(*a*) How will alternative programs affect the incentive to work? If standards are raised to the point where some persons on welfare might be almost as well off as persons in unattractive low-paying jobs, will this encourage persons to drop out of the labor force and go on public assistance? On the other hand, if more liberal provisions are made for the retention of earned income while still retaining part of assistance payments, will some persons currently on public assistance be encouraged to enter the labor force or increase their work effort?

(*b*) What interactions will occur with manpower and work-related programs and services including job creation and training, day care and transportation services? Will the benefits achieved through a combination of income mainte-

nance and job-related programs be multiplicative in the sense that they will be greater than what we could expect from adding together the observed effects of each type of program operating alone?

(*c*) How will alternative programs affect mobility—in particular, will it tend to accelerate, decelerate or reverse the current rural-urban migration pattern?

(*d*) Will family stability be enhanced by changes in income maintenance policies and if so what types of plans and variations within them will serve this purpose best? For nstance, if male-headed families are included in the program, will this help to reduce family breakups and illegitimacy?

(*e*) Will certain types of programs produce an adverse effect on family size—particularly child-oriented allowance systems?

(*f*) Will demand for social services, both public and private, be affected? Will the injection of additional money into a community of itself promote spontaneous development of private medical, legal and educational services for the community thus reducing the demand for Government-provided services; or will the latter still be required?

(*g*) Will consumption patterns change among low-income families? How high much payments be before families will budget significant amounts of money for more long-run investments in the health, education and general well-being of their families?

(*h*) What will be the general effects on the social and economic life of a community, particularly a small community? Will prices of goods and services change; will community cohesiveness be enhanced; will the location of businesses shift?

A parallel set of questions relates to how the same sort of policies might impact differently on different population groups and different areas—urban vs. rural; white vs. nonwhite; female-headed families vs. male-headed; aged vs. nonaged; persons in families vs. unrelated individuals and childless couples.

It is clearly not possible to obtain reliable answers to all these questions in a single experiment. At the same time, experiments are costly and difficult to design and implement. Consequently, the number and size of the experiments will be kept as small as possible. To do this, a series of well-controlled and carefully designed experiments is proposed, each of which will be a necessary and integral part of an overall strategy. The development of such a strategy with the help of the Institute for Research on Poverty of the University of Wisconsin has already begun. This strategy can roughly be described as follows:

(1) First, maximum use will be made of the techniques and information available from currently operating and planned experiments, specifically the OEO sponsored New Jersey negative income tax for male-headed families and the planned OEO sponsored rural experiment.

(2) Second, an effort will be made to focus each experiment on one or more issues of importance, these issues being determined both by their priority in policymaking and by their suitability for exploration through the experimental method. This is a point worth stressing. There are clearly some important questions which are not particularly suited for experimental exploration. Some questions involving national impact, interaction with the positive tax structure and the like can more easily be answered by the type of analysis which uses existing statistical data. This type of analysis is currently being undertaken in HEW, the Income Maintenance Commission and in numerous universities and other private and public research groups. Other questions involving long-run effects on community and individual development are also clearly outside the scope of the program. For instance, it will not be possible to gain definitive information on the impact of innovations on the so-called cycle of poverty or other intergenerational effects from a 3–5 year experiment.

(3) A third requirement is adherence in all approved experiments to a uniform set of standards covering the operating "rules" of the experiment (the equivalent of what would be statutory requirements if the plan were implemented on a national basis). Such rules would cover the definition of family units, the definition of income to be used in determining eligibility and size of payment, evaluation and administrative procedures and of course the level and timing of payments. This isn't to say that we don't wish to examine the effect of variation in many of these "rules" since, in fact, they may be extremely important in their effect on, for instance, work incentives and family size and stability. But simply that all allowed variation must serve an experimental purpose, it must be systematically done to provide reliable insights on some important issue.

In summarizing this strategy, the most important point to be made is that these experiments are to be, to the extent that we can possibly make them, true

scientific experiments. The knowledge gained from them must have direct relevance to policymaking. In other words, simple demonstrations of the fact that the Government can give away money are not to be undertaken.

Within the next year some five or six different experiments, each one aimed at filling in one or more "pieces" of the overall puzzle, are planned. Priorities for research are as follows:

Work incentive effects.—There are two major issues we want to explore on this subject.

First, HEW wants to fill in the gap between the OEO sponsored New Jersey Negative Income Tax (which covered only urban male-headed families) and the OEO planned Rural experiment (which covers both male and female but, of course, only rural). HEW will focus its first experiment on the female-headed urban family with particular attention to the work response of such families as well as the effects on family structure and quality of life.

The second thing to be determined about work response is how various income maintenance programs would interact with manpower and other work related public programs. For instance, if income maintenance programs are combined with liberal earnings retention features, will programs for job training and employment as well as day care and transportation programs interact to produce a combined effect greater than the simple sum of benefits obtained from each of these types of programs taken alone?

Design of such an experiment is underway. It will probably be situated in a model city area with a fair number of ongoing work-related public programs. More than one experiment on this subject will probably be required to focus on different sorts of manpower-related programs and different incentive schemes. Other priority areas for exploration are:

The aged.—Here primary interest is focused on the retirement decision, i.e., the extent to which it is currently voluntary or forced and how retirement patterns will shift both as income maintenance payments become more adequate and as more liberal earnings retention features are introduced.

A national sample experiment.—This experiment would deal with the problem that the other urban samples might not provide an adequate representation of national labor market conditions and other environmental effects.

Birth rates.—This is another major area of interest. New techniques are needed to offset the fact that a 3–5 year experiment period is probably too short to give reliable results on the effect of more adequate family allowances on family size.

Community effects experiments.—These will also receive priority though a greater amount of technical effort will be required to get these launched. To get any reliable estimates of the effects of an income maintenance plan on the actual structure of a community it will be necessary to select a small rural community that can be "blanketed", that is, make payments to everyone eligible instead of simply drawing a sample.

Of course in all these experiments effects on family stability, consumption patterns, work effort and so forth will be evaluated carefully.

HEW would hope to launch five or six experiments, following the priorities outlined, within the next year. It is estimated that each experiment will cost around $1 to $1½ million annually including the costs of the maintenance payments, research, administration and evaluation. The payments themselves would probably account for about two-thirds of the annual cost. Each experiment would probably run from 3 to 5 years depending on its focus. The actual costs would of course vary with sample size, control group size, level of payments, and intricacy of the design problem. HEW does, however, hope to realize some "economics of scale" by drawing heavily on the experience gained in the development of the OEO sponsored experiments.

Secretary FINCH. As you know, there has been one variation of that under OEO. We have had a variety of programs submitted by the model cities in their program applications. And I think since Mr. Kelly participated in one of our teams that went out to look at the programs, he can respond to this better than I can. But whether we are talking about trying to get away from the social worker concept, or simplifying the administration of income maintenance programs, or other more extreme suggestions, I must say there have been quite a variety of interesting suggestions that have come out of the model cities.

Mr. FLOOD. You are talking here about guaranteed annual income, or children's allowances?

Mr. KELLY. Those approaches have been suggested. The public assistance programs have developed by a process of evolution. There has never been any substantial amount of research on alternative methods of assisting the needy.

The model cities program provides an intensive program of social improvement for a neighborhood. Plans and proposals have been developed by these cities and neighborhoods.

Mr. FLOOD. Secretary Romney suggested in the last couple days it be increased beyond a mere neighborhood.

Mr. KELLY. He is talking about a citywide program. The part that so far as been developed, where plans have been developed, deals with neighborhoods. Almost every one of the plans has included some proposal for improving income maintenance. Some deal strictly with the administration of it, some deal with the whole approach. They have picked up ideas that have been discussed around the country: Negative income tax, family allowance, guaranteed income, limited deduction for income from employment.

Secretary FINCH. There have also been proposals about food stamps and the WIN program.

Mr. KELLY. This research proposal still allows the model cities to do some experimentation, but will now provide for some real research. We want to see properly developed research projects with control groups and careful evaluation. Then we can come before the Congress and be able to say which approaches work, and which approaches do not work.

There are such huge sums of money spent in this field today, without any research and experimentation in alternative approaches. It appears we are not being as wise in the investment of research in this area as we are in the science areas.

REQUESTED POSITIONS

Mr. FLOOD. Regarding personnel, how many positions requested in the Johnson budget have been dropped in the Nixon budget?

Mr. KELLY. 1,600.

Mr. FLOOD. Where have you asked for increases over the Johnson budget?

Mr. CARDWELL. Essentially there are two increases over the Johnson budget. One is in the Office of Education. It is an increase of 57 jobs to be assigned to title IV of the Civil Rights Act.

That particular appropriation is not considered by this committee, but is in our total array of manpower.

The other is an increase of 100 positions for the social and rehabilitation service. It represents an effort to strengthen the management of that organization and to provide staff to do experimentation and evaluation work on their ongoing programs.

Mr. FLOOD. Will you place in the record a table showing for each appropriation, first, the 1969 authorized positions, and the average employment?

Two, the most recent actual employment figure you have.

Three, estimated June 30 employment.

Four, the number of positions and man-years in the Johnson budget.

Five, the number of positions and man-years in the Nixon budget.

(The information follows:)

EMPLOYMENT IN THE REVISED BUDGET, FISCAL YEAR 1970

Appropriation/account	1969 positions	1969 average employment	March 31, actual	June 30, anticipated	January budget: 1970 positions	January budget: 1970 average employment	Revised budget: 1970 positions	Revised budget: 1970 average employment
Consumer Protection and Environmental Health Service:								
Food and drug control	4,247	4,222	4,091	4,123	4,370	4,280	4,252	4,225
Air pollution control	1,065	1,083	1,006	1,034	1,203	1,205	1,102	1,137
Environmental control	2,085	2,152	1,980	2,000	2,098	2,135	1,994	2,040
Salaries and expenses, Office of the Administrator	381	352	298	370	387	384	381	379
Revolving fund for certification and other services, food and drug control	247	240	240	240	247	240	247	240
Advances and reimbursements	243	236	223	236	243	268	243	268
Total, Consumer Protection and Environmental Health Service	8,268	8,285	7,838	8,003	8,548	8,512	8,219	8,289
Health Services and Mental Health Administration:								
Mental health	2,459	2,645	2,172	2,329	2,591	2,937	2,565	2,921
Saint Elizabeths Hospital	3,914	3,996	3,719	3,800	3,925	3,816	3,925	3,816
Health services research and development	222	211	187	216	238	250	230	245
Comprehensive health planning and services	639	1,505	558	620	658	1,517	646	1,511
Regional medical programs	770	818	743	748	783	827	791	839
Communicable diseases	2,369	2,568	2,211	2,300	2,374	2,575	2,359	2,565
Hospital construction	248	241	239	241	258	251	248	244
Patient care and special health services	6,492	6,516	6,071	6,303	6,664	6,558	6,224	6,252
National health statistics	460	440	426	447	488	479	469	464
Salaries and expenses, Office of the Administrator	587	567	546	570	596	578	587	569
Indian health services	6,312	6,248	5,916	6,128	6,459	6,320	6,459	6,320
Indian health facilities		182				212		212
Emergency health	207	202	192	201	208	202	111	111
Operation of commissaries, narcotic hospitals	6	6	6	4	3	3	3	3
Service and supply fund	121	119	110	117	151	141	151	141
Working capital fund, narcotic hospital	32	32	30	31	22	22	22	22
Advances and reimbursements	552	584	453	536	587	601	587	601
Health Services and Mental Health Administration trust funds	2	8	1	2	3	5	3	5
Allocations and allotments from other agencies	388	372	387	366	441	422	441	442
Total, Health Services and Mental Health Administration	25,780	27,260	23,967	24,959	26,449	27,716	25,821	27,263
National Institutes of Health:								
Biologics standards	280	281	272	270	285	280	280	275
National Cancer Institute	1,390	1,417	1,380	1,370	1,427	1,409	1,390	1,401
National Heart Institute	600	610	581	501	620	626	600	610
National Institute of Dental Research	301	303	292	290	306	309	301	309
National Institute of Arthritis and Metabolic Diseases	630	612	547	610	647	623	630	645
National Institute of Neurological Diseases and Stroke	685	660	724	662	690	713	685	713
National Institute of Allergy and Infectious Diseases	718	713	678	692	737	720	718	713

National Institute of General Medical Sciences	202	202	191	195	202	202	202	202
National Institute of Child Health and Human Development	409	423	398	397	475	456	432	434
National Eye Institute	63	60	59	61	78	76	78	76
Environmental health sciences	194	184	176	188	229	220	229	220
General research and services	256	254	238	249	260	263	254	262
John E. Fogarty International Center for Advanced Study in the Health Sciences	52	52	46	50	58	57	52	55
Health manpower	449	472	398	423	459	483	449	472
Dental health	243	257	231	234	243	258	243	258
National Library of Medicine	470	485	471	458	492	491	470	491
Salaries and expenses, Office of the Director	460	453	484	447	467	467	460	457
NIH management fund	3,755	3,773	3,544	3,618	3,778	3,807	3,755	3,790
Services and suppy fund	685	660	679	673	700	676	700	676
Advances and reimbursement	77	71	69	75	77	71	77	71
Total, National Institutes of Health	11,919	11,942	11,458	11,543	12,230	12,207	12,005	12,130
Office of Education:								
Salaries and expenses	2,221	2,529	2,279	2,160	2,410	2,567	2,410	2,567
Higher education	287	293	195	287	331	325	331	325
School assistance in federally affected areas	64	64	39	64	64	64	64	64
Civil Rights education	86	86	73	83	121	113	178	151
Advances and reimbursements	47	47	44	45	47	47	47	47
Allocations and allotments from other agencies	209	209	214	209	227	209	227	209
Total, Office of Education	2,914	3,228	2,844	2,848	3,200	3,325	3,257	3,363
Social and Rehabilitation Service:								
Salaries and expenses	1,708	1,739	1,580	1,656	1,768	1,778	1,868	1,845
Assistance to refugees in the United States	122	167	110	117	177	172	177	172
Advances and reimbursements	25	25	20	25	15	15	15	15
Allocations and allotments from other agencies	50	50	48	49				
Child welfare						21		21
Development of programs for the aging						7		
Juvenile delinquency prevention and control		12				12		12
Total, Social and Rehabilitation Service	1,905	1,993	1,758	1,847	1,960	2,005	2,060	2,065
Social Security Administration:								
Limitation on salaries and expenses (Trust Fund)	51,076	51,484	50,420	49,526	53,941	51,936	53,941	51,936
Advances and reimbursements	201	214	200	200	202	216	202	216
Operating fund, Bureau of Federal Credit Unions	481	488	428	480	500	497	500	497
Consumer Credit Training					12	8	12	8
Total, Social Security Administration	51,758	52,186	51,048	50,206	54,655	52,657	54,655	52,657
Special institutions:								
National Technical Institute for the Deaf: Salaries and expenses	2	2	2	2	2	2	2	2
Model Secondary School for the Deaf: Salaries and expenses	2	2	2	2	2	2	2	2
Total, Special institutions	4	4	4	4	4	4	4	4

EMPLOYMENT IN THE REVISED BUDGET, FISCAL YEAR 1970—Continued

Appropriation/account	1969 positions	1969 average employment	March 31, actual	June 30, anticipated	January budget: 1970 positions	January budget: 1970 average employment	Revised budget: 1970 positions	Revised budget: 1970 average employment
Departmental management:								
Salaries and expenses, Office of the Secretary	287	307	276	279	344	341	344	341
Salaries and expenses, Office of Community and Field Services	795	798	741	771	946	889	545	519
Salaries and expenses, Office for Civil Rights							401	370
Salaries and expenses, Office of the Comptroller	634	628	609	615	796	734	796	734
Salaries and expenses, Office of Administration	404	398	356	392	434	416	434	416
Surplus property utilization	101	99	96	98	101	98	101	98
Salaries and expenses, Office of the General Counsel	263	259	233	255	273	262	273	262
Working capital fund	663	655	621	643	669	653	669	653
Advances and reimbursements	122	141	87	118	108	147	108	147
Total, departmental management	3,269	3,285	3,019	3,171	3,671	3,540	3,671	3,540
Grand total, Department of Health, Education, and Welfare	105,817	108,183	101,936	102,581	110,717	109,966	109,692	109,311

APPROPRIATIONS, OBLIGATIONS, AND EXPENDITURES FOR 1969 AND 1970

Mr. FLOOD. Will you also place in the record another table showing by appropriation items:

The appropriation, estimated obligations, and estimated expenditures for 1969; the requested appropriation, estimated obligations, and estimated expenditures for 1970 under the Johnson budget and the same information on the Nixon budget.

(The information follows:)

This table shows the budget authority, obligations, and outlays, for every HEW Federal fund appropriation included in the Labor-HEW Appropriations Bill. It does not include the Department's trust funds, intragovernmental funds, and public enterprize funds not supported by appropriations. It includes funds for the legislative proposals for fiscal year 1970 as well as the proposed supplemental request for fiscal year 1969. The budget authority figures in the 1969 column have been adjusted to be comparable to the appropriation and activity structure used in the FY 1970 budget. Because of these comparability adjustments some of the 1969 budget authority figures will not be the same as shown in the printed budget schedules. The 1969 obligations agree with the printed budget schedules and are also comparable to the 1970 structure. Outlay figures are not adjusted for comparability.

June 2, 1969

HEW Federal Fund Estimates in the Labor-HEW Bill

(Includes proposed legislation)
(Dollars in thousands)

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERIVCE	BA:	$ 227,064	$ 232,799	$ 229,477
	Obligs:	224,728	243,708	240,386
	Outlays:	184,154	219,259	217,208
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION	BA:	1,060,048	1,178,101	1,045,441
	Obligs:	1,200,016	1,251,628	1,219,915
	Outlays:	945,431	1,114,695	1,105,537
NATIONAL INSTITUTES OF HEALTH	BA:	1,394,549	1,484,127	1,448,610
	Obligs:	1,518,157	1,568,797	1,506,081
	Outlays:	1,220,762	1,280,518	1,411,955
SCIENTIFIC ACTIVITIES OVERSEAS	BA:	15,000	15,322	3,455
	Obligs:	17,460	15,322	3,455
	Outlays:	12,329	15,360	11,309
Subtotal, Health Agencies	BA:	2,696,661	2,910,349	2,726,983
	Obligs:	2,960,361	3,079,455	2,969,837
	Outlays:	2,362,676	2,629,832	2,746,009
OFFICE OF EDUCATION	BA:	3,654,441	3,566,212	3,190,393
	Obligs:	3,834,250	3,628,457	3,252,638
	Outlays:	3,424,722	3,821,608	3,701,201
SOCIAL AND REHABILITATION SERVICE	BA:	7,338,302	8,625,401	8,614,241
	Obligs:	6,962,851	8,631,261	8,620,101
	Outlays:	6,475,366	8,373,085	8,414,589

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
SOCIAL SECURITY ADMINISTRATION	BA:	$ 1,690,772	$ 2,014,864	$ 2,014,864
	Obligs:	1,690,772	2,014,864	2,014,864
	Outlays:	2,168,800	2,014,847	2,014,847
SPECIAL INSTITUTIONS	BA:	36,146	76,175	62,409
	Obligs:	62,911	106,031	92,153
	Outlays:	41,474	50,261	50,166
DEPARTMENTAL MANAGEMENT	BA:	35,898	55,160	45,160
	Obligs:	41,962	62,483	52,483
	Outlays:	30,646	53,991	43,991
TOTAL, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE	BA:	15,452,220	17,248,161	16,654,050
	Obligs:	15,553,107	17,522,551	17,002,076
	Outlays:	14,503,684	16,943,624	16,970,803

HEW Federal Fund Estimates in the Labor-HEW Bill

(Includes proposed legislation)
(Dollars in thousands)

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE:				
Food and drug control.....	BA:	$ 70,444	$ 72,698	$ 72,007
	Obligs:	70,444	72,698	72,007
	Outlays:	59,810	69,410	68,706
Air pollution control.....	BA:	87,960	95,800	95,800
	Obligs:	84,819	96,800	96,800
	Outlays:	65,482	77,965	77,965
Environmental control.....	BA:	62,831	57,698	55,208
	Obligs:	61,560	57,698	55,208
	Outlays:	37,172	52,810	51,587
Buildings and facilities.....	BA:	---	400	300
	Obligs:	22,075	10,309	10,209
	Outlays:	3,127	9,284	9,200
Salaries and expenses, Office of the Administrator.....	BA:	5,829	6,203	6,162
	Obligs:	5,830	6,203	6,162
	Outlays:	18,563	9,790	9,750
Total, Consumer Protection and Environmental Health Service.....	BA:	227,064	232,799	229,477
	Obligs:	244,728	243,708	240,386
	Outlays:	184,154	219,259	217,208

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION:				
Mental health.....	BA:	$ 338,171	$ 367,129	$ 357,904
	Obligs:	367,923	377,299	366,140
	Outlays:	285,219	332,064	330,913
St. Elizabeths Hospital.....	BA:	11,167	10,405	10,405
	Obligs:	39,832	38,876	38,876
	Outlays:	12,503	10,176	10,176
Health services research and development.....	BA:	41,907	44,975	44,975
	Obligs:	40,922	44,975	44,975
	Outlays:	54,110	54,977	54,977
Comprehensive health planning and services.....	BA:	187,109	212,030	214,033
	Obligs:	194,040	216,350	218,353
	Outlays:	146,133	181,727	186,074
Regional medical programs....	BA:	83,133	120,641	100,000
	Obligs:	119,081	120,641	120,000
	Outlays:	50,768	96,479	86,979
Communicable diseases.....	BA:	39,084	38,731	38,638
	Obligs:	41,397	38,731	38,638
	Outlays:	62,830	44,834	44,744
Hospital construction.....	BA:	258,289	258,415	153,923
	Obligs:	271,546	268,675	247,683
	Outlays:	232,129	280,462	277,910
D.C. medical facilities.....	BA:	---	15,000	15,000
	Obligs:	---	15,000	15,000
	Outlays:	---	1,481	1,481

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION: (CONT)				
Patient care and special health services.....	BA:	$ 71,437	$ 72,224	$ 72,224
	Obligs:	85,279	86,702	86,083
	Outlays:	69,710	69,824	69,824
National health statistics.....	BA:	8,109	9,773	9,641
	Obligs:	8,028	9,773	9,641
	Outlays:	8,137	9,452	9,318
Retired pay of commissioned officers.....	BA:	13,041	16,700	16,700
	Obligs:	13,041	16,700	16,700
	Outlays:	11,712	15,280	15,280
Buildings and facilities.	BA:	---	2,100	2,100
	Obligs:	10,326	7,928	7,928
	Outlays:	3,518	9,100	9,100
Salaries and expenses, Office of the Administrator.....	BA:	8,601	9,978	9,898
	Obligs:	8,601	9,978	9,898
	Outlays:	8,662	8,839	8,761
Total, Health Services and Mental Health Administration.....	BA:	1,060,048	1,178,101	1,045,441
	Obligs:	1,200,016	1,251,628	1,219,915
	Outlays:	945,431	1,114,695	1,105,537
NATIONAL INSTITUTES OF HEALTH:				
Biologics Standards.....	BA:	8,305	8,338	8,225
	Obligs:	8,305	8,338	8,225
	Outlays:	8,180	7,407	7,347
National Cancer Institute.....	BA:	183,486	184,402	180,725
	Obligs:	181,419	184,402	180,725
	Outlays:	161,425	178,595	176,896

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
NATIONAL INSTITUTES OF HEALTH: (CONT)				
National Heart Institute.....	BA:	$ 166,009	$ 163,141	$ 160,513
	Obligs:	161,010	163,141	160,513
	Outlays:	142,710	155,965	154,481
National Institute of Dental Research.....	BA:	29,698	30,062	29,289
	Obligs:	29,419	30,062	29,289
	Outlays:	25,765	28,286	28,024
National Institute of Arthritis and Metabolic Diseases.....	BA:	143,402	139,968	137,668
	Obligs:	140,232	139,968	137,668
	Outlays:	121,719	133,699	132,430
National Institute of Neurological Diseases and Stroke.....	BA:	106,014	103,485	101,256
	Obligs:	103,265	103,485	101,256
	Outlays:	106,307	110,629	109,567
National Institute of Allergy and Infectious Diseases.....	BA:	106,624	103,922	102,389
	Obligs:	103,173	103,922	102,389
	Outlays:	85,073	95,429	94,531
National Institute of General Medical Sciences.....	BA:	163,123	157,803	154,288
	Obligs:	159,955	157,803	154,288
	Outlays:	136,548	156,798	155,314
National Institute of Child Health and Human Development.....	BA:	72,591	78,411	75,852
	Obligs:	70,800	78,411	75,852
	Outlays:	59,140	71,295	70,607
National Eye Institute..	BA:	22,240	25,778	23,685
	Obligs:	22,240	25,778	23,685
	Outlays:	---	12,165	12,040

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
NATIONAL INSTITUTES OF HEALTH: (CONT)				
Environmental health sciences.....	BA:	$ 17,785	$ 19,004	$ 18,328
	Obligs:	17,682	19,004	18,328
	Outlays:	15,928	17,911	17,732
General research and services	BA:	71,230	74,809	69,698
	Obligs:	70,685	74,809	69,698
	Outlays:	71,503	73,482	72,777
John E. Fogarty International Center for Advanced Study in the Health Sciences.....	BA:	3,374	3,460	2,954
	Obligs:	3,874	3,460	2,954
	Outlays:	395	2,525	2,497
Health manpower.....	BA:	172,086	218,824	218,021
	Obligs:	206,659	245,464	247,161
	Outlays:	109,255	165,907	160,847
Health education loan fund.....	BA:	200	957	957
	Obligs:	13,416	3,113	3,113
	Outlays:	11,456	1,841	1,841
Dental health.....	BA:	10,185	11,888	10,887
	Obligs:	10,185	11,888	10,887
	Outlays:	4,379	8,675	8,619
Construction of health educational, research and library facilities	BA:	93,200	126,100	126,100
	Obligs:	173,875	149,000	149,000
	Outlays:	127,472	165,595	165,595
National Library of Medicine.....	BA:	18,009	22,182	19,682
	Obligs:	20,175	22,882	20,382
	Outlays:	22,309	23,405	22,055

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
NATIONAL INSTITUTES OF HEALTH: (CONT)				
Buildings and facilities.....	BA:	$ ---	$ 4,400	$ 1,000
	Obligs:	14,795	6,674	3,575
	Outlays:	11,198	14,471	12,371
Salaries and expenses, Office of the Director.....	BA:	6,993	7,193	7,093
	Obligs:	6,993	7,193	7,093
	Outlays:	---	6,438	6,384
Total, National Institutes of Health.....	BA:	1,394,549	1,484,127	1,448,610
	Obligs:	1,518,157	1,568,797	1,506,081
	Outlays:	1,220,762	1,280,518	1,411,955
Scientific activities overseas.....	BA:	15,000	15,322	3,455
	Obligs:	17,460	15,322	3,455
	Outlays:	12,329	15,360	11,309
OFFICE OF EDUCATION:				
Elementary and secondary education.....	BA:	1,475,993	1,525,876	1,415,393
	Obligs:	1,475,993	1,525,876	1,415,393
	Outlays:	1,362,956	1,445,712	1,402,372
School assistance in federally affected areas.....	BA:	521,253	315,167	202,167
	Obligs:	580,151	315,167	202,167
	Outlays:	405,507	456,020	400,620
Education professions development.....	BA:	95,000	105,000	95,000
	Obligs:	95,000	105,000	95,000
	Outlays:	35,290	162,440	158,890
Teacher Corps.....	BA:	20,900	31,100	31,100
	Obligs:	20,900	31,100	31,100
	Outlays:	19,000	24,243	24,243

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
OFFICE OF EDUCATION: (CONT)				
Higher education.....	BA:	$ 815,444	$ 897,259	$ 780,839
	Obligs:	976,622	944,546	828,126
	Outlays:	965,915	994,850	992,943
Vocational education.....	BA:	248,216	279,216	279,216
	Obligs:	248,216	279,216	279,216
	Outlays:	242,458	255,489	255,489
Libraries and community services.....	BA:	147,144	155,625	107,709
	Obligs:	162,242	155,625	107,709
	Outlays:	123,983	159,858	138,522
Education for the handicapped.....	BA:	79,795	85,850	85,850
	Obligs:	79,795	85,850	85,850
	Outlays:	58,766	71,016	71,016
Research and training.....	BA:	87,452	90,000	115,000
	Obligs:	117,033	90,585	115,585
	Outlays:	72,579	102,446	108,696
Education in foreign language and world affairs.....	BA:	18,165	20,000	20,000
	Obligs:	18,165	20,000	20,000
	Outlays:	14,400	15,592	15,592
Research and training (special foreign currency program).....	BA:	1,000	4,000	1,000
	Obligs:	1,039	4,000	1,000
	Outlays:	800	2,024	900
Salaries and expenses.....	BA:	40,804	43,375	43,375
	Obligs:	40,804	43,375	43,375
	Outlays:	41,300	42,115	42,115

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
OFFICE OF EDUCATION: (CONT)				
Student loan insurance fund.....	BA:	---	$ 10,826	$ 10,826
	Obligs:	1,948	16,388	16,388
	Outlays:	1,543	12,976	12,976
Higher education facilities loan fund..	BA:	103,275	2,918	2,918
	Obligs:	16,342	11,729	11,729
	Outlays:	80,275	76,827	76,827
Total, Office of Education	BA:	3,654,441	3,566,212	3,190,393
	Obligs:	3,834,250	3,628,457	3,252,638
	Outlays:	3,424,722	3,821,608	3,701,201
SOCIAL AND REHABILITATION SERVICE:				
Grants to States for maintenance payments..	BA:	3,395,424	3,638,084	4,239,618
	Obligs:	3,212,143	3,638,084	4,239,618
	Outlays:	2,938,046	3,638,000	4,188,534
Work incentives.....	BA:	117,500	164,640	129,640
	Obligs:	117,019	164,640	129,640
	Outlays:	90,085	163,265	148,265
Grants to States for medical assistance....	BA:	2,396,322	3,057,025	2,551,969
	Obligs:	2,191,037	3,057,025	2,551,969
	Outlays:	2,118,018	2,915,000	2,477,944
Social services and administration.....	BA:	624,800	730,720	725,242
	Obligs:	622,475	730,720	725,242
	Outlays:	590,856	729,000	723,522
Assistance for repatriated U.S. nationals	BA:	645	700	700
	Obligs:	645	700	700
	Outlays:	638	681	681

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
SOCIAL AND REHABILITATION SERVICE: (CONT)				
Grants for rehabilitation services and facilities.....	BA:	$ 368,990	$ 564,123	$ 499,783
	Obligs:	371,597	564,123	499,783
	Outlays:	369,417	509,300	460,130
Mental retardation.....	BA:	32,556	33,629	33,629
	Obligs:	44,569	39,129	39,129
	Outlays:	6,207	22,376	22,376
Maternal and child health.....	BA:	209,200	230,700	228,500
	Obligs:	209,200	230,700	228,500
	Outlays:	246,320	216,372	215,272
Child welfare.....	BA:	56,200	57,000	56,800
	Obligs:	56,200	57,000	56,800
	Outlays:	---	44,435	44,429
Development of programs for the aging.....	BA:	32,250	29,500	28,360
	Obligs:	32,250	29,500	28,360
	Outlays:	18,933	27,686	27,211
Juvenile delinquency prevention and control.....	BA:	5,000	15,000	15,000
	Obligs:	5,000	15,000	15,000
	Outlays:	3,638	9,853	9,853
Rehabilitation research and training.....	BA:	64,000	64,000	60,000
	Obligs:	64,017	64,000	60,000
	Outlays:	59,259	60,795	57,800
Cooperative research or demonstration projects	BA:	3,150	6,500	11,500
	Obligs:	3,150	6,500	11,500
	Outlays:	2,220	2,950	3,600

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
SOCIAL AND REHABILITATION SERVICE: (CONT)				
Research and training (special foreign currency program).....	BA:	$ 5,000	$ 5,000	$ 2,000
	Obligs:	5,936	5,000	2,000
	Outlays:	4,353	4,762	3,862
Salaries and expenses...	BA:	27,265	28,780	31,500
	Obligs:	27,613	29,140	31,860
	Outlays:	27,376	28,610	31,110
Total, Social and Rehabilitation Service..	BA:	7,338,302	8,625,401	8,614,241
	Obligs:	6,962,851	8,631,261	8,620,101
	Outlays:	6,475,366	8,373,085	8,414,589
SOCIAL SECURITY ADMINISTRATION:				
Payment to the trust funds for health insurance for the aged	BA:	1,360,227	1,545,413	1,545,413
	Obligs:	1,360,227	1,545,413	1,545,413
	Outlays:	1,733,255	1,545,413	1,545,413
Payment for military service credits.....	BA:	105,000	105,000	105,000
	Obligs:	105,000	105,000	105,000
	Outlays:	210,000	105,000	105,000
Payment for special benefits for the aged.	BA:	225,545	364,151	364,151
	Obligs:	225,545	364,151	364,151
	Outlays:	225,545	364,151	364,151
Consumer credit training	BA:	---	300	300
	Obligs:	---	300	300
	Outlays:	---	283	283

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
SOCIAL SECURITY ADMINISTRATION: (CONT)				
Limitation on salaries and expenses (Trust fund).....	BA:	$ [802,792]	$ [885,000]	$ [901,500]
	Obligs:	[802,605]	[885,000]	[901,500]
	Outlays:	[799,091]	[855,505]	[871,805]
Total, Social Security Administration.....	BA:	1,690,772	2,014,864	2,014,864
	Obligs:	1,690,772	2,014,864	2,014,864
	Outlays:	2,168,800	2,014,847	2,014,847
SPECIAL INSTITUTIONS:				
American Printing House for the Blind.....	BA:	1,340	1,404	1,404
	Obligs:	1,340	1,404	1,404
	Outlays:	1,340	1,404	1,404
National Technical Institute for the Deaf: Salaries and expenses	BA:	800	2,851	2,851
	Obligs:	2,298	3,208	4,320
	Outlays:	2,375	2,626	3,126
Construction.....	BA:	---	13,766	---
	Obligs:	---	14,990	---
	Outlays:	---	595	---
Total, National Technical Institute for the Deaf.....	BA:	800	16,617	2,851
	Obligs:	2,298	18,198	4,320
	Outlays:	2,375	3,221	3,126
Model Secondary School for the Deaf: Salaries and expenses	BA:	400	415	415
	Obligs:	333	485	485
	Outlays:	311	403	403

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
SPECIAL INSTITUTIONS: (CONT)				
Model Secondary School for the Deaf: (Cont)				
Construction.....	BA:	$ 445	$ 351	$ 351
	Obligs:	100	971	971
	Outlays:	86	513	513
Total, Model Secondary School for the Deaf.....	BA:	845	766	766
	Obligs:	433	1,456	1,456
	Outlays:	397	916	916
Gallaudet College:				
Salaries and expenses....	BA:	3,691	4,257	4,257
	Obligs:	5,410	6,170	6,170
	Outlays:	3,555	4,292	4,292
Construction.....	BA:	---	867	867
	Obligs:	1,669	838	838
	Outlays:	1,585	1,093	1,093
Total, Gallaudet College...	BA:	3,691	5,124	5,124
	Obligs:	7,079	7,008	7,008
	Outlays:	5,140	5,385	5,385
Howard University:				
Salaries and expenses	BA:	18,231	20,445	20,445
	Obligs:	33,152	35,366	35,366
	Outlays:	17,588	20,015	20,015
Construction.....	BA:	2,209	22,710	22,710
	Obligs:	10,001	29,890	29,890
	Outlays:	6,026	10,120	10,120

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
SPECIAL INSTITUTIONS: (CONT)				
Howard University: (Cont) Freedmen's Hospital.....	BA:	$ 9,030	$ 9,109	$ 9,109
	Obligs:	12,630	12,709	12,709
	Outlays:	8,608	9,200	9,200
Total, Howard Unversity.....	BA:	29,470	52,264	52,264
	Obligs:	51,761	77,965	77,965
	Outlays:	32,222	39,335	39,335
Total, Special Institutions...	BA:	36,146	76,175	62,409
	Obligs:	62,911	106,031	92,153
	Outlays:	41,474	50,261	50,166
DEPARTMENTAL MANAGEMENT:				
Office of the Secretary.....	BA:	5,133	5,975	5,975
	Obligs:	5,522	6,373	6,373
	Outlays:	8,895	6,239	6,239
Office of Community and Field Services.....	BA:	8,193	9,989	4,730
	Obligs:	11,165	13,331	7,216
	Outlays:	2,709	9,112	4,431
Office for Civil Rights.....	BA:	---	---	5,259
	Obligs:	---	---	6,115
	Outlays:	---	---	4,681
Office of the Comptroller...	BA:	9,242	10,425	10,425
	Obligs:	10,268	12,233	12,233
	Outlays:	7,921	10,184	10,184

Appropriation		1969 Comparable	1970 January Budget	1970 Revised Budget
DEPARTMENTAL MANAGEMENT: (CONT)				
Office of Administration....	BA:	$ 4,926	$ 5,234	5,234
	Obligs:	5,228	5,593	5,593
	Outlays:	2,777	4,978	4,978
Surplus property utilization.....	BA:	1,243	1,255	1,255
	Obligs:	1,243	1,255	1,255
	Outlays:	1,213	1,236	1,236
Office of the General Counsel.....	BA:	2,161	2,282	2,282
	Obligs:	3,536	3,698	3,698
	Outlays:	2,131	2,242	2,242
Payment to the Corporation for Public Broadcasting.....	BA:	5,000	20,000	10,000
	Obligs:	5,000	20,000	10,000
	Outlays:	5,000	20,000	10,000
Total, Departmental Management.....	BA:	35,898	55,160	45,160
	Obligs:	41,962	62,483	52,483
	Outlays:	30,646	53,991	43,991

REPEAL OF EMPLOYMENT PROVISIONS OF THE REVENUE AND EXPENDITURE CONTROL ACT

Mr. FLOOD. We have been holding hearings on the Johnson budget and the Nixon amendments for over 2 months, and nobody seems to be really concerned about whether we are spinning our wheels here or not. As far as personnel is concerned, nothing we do in working up the appropriation bill has any significance unless the personnel provisions of the Revenue and Expenditure Control Act are repealed. There can be no doubt about that.

Mr. KELLY. That is correct.

Mr. FLOOD. What legislative proposals have you made, when was it submitted, who did you talk with about this, and with what result?

Mr. KELLY. To my knowledge, no legislative proposal has yet been submitted. However, the Bureau of the Budget has advised us of the intent of the President to seek relief from the present provisions of the Revenue and Expenditure Control Act. He is suggesting that in order to persuade the Congress to give him this relief, he will control employment at the aggregate level predicted for June 30, 1969. That is the basis on which the budget amendments are being submitted.

Mr. FLOOD. Is there not a very real possibility that instead of repeal the law will simply be amended to soften it somewhat? Leave teeth in it, but extract a few of the big ones?

Do you see how we can sit around this table and have a sensible markup without knowing what is going to happen to that law?

Mr. KELLY. I think it is a real threat, Mr. Chairman. It would be done in lieu of congressional budgeting. I think it is preferable that you go through this budget item by item and decide what needs to be done, what should be done and how it should be done.

The first determination of how many positions can be employed is the money and resources made available in the appropriation. The Secretary cannot spend more than you authorized for any account.

If in the aggregate he cannot spend that much for an account because of the personnel ceiling, he can shift resources. But you still have to have a determination made on a case by case basis. The restructuring or reshuffling or replanning is done within that limit.

Mr. FLOOD. It is a most serious question for this subcommittee.

Secretary FINCH. I can only assure you that I have been pushing hard to get the White House to give us a decision. I stated this on my first appearance here.

This has probably caused us more acute discomfort in HEW than any other development. I feel very strongly about that.

Mr. FLOOD. Mr. Michel?

PRIORITIES AMONG VARIOUS EDUCATION PROGRAMS

Mr. MICHEL. Mr. Secretary, I would first like to develop a line of questioning with respect to the education items. I realize some of these questions might more appropriately be asked of the Commissioner of Education, but let me set it out here and maybe we can get some thoughts from you on the subject too.

I have been informed that 88 percent of the school children in our country benefit directly from title III of NDEA and title II of ESEA in comparison with approximately 17 percent that are served by the

supplementary services of the Elementary and Secondary Education Act, title III. Yet since 1965 ESEA title III has received $253 million more in unmatched Federal funds than has NDEA title III, and the 1970 budget proposes over $116 million for ESEA title III, but none at all for the two programs which reach almost 90 percent of our children.

And the educational research programs, which at best provide long-range benefits to students, would receive close to $100 million under this budget, yet we know that much of this research deals with limited populations and unique problems, not with the immediate problems facing the entire educational system, and we know that the amount of this theoretical research that is ever implemented is very small.

These facts cause me to have some very serious doubts about the criteria used in establishing budget priority. Why is it that two popular effective programs reaching 90 percent of the student population are passed over in favor of those of unproven worth that help comparatively few of our children?

This seems to be a very crucial question in light of the fact we already have $1.260 billion on the title I of ESEA, title VII bilingual, and title VIII dropout prevention programs. And title I, the largest, will provide benefits, as I said, to 10 to 15 percent of our children, and title VII and VIII to many less.

I just wondered what the rationale was behind this whole make-up of the budget. Are we reworking the budget along these lines or holding fast as a matter of fact to what the previous administration had done?

Mr. KELLY. I think your question reflects a good analysis of the problem.

Take the elementary and secondary program. There is over a billion dollars being spent on some 40 million children enrolled in elementary and secondary education. Their unmet needs are very great, and the amount of money the Federal Government is going to put in the system is limited. The question is, how do you use those limited resources to do the most good for the system?

The conclusion is, you will do the most good for the system if you help the persons who are most disadvantaged by the system. This involves taking those people who do not fit into the system and helping them to learn and develop so that they will fit into the public educational system and learn and prosper while they are there. In other programs, such as title III of the National Defense Education Act, we are spending about $80 million in 1969 on all of the school systems and all of the children. But there is such a wide distribution of these funds that they really become quite dissipated and they do not exercise much leverage to bolster the whole system.

And I think it is very probable that all that is done in this program is to substitute Federal dollars for local dollars. This does not exercise leverage for the major improvement of the system.

Secretary FINCH. Could I respond further?

Mr. MICHEL. Surely.

Secretary FINCH. I think this is critical. We want to look closely at each of those titles in the Elementary and Secondary Education Act. That is why we argued so strongly for the 2-year extension rather than the 5-year extension, because we just do not know whether all of

these compensatory education programs are working or not. You put your finger on some of them in the examples you cited.

Mr. MICHEL. You see we have given all of these districts around the country a taste of this. Once we embark upon any given program they get the idea that it's permanent. I sense it already. I can feel it. We are all getting it in the mail and when we go to the floor we are going to have all the pressure in the world on us from educators all around this country.

REDUCTIONS IN PROGRAMS SUPPORTING EDUCATIONAL EQUIPMENT AND SCHOOL LIBRARY MATERIALS

I read with some interest the survey of educators over here in the neighboring State of Virginia, which was conducted recently by Senator Spong and the school administrators in the State of Virginia. I am quite sure that what was said about Virginia would very well hold true in my home State of Illinois from the kind of information we are getting. Our school administrators feel title II ESEA, library material title, and title III of NDEA, which provides for laboratory and instructional equipment materials, are doing the most good in their local school system. In view of this then, as I said, it is rather puzzling to me that you are recommending increases in some programs and the maintenance of others at existing levels while you are recommending no funds at all for title III in NDEA, and title II in ESEA.

Secretary FINCH. We have really had mixed evidence in the correspondence I have had from superintendents about title II. Some have complained about the seductive powers of a hardware salesman. I do not at this point have any firm convictions about it. I am not prepared to say it has been as successful as your question might suggest.

Mr. KELLY. You should not view this as being "against books" though.

The funds that are available to school districts under title I of the Elementary and Secondary Education Act can be used, at the discretion of the local school superintendent, for the purchase of books and equipment.

So it will now be possible for the school district to determine what to spend its funds on, rather than being constrained to spend only within the narrow categories of each specific grant.

Mr. SMITH. Will the gentleman yield?

Mr. MICHEL. Yes.

Mr. SMITH. I do not think there is anything inconsistent about what the two of you are saying. It depends on the local school board. Some of them have imagination and some do not. Some waste the money and others get a lot of mileage out of it.

Mr. MICHEL. I do not want to push anything on anybody that is going to cause them to fritter the money away. I have been very critical of cases brought to our attention where, as you indicate, hardware salesmen put the muscle on, and we have stuff sitting in warehouses, down in basements, up in attics, and doing no good.

Mr. FLOOD. There is lot of that.

ASSISTANCE FOR DENTAL SCHOOLS

Mr. MICHEL. In the medical field, where you assist medical schools in providing a thousands more medical students than the Johnson budget, does that include any dental students?

Mr. KELLY. That particular figure does not. There is in the budget additional aid to dental schools. I do not have that.

Mr. CARDWELL. We are requesting a total of $101,400,000. About $20 million of that will go to dental schools specifically. They are included in the category of the schools that can receive assistance.

Mr. KELLY. They are not in the $5 million additional increase being proposed. That is strictly for medical schools.

USE OF PARTNERSHIP FOR HEALTH FORMULA GRANTS FOR TUBERCULOSIS CONTROL

Mr. MICHEL. I note that you transferred $18 million to the partnership for health formula grants from project grants and will encourage States to use these funds for TB and venereal disease control activities.

I understand that some of the States have been closing their TB sanitoriums and am wondering whether or not this is a high priority item.

Mr. KELLY. The funds are not likely to go for the operation of sanatoriums. The funds are much more likely to go into the area of case finding and epidemiology. They are much more likely to be used for preventive techniques than for hospitalization.

The sanitoriums are now being supported by the project grant mechanism, and would continue to receive support if the State considers it to be a wise investment.

ALCOHOLIC TREATMENT CENTERS

Mr. MICHEL. Later in your budget analysis, you cut out the funds for the alcoholism program and state you will encourage the use of partnership for health funds for this purpose.

My question is, how hard-pressed will the partnership for health funds then be?

Mr. CARDWELL. There is no guarantee they will pick up these proposed alcoholic treatment centers.

This was a new item in the 1970 budget submitted in January. They will have to compete among the other activities within the partnership for health program. There is no doubt about that.

Mr. MICHEL. Do you have any idea what amount of money from last year is really being displaced here on the alcoholic treatment centers?

Mr. KELLY. That was a new proposal in the Johnson budget and then dropped. It has not gotten off the ground.

Mr. CARDWELL. It is a question of whether the States would pick it up and initiate it. If they did, they might have to displace something, but it would be their initiative and not the Federal Government's initiative.

INCREASE FOR NUTRITION ACTIVITIES

Mr. MICHEL. Under this increase for nutrition, are any of these funds going to be used to actually get this information to the people? This

has been kind of a bug with me. We have been talking about nutrition for years over in Agriculture for example. You folks are in it and everybody else is in it.

What are we doing to get this information to the people?

Last week, I guess, I got a report from our Agricultural Extension Agent. In my home county of Peoria and neighboring county they put on seven additional people in one county and six or seven in another, and are actually trying to get into these homes to get this point across.

Apparently under the traditional Extension Service operated by the land grant colleges, of course, and funded in part by the Federal Government, they call meetings, have seminars, but we are in the area now where apparently the people who need it most are not the kind of people inclined to come to any scheduled meeting, and you have to go to them and put it in their hands, spoon-feed them so to speak.

Secretary FINCH. We have had a lot of discussion about this, Congressman.

First, as I indicated before, the basic concept of nutrition has altered, and a lot of our literature is not up-to-date.

Second, if it is up to date, a lot of that lies around and is not disseminated very well.

One thing we talked about is that the educational television stations can do a great deal. The kind of people who need this information usually have television sets and could receive this information through imaginative public service programing.

We want to give particular emphasis to that. A similar situation exists for family planning information. More work has been done there.

Mr. MICHEL. That is an expensive medium.

Secretary FINCH. When you get down to how you get the message across, it is about as effective—we think it is the most effective——

Mr. BLACK. There are a lot of public service programs available to you on television at no cost at all.

EXPERIMENTAL SCHOOLS

Mr. MICHEL. The funds for the experimental schools are budgeted under what appropriation item?

Mr. CARDWELL. Under "Educational research and training."

Mr. KELLY. The authority for requesting the appropriation will be the research authority of the Office of Education.

Secretary FINCH. The Commissioner will be the one directly responsible for developing the program.

Mr. MICHEL. Will this money be channeled to educators and foundations and private industry?

Secretary FINCH. I do not want to speak for Dr. Allen at this point, but we have talked about this. We would encourage individual districts, in some cases individual States, to come in with their prototypes for 18-hour-a-day school use, year-round use, for example, or adult use, and then we will make the grants on a competitive basis.

ASSESSMENT OF TITLE III ESEA, SUPPLEMENTARY CENTERS PROGRAM

Mr. MICHEL. Now you are reducing the funds for the supplementary education centers until you can assess what good they are really doing?

Secretary FINCH. Right.

Mr. MICHEL. Is this an in-house kind of assessment?

Secretary FINCH. Yes.

I do not think we have proceeded far enough to give you a judgment on it.

Mr. CARDWELL. The State would become involved in the assessment because they operate such a large part of the program.

PAYMENT FOR PRESCRIPTION DRUGS UNDER MEDICARE

Mr. MICHEL. Your predecessor, Mr. Secretary, made a recommendation that, or at least there was talk about, reducing the cost of prescription drugs for persons on medicare by the medicare program paying everything over a dollar. Do you know about that?

Secretary FINCH. Yes. I will let the others speak, but I believe that some of the administrative problems involved in that proposal would be overwhelming.

Mr. KELLY. There was a drug test task force established that made a report. Actually it turned out to be a very useful exercise because they made a substantial contribution to the literature in this field.

Among the recommendations of the report was coverage under medicare for prescription drugs. These would only be those drugs which are maintenance drugs for people with a chronic illness, such as a heart condition.

The Secretary has appointed a group——

Mr. FLOOD. What is a maintenance drug?

Mr. KELLY. Like digitalis. A person takes it every day the year around. This becomes a very expensive part of their health care.

The Secretary has now appointed a group of consultants. Dr. John T. Dunlop is in charge of this group. They are making an independent evaluation of the task force recommendations. We will want to look at their evaluation before any legislation is proposed.

Secretary FINCH. The payment process involved in this would have some very real administrative problems.

Mr. KELLY. This is one reason the earlier task force limited it to the maintenance drugs. The problem of dealing with all of the drugstores in the United States and maintaining a centralized record of drug purchases would be a tremendously complex problem.

Right now the coverage is exclusively for prescription drugs administered in a hospital. Once the patient left the hospital, it would require a complicated piece of administrative machinery to keep the records at a reasonable cost.

CHIROPRACTIC SERVICES

Mr. MICHEL. Did HEW or Public Health Service itself ever conduct a research study or make grants for research to determine the actual efficacy of chiropractic care?

Secretary FINCH. Not to my knowledge. Not during my tenure here.

Mr. MICHEL. Has HEW studied the efficacy of chiropractic services

provided under medicaid or workmen's compensation or commercial insurance policies?

Mr. KELLY. I am not familiar with any.

Secretary FINCH. We can find out, Congressman. I do not know.

Mr. MICHEL. I understand there are 48 States that authorize chiropractic services under workmen's compensation laws and 17 States provide chiropractic care under medicaid, including my home State of Illinois, and hundreds of commercial insurance companies provide chiropractic coverage in their policies, and section 121 of the social security amendments of 1967 requires HEW to report on "the cost of covering such additional services."

There has been some kind of report that has been going around. It seemed to be just horribly biased. The conclusions were already agreed to before they even got off the ground.

Mr. CARDWELL. Is this a social security report?

Mrs. REID. There has been legislation introduced, has there not, to provide payment for chiropractic services?

Mr. MICHEL. There have been a number.

Mr. KELLY. It is very controversial.

Mr. MICHEL. I know a number of members have, but I wanted to get some more information before proceeding.

Mr. KELLY. We will see if we can get this.

INDEPENDENT PRACTITIONERS UNDER MEDICARE

Mr. MICHEL. In the interest of time, I might submit a few other questions in the field I would like to have some responses to.

(The information follows:)

Question. "How much was spent by HEW in preparing the report 'Independent Practitioners Under Medicare'?"

(a) how much for HEW staff?

(b) how much for the ad hoc consultant group?

(c) how much for each of the expert review panels?

(d) how much for other persons or groups? and what were they?

Answer. The report "Independent Practitioners Under Medicare" concerned a study of 10 different practitioner groups including chiropractors. For the most part, staff and the ad hoc consultant group devoted an equal amount of time to the consideration of each discipline.

(a) Total HEW staff costs for the study were $53,072.

(b) Total costs for the ad hoc consultant group, including travel and consultant fees, were $32,352.

(c) Travel costs and consultant fees for the expert review panel on chiropractic and naturopathy were $5,720.

(d) There were no other persons or groups involved.

Question. "How much has HEW spent for reproducing copies of the report?"

(a) how many copies has it distributed?

(b) on what basis is it being distributed?

Answer. In addition to the copies of the report sent to Congress, the Department has sent copies to public and private organizations that have a concern with the medicare program. These were sent as a part of routine mailings of materials on medicare. Numerous requests for copies of the report have been received by the Department. Requests have been made not only by persons interested in the chiropractic section of the report, but also the sections on the other nine professions included in the study. Copies of the report have been sent to any organization that has requested it. The two national chiropractic associations have both asked for multiple copies which have been mailed to them. This distribution required approximately 3,000 copies of the report. The cost to the Government for these copies is about $2,400.

Question. A. "Do you think that this ad hoc consultant group could possibly have been impartial and objective in its study of chiropractic in view of its composition?

Facts: Ad hoc consultant group (p. 212 of report).

(1) Composed of 22 members.

(2) Of 22 members, over half were precommitted by virtue of their prior acceptance of AMA's opposition to chiropractic, as follows:

7 MD's.
1 doctor of osteopathy.
1 dentist.
1 hospital official.
1 nursing official.
1 health college dean.
1 had already testified against chiropractic.

B. "In appointing an expert review panel of eight members specifically for chiropractic and naturopathy, why did HEW select six persons who were institutionally opposed to chiropractic?"

C. "Why wasn't at least one technically qualified chiropractor or chiropractic educator chosen to be on this expert review panel?"

Answer. In the development of the plans for the study it was decided that staff should have advice from outside consultants on the overall study and on each practitioner group. It was felt that the objectivity of the study would have been greatly compromised if representatives of the professions being studied were included in the advisory groups. An ad hoc consultant group was appointed to study all 10 of the disciplines to consider the total impact of changes in medicare coverage along with the technical and scientific aspects of each discipline. In addition, an expert review panel was appointed for each discipline, each was composed of individuals with specialized scientific and technical knowledge related to that discipline. The results of their deliberations were incorporated into an advisory report for the ad hoc consultant group. Unlike the expert review panels, the membership of the ad hoc consultant group comprised a broad range of expertise. However, in both advisory groups all members served as individuals rather than as representatives of their professional groups, and were selected for their capacity to do so. In the study of chiropractic, it was recognized that obtaining objectivity was a particularly sensitive problem. Unlike most of the other disciplines in the study, chiropractic has not gained acceptance of the medically oriented health care system, and its services have not been incorporated into that system. Its integration into the health care system. in addition, is vigorously opposed by the American Medical Association.

It was also recognized that fulfillment of the charge to investigate need, cost, and means of assuring safety of patients in regard to chiropractic was particularly difficult. To attempt such an evaluation without the chief reservoir of technical and scientific knowledge—the medical and scientific professions—would have been impossible. However, the health professions are large and diverse enough to contain within their ranks—and particularly in the education and research institutions—many men of independent mind who are dedicated primarily to science and are able to function in such a situation as individuals rather than as members of their professional association. None of seven doctors of medicine, who were a minority of the members of ad hoc consultant group, nor the five doctors of medicine on the expert review panel on chiropractic was or had been known as a spokesman for AMA policy. Nearly all were on the staffs of research and educational institutions or held administrative positions. I want to emphasize the fact that the numerical majority of the group were nonmedical people, known for their integrity and high professional competence.

The ad hoc consultant group itself recognized and discussed possible sources of bias. For example, attempts were made by organized groups (other than those representing the disciplines studied) to influence the course of the study by seeking the opportunity to meet with the ad hoc group. The members of the group unanimously agreed that it would not be appropriate to meet with representatives of any group not directly connected with the study. The other potential source of bias could have resulted from the fact that many members of the ad hoc consultant group were sophisticated, professional persons, familiar with all aspects of health care, and therefore, inevitably brought to their deliberations on this study some preconceived ideas on all the professions studied, including chiropractic. This was coped with in two ways. First were the procedures for conducting the study which assured that all aspects of each profession were

considered. The second was through the group's recognition of the potential hazard and their determination to give each profession a fair and unbiased consideration.

Question. "What effort was made to assure fairness to the professional groups being studied?"

Answer. The Department did not depend alone on the appointment of objective and knowledgeable consultants, as discussed above, for objectivity in the study. The study procedures were constructed to assure that all aspects of each profession were adequately considered. This required input from each of the professional associations. This input was achieved, without jeopardizing objectivity, through two mechanisms: first, the professional associations representing the diciplines studied were asked to prepare detailed reports on their professions including: historical development of the profession; definition and clinical and scientific bases of the practice; education and training; relationships with other health care professionals and with health care institutions; and their views on coverage of their services under medicare. Second, the associations were invited to meet with the ad hoc consultant group to discuss their views. (Each association also prepared a brief summary of its views to be included in app. B of the Secretary's report.)

The report on chiropractic was written primarily fom the materials submitted by the chiropractors themselves and from the discussions with them, and included primarily factual and documented statements. The report does not include statements or references to studies made by other health organizations concerning chiropractic.

Question. Was any part of the Department's report prepared by anyone or any group outside the Department, or on the basis of material prepared by any such person or groups? If so, who? At what cost?

Answer. No. The section on chiropractic was based primarily on an evaluation of statements made by the chiropractic associations and chirapractic's leaders, on studies undertaken by the chiropractic associations and on the contents of the basic textbooks used in chiropractic schools. Available literature on chiropractic was reviewed by staff and consultants, and summaries of these were prepared as part of the work of the Expert Review Panel. No outside documents were written for the study other than those prepared by the chiropractic associations themselves.

*Question. I am puzzled by the language on page 157 of the Department's report, which reads: In the following sections of this paper * * * What paper was used in preparing this report? Who prepared that paper?*

Answer. The sentence referred to in this question reads as follows: "In the following sections of this paper, leading men from each of the chiropractic associations will be quoted extensively." The word paper refers to the report itself and not to another paper. From pages 157 to 181 of the Independent Practitioners Study, leading men from the chiropractic associations are quoted extensively and this sentence points out this fact. No outside paper was used to prepare this section of the report. Perhaps report would have been a better choice of a word than paper.

Question. Why does the Internal Revenue Service allow medical deductions for chiropractic care under Federal income tax laws and yet HEW reject such chirapractic care under another Federal law?

Answer. The Internal Revenue Service allows income tax deductions for services of any health practitioner who is licensed by a State or who may legally provide health care. For purposes of income tax deductions, the Internal Revenue Service is not required to obtain decisions about the patient's need for health care, the capability of a practitioner to provide health care, or the validity of the practitioner's approach to health care.

Question. Since the Congress has authorized chiropractic services to the medically indigent under medicaid (title 19), why shouldn't chiropractic also be provided to the medically self-sufficient, at their choice, under medicare (title 18)?

Facts: 1. Title 19, § 1905 (a) (6) authorizes medicaid payment for medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

2. To date, 17 States authorize chiropractic services in their medicaid programs.

Answer. The present matching provisions of title XIX permit but do not require the State medicaid agency to include payment for any type of remedial care recognized under State law and specified by the Secretary. Under this

provision, only 15 of the 43 State medicaid programs have chosen to include chiropractic services. The question has also been asked whether the logical extension of the study would be to prohibit the use of Federal funds to pay for such services under title XIX.

Question: HEW (like all Federal agencies under Federal law) accepts statements from chiropractors for sick leave of all Federal employees. Why shouldn't the ordinary American citizen have the same privilege under Federal medicare law to go to a chiropractor? Are Federal employees to be specially privileged under Federal law?

Answer. The purpose of sick leave statements is to document the fact that an employee was actually sick. This documentation does not have to be in form of a medical doctor's statement, but can be anything that is administratively acceptable. For example, some supervisors accept a signed statement from the employee. The Civil Service Rules and Regulations for supporting evidence of sick leave are as follows:

> SEC. 630.403 Supporting evidence. An agency may grant sick leave only when supported by evidence administratviely acceptable. Regardless of the duration of the absence, an agency may consider an employee's certification as to the reason for his absence as evidence administratively acceptable. However, for an absence in excess of three workdays, or for a lesser period when determined necessary by an agency, the agency may also require a medical certificate, or other administratively acceptable evidence as to the reason for the absence.

The fact that sick leave statements signed by chiropractors are also acceptable in no way means that the Federal Government is making a judgment as to the capability of a practitioner or the validity of his approach to health care.

Question: What are the prospects of HEW changing its position on this subject under your administration?

Answer. The new administration, of course, is currently engaged in an extensive reexamination of all aspects of the medicare program. In considering coverage of any additional services it is, of course, necessary to also consider other services that might be covered, and to determine which ones are most needed and which would make the best possible use of the funds available to the program.

FOOD STAMP PROGRAM

Mr. MICHEL. On the food stamp program, we are funding that over in Agriculture. It is a charge against the farmer for all practical purposes, when in fact it is a welfare program.

You indicate by your earlier testimony that you are not altogether sure you would like to have that in your shop.

Secretary FINCH. I made it a little stronger than that, Congressman.

Mr. MICHEL. Would you not regard the food stamp plan as a welfare program?

Secretary FINCH. No, sir; not necessarily.

What I did say was that the food stamps should be counted as real income against your minimum income standards in a maintenance program.

But the delivery system, although basically tied to the States and localities, is really a part of Agriculture, I think we would have just great trauma and almost unbelievable administrative problems in trying to transfer that whole mechanism into HEW.

I have had long discussions with Secretary Hardin about this, and he and I are both in strong agreement this is not a piece of real estate that HEW should acquire.

We regard our function as investigative. We should come forward with information about what the nutritional components particularly in the food stamp program should be. But we just do not feel we should try to take that program on.

Mr. MICHEL. Thank you.

Mr. FLOOD. Mr. Smith?

Mr. SMITH. Is some of this research you are speaking of with regard to what should be in a food stamp program?

Secretary FINCH. Yes, sir; and it already has caused Agriculture to modify the components of some of the surplus food packages they make available.

RESEARCH ON PROTEIN

Mr. SMITH. One of the things that has interested me is the basic research which needs to be done with regard to protein.

Secretary FINCH. Yes.

Mr. SMITH. We really do not know enough about protein.

Secretary FINCH. That is right.

Mr. SMITH. Agriculture through the land grant colleges has done a great job with regard to animal nutrition, and we do know now, through controlled experiments, pretty much what balance an animal needs to develop best, but we do not have this extensive knowledge about humans. We have never had controlled research for humans.

NIH is certainly in some kind of a position to do some basic research. Agriculture probably could do more as an extension of the animal research they have done for a hundred years. Strangely enough, I find that the AEC of all people have chemists and personnel who could do some basic research on proteins.

I think we need to get all of this together within one funding operation. I think we really need some basic research, what is a protein, how much of it does a human need and what results do you get with certain quantities?

Is this the kind of basic research you are thinking about?

Secretary FINCH. Yes, sir.

Mr. SMITH. Are you expecting to fund that out of NIH or where?

Secretary FINCH. Some of that would be done at NIH.

Mr. SMITH. I am a strong supporter of getting something done on this.

Mr. FLOOD So am I.

Mr. SMITH. I am absolutely convinced from having witnessed what happens to animals that we could make a man 10 feet tall if we knew from the day he was born what he should be fed, how much in the way of protein; if we could break the proteins down to get them properly identified, and then keep him on the ideal diet.

Secretary FINCH. One of the gentlemen we are looking forward to having as a consultant in our Department is a distinguished educator I have heard make very similar statements to the one you just made—Chancellor Emil Mrak at Davis.

Mr. SMITH. I am as enthusiastic anybody in the United States to support research in this area. If the people are hungry, they need whatever kind of food they can get, but it is a terrible mistake to assume giving unlimited food stamps to people is going to solve their dietary problem. In most cases they will buy more starches and carbohydrates, just what their parents bought.

What we really need is to know what kind of a diet they need and figure out how they get that kind of a diet. To break the cycle we will

probably have to do it through the school lunch program or some program where we can control a diet.

I know it has an effect in their parents household. If children want hamburgers more than the parents, they too will eat more hamburger and proteins. If we can develop a habit with the children, it will have some effect even on the older generation and hamburger is one kind of good high protein diet.

IMPACTED AREA AID

With regard to aid to schools in impacted areas, I do not think anybody quarrels about category A. Everybody is in agreement that is justified. With regard to category B, perhaps I am just guessing, maybe a third of it goes to help pay for the education of children that really do impact the district without adequate tax support. The other two-thirds probably goes to districts relatively rich. Their parents, between real estate tax and local sales tax and other tax, pay far more than the average citizen in the community. I agree that something really needs to be done with regard to impact aid, but it seems to me we need a change in the formula.

Are you proposing to change the formula so we can sort out the category B justified cases and exclude the others?

Secretary FINCH. No, we are not changing the formula. We are simply restricting it to category A at this point as the prior administration suggested.

I think you are probably right, the formula needs to be changed. Maybe we need to have a better set of social indicators so that at least we would not be locked into a 10-year-old census for the basic data from which we have to build a base. Maybe the fault lies in that mechanism.

Mr. SMITH. Of course we are referring to the authorizing committee but it seems to me before we can tackle the problem head-on and succeed, we need some kind of drive to change the formula so you can sort out the justified cases in category B.

Mr. KELLY. We have experimented with a lot of different approaches. One seems to be that if you are going to provide any funds for the "B" children, then you should not have to pay for the first child.

If, in order to be eligible, you have to have 3 percent of your children or 6 percent of your children in that category, then you should only be paid for the excess beyond that percentage of those that made you eligible, rather than taking you back to the first child.

Another one is, you should either not pay at all or pay in much lesser proportion for those children who go to school in a different jurisdiction than where the family works. This would be aimed at the District of Columbia situation.

There have been a number of attempts at a new formula, but there has been very little receptivity to dealing with changes in the formula. The attempt made last year by the Appropriations Committee is the first evidence of any attempt by the Congress to really deal with this question.

Mr. SMITH. You are proposing, however, that we use that or similar language?

Mr. KELLY. Yes, language very similar to last year.

Mr. SMITH. And will prevent the penalizing of (A) category people?

Mr. KELLY. Right, it would not penalize the "A" category.

AUDITS OF HOSPITALS UNDER MEDICARE

Mr. SMITH. I have been told there has been considerable complaint concerning auditing of hospitals, that hospitals have a certified public accountant do an audit and then about the same time, or shortly thereafter, a new audit that duplicates that audit to a large extent must be made to satisfy regulations under medicare. Is this the case?

Mr. KELLY. It is in part. We have come much closer to a single audit. There are many systems used, but the system used by the largest intermediary, Blue Cross, is to employ large public accounting firms to audit the hospitals. We are trying to make that audit serve medicare, medicaid, and Blue Cross, as well as the needs of the hospital itself.

We are sponsoring an experiment in Massachusetts where we are attempting to have the insurance companies, State agencies, and HEW programs use the same audit system.

We are going to experiment with seven hospitals to see if we cannot set a pattern that everybody can use. One form can supply data for everyone to use, despite the different needs for the data.

Secretary FINCH. In California, we had to live with this probably longer than any other State. The practical effect has been the one that Mr. Kelly described. Just due to the nature of the economics of it, they have tended to merge.

Mr. SMITH. An overall audit and break them down?

Secretary FINCH. Yes.

Mr. SMITH. I know in Iowa in recent months the same firm of certified public accountants made an audit for the hospital and turned right around and made a separate audit covering much the same ground for medicare.

You hope to get this solved in another year or two?

Mr. KELLY. Yes.

Secretary FINCH. We have a problem in that the States are in such different stages that we must be a little careful about imposing rigid requirements too fast.

TWO PERCENT UNALLOCATED COST ALLOWANCE FOR HOSPITALS

Mr. SMITH. When we had the argument about the 2 percent a couple of years ago, I understood at the time there was some kind of strong assurance that it would stay in until a study or review based upon experience indicated something different was justified.

Has there been such a review or such a study?

Mr. KELLY. This is the unallocated 2 percent on the cost reimbursement formula.

At the time the reimbursement formula was developed, this was controversial. Different people had different ideas as to how it should be created and what items should be covered in it. The formula which was developed was, I think, a good cost distribution system. The 2 percent was a compromise. It was justified as the sum of unidentified costs, allowed in lieu of trying to deal with small costs that were difficult to measure.

We have striven to use the same hospital reimbursement formula in the medicaid program and in medicare. The States have resisted this because they have felt that they could negotiate lower rates. Of course the idea was not to negotiate subsidized rates, because this

merely forces somebody else to pay the bill when you do not pay it. It ended up that their greatest resistance was to the 2 percent. If they had to pay costs why did they not only pay identified costs but also have to pay unidentified costs.

Mr. SMITH. Is the decision to eliminate the 2-percent add-on the result of a review or not?

Mr. KELLY. It was the result of an examination of the prevalent attitudes more than it was a cost review.

COST OF HOSPITAL CARE OF THE ELDERLY

Mr. SMITH. Is the cost to care for elderly patients more than average costs of caring for patients in a hospital?

Mr. KELLY. My recollection is that the cost of caring for elderly patients is somewhat less than the average hospital cost. I think that this is because there are some very costly services which they do not use—obstetrics, for example, and pediatrics.

Also, costs are much higher for the initial days in the hospital than for a longer stay, and elderly patients tend to stay longer.

There is an argument that the cost of nursing care for elderly patients is greater than the cost of nursing care of younger patients. The present reimbursement formula does not recognize this but groups all of the nursing care patients and averages the costs.

Mr. SMITH. You are negotiating right now with the American Medical Association, at least you are meeting and discussing this overall?

Mr. KELLY. With the American Hospital Association.

SUPPORT FOR DIPLOMA SCHOOLS OF NURSING

Mr. SMITH. With regard to the Nurse Training Act, there is some strong feeling, and I think there is justification for it, that the administrators of the act, ever since it was enacted, have been extremely probaccalaurate to the extent of opposing the diploma schools. The allegation is made that the criteria that have been established by the Office of Education as a matter of fact make it very difficult for some hospitals to meet accreditation.

Have you looked into this?

Secretary FINCH. Speaking for myself, no, sir.

But I have heard this argument before, and I want to look into it. I am sure some work has already been done in the Department.

Mr. SMITH. In good faith some people think nurses should be limited to those with a baccalaurate degree.

Secretary FINCH. Given the demands we have now, I cannot see how that resistance can continue much longer.

Mr. SMITH. They do not furnish enough nurses. We have to depend on hospitals to furnish nurses.

Mr. KELLY. Accreditation problems have occurred most frequently in connection with the 2-year college, not the hospital schools. It is not with the bachelor of science but with the associate degree that they had a problem with accreditation.

Mr. SMITH. The hospital diploma schools claim——

Mr. FLOOD. You are being very kind. Why do you not say it has elements of conspiracy in it?

Mr. SMITH. I suppose you could call it that. I think these people are in good faith. They think we should not have diploma schools.

Mr. FLOOD. Do you not think there is a deliberate planned attempt to phase these people out as soon as possible? That is what they think.

Mr. SMITH. The hospitals that operate these nursing schools have actually, in spite of the fact there are fewer of them operating, increased enrollment. This is what I like. I like to see increased personnel. They have actually been able to do it, but they say they are having terrible financial trouble and that the cost is considerably in excess of what they have been able to get in the way of tuition.

Mr. FLOOD. And the powers that be are planning to put them out of business as painlessly and as soon as possile.

Mr. SMITH. So the real question is, Do you at least have under consideration some means of helping them expand and meet this financial problem?

Secretary FINCH. I supopse we could use some of the money we have in both guaranteed loans and the direct-grant moneys. I would want to come back with a more considered response on that.

I do not have a ready response.

(The following information was submitted later:)

Assistance for nursing schools and students nurses has been provided through two laws.

NURSE TRAINING ACT OF 1964

The following table shows amount of financial support provided under the Nurse Training Act by the three types of nursing programs. Payments to Diploma Schools of Nursing are made exclusively to the one type of nursing program to help defray cost of training attributed to the provisions of the Nurse Training Act. Traineeships are applicable to baccalaureate and higher degree programs. They provide financial support to registered nurses (most of whom are hospital school graduates) enabling them to pursue further academic training. Participation in the remaining four programs is dependent on the school initiating a request for grant support.

NUMBER OF GRANTS AWARDED AND AMOUNT FUNDED UNDER THE NURSE TRAINING ACT OF 1964 BY TYPE OF NURSING PROGRAM AND TYPE OF GRANT, 1965-68

[Dollars in thousands]

Type of grant	Type of nursing program							
	Total		Diploma		Associate degree		Baccalaureate and higher degree	
	Grants	Funds	Grants	Funds	Grants	Funds	Grants	Funds
Total	4,724	$151,442	3,070	$56,209	238	$9,726	1,416	$85,507
Construction [1]	93	54,220	44	20,286	18	5,853	31	28,081
Projects for the improvement of nurse training	308	11,435	115	3,068	14	710	179	7,657
Payments to diploma schools	1,292	9,003	1,292	9,003				
Student loan	2,361	41,028	1,505	22,015	164	2,682	692	16,331
Nursing educational opportunity grants [2]	255	4,120	114	1,837	42	481	99	1,802
Traineeships [3] (long term)	415	31,636					415	31,636

[1] Program funds began in fiscal year 1966.
[2] Program funds began in fiscal year 1967.
[3] Advanced training for registered nurses—offered only in baccalaureate and higher degree programs. Excluded $4,681,000 awarded for short-term training courses.

HEALTH MANPOWER ACT OF 1968

These provisions were extended and amended by the Health Manpower Act of 1968. This new legislation authorizes two programs which provide a means of helping schools expand and meet their financial problems (formula grants and project grants for the improvement of nurse training). Formula grants, to all three types of schools of nursing, provide for a basic grant to each school of $15,000 and of the remaining funds, 75 percent will be distributed on the basis of enrollment and 25 percent on the basis of the relative number of graduates. Project grants for the improvement of nurse training provide grants to institutions to establish new or modify existing programs of nursing education; to effect significant improvements in curriculums of schools of nursing; for research in the various fields of nursing education; and to assist schools of nursing which are in serious financial straits to meet their costs of operation. Priority in the awarding of these grants will be given in the following order:

(1) The relative need of the applicant (if school of nursing) for financial assistance to continue in operation or avoid curtailing enrollment or reduction in the quality of training provided;

(2) The special need of the applicant for financial assistance in connection with its merger with a school of nursing;

(3) The relative need for the applicant for financial assistance to maintain or provide for accreditation as a school of nursing; and

(4) The extent to which the project will increase enrollment of full-time students receiving nursing training.

Section 808 provides a combined authorization for these two separate programs under the broad heading of institutional grants. It also specifies that of the sums appropriated the first $15 million shall be available for competitive project grants for the improvement of nurse training.

FISCAL YEAR 1970 BUDGET

There are over 1,300 schools eligible for the formula grants. It would require $20 million to fund the basic $15,000 grant without any provision for the incentive payments based on the numbers of students and graduates. By law, at least the first $15 million of any sums appropriated must be used for the support of competitive project grants. Since fiscal restraints have limited the request for nursing institutional support to $7 million, funds for formula grants are not included in the 1970 budget. The $7 million which is requested for nursing institutional support will be used for the competitive project grants.

Mr. KELLY. I would hope, Mr. Smith, we could some day be able to develop a consensus of opinion within the nursing profession as to what the distinctions are between the practical nurse, the associate degree nurse, the diploma nurse, and the baccalaureate nurse, and the differences in their job assignments. It seems to me if you do not have that kind of thing, the very thing you are talking about——

Mr. FLOOD. How do they do that kind of thing? They know the circumstances. Why should it not be done starting Monday morning?

Mr. KELLY. The nursing profession really needs to develop a consensus in order to gain support for the development of their program. I do not believe this has yet occurred.

Secretary FINCH. It is going to be a long hard process. There needs to be some standardization of licensing and accreditation standards in the States.

Mr. CARDWELL. There is about $37 million in the 1970 budget to support nursing manpower development, including $8 million for construction of teaching facilities. Of course, this is directed to the present-day system.

Mr. SMITH. There is less money available next year than last because there are no PC's, $4.6 million, I think.

Mr. CARDWELL. The obligations are less; yes. In terms of appropriations, the level is about the same.

Mr. SMITH. They know they are getting a third less money.

EXPERIMENTAL SCHOOLS

Mr. Secretary, you said in your statement something about a new program of elementary and secondary school experimentation.

Secretary FINCH. Yes, sir.

Mr. SMITH. What is that?

Secretary FINCH. This is the new experimental school program that Dr. Allen will be drawing up. We contemplate having some 48 schools, probably used 18 hours-a-day, all year long, by all age groups—models of new teaching and learning centers.

Mr. SMITH. You are not then speaking of developing some new method of testing pupils to determine their creative ability, planning ability, and so forth?

Secretary FINCH. I am not excluding that. What Dr. Allen has talked about is to have districts make proposals on a competitive basis. We have had some rather interesting material developed in terms of mixing students with others who were 4 years ahead of them. The older student, even some "low-achievers," often responds when he is given the challenge of trying to work with the younger student. Testing techniques might be another new direction.

I do not want to lock ourselves into certain proposals by my comments in this testimony. We would like to see these districts come in with innovative proposals.

Mr. FLOOD. When Dr. Allen appears, can you appear with him?

Secretary FINCH. Perhaps we could come up some time together and talk to you about the experimental schools.

Mr. SMITH. Are you saying you are going to have a new program but it is going to come from less funds?

Secretary FINCH. You mean in terms of the experimental school program?

Mr. SMITH. Yes.

Secretary FINCH. We did not cut educational research.

Mr. CARDWELL. We are proposing to increase the educational research budget by $25 million. This would be for the experimental schools.

Mr. SMITH. You are not funding this from ESEA, then.

Mr. CARDWELL. No. We are actually decreasing the level of Federal support for title II and III of ESEA, while increasing support for the appropriations for educational research and development.

The experimental school program would be a directed program at the Federal level. Although the State and local districts would participate, the money would not be spread out as it is under title III.

Mr. SMITH. You could have specific research projects, for example, in developing alternative methods of teaching that do not depend upon the traditional memorize and recall.

Mr. CARDWELL. Absolutely.

Mr. SMITH. Mrs. Reid?

Mrs. REID. Mr. Secretary, I would like to go back just briefly to the question of the guaranteed annual income.

In your statement, at least as reported in the press, you said:

"I want to go ahead as quickly as possible with a series of well-designed income maintenance experiments."

Apparently you are considering test cities for the experimental program.

Secretary FINCH. Right.

Mrs. REID. What would be your criteria for selection of these cities?

Secretary FINCH. I think it should be made clear that many of these proposals are coming in under the model city applications. The cities themselves have structured various kinds of maintenance programs. Mr. Kelly was part of a team that went out to three cities and looked at this.

In each case they had programs they wanted to test, in addition to the ones OEO is testing. We want to expand on this beyond just utilizing the model cities; I think our primary source of information will come from our own program of experimentation, not from the model cities demonstration grants.

Mrs. REID. I know you are aware there is a wide range of opinion on this subject. As a general rule, would not a guaranteed income plan affect many people who are not presently receiving public assistance and to some extent might be a disincentive to work?

Secretary FINCH. This is part of the raging argument I alluded to earlier.

In one of the proposals, and I have to be necessarily vague here, we built in an additional incentive to work because, first of all, you should not penalize a person for working. If he is on a training program, he gets an additional stipend. We modify, at various levels, the tax he pays on additional income even over and above a minimum maintenance figure.

But that is just one proposal, and there are many other things we are thrashing out.

Mr. KELLY. One of the things I would think you would get from this kind of experimentation is the answer to those kinds of questions.

There has been a lot of talk about alternative methods of income maintenance, but this has been instinctual talk. There has been very little experimental data to help provide informed proposals.

Secretary FINCH. We have some controlled experiments that show when we concentrate solely on services, we are never going to break the person out of that box. There are others who argue that you should just give a person a certain amount of dollars and let him spend the money as he sees fit, and not provide any services.

We do not even have much in the way of reliable data testing the basic assumptions of the program, specifically the problems of incentives.

Mrs. REID. Of course, there is speculation, too, whether a guaranteed income would completely replace public assistance. Then if it would not, whether is would be actually piling another welfare program on top of the existing one.

Secretary FINCH. I feel very strongly about this. I think the weaknesses of the AFDC program are such that, if you were going to have a guaranteed income, you would have to replace that totally. This has been my operating assumption all along.

We get hung up on a lot of other arguments, but there is pretty substantial agreement on that.

NATIONAL STANDARD FOR WELFARE PAYMENTS

Mrs. REID. There has been a great deal in the news also concerning the recent Supreme Court decision which decreed that no State can set up residency requirements, the fact that this has removed States rights in welfare, and many feel, I think, that this decision sets up welfare as a national right, not under control of any State government.

In the light of the Court's decision, do you feel that the Congress should take action to even out payments and prevent the inundation of high welfare States?

Who is going to have the responsibility on this?

Secretary FINCH. We have talked about this, but we just are not able to respond in this fiscal year. That is why we need to get a Presidential statement down to Congress very quickly. I do not see any alternative. Given the Supreme Court decision, and given the disparity between the States, we need to examine the need for a minimum standard in this area.

I think Congress is going to have to respond. The question is, How soon and with what kind of a formula?

ABUSES OF MEDICAID

Mrs. REID. I am sure you have seen news stories about some of the flagrant abuses of medicaid, particularly those about medicaid identification cards being loaned to others not covered and nonprescription medicine charged to medicaid in violation of regulations, and patients obtaining prescription drugs without seeing a doctor, and so on.

Would you care to comment on this?

Secretary FINCH. Monitoring this is very difficult. I cited in my earlier testimony some gross examples of this kind that we have seen. We have to rely chiefly on the intermediaries to pick up the fee variations where we have the usual and customary fee system. I am not at all satisfied that our present monitoring system is adequate, any more than it is adequate in the food stamp program, where there are violent abuses.

We think some of this evaluation money we have asked for ought to be used to find better mechanisms for checking these kinds of abuses.

Mr. KELLY. One of the things we have done is put a substantial part of our audit resources to work in the medicaid program. We are working in a large number of States now trying to identify their weaknesses and problems.

And before this fiscal year is over, I hope to have in the Secretary's hand a summarization of everything we have done in audit. It will show all kinds of problems and will really cast more light on the kind of problems you talk about. I think it will help to cast light on why

the problem exists, where the weaknesses are, which States have control systems that work and which ones have lax systems.

This would help us motivate the States to adopt the best practices.

PROVISION OF LEGAL SERVICES TO WELFARE RECIPIENTS

Mrs. REID. It is my understanding that a regulation was proposed by the previous administration which would require State welfare administrators to provide lawyers to welfare recipients when they appeal adverse administrative decisions concerning their rights to welfare payments and in certain other instances.

What is your view on this?

Secretary FINCH. I have not yet made a final decision on what to do about this. I think there is almost universal opposition to this by the welfare directors of the various States. They would like to have that done away with.

Mrs. REID. Has this been in practice at all?

Secretary FINCH. As I understand it, this regulation, promulgated by my predecessor, only recently became effective.

Mr. CARDWELL. It resulted from the poor people's March. The States are required to have this provision in their State plans by October.

Secretary FINCH. We are trying to look at this problem very carefully. There is a great deal of variation in the States in how this legal assistance is provided, and how often it is required.

I will have to make a decision on this very shortly. I have by no means prejudged it.

Mrs. REID. That is all.

Mr. SMITH. Mr. Casey?

OPERATION OF EDUCATION PROGRAMS UNDER CONTINUING RESOLUTION

Mr. CASEY. Mr. Secretary, these items that are being reduced, the ongoing programs that are being reduced below the 1969 budget, what is going to happen to us when we run out of time here and we have to start operating on a continuing resolution?

What position are you going to be in?

Secretary FINCH. I am sorry, I missed the first part of your statement.

Mr. CASEY. For instance, elementary and secondary education. You revised the budget down by $116 million. What is going to happen when we reach June 30 and we still do not have an appropriation bill?

Mr. KELLY. When we administer a continuing resolution, Mr. Casey, we never exceed the level of the President's recommendation to the Congress, even if that is lower than the ongoing program. So that we would administer the continuing resolution as if you had appropriated the lesser amount of the pending request until you take some different final action.

Now there are some other cases where we are going to have some difficulty with the continuing resolution, and we may be asking for consideration of language in the continuing resolution to help.

One deals with the change in law and the change in the matching formula for vocational rehabilitation.

Mr. SMITH. Mr. Casey is referring to the language that for years has required you take the lowest level.

Mr. CARDWELL. That is right. You take the lowest level only for the period during which the continuing resolution is in effect. Let's assume the Congress, then, in this case would appropriate a higher level. Then we could switch and start making grants at the higher level. We would not have made all the grants at once, anyway.

Mr. CASEY. You have cut out some programs entirely under your recommendation.

Mr. KELLY. There are some where the recommendation is for no funds, and until the Congress acts, we would administer it on the assumption that there would be no funds appropriated.

Mr. CASEY. Is it not going to be a little rough to just chop some of these off?

Secretary FINCH. There could be some problems; yes, sir.

Mr. CASEY. No time to change gears or anything.

EDUCATIONAL TELEVISION GRANTS

Mr. Secretary, what is your concept of educational broadcasting facilities under Library and Community Services?

In your short period here, have you thought about that?

Secretary FINCH. I am not yet well-versed in that. I have had a little difficulty relating that function with the Public Broadcasting Corp. grant.

Mr. CASEY. I have trouble distinguishing between the two.

Secretary FINCH. I am advised by Mr. Cardwell that when John Gardner, my predecessor, serving not as HEW Secretary, but as head of the Carnegie Foundation, set up the Public Broadcasting Corp., the Congress decided they needed this extra program to help meet the need for facilities, which the Public Broadcasting Corp. does not provide.

There is some interphase, as I understand it, between the staffs, but both are in an early formative period still. I think it is a relationship that has to be worked out. I do not think we can define the relationship between the two in very specific language.

Mr. CASEY. I would hope you will take a look at those that have been granted and what they are broadcasting in the name of education.

Mr. KELLY. There is a very basic distinction.

The only thing done with the funds appropriated to the program in the Office of Education is to assist in the provision of a facility. The Public Broadcasting Corp. is concerned with the development of programs.

Mr. CASEY. I understand, but they cannot get on the air unless you help them get the facilities. I want you to be careful about who you give the facilities to.

Secretary FINCH. I think we have an FCC input in this. They are the ultimate licensing authority.

Mr. CASEY. Sure, licensing is their problem. I am not worrying about the license with you. I am worrying about who gives them the money to get on the air after they get the license.

Secretary FINCH. I have had some extended conversations with the gentlemen involved in both agencies. I think it would be wise for us not to become involved in program content or the operations of the

programs. I think there is a strong case that they ought to be separated from this agency and perhaps be independent agencies.

I am not saying that is a final judgement. This is another case where I have to come marching down and argue about budget levels when I do not have a thing to do with how the money is spent once it has been appropriated.

Mr. CASEY. Of course you would know some people are getting an awful broad idea of what is educational. I get a lot of mail that is sent to my constituents. I guess one can buy a mailing list from the county clerk or whoever sells the automobile plates.

Secretary FINCH. They are evidently very easy to obtain.

REGIONAL MEDICAL PROGRAM

Mr. CASEY. The regional medical program. You have given that a good whack. Do you think that is going to slow down something that had been a great deal of enthusiastic support around here when first talked of has continued to have since it has been and developed and implemented?

Secretary FINCH. This is another one of those programs where I had some doubts as to whether the program could move as fast as was expected.

Mr. CARDWELL. I think we were trying to perhaps read the committee. Maybe we misread it.

Remember during the hearing on this item several members of the committee—Mr. Natcher was the most vocal of the group—raised the issue about the $36 million in unobligated balances on hand this year.

What we have done under this amendment is to free $20 million of that, and carry it into next year. We have lowered 1970 by $22 million, but we end up with $94 million worth of grants in 1970 where the Johnson budget had $96 million. We think we have smoothed out the program rather than having this big bubble in it for 1969. This was one of the things which seemed to bother Mr. Natcher.

And, as the Secretary points out, there is the basic issue of whether the program can effectively move as fast as originally had been hoped.

REDUCTION IN CHRONIC DISEASE PROGRAMS

Mr. CASEY. When you shifted the budget around to the way it was presented, I am told there was a $6 million training grant program that got lost somewhere.

Do you know what happened?

Secretary FINCH. Out of which agency?

Mr. CASEY. You used to have a chronic——

Mr. CARDWELL. Chronic diseases.

Mr. CASEY. Yes.

You carried there a training grant program. I cannot find it any more. Do you know where it is?

Mr. KELLY. The reduction that was made in the chronic disease program this year has caused the Health Services and Mental Health Administration to modify the projects they support. They have been phasing out some of the projects involved in training.

Most of those, as I recall, were related to the cervical cancer program in the chronic disease program.

Mr. CASEY. You will get a little more data on that?

Mr. CARDWELL. We will be glad to give you a paper on it.

Mr. CASEY. Before you start doing any digging, let me get the precise information.

Secretary FINCH. We will wait on your request then. If we have really lost $6 million we would like to know about it.

Mr. CASEY. I do not think you have. I think you forgot to put it in.

UNFUNDED AUTHORIZATIONS

On impacted area aid, it is getting difficult in view of the fact that school people come to me and say "Well, the law is such and such, Congress passed it, why do you not fund it? We depend on it. For our category B students we get $500,000 out of it for our district under the authorization and the budget says to appropriate nothing."

I have not seen your paper on it, but I do not know as that old dog will hunt, as they say down in my country, unless we can change the law.

Mr. KELLY. The amounts which are authorized for appropriation in the education programs exceed the amounts we are requesting by more than $6 billion.

Mr. CASEY. Is that right?

Mr. KELLY. Yes, sir.

Mr. CASEY. Why do they always run out of money on those I have down in district? I got two letters this past week regarding projects that had been approved, but no money.

I have no more questions.

AVAILABILITY OF GUARANTEED STUDENT LOANS

Mr. SMITH. What about these guaranteed student loans? Have you had a chance since you were here earlier, in February, to look into this program? All the information I get is that it is just not working, the bankers are not making loans, they do not want to make the loans, and students who have to depend upon bank loans are just out of luck.

Secretary FINCH. We did dig into that.

There again we found very, very uneven performance. It seems related to lending to institutions where they have had student trouble. They are also a lot less ready to make the loans in smaller towns, even where there is no trouble.

Mr. KELLY. As I recall, we went well over a billion dollars in loans involving thousands of institutions. We are now working with the Federal Deposit Insurance Corp. and the Department of the Treasury to attempt to use an existing examination for validating the data on which we are paying the interest rather than audit each of these institutions.

So I know that the number of institutions involved is very widespread and that the number of loans that have been paid is very large.

Mr. SMITH. Enough of the direct loan money has not been available and guaranteed loans are not always available either. The bankers tell me, "Look, after all, I can put the money out a million dollars at a time and get it back any day I want it. To loan some student a thousand dollars and getting it back in payments over a period of 10 years is not practical."

In addition, the kids that need it the worst are the last ones that are going to get one of these guaranteed loans because the boy walks in with his mother, they do not want to——

Mr. KELLY. That is exactly right. This is why when we made the recommendations on the National Defense Education Act student loans, we urged that loans not be made to a family with an income above $10,000, until he had exhausted his ability to try and get it from the banks. This is because it is the low-income student that needs the direct loans.

REGIONAL MEDICAL LIBRARIES

Mr. CASEY. Mr. Secretary, you say you have been examining some of these and whether or not they are utilizing the money. How about the regional medical libraries. You cut that $2 million. Do you think they have not been using what they got too well?

Secretary FINCH. I know very little about that program as yet. Mr. Cardwell, will you respond?

Mr. CARDWELL. This is about the third year for that program. This is a case of——

Mr. CASEY. Priority?

Mr. CARDWELL. Priorities.

We are saying that we are not against libraries, we are not against books, but if you have to choose between training doctors and providing support to medical libraries to be used by physicians in practice, then we favor at this time, training the physicians.

The budget amendment connected with the National Library of Medicine does not have anything to do with the basic support of the medical libraries. It is asking to postpone the enlargement of the Lister Hill Biomedical Communications System that is being designed. We eventually hope to put it in effect.

ACQUISITION AND CATALOGUING OF FOREIGN LANGUAGE PUBLICATIONS BY LIBRARY OF CONGRESS

Mr. CASEY. How important do you think it is that we translate technical documents and books from Russia, for instance?

Mr. CARDWELL. I do not think that would be affected by the budget reduction.

Mr. CASEY. These people are over here looking for a job and said you cut them out completely.

Mr. CARDWELL. Are you talking about the Library of Congress item now?

Mr. CASEY. Yes.

Mr. KELLY. That item was reduced by about $3 million.

Mr. CASEY. There was $7 million in there in the original budget.

Mr. KELLY. We will be glad to have that put in the Library of Congress's budget rather than HEW.

It was $5.5 million in 1969, the Johnson budget was for $7,356,000 and the revised budget $4,500,000.

Mr. SMITH. I thought we had people in other countries that would take counterpart funds to do this kind of work.

Mr. KELLY. We did a very substantial amount of that in Israel. Israel I think is outstanding of all countries in the world for scientific

translation, but the amount of surplus funds available in Israel is borderline.

Mr. CARDWELL. This item is in our budget just by happenstance. It is not directly related to HEW.

Secretary FINCH. Like the Public Broadcasting Corp. If you would move that to the Library of Congress we would be delighted.

Mr. SMITH. Thank you, Mr. Secretary.

This completes the hearing on budget amendments except as we will discuss them in connection with the relatively few appropriation items on which we have not yet had detailed hearings.

Secretary FINCH. Thank you, Mr. Chairman.

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