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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1974

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HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETY-THIRD CONGRESS

FIRST SESSION

SUBCOMMITTEE ON DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS

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HENRY A. NEIL, Jr., FREDERICK F. PFLUGER, and ROBERT L. KNISELY, *Staff Assistants*

PART 1

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Budget Overview
Reports on Various Programs
Secretary's Testimony

Printed for the use of the Committee on Appropriations

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

MONDAY, MARCH 5, 1973.

OVERVIEW OF THE 1974 BUDGET

WITNESSES

JAMES B. CARDWELL, ASSISTANT SECRETARY, COMPTROLLER
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, BUDGET

Mr. FLOOD. The committee will come to order. We are going to take the curtain up on the 1974 budget request for the Department of Health, Education, and Welfare.

INTRODUCTION OF WITNESS

The committee is very pleased to have with us as the first witness for this awesome task a gentleman who, if it can be done, is the one to do it—Mr. James B. Cardwell, Assistant Secretary and Comptroller for the Department. He will make his customary presentation in the form of a chart talk on the 1974 budget, which he does every year and has been doing every year since the memory of man runneth not to the contrary. This is one of the very few chart presentations that I am able to understand.

Mr. Cardwell, you may proceed. I see you have given to each member of the subcommittee a brochure which constitutes the HEW budget in brief. I hasten to add in parenthesis is (billions). It is a very definitive document. I see your charts are ready, so you may proceed.

Mr. CARDWELL. Thank you, Mr. Chairman.

As I came into the room, you were eulogizing a very good friend of mine, Bob Ball. I have worked in HEW, it seems to me, ever since it started, and I have worked with Bob Ball and a lot of SSA's fine public servants since that time. There are very few men that I know who have done more for an institution than Bob Ball has done for social security. What one does for social security is a service to people. There is no single program that I know of that serves more people. I know of no program that serves them better.

Mr. FLOOD. Because of your fiscal responsibility as Budget Director and now Assistant Secretary and Comptroller those words have added significance because certainly no one, but no one, would know better than you. It is good to hear you say so.

Mr. CARDWELL. My purpose, Mr. Chairman, is to run through the 1974 budget for the Department of HEW in a kind of a brief overview to give you some of the basic facts and figures. My hope is that I will help you get ready for Secretary Weinberger when he arrives on Wednesday.

Mr. FLOOD. I hope you get your hope.

Mr. CARDWELL. In that regard, I might tell you that he will come to you with a great deal of experience under his belt vis-a-vis the budget. We have had four hearings on the HEW budget already before Congress, none of which was before a committee on appropriations. The budget was discussed during his confirmation hearings before Senate Finance, before some special hearings held by the Senate Committee on Labor and Public Welfare, before a Special Subcommittee on Health of the House Committee on Interstate and Foreign Commerce, and just this morning before a subcommittee dealing with aging, the subcommittee of the Committee on Labor and Public Welfare of the Senate. He has a lot of practice.

Mr. FLOOD. Four of these appropriation bills for the Department of HEW have been vetoed in the last few years, have they not?

Mr. CARDWELL. There have been several.

Mr. FLOOD. The Office of Management and Budget was identified in some way with these matters.

Mr. CARDWELL. Yes. OMB does provide advice and recommendations to the President on the signing of appropriations bills and there were two involving the fiscal year 1973.

HEW BUDGET IN BRIEF

If you will, I would like to take you through the charts that you have before you and that appear in the back of the room.

HEW BUDGET IN BRIEF

(IN BILLIONS)

	1972	1973	1974
FEDERAL FUNDS:			
BUDGET AUTHORITY (APPROPRIATIONS)	$26.9	$29.6	$31.5
OUTLAYS	26.0	27.8	30.6
TRUST FUNDS:			
BUDGET AUTHORITY (RECEIPTS)	51.2	60.7	73.5
OUTLAYS	48.2	58.1	66.3
INTERFUND ADJUSTMENT:	-2.5	-2.4	-3.1
TOTAL:			
BUDGET AUTHORITY	75.7	87.9	101.9
OUTLAYS	71.8	83.6	93.8

The total HEW budget in terms of budget authority will reach $101.9 billion in fiscal year 1974 as proposed by the President compared to $87.9 billion in 1973.

Mr. FLOOD. Will you tell us from page to page what topic you are discussing?

Mr. CARDWELL. I am on the cover sheet and I am looking at the grand totals. I will be glad to explain some of the key figures. I think most of them are self-explanatory. The cover sheet deals with the difference between budget authority and outlays. Budget authority is, in effect, the language that this committee deals with, authority to commit money in the form of appropriations or receipts to the social security trust funds. Outlays as shown here reflect estimates of cash flow from the Treasury for these activities during the fiscal years 1972, 1973, and 1974.

Mr. FLOOD. What is the interfund adjustment?

Mr. CARDWELL. It represents a selected number of payments from the general fund of the Treasury into the social security trust funds. They are largely to cover special benefits to beneficiaries who have not on their own contributed to the trust funds, notably former servicemen of past wars and certain older people who have now reached age 72 and who did not contribute to the social security trust funds, but who under law are now eligible for medicare benefits. In other words, the general funds of the Treasury pay, into the trust funds, the share of the cost for providing benefits to this select group of people. Rather than have the figure show twice, we have the offset adjustment of $3.1 billion in 1974.

HEW SHARE OF THE FEDERAL BUDGET

You have heard a great deal about the share that the HEW budget constitutes of the total budget. You will hear some more about it. The share in terms of outlays in 1974 would be about 35 percent of the total federal budget that is proposed by President Nixon for HEW. In 1973 that share was about 33 percent. In 1972 it was 31 percent.

Mr. FLOOD. What about the trust funds?

Mr. CARDWELL. That includes the trust funds.

Mr. FLOOD. Will you tell us, since you raised the question, if that is so, included in that are trust funds amounting to how much? What percentage?

Mr. CARDWELL. $66.3 billion or 71 percent of the HEW total budget outlays.

Mr. FLOOD. Of the HEW budget?

Mr. CARDWELL. Yes. I might mention that many people debate the issue of whether these trust funds——

Mr. FLOOD. If you will yield, if somebody goes around saying, look at this HEW budget, it is now bigger than the Department of Defense. Did you ever think you would live long enough when you would see the HEW budget bigger than the Department of Defense? As a matter of fact, 71 percent of the HEW budget is trust funds that you cannot put a glove on.

Mr. CARDWELL. That is correct.

Mr. FLOOD. So the actual HEW budget minus the trust funds is what in dollars?

Mr. CARDWELL. In terms of outlays it would be a difference between $66.3 billion and $93.8 billion or about $27.5 billion. I might emphasize that the social security payments, both for old-age and survivor's insurance and for medicare are in my judgment properly a part of the program, because income to the U.S. Government from taxes collected from employers and employees now constitute the second largest source of revenue for the U.S. Government. By 1974 they will be almost double the income and revenue collected in the form of taxes from corporations, for example. The only larger single source will be from general taxpayers.

Mr. FLOOD. That is a good statement. Will you repeat that for the record?

Mr. CARDWELL. It has often been debated as to whether the SSA trust fund should be treated as a part of the regular budget. The point I am trying to make is that I believe they should, largely because the revenues that finance the services and benefits provided by trust fund activities are a form of taxation, and by 1974 that form of taxation will be the second largest source of revenue for the U.S. Government.

Mr. FLOOD. What is sacred about 1974?

Mr. CARDWELL. It takes a big jump in 1974 because of the large increase in social security taxes that were just recently authorized by the Congress.

BUDGET BY OPERATING AGENCY

Going next to the second chart, the HEW budget by operating agency.

HEW BUDGET BY OPERATING AGENCY

(BUDGET AUTHORITY IN MILLIONS)

	1972	1973	1974
FOOD & DRUG ADMINISTRATION	$117	$144	$166
HEALTH SERVICES & MENTAL HEALTH ADMINISTRATION	2,236	1,933	2,771
NATIONAL INSTITUTES OF HEALTH	2,217	1,998	1,965
SUBTOTAL	4,570	4,076	4,902
EDUCATION DIVISION	5,301	5,485	5,277
SOCIAL AND REHABILITATION SERVICE	13,498	15,451	14,413
SOCIAL SECURITY ADMINISTRATION	51,820	62,309	76,657
(OUTLAYS)	(48,646)	(59,682)	(69,502)
SPECIAL INSTITUTIONS	101	81	81
OFFICE OF CHILD DEVELOPMENT	390	416	444
OFFICE OF THE SECRETARY	65	75	141
ADJUSTMENT FOR PROPRIETARY RECEIPTS	-30	-30	-34
TOTAL, HEW	**75,715**	**87,863**	**101,880**
(OUTLAYS)	(71,780)	(83,580)	(93,822)

There are increases for the Food and Drug Administration and the Health Services and Mental Health Administration. There is a net decrease for the National Institutes of Health of about $33 million. They go down from $1,998 million in 1973 to $1,965 million in 1974, a minus $33 million. I will explain that later. Education activities also show a net decrease of about $200 million.

Mr. FLOOD. Going back to NIH, you indicate a drop in 1973, $1,998 million to $1,965 million in 1974.

Mr. CARDWELL. That is right.

Mr. FLOOD. However, in 1972 it was $2,217 million.

Mr. CARDWELL. That is correct.

Mr. FLOOD. From 1972 you have gone down from $2,217 million to $1,965 million in 1974 for NIH?

Mr. CARDWELL. That is correct. NIH will be about $250 million lower in 1974 in terms of its funding than it was in 1972. Activities of the new Education Division, consisting of the Office of Education, the National Institute of Education and certain other educational activities under the Department will be down by $200 million net in 1974.

Activities of the Social and Rehabilitation Service will be down about a million. Activities of the Social Security Administration will be up $14.3 billion and outlays up by nearly $10 billion. This is significant and we will talk about that later in some detail. The so-called special institutions—Howard University, the Model Secondary School for the Deaf, NTID, Gallaudet College—will remain the same in 1974 as in 1973. The Office of Child Development goes up by about $28 million. The Office of the Secretary shows an increase of $66 million; but, I would like to mention very quickly that this is a reflection of the transfer of OEO activities.

Mr. FLOOD. If and when. As far as your presentation is concerned, that is a fait accompli.

Mr. CARDWELL. It is a part of the budget. It is an assumption of the budget. I will leave it to you gentlemen if and when and how it happens.

Mr. FLOOD. It is a presumption and not an assumption.

Mr. CARDWELL. To summarize quickly, the totals come out in terms of budget authority, appropriations and other authorities to commit, at $101.9 billion, an increase of $14 billion over the prior year.

Mr. FLOOD. Where did you get that figure?

Mr. CARDWELL. Looking at the total line on the bottom, total HEW, the 1974 column, $101.9 billion is the total figure compared to $87.9 billion.

I would suggest we skip the next three cards. They deal with 1973 rescissions and amendments; and, the hearings you just completed dealt with those items.

Mr. FLOOD. That is correct.

1973 SPENDING

Mr. OBEY. Mr. Chairman, if I may ask a question at that point, does the 1973 budget level indicated in these charts for these different agencies include or exclude the rescissions?

Mr. CARDWELL. From here on in, the discussion on 1973 figures would assume congressional approval of the proposed rescissions and amendments, both upward and downward.

Mr. OBEY. How about on page 2; are they included or excluded?

Mr. CARDWELL. They are included in that sense.

Mr. OBEY. They include the rescissions?

Mr. CARDWELL. And amendments, up or down.

Mr. FLOOD. The point I want to make is that when you are talking about these 1973 figures, regardless of what page you are talking about, these are your figures.

Mr. CARDWELL. They are our figures.

Mr. FLOOD. These are Administration figures.

Mr. CARDWELL. Downtown, Administration, OMB, HEW.

Mr. MILLER. So is 1974, Mr. Chairman.

Mr. FLOOD. The amounts in the so-called revised budget for 1973, these figures that you are bandying around are not the figures of Congress, exclamation mark.

Mr. CARDWELL. That is right. At this stage they are not.

Mrs. GREEN. Mr. Chairman, for clarification on the 1973 budget, you have $87 billion and then you have outlays, $83 billion. Would the difference between the 83 and 87 represent the rescissions and/or impoundments?

Mr. CARDWELL. No, ma'am. That would be the difference between cash flow during fiscal year 1973 and budget authority proposed by the Administration for 1973. And, the factor in that is that more social security taxes will be collected than disbursed.

Mrs. GREEN. Thank you.

Mr. FLOOD. Please continue.

HEALTH PROGRAMS

Mr. CARDWELL. On the chart health programs.

HEALTH PROGRAMS

(BUDGET AUTHORITY IN MILLIONS)

	1972	1973	1974
FOOD, DRUG, AND PRODUCT SAFETY	$117	$144	$166
MENTAL HEALTH	633	640	1,320
HEALTH SERVICES PLANNING AND DEVELOPMENT	548	157	163
HEALTH SERVICES DELIVERY	853	919	1,070
PREVENTIVE HEALTH SERVICES	145	139	125
BIOMEDICAL RESEARCH	1,475	1,483	1,532
HEALTH MANPOWER	678	444	386
OTHER	121	148	139
SUBTOTAL, HEALTH AGENCIES	4,570	4,076	4,902
MEDICARE AND MEDICAID BENEFITS*	13,098	14,301	17,357
TOTAL, HEALTH PROGRAMS	**17,668**	**18,377**	**22,259**

*OUTLAYS

Mr. CARDWELL. We might look first at the total. It shows, going from the amended budget of $18.4 billion in 1973, an increase of $3.8 billion proposed for health activities of the Department for fiscal 1974. If you look at health activities for the Government as a whole they go up about $3 billion net as well, from about $27 billion to about $30 billion. I just throw that figure in to give you some perspective.

The comparable 1973 figure, as originally proposed by the President last January before he adjusted it, was $18.1 billion. That figure does not show on the charts; but, since you have shown an interest in the base, I thought I would mention it. Running down the changes, Food and Drug Administration would go up $22 million in 1974. Mental health activities would go up $680 million. The largest single item in that, which we will run into later, has to do with the proposal to buy out, in effect, future grants for the community mental health centers—that is, to guarantee budget authority, here and now sufficient to pay off every 8-year grant period for every community mental health center in the country.

COMMUNITY MENTAL HEALTH CENTERS

Mr. FLOOD. What is the significance of the use of your figure 8 years?

Mr. CARDWELL. That program authorizes Federal grants.

Mr. FLOOD. What program?

Mr. CARDWELL. The community mental health authorizes Federal grants for a period of up to 8 years for each grant and the theory is at the end of 8 years each center would become self-sufficient.

The President is proposing that the program be terminated at the end of the next fiscal year. In order to assure that the individual programs and projects would stay in place, he is asking the Congress to give him budget authority sufficient to underwrite their full 8-year grant in each and every case, assuming that it would take them that long to develop permanent regular non-Federal financing.

Mr. MICHEL. Does that mean from a practical point of view that those areas and locations which have been fortunate enough up to this point to have had an additional grant will have this secured then for the balance of the 8 years?

Mr. CARDWELL. Yes. Some are well into their 8-year period. Others are just beginning. There are 515 such centers across the country. That is what it means, just as you described it.

Mr. FLOOD. I was concerned very much about that phrase, "the 8-year period." That is not understood at all.

Mr. CARDWELL. Health services, planning and development, a net increase of $6 million. Health services, delivery activities, an increase of $1.51 million. Included in that is a $40 million figure involving a transfer from OEO for community neighborhood health center activities.

Preventive health services would show a decrease of $14 million. That relates to a termination of certain chronic disease activities adminiministered by the communicable disease center.

BIOMEDICAL RESEARCH

Biomedical research is taking NIH and separating the research activities from their manpower development activities. Looking at the biomedical research part of NIH, there is a net increase of $49 million, centered largely in heart and cancer activities.

Mr. FLOOD. Centered entirely on cancer and heart?

Mr. CARDWELL. If you look at the Institutes, Institute by Institute. First of all, look at the total. There is a gross increase for heart and cancer in the amount of $92 million. There are decreases of about $46 million among all of the other Institutes.

Then if one looks inside the budgets of each of the other Institutes, he will find some pluses and minuses. Certain activities go up. Other activities go down.

It is true that, except for heart and cancer, the budget of each Institute shows a net decline in 1974.

Mr. FLOOD. That is the point I wanted to make here.

Mr. CARDWELL. Preventive Health Services have an increase of $49 million.

Health manpower has a net decrease of $58 million. All other health activities of the Department have a minus $9 million, going from $148 million to $139 million.

Looking at the health agencies, excluding medicare and medicaid, we find a net increase of $826 million, $147 million of which are related to OEO health activities that are being transferred from OEO to HEW.

MEDICARE AND MEDICAID

Medicare and medicaid benefits show an increase of about $3 billion. Of course, this is the largest single health increase anywhere in the budget. Yes, it's probably the largest single increase in the Federal budget, an increase of $3 billion for medicare and medicaid. Lumped together, if you look at them as a means by which people pay their medical bills, this Administration sees this as a most significant and important part of its overall health budget.

Including medicare and medicaid, the health budget goes up $3.9 billion to a total of $22.3 billion in 1974.

Moving on to the next chart, Health Services and Mental Health Administration, there is a breakdown between Mental Health and Health Services, you will find a repeat of some of the figures in a more refined way.

HEALTH SERVICES & MENTAL HEALTH ADMINISTRATION

(BUDGET AUTHORITY IN MILLIONS)

MENTAL HEALTH	1972	1973	1974
GENERAL MENTAL HEALTH:			
RESEARCH AND TRAINING	$201	$161	$152
COMMUNITY MENTAL HEALTH CENTERS	160	134	518*
DRUG ABUSE:			
RESEARCH AND TRAINING	36	42	51
COMMUNITY PROGRAMS	81	149	382*
ALCOHOLISM:			
RESEARCH AND TRAINING	13	10	11
COMMUNITY PROGRAMS	69	60	117*
SAINT ELIZABETHS HOSPITAL	30	36	38
ADMINISTRATION AND INFORMATION	43	48	51
TOTAL	633	640	1,320
HEALTH SERVICES PLANNING AND DEVELOPMENT			
RESEARCH AND DEVELOPMENT	62	51	60
COMPREHENSIVE HEALTH PLANNING	26	35	38
REGIONAL MEDICAL PROGRAMS	100	60	—
HEALTH MAINTENANCE ORGANIZATIONS	—	—	60
MEDICAL FACILITIES CONSTRUCTION	357	8	2
PROGRAM DIRECTION	3	3	2
TOTAL	548	157	163

* INCLUDES FUNDS FOR USE AFTER 1974 TO SUPPORT ALL COMMUNITY MENTAL HEALTH CENTER COMMITMENTS

MENTAL HEALTH

Research and training under general mental health shows a slight decrease of minus $9 million. Community mental health centers show a net increase for general mental health of $348 million. Drug abuse activities under the heading mental health show an increase of $9 million for research and training and $233 million for community programs.

Alcoholism shows just about the same level in 1974, $11 million compared to $10 million for research and training, but an increase of $57 million for community programs.

St. Elizabeths Hospital holds its own at about $38 million, a slight cost-of-living increase.

Mental health administration and information activities show a net increase of about $3 million.

In that total increase of $680 million, $636 million are related to this buyout of the community mental health centers we discussed a moment ago: $384 million involve general mental health activities; $205 million relate to drug abuse activities within community mental health centers; and $47 million relate to alcoholism activities within community mental health centers.

Mr. MICHEL. Will you repeat those three figures?

Mr. CARDWELL. The total is $636 million, broken down into three parts: General mental health, $384 million; drug abuse, $205 million; and alcoholism, $47 million. In other words, various community mental health centers operate special projects in the fields of general mental health, drug abuse, and alcoholism. We have broken down the buyout in terms of how it will affect those various priorities.

Mr. PATTEN. That means the alcoholism program is being phased out?

Mr. CARDWELL. No. There are two aspects of the Federal program on alcoholism. One is the financing of various research activities through grants to community mental health centers and neighborhood health centers, hospitals, clinics, and other researchers, and the direct financing by the Federal Government of community mental health centers and neighborhood health centers.

The community mental health centers' portion would be phased out at the end of the 8-year period for the individual project. Other activities in the community financed by HEW would continue unabated.

Mr. MILLER. There is also another major component of about $30 million for the alcoholism formula grant program.

Mr. PATTEN. That will be the end of that?

Mr. MILLER. No. No. There is no plan to phase that down.

Mr. FLOOD. It's going on?

Mr. CARDWELL. Maybe I should use another term more familiar to you. The mental health center program had two forms of grants. One form was to underwrite construction for modernization of facilities. Those were called construction grants. The other ones were called staffing grants, to finance salaries and expenses of the staff of these centers once they came into place.

It's the staffing grant part of the program that the $636 million relates to. It's that part of the program that we have broken down in terms of general mental health, drug abuse, and alcoholism.

HEALTH SERVICES PLANNING AND DEVELOPMENT

Health services planning and development consists of a number of key programs. The first is the activities of the National Center for Health Services, Research and Development. On the chart that is shown as research and development.

This appropriation also includes comprehensive health planning, the so-called partnership for health program, the regional medical program, and the new legislative proposal to authorize the financing of health maintenance organizations. The most controversial part of this section of the budget deals with the administration's proposal to terminate the regional medical program.

Mr. FLOOD. That is an understatement.

Mr. CARDWELL. We would allow the authorizing legislation to expire automatically at the end of this fiscal year, June 30 next. That accounts for a decrease in that portion of the budget of $60 million.

There is an offsetting increase of $60 million directed to the new legislative proposal that the Congress has yet to deal with authorizing Federal assistance for the creation of health maintenance organizations.

The second most controversial part of this heading is the proposal to allow the Hill-Burton program to expire at the end of this fiscal year.

Mr. CONTE. Where is that shown?

Mr. CARDWELL. That is under "Medical facilities construction." In fact, one of the budget amendments proposed by the administration for 1973 deals with that activity.

Mr. FLOOD. What did you say about the HMO's? I am not sure I am clear about that.

Mr. CARDWELL. The $60 million shown in the 1974 column under the heading "Health maintenance organizations" relates to budget authority requested in this budget to finance a legislative proposal that the Administration will submit on this subject. It's similar to a proposal that was submitted last year, except that this one will center on the development and basic support for the initiation of health maintenance organization as a deliberate device.

HEALTH SERVICES DELIVERY

Still with the Health Services Mental Health Administration on the next chart, we move to the health delivery portion of the health budget.

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HEALTH SERVICES & MENTAL HEALTH ADMINISTRATION

(BUDGET AUTHORITY IN MILLIONS)

HEALTH SERVICES DELIVERY	1972	1973	1974
COMPREHENSIVE HEALTH SERVICES	$226	$239	$341
MATERNAL AND CHILD HEALTH	239	244	244
FAMILY PLANNING	90	107	122
DIRECT PATIENT CARE:			
PHS BENEFICIARIES	90	94	99
INDIAN HEALTH	186	213	219
NATIONAL HEALTH SERVICE CORPS	11	11	34
PROGRAM DIRECTION	11	12	11
TOTAL	**853**	**919**	**1,070**
PREVENTIVE HEALTH SERVICES			
DISEASE CONTROL	90	84	74
COMMUNITY ENVIRONMENTAL MANAGEMENT	26	27	22
OCCUPATIONAL HEALTH	25	24	26
PROGRAM DIRECTION	4	4	4
TOTAL	**145**	**139**	**125**

There we find a large increase in comprehensive health services from $239 million in 1973 to $341 million in 1974, an increase of $102 million, almost entirely funds to support OEO neighborhood health centers transferring.

Maternal and child health would continue at the same dollar level, but consistent with a change in the basic law, the funding would shift from project grants to formula grants in 1974. Family planning activities show an increase of $15 million in 1974, again transferred OEO projects.

DIRECT PATIENT CARE

Direct patient care activities would increase a net of $5 million for PHS beneficiaries. I would like to explain that a little more.

Mr. FLOOD. What is the PHS?

Mr. CARDWELL. The Public Health Service Commission Corps beneficiaries and merchant seaman.

Mr. FLOOD. I am not that dumb, but somebody may ask that.

Mr. CARDWELL. I understand. Thank you.

Indian health activities, care for American Indians, would be increased by about $6 million. That particular item does not come before this committee, but it's included in this presentation because it's a part of our overall health budget.

The National Health Service Corps is proposed to increase $23 million, with $22 million of that related to a legislative proposal that we are making to provide scholarships to medical students who will sign up to serve in the National Health Service Corps after completing their medical education. The National Health Service Corps itself has already been authorized and it's a part of existing law.

Mr. CONTE. You show Indian health going up $6 million and on page 3 you show the Indian Health Service going down $5 million. Can you explain that? What is the difference?

Mr. CARDWELL. That was the chart that dealt with 1973 revised spending proposals.

Mr. CONTE. Why are you asking for a rescission and then you are coming up here and asking for more?

Mr. CARDWELL. It's largely the matter of assimilation in 1973. The administration is committed to a steady increase in the provision of health care to Indians. It just says in 1973 we think the Congress has tried to move a little too fast. We would like to slow it down in 1973 and pick up the slack again in 1974.

Mr. OBEY. I was on the subcommittee last year that handled Indian health care. There was no indication at that time that they couldn't absorb that money a hell of a lot more. What exactly do you mean by "ability to absorb"?

Mr. CARDWELL. My recollection, sir—and we can doublecheck this—is that the Congress did increase funds for health care for Indians above the levels proposed by the administration.

Mr. OBEY. That is right.

Mr. MILLER. We are not requesting a rescission of all of that. We are still retaining $1½ million of congressional increase on top of the original President's budget. That includes the construction appropriation. The figures on page 3 do not.

Mr. CARDWELL. Moving back to the item "PHS beneficiaries," that is centered largely on care provided through the eight PHS hospitals, Public Health Service hospitals, to merchant marines and certain other beneficiaries of the Public Health Service.

This has been one of the most controversial items between the administration and the Hill. It's a controversy that goes back to every HEW administration since 1965. Every Secretary that I ever worked for has come to the Hill with exactly this same proposal and it has been sent back down again. This Secretary is back with the same proposal one more time.

The proposal is to convert the hospitals to community use if, and when, and where the communities indicate a need and interest in it.

It's essentially the same proposal he made last year. The increase shown there is to help bring one of the community hospitals where a community has shown an interest in taking the facility over to bring it up to local safety standards.

Mr. PATTEN. Would you say which one?

DISEASE CONTROL

Mr. CARDWELL. Boston. Preventive health services is next on the same chart. Disease control goes down minus $10 million. This is a reflection of a phaseout that begins in 1973 following the completion of the rubella vaccine program and a phase-down of chronic disease and nutrition activities operated by the Communicable Disease Center in Atlanta, on the theory that these particular activities have also run their natural course. The nutrition surveys have been completed.

Mr. FLOOD. How long did that rubella program go on—how many years?

Mr. CARDWELL. About 2 years.

Mr. FLOOD. Longer than that, wasn't it?

Mr. MILLER. Three or four years.

Mr. FLOOD. Three, I would say. That was a pretty good show.

Mr. CARDWELL. Yes, at the Communicable Disease Center.

Mr. MILLER. The communities have picked it up, too.

Mr. CARDWELL. This is our perfect idea. It's interesting that here everybody seems to be running out of work. The Federal Government moved in and put up the basic financing and technology for immunization. The communities have picked it up and now rubella vaccination has become a permanent part of every local health activity in each State.

Mr. FLOOD. It got off to a slow start, but certainly caught on.

Mr. CARDWELL. Community environmental management is down $5 million. This is related to the proposal to terminate the Arctic Health Center in Alaska and certain injury control activities of the Health Services Mental Health Administration.

Occupational health shows an increase of about $2 million compared to $24 million in the 1973 budget.

BIOMEDICAL RESEARCH

Now the National Institutes of Health. There are several ways to look at that. This chart looks at it in terms of functions rather than in terms of disease of Institute.

NATIONAL INSTITUTES OF HEALTH

(BUDGET AUTHORITY IN MILLIONS)

BIOMEDICAL RESEARCH	1972	1973	1974
BY AREA OF RESEARCH:			
NATIONAL CANCER INSTITUTE	$373	$426	$500
NATIONAL HEART AND LUNG INSTITUTE	224	247	265
OTHER RESEARCH INSTITUTES	878	810	767
TOTAL	1,475	1,483	1,532
BY FUNCTION:			
RESEARCH GRANTS	802	812	825
GENERAL RESEARCH SUPPORT	(55)	(26)	(17)
RESEARCH CONTRACTS	229	246	290
INTRAMURAL RESEARCH	116	121	127
TRAINING GRANTS AND FELLOWSHIPS	186	150	99
CONSTRUCTION (CANCER)	51	49	34
OTHER DIRECT OPERATIONS	91	105	157
TOTAL	1,475	1,483	1,532

First, a breakdown of research. The budget shows a $74 million increase for cancer, an $18 million increase for heart and lung research, and a net increase for all other research institutes of $43 million. Overall, there is a net increase, however, of $49 million for research grants and other research activities, including intramural research.

Looking at it in terms of grants in general research support contracts, intramural and extramural, training and so forth, you will find pluses and minuses.

Research grants in all NIH go up in the aggregate of $13 million. General research support grants go down by $9 million. This is a deliberate proposal to phase down that particular kind of research activity beginning in 1974.

Research contracts, the financing of extramural research activities through the contract instrument rather than a grant shows——

Mr. FLOOD. You don't want to go into this business with us of discussing the use or abuse of the extent of research by contract vis-a-vis grants. We should probably wait until the appropriate NIH witnesses are here.

Mr. CARDWELL. Either way.

Mr. FLOOD. I think that will be more appropriate if we wait for them.

Mr. CARDWELL. I will try to be here at that time.

Mr. FLOOD. You might pass the word.

Mr. CARDWELL. Yes, sir. Research contracts. Extramural research contracts are centered in the majority at the National Cancer Institute.

Mr. FLOOD. That is right.

Mr. CARDWELL. Activities such as cancer chemotherapy, the analysis and exploration of the use of drugs as a means of both identifying cancer and treating cancer, is often done through contracts with manufacturers as well as with nonprofits.

As you all probably remember, NIH does have a uniform policy that has been carried on down the years of not awarding grants to profitmakers. That accounts for this concentration of contract work in cancer chemotherapy.

Mr. FLOOD. That may very well be, but you are going once over lightly the Tinker to Evers to Chance system they have out here for the built-in business of selection of contracts.

Mr. CARDWELL. That is something I happen to be personally interested in.

Mr. FLOOD. So am I.

Mr. CARDWELL. I am a strong advocate for objective rather than subjective selection on awarding of contracts, whether it be for research or anything else. I really think there is little justification, even in the name of science, for not following concepts of objectivity, including competition in the selection of contracts.

Mr. FLOOD. That is my speech.

Mr. CARDWELL. I would urge you to take it up with the Secretary when he gets here.

Mr. FLOOD. Don't worry about that.

Mr. CARDWELL. It's an important subject. Intramural research is largely research centered at the National Institutes of Health at Bethesda in their own laboratories in the Clinical Center. That would go up from $121 million in 1973 to $127 million in 1974.

Training grants and fellowships show a phasedown beginning in 1973. The original 1973 budget was $180 million. We propose to cut that back to $150 million this current fiscal year and down to $99 million in 1974. This is a reflection of a very deliberate policy and one that the administration would commend to the Congress, of phasing down the direct support of either institutions or individuals in forms of grants and fellowships for their training as postgraduate researchers. We are suggesting instead that the individual trainee, who would pursue an advanced degree in the name of research, finance this through regular student loan channels or through other private channels.

Construction shows a decrease of $51 million in 1974. That construction, as is noted on the chart, is related to special construction authority that was granted at the National Cancer Institute as a partner of the special cancer initiative authorized 2 years ago.

Mr. MICHEL. How much of that $34 million is out in Fort Detrick, Md.?

Mr. CARDWELL. I think that is significant. You mean in other direct operations?

Mr. MICHEL. Yes.

Mr. MILLER. You mean in the construction?

Mr. MICHEL. Yes.

Mr. MILLER. Very little.

Mr. CARDWELL. You remember they moved into Detrick and took it over as is. I don't know what the long-term picture contruction is there. You might ask NIH when they get here. I think they do have some plans for conversion of some of those buildings.

HEALTH MANPOWER

Still on the National Institutes of Health, moving to the next chart, we look at the manpower programs of NIH and see a lot of minuses.

NATIONAL INSTITUTES OF HEALTH

(BUDGET AUTHORITY IN MILLIONS)

HEALTH MANPOWER	1972	1973	1974
HEALTH PROFESSIONS:			
INSTITUTIONAL ASSISTANCE	$259	$232	$222
STUDENT ASSISTANCE	46	51	46
CONSTRUCTION	143	1	1
NURSING:			
INSTITUTIONAL ASSISTANCE	72	39	17
STUDENT ASSISTANCE	52	52	34
CONSTRUCTION	20	1	1
PUBLIC HEALTH	18	15	–
ALLIED HEALTH	29	21	–
SPECIAL EDUCATIONAL PROGRAMS	23	12	47
ADMINISTRATION	16	20	18
TOTAL	678	444	386

Institutional assistance is going down from $232 million to $222 million. Student assistance is going from $51 million down to $46 million. That is for the health professionals. Nursing shows a decrease of $22 million for institutional assistance with a decrease in student assistance of $18 million. Support of schools of public health would be completely terminated by the end of fiscal year 1973.

Mr. FLOOD. That includes modernization, as well as new bricks and mortar?

Mr. CARDWELL. No. These items I am mentioning are payments to colleges and universities to help underwrite their training and teaching programs and fellowships and other forms of assistance to students.

There is a construction item in there. That is the health educational construction program, which is in effect not operational under the 1973 budget; $140 million was included in the vetoed bills, but the President's budget shows only $1 million for 1973, which is for interest subsidies on construction loans.

Allied health support would go down $21 million and would be zeroed out at the end of 1973. Special educational programs in medicine and dentistry and nursing would be increased. The theory of this part of the health manpower budget is to deemphasize institutional aid and student aid and rely on general financing of students; to emphasize the special capitation institutional awards to schools of medicine and dentistry and osteopathy; and to emphasize special project grants to medical schools and medical centers for the financing of special training programs directed at enlarging means of shortening the curriculum and enlarging the supply and developing special subprofessional disciplines.

Mr. FLOOD. By reducing the number of years, are you talking about reviving the system of combination courses of medicine from 8 to 6 years?

Mr. CARDWELL. That sort of thing. The most significant feature of the health manpower budget is the proposal to back away from, to terminate Federal involvement in both institutional and student assistance for the training of researchers. The theory is that the research budget has begun to stabilize. Otherwise there is a lack of overshooting the manpower pool as we have done in some of the other sciences and as we have done among teachers.

Mr. CONTE. I know you explained it, but I didn't catch it.

Mr. CARDWELL. I am not sure I explained it.

Mr. CONTE. You did. Why do you rap the nurses the way they are rapped there? You knock them down $19 million in institutional assistance and $18 million in student assistance. Then you add up $35 million in special educational programs. Is that for doctors and dentists?

Mr. CARDWELL. Including nurses.

Mr. CONTE. The whole amount?

Mr. CARDWELL. Yes. I think the answer has to be the administration has concluded that the capitation for nurses really isn't going to make any difference in terms of production.

Mr. CONTE. They are going to have to come up with something. There is a tremendous shortage of nurses.

Mr. CARDWELL. But that problem is not going to be solved in that way. Beyond that, I would suggest that you hit the subject when the

National Institutes of Health comes up. It's going to be one of the things that will be debated most.

Mr. FLOOD. One thing you have to understand, and that is, never turn your back on a nurse. You know what I mean. I found that out the hard way.

Mr. CARDWELL. I was struck with the term "post-secondary."

Mr. FLOOD. You will get struck all right. Don't worry about that.

EDUCATION

Mr. CARDWELL. Moving on to education, the next chart, I don't want to center my attention on it, but it summarizes the breakdown of education in the budget in terms of education revenue sharing, and emergency school assistance, library resources, and so forth.

EDUCATION

(BUDGET AUTHORITY IN MILLIONS)

	1972	1973	1974
EDUCATION REVENUE SHARING	$2,496	$2,521	$2,527
EMERGENCY SCHOOL ASSISTANCE	106	271	271
OTHER ELEMENTARY AND SECONDARY EDUCATION	706	461	276
HIGHER EDUCATION	1,430	1,697	1,813
EDUCATIONAL DEVELOPMENT	207	176	123
LIBRARY RESOURCES	176	138	—
NATIONAL INSTITUTE OF EDUCATION	99	119	162
POSTSECONDARY INNOVATION	—	10	15
ADMINISTRATION	80	93	90
TOTAL	5,301	5,485	5,277

Maybe we ought to discuss the emergency school assistance item now because I don't think that shows on a later chart. The budget will continue that program at the same funding level in 1974 as has been proposed for 1973.

Library resources also does not appear on the later charts. We are proposing to phase out at the end of this fiscal year, beginning this fiscal year, Office of Education support for libraries.

NATIONAL INSTITUTE OF EDUCATION

The National Institute of Education shows an increase from $119 million up to $162 million. Funds to implement the postsecondary innovation authority in 1972 education amendments is included in 1973 at $10 million and up another $5 million to a total of $15 million in 1974.

Mrs. GREEN. May I ask a question there, Mr. Chairman?

Mr. FLOOD. Yes.

Mrs. GREEN. You have for NIE, $162 million. How much is now being spent for contracts and grants in research?

Mr. CARDWELL. The $119 million in the 1973 column represents their budget for grants and contracts for 1973.

Mrs. GREEN. The total amount?

Mr. CARDWELL. Except for about $11 million for administrative expenses, yes, Ma'am. The $99 million represents the last year's budget for the comparable activities shifted to NIE.

There is other contractual grant support for project grants and contracts under educational development and to some extent under other elementary and secondary education.

Mrs. GREEN. What else is included under educational development besides contracts and grants?

Mr. CARDWELL. The teacher corps and other EPDA training, as well as project grants.

Mrs. GREEN. Is there an educational development formula?

Mr. CARDWELL. No, all the personnel development and special projects are awarded as project grants or contracts, not by formula. I would just like to add that the research-related and developmental-related activities, innovative activities, have been shifted under the heading NIE and are budgeted at the level of $119 million in 1973 and $162 million in 1974.

GRANTS AND CONTRACTS, 1973 AND 1974

Mrs. GREEN. Would you provide for the record a total summary of all the contracts and grants, all the research from every bureau or agency under OE, and then everyone under HEW?

Mr. CARDWELL. Yes, Ma'am.

[The information follows:]

GRANTS AND CONTRACTS

	1973		1974	
	No. of Projects	Amount	No. of Projects	Amount
Health Services and Mental Health Administration....	7,412	$1,464,376,000	11,227	$1,467,492,000
National Institutes of Health.....	132,859	1,633,668,000	97,644	1,611,935,000
Office of Education.....	14,805	930,576,933	7,687	803,496,000
Social and Rehabilitation Service.....	3,020	212,302,155	2,244	167,682,160
Social Security Administration.....	12	3,153,658	12	3,683,503
Office of Child Development.....	1,725	404,600,000	1,749	432,000,000
Office of the Secretary.....	325	46,426,000	320	47,717,000
TOTAL.....	160,158	$4,695,102,746	120,883	$4,534,005,663

Health Services and Mental Health Administration

Grants and Contracts
(In thousands of dollars)

Appropriation/Activities	1973 No.	1973 Amount	1974 No.	1974 Amount
Mental health				
General mental health:				
Research				
Grants	1,041	$62,737	1,022	$62,737
Training				
Grants	1,786	81,841	1,409	71,876
Community programs:				
Construction				
Grants	36	14,414	---	---
Staffing of centers				
Grants	464	125,100	456	125,100
Mental health of children				
Grants	60	8,600	60	8,448
Drug abuse:				
Research				
Grants	258	17,724	273	18,724
Contracts	---	7,495	---	9,245
Training				
Grants	114	8,944	108	8,944
Contracts	6	3,638	7	6,238
Community programs:				
Project grants and contracts				
Grants	359	158,480	365	159,270
Contracts	---	4,747	---	1,500
Grants to States	---	15,000	---	15,000

Appropriation/Activities	1973 No.	1973 Amount	1974 No.	1974 Amount
Mental health (continued)				
Alcoholism:				
Research				
Grants	101	6,392	98	6,392
Training				
Grants	36	3,546	37	3,763
Community programs:				
Projects				
Grants	469	44,697	469	40,322
Grants to States	---	30,000	---	30,000
Total, Mental health				
Grants	4,724	577,475	4,297	550,576
Contracts	6	15,880	7	16,983
Total, Grants and contracts	4,730	593,355	4,304	567,559
Health services planning and development				
Health services research and development:				
Grants	236	29,086	187	25,697
Contracts	110	16,764	90	25,946
Comprehensive health planning:				
Grants	276	30,850	314	33,750
Contracts	54	2,895	60	3,245
Regional medical programs:				
Grants	56	52,836	---	---
Contracts	20	1,022	---	---
Medical facilities construction:				
Construction grants	---	2,000	---	---
Total, Health services planning and development				
Grants	568	114,772	501	59,447
Contracts	184	20,681	150	29,191
Total, Grants and contracts	752	135,453	651	88,638

Appropriation/Activities	1973 No.	1973 Amount	1974 No.	1974 Amount
Health services delivery				
Comprehensive health services:				
Grants to States	56	90,000	56	90,000
Health services grants	273	181,000	273	211,100
Migrant health grants	114	23,750	114	23,750
Direct operations:				
Contracts	83	7,300	79	7,000
Maternal and child health:				
Grants to States	---	125,678	---	217,951
Project grants	141	89,273	---	---
Research and training				
Grants	105	21,917	105	21,917
Family planning services:				
Grants	550	113,500	400	113,500
Contracts	55	6,115	55	6,115
National health service corps:				
Contracts	17	1,326	9	912
National health service scholarships				
Grants	-0-	-0-	4,700	44,200
Patient care and special health services				
Grants	1	1,200	1	1,200
Total, Health services delivery				
Grants	1,240	646,317	5,649	723,618
Contracts	155	14,741	143	14,027
Total, Grants and contracts	1,395	661,059	5,792	737,645
Preventive health services				
Disease control:				
Infectious diseases:				
Research grants	65	2,215	---	---
Project grants	134	33,000	112	31,000
Direct operations				
Contracts	35	720	20	500
Nutrition and chronic diseases				
Contracts	14	1,004	2	100

Appropriation/Activities	1973 No.	1973 Amount	1974 No.	1974 Amount
Preventive health services (continued)				
Community environmental management:				
Grants	82	21,500	82	19,600
Occupational health:				
Grants	58	2,852	44	2,252
Direct operations				
Contracts	97	5,832	140	8,446
Total, Preventive health services				
Grants	339	59,567	238	52,852
Contracts	146	7,556	162	9,046
Total, Grants and contracts	485	67,123	400	61,898
National health statistics				
Contracts	50	7,386	80	11,752
Total, National health statistics				
Grants	---	---	---	---
Contracts	50	7,386	80	11,752
Total, Grants and contracts	50	7,386	80	11,752
Total, Health Services and Mental Health Administration				
Grants	6,871	1,398,132	10,685	1,386,493
Contracts	541	66,244	542	80,999
Total, Health Services and Mental Health Administration Grants and contracts	7,412	1,464,376	11,227	1,467,492

Research Grants and Contracts
(Dollars in thousands)

Appropriation/Activities	1973 No.	1973 Amount	1974 No.	1974 Amount
Mental health				
General mental health:				
Research				
Grants	1,041	$62,737	1,022	$62,737
Drug abuse:				
Research				
Grants	258	17,7[illegible]	273	18,724
Contracts	---	7,4[illegible]	---	9,245
Alcoholism:				
Research				
Grants	101	6,392	98	6,392
Total, Mental health				
Research grants	1,400	86,853	1,393	87,853
Research contracts	---	7,495	---	9,245
Total, Research grants and contracts	1,400	94,348	1,393	97,098
Health services planning and development:				
Health services research and development:				
Research				
Grants	145	24,529	123	22,688
Contracts	108	16,621	90	25,946
Total, Health services planning and development				
Research grants	145	24,529	123	22,688
Research contracts	108	16,621	90	25,946
Total, Research grants and contracts	253	41,150	213	48,634

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Appropriation/Activities	1973 No.	1973 Amount	1974 No.	1974 Amount
Health services delivery				
Maternal and child health:				
Research				
Grants	68	6,035	68	6,035
Total, Health services delivery				
Research grants	68	6,035	68	6,035
Research contracts	---	---	---	---
Total, Research grants and contracts	68	6,035	68	6,035
Preventive health services				
Disease control:				
Infectious diseases				
Research				
Grants	65	2,215	---	---
Occupational health:				
Research				
Grants	38	1,652	32	1,652
Contracts	97	5,832	140	8,446
Total, Preventive health services				
Research grants	103	3,867	32	1,652
Research contracts	97	5,832	140	8,446
Total, Research grants and contracts	200	9,699	172	10,098
Total, Health Services and Mental Health Administration				
Research grants	1,716	121,284	1,616	118,228
Research contracts	205	29,948	230	43,637
Total, Health Services and Mental Administration grants and contracts	1,921	151,232	1,846	161,865

NATIONAL INSTITUTES OF HEALTH

	1973 Comparable		1974 President's Budget	
	No.	Amount	No.	Amount
Training Programs		$273,596		$211,225
Research training grants	8,918	112,783	6,568	95,402
Research fellowships	2,247	36,677	1,533	30,592
Health Manpower:				
Loans	55,500	57,000	55,250	57,000
Scholarships	36,250	35,000	21,886	21,000
Traineeships	15,020	24,250	.....	.....
Loan repayments	.....	.....	.....	2,000
Family medicine	650	5,000	650	5,000
Teacher training	45	1,000	.....	.....
Fellowships	132	800	1	19
Research training	147	1,086	13	212
Research Grants	9,623	812,415	8,989	826,518
Research Contracts	1,578	243,352	1,684	288,241
Other Grants		291,687		278,395
Medical Library Ass't Grants	229	6,622	168	6,522
Health Manpower:				
Capitation grants	1,290	169,000	183	152,500
Start-up and conversion	2	6,000	2	6,000
Financial distress	18	15,170	15	10,000
Special projects	654	59,475	274	49,000
Construction interest subsidy	.....	2,000	.....	2,000
Education assistance	97	9,980	47	5,873
Formula	18	5,554	.....	.....
Project	5	386	.....	.....
Special improvement	145	5,500	.....	.....
Special education programs-HMEIA	107	12,000	255	46,500
Other Contracts[1/]	184	12,618	126	7,556
Project contracts - NLM	62	4,071	61	3,971
Project contracts - HM	122	8,547	65	3,585

1/ Excludes service contracts

NOTE: Number of training grants indicate FTE of Trainees

OFFICE OF EDUCATION

CONTRACTS AND GRANTS

	1973 Estimate				1974 Estimate			
	Contracts	Amount	Grants	Amount	Contracts	Amount	Grants	Amount
Research.....	30	$ 2,972,000	121	$ 18,064,000	12	$ 2,056,000	107	$ 17,000,000
Training.....	38	8,500,000	5,183	178,510,784	41	10,500,000	2,596	127,918,500
Other.....	430	60,826,381	9,003	661,703,768	437	59,274,049	4,494	586,747,451
Total.....	498	72,298,381	14,307	858,278,552	490	71,830,049	7,197	731,665,951

SRS Project Grants and Contracts

Appropriation/Activity	1973 No. of Projects	1973 Amount	1974 No. of Projects	1974 Amount
Grants to States for Public Assistance	Not Applicable		Not Applicable	
Work Incentives	Not Applicable		Not Applicable	
Social and Rehabilitation Services				
A. Rehabilitation Services				
1. Research	---	---	---	---
2. Training	---	---	---	---
3. Other				
a. Basic State Grants 3/				
Grants	8	861,000	8	861,000
Contracts	8	139,000	8	139,000
b. Service Projects-Basic State Grants				
Grants	362	50,311,000	292	39,800,000
Contracts	344	200,000	344	200,000
B. Developmental Disabilities				
1. Research	---	---	---	---
2. Training	---	---	---	---
3. Other				
a. Developmental Disabilities				
Grants	15	3,858,000	12	2,139,000
Contracts	4	33,000	4	33,000
b. Service Projects-Developmental Disabilities 5/				
Grants	839	18,420,000	607	18,420,000
Contracts	1	80,000	1	80,000
c. UAF				
Grants	35	4,549,000	34	4,250,000
Contracts	---	---	---	---
Subtotal	1,616	78,451,000	1,310	65,922,000
C. Special Programs for the Aging				
1. Research	---	---	---	---
2. Training	---	---	---	---
3. Other				
a. Model project grants	62	15,000,000	62	15,040,000
b. Evaluation contracts	28	2,000,000	28	1,956,000
Subtotal	90	17,000,000	90	16,996,000
D. Youth Development and Delinquency Prevention				
1. Training grants	2	99,919	2	100,000
2. Other grants	74	9,600,561	65	9,711,160
3. Other contract	1	92,675	1	90,000
Subtotal	77	9,793,155	68	9,901,160

SRS Project Grants and Contracts (Cont.)

Appropriation/Activity	1973 No. of Projects	1973 Amount	1974 No. of Projects	1974 Amount
E. Research				
1. Grants				
a. Research and Demonstration	261	28,322,000 1/	235	25,122,000
b. Income maintenance	4	11,000,000	4	11,000,000
c. Special centers	36	12,241,000	20	10,941,000
Subtotal	301	51,563,000	259	47,063,000
F. Training				
1. Grants				
a. Rehabilitation	598	27,700,000	422	17,000,000
b. Community services	126	8,900,000	---	---
c. Aging	122	10,895,000 2/	---	---
Subtotal	846	47,495,000	422	17,000,000
Salaries and Expenses				
A. Grants	---	---	---	---
B. Contracts				
1. Research	---	---	---	---
2. Training	8	396,000	3	800,000
3. Other	82	7,604,000	92	10,000,000
Subtotal	90	8,000,000	95	10,800,000
Research and Training Activities Overseas (SFCP)	Not Applicable		Not Applicable	
Assistance to Refugees in the U.S.	Not Applicable		Not Applicable	
Summary				
Research				
Grants	301	51,563,000	259	47,063,000
Contracts	---	---	---	---
Training				
Grants	848	47,594,919	424	17,100,000
Contracts	8	396,000	3	800,000
Other				
Grants	1,345	102,599,561	1,080	90,221,160
Contracts	468	10,148,675	478	12,498,000
TOTAL	3,020	212,302,155	2,244	167,682,160

1/ Includes $4,500,000 carry over from FY 1972 appropriation
2/ Includes $2,895,000 carry over from FY 1972 appropriation
3/ Program Evaluation
4/ Program Evaluation and Items of National Priority
5/ All Projects are service orientated and only a side benefit of training. The $80 thousand contract is for the Mental Retardation Abstracts.

SSA Grants and Contracts

Activity	1973 No. of Projects	1973 Amount	1974 No. of Projects	1974 Amount
Limitation on Salaries and Expenses, SSA (Research Contracts).....	12	$3,153,658	12	$3,683,503

OFFICE OF CHILD DEVELOPMENT

(in thousands)

	1973 No. of Projects	1973 Amount	1974 No. of Projects	1974 Amount
Research and Development				
Grants:				
Research.....	141	$ 11,588	161	$ 22,188 1/
Training.....	---	---	---	---
Other.....	---	---	---	---
Contracts:				
Research.....	8	$ 912	12	$ 2,012 1/
Training.....	---	---	---	---
Other.....	---	---	---	---
Head Start				
Grants:				
Research.....	---	---	---	---
Training.....	134	$ 15,030	134	$ 15,030
Other.....	1,400	371,695	1,400	387,019
Contracts:				
Research.....	---	---	---	---
Training.....	26	$ 4,120	26	$ 4,120
Other.....	16	1,255	16	1,631
Summary				
Grants.....	1,675	$398,313	1,695	$424,237
Contracts.....	50	6,287	54	7,763

1/ Includes projects previously funded by OEO.

CONTRACT AND GRANT OBLIGATIONS

	1973		1974	
Departmental Management:	No. of Projects	Amount	No. of Projects	Amounts
1. Executive Direction:				
Contracts	14	$ 892,000 5/	--	$ ---
2. Public Affairs:				
Contracts	9	195,000	9	195,000
3. Community and Field Services: 2/				
Contracts	20	400,000	20	400,000
4. Comptroller:				
Contracts	62	550,000	50	400,000
5. Administration and Management:				
Contracts	6	233,000	6	271,000
6. Indian program: 3/				
Grants	105	14,775,000	105	14,775,000
Contracts	7	1,373,000	7	1,373,000
7. Policy Research: 3/				
Contracts 4/	17	19,064,000	17	19,064,000
Total, Departmental Management...	240	37,482,000	214	36,478,000
Civil Rights:				
Contracts	5	510,000	5	510,000
Consolidated Working Fund:				
1. Executive Direction:				
Contracts	72	5,500,000	100	8,000,000
2. Administration and Management:				
Contracts	7	2,829,000	1	2,729,000
3. Public Affairs:				
Contracts	1	105,000	--	---
Total, Consolidated Working Fund	80	8,434,000	101	10,729,000
Total, Office of the Secretary..	325	46,426,000	320	47,717,000

1/ All the FY 1973 and FY 1974 figures are estimates; however, the FY 1974 estimates are especially soft given the amount of time from the end of FY 1974. If no realistic FY 1974 estimates are available, we used the FY 1973 base.

2/ The $400,000 is for small value contracts to be used by the Regional Directors in support of State government planning or evaluation efforts.

3/ The OEO is based on gross preliminary data funished by OEO.

4/ The data furnished by OEO did not permit a breakout of grants and contracts.

5/ Commission on Medical Malpractice.

Mr. CARDWELL. You are going to find it's a lot of money.

Mrs. GREEN. How well I know. Your figures, I do not think, accurately reflect the picture. That is why I asked the question.

Mr. CARDWELL. The way the figures themselves are displayed here do not demonstrate a breakdown by grants versus contracts, formula versus projects, and that sort of thing. You are correct.

EDUCATION REVENUE SHARING

Educational revenue sharing. As you know, the same proposal was presented to Congress by the administration last year. The Congress did not choose to follow the recommendation of the President. He is making a new proposal. A legislative recommendation will be submitted to the Congress, the exact details of which, as of this hour, have not been worked out.

EDUCATION REVENUE SHARING

(BUDGET AUTHORITY IN MILLIONS)

	1972	1973	1974
EDUCATION REVENUE SHARING	$—	$—	$2,527
CATEGORICAL PROGRAMS TO BE FOLDED INTO REVENUE SHARING:			
EDUCATIONALLY DEPRIVED CHILDREN (TITLE I)	1,598	1,585	—
SUPPLEMENTARY SERVICES	146	146	—
IMPACTED AREA AID ("A" CHILDREN)	189	227	—
EDUCATION FOR THE HANDICAPPED	37	37	—
VOCATIONAL EDUCATION	475	475	—
ADULT BASIC EDUCATION	51	51	—
TOTAL	2,496	2,521	2,527*

*$244 MILLION FOR THE SCHOOL LUNCH PROGRAM, CARRIED IN THE AGRICULTURE BUDGET, WILL ALSO BE INCLUDED, BRINGING THE TOTAL TO $2,771 MILLION

The aggregate amount and the overall concept have been decided on, but the issue of whether there should be passthroughs and earmarks and that sort of thing has not yet been decided.

Mr. FLOOD. Of course, the program also is better known as "special revenue sharing," isn't it, as distinguished from "general revenue sharing"?

Mr. CARDWELL. Another way of looking at it is a means of consolidating grants.

Mr. FLOOD. But the phrase has now been special revenue sharing as distinguished from so-called general revenue sharing?

Mr. CARDWELL. Special revenue sharing.

Mr. FLOOD. This is the second generation. Special revenue sharing.

Mr. CARDWELL. Yes; that is the way to put it. There are some 30 individual authorities that would be melded into this one program. This chart attempts to show on a comparable basis the budget for those programs as it stands in 1973 compared to the aggregate proposed for special revenue sharing in 1974.

However, there is one program, impacted area aid for the so-called B children, that is in the 1973 budget, which is not anticipated as being a part of educational revenue sharing and is not in the $2.5 billion figure.

Mr. MICHEL. Why wouldn't you in that footnote include the school milk program along with the school lunch program?

Mr. CARDWELL. Can anybody here answer that question?

Mr. MICHEL. Or is that one they would just as soon eliminate altogether? There was some suggestion like that made.

Mr. CARDWELL. I am not familiar with the decision.

Mr. FLOOD. Be sure you have an answer to the question. The question belongs here.

Mr. CARDWELL. Yes, I will.

[The information follows:]

That portion of the school milk program for which there is also authority in the school lunch program is being phased out in the fiscal year 1974 budget. The remaining funds—approximately $25 million—are associated with schools which do not have a federally supported school lunch program. These funds must be maintained separately from special education revenue sharing since they must be targeted toward a specific set of schools, which could not be done under revenue sharing.

HIGHER EDUCATION

(BUDGET AUTHORITY IN MILLIONS)

	1972	1973	1974
STUDENT ASSISTANCE:			
BASIC OPPORTUNITY GRANTS	$220	$622	$959
WORK-STUDY AND COOPERATIVE EDUCATION	428	261	261
INSURED LOANS, SUBSIDIES, AND DEFAULTS	210	292	368
DIRECT LOANS	317	293	5
SUBTOTAL	1,175	1,468	1,593
SPECIAL PROGRAMS FOR THE DISADVANTAGED	56	70	70
INSTITUTIONAL ASSISTANCE:			
STRENGTHENING DEVELOPING INSTITUTIONS	52	100	100
CONSTRUCTION GRANTS, SUBSIDIES & LOANS	77	19	36
OTHER INSTITUTIONAL SUPPORT	43	20	7
SUBTOTAL	172	139	143
COLLEGE PERSONNEL DEVELOPMENT	27	20	7
TOTAL	1,430	1,697	1,813

HIGHER EDUCATION

Mr. CARDWELL. Higher education. The students assistance item, covering the first four activites, I gather has occupied a good bit of this subcommittee's time in the last several days?

Mr. FLOOD. Yes.

Mr. CARDWELL. I don't want to belabor it any longer. The shift in financing toward the basic opportunity grants and work study and cooperative education away from the old EOG program, as you know, is really proposed to begin in 1973. The 1973 column shown there assumes congressional approval of the budget amendments that you now have under consideration. If that assumption were to be verified by the Congress, there would still be a further increase in 1974 of $125 million going from $1.468 billion in 1973 to $1.593 billion.

Special programs for the disadvantaged—Talent Search, Upward Bound and Special Services—would remain at the 1973 level. Our 1973 proposal to increase the strengthening developing institutions program would be continued in 1974 at $100 million.

Construction interest subsidies for loans will increase $17 million to finance, largely, commitments from prior years.

Other institutional support, consisting of NDEA title 6 university community services and land-grant colleges would be phased out at the end of 1973.

Fellowships under the heading of college personnel development also would be phased out beginning in 1973.

So that in total, because of the large increase in general student assistance under the four items described above, the total would go up $116 million for 1974 over 1973.

If you look at the $1.697 billion in the 1973 column, that compares to $1.212 billion that was in the President's budget as he submitted it to Congress last January. So there was a big step-up beginning this fiscal year.

OTHER EDUCATION PROGRAMS

Other education programs, under elementary and secondary education, are next.

OTHER EDUCATION PROGRAMS

(BUDGET AUTHORITY IN MILLIONS)

ELEMENTARY AND SECONDARY EDUCATION	1972	1973	1974
BILINGUAL EDUCATION	$35	$35	$35
FOLLOW THROUGH	62	58	41
EDUCATION FOR THE HANDICAPPED	72	93	94
VOCATIONAL AND ADULT EDUCATION SPECIAL PROJECTS	31	31	45
IMPACTED AREA AID	423	204	61
OTHER	83	40	–
TOTAL	706	461	276
EDUCATIONAL DEVELOPMENT			
EDUCATION PROFESSIONS DEVELOPMENT:			
TEACHER CORPS	37	37	37
OTHER PROFESSIONAL DEVELOPMENT	107	69	36
SUBTOTAL	144	106	73
EDUCATIONAL BROADCASTING FACILITIES	13	13	10
RIGHT TO READ	2	12	12
DATA SYSTEMS IMPROVEMENT	10	10	15
OTHER PROGRAMS	38	35	13
TOTAL	207	176	123

Bilingual education would be held steady at $35 million. Follow Through would show a decline of $17 million in 1974 as a part of a phase-out proposed for that program.

Education for the handicapped would be held relatively steady with a net increase of $1 million. Vocational and adult special projects would go up $14 million.

IMPACTED AREA AID

But impacted area aid would go down $143 million. This committee knows all so well how many times we have tried to form this program through the appropriation process. I think you will be relieved this year to know that our attempt does not rely on point of order or appropriation language or anything like that. It's very simple. We are proposing that the Congress allow the authority to provide funds to the so-called B children expire. Just by good fortune that legislation is scheduled to automatically expire, unless Congress reactivates it, at the end of this fiscal year. That accounts for the reduction, Montgomery County and Fairfax County, notwithstanding.

Mr. CONTE. You want to bet?

Mr. CARDWELL. No, I wouldn't want to bet. I happen to live in Montgomery County.

Mrs. GREEN. Mr. Chairman, may I offer a suggestion, and I offer it not facetiously, that you substitute the term "impacted aid" for revenue sharing and incorporate all of your plans and goals. There are no strings attached to impacted aid on how they can be spent by local school districts. That is why it has the support of so many. It seems to me the administration could actually accomplish its purpose that way. There could be many kinds of Federal impact besides the one under category A and category B students.

Mr. CARDWELL. I think the problem is that the impacted aid program as it is now conceived is so inequitably distributed among school districts that some of the richest school districts get most of the money and some of the poorest get none at all.

Mrs. GREEN. I do not disagree with that, but I am suggesting changes on distribution formula might be made as we enlarge the definition of "impact aid". In these days the "impact" on a local school district might be based on several factors.

Mr. CARDWELL. You suggest changing the nomenclature?

Mrs. GREEN. Yes. And with some changes, you might achieve something that the administration is after in revenue sharing and everybody in Congress loves impact aid.

Mr. FLOOD. Just wave a wand.

Mr. CARDWELL. You know that sad, sad story.

Moving on to Education Professions Development, the Teacher Corps would be held steady at $37 million. Other activities financed under the Education Development Act would decrease by $33 million from $69 million down to $36 million. Educational broadcasting facilities would show a minus $13 million. Right to read would be held steady at $12 million. Statistics, technical assistance and the gathering of data about education by the Office of Education would go up $5 million.

Dropout prevention, drug abuse and environmental education, and so forth, would take a fairly steep dropoff from $35 million down to $13 million. This reflects a reduction in dropout prevention, drug abuse education, nutrition and health, and elimination of any special fund tabbed with the heading environmental education. Instead we would rely on the basic educational system to pick that up. In fact, we think it has already been picked up and it has been made a part of the curriculums in just about every school in the country.

What we think has happened here is that everybody has clung to this label. Nobody wants to be against or vote for the termination of an unneeded program that happens to have environment in its label. We are trying to highlight that.

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SOCIAL & REHABILITATION SERVICE

(BUDGET AUTHORITY IN MILLIONS)

	1972	1973	1974
PUBLIC ASSISTANCE:			
MAINTENANCE ASSISTANCE	$6,143	$6,488	$5,371
MEDICAL ASSISTANCE (MEDICAID)	4,279	4,728	5,261
SOCIAL SERVICES	1,712	2,655	2,000
TRAINING	35	42	45
CHILD WELFARE	46	46	46
SUBTOTAL	12,215	13,959	12,722
WORK INCENTIVES	259	291	534
SOCIAL AND REHABILITATION SERVICES:			
REHABILITATION SERVICES	618	640	650
DEVELOPMENTAL DISABILITIES	50	44	44
PROGRAMS FOR THE AGING	44	196	196
DELINQUENCY PREVENTION	10	10	10
RESEARCH AND TRAINING	117	102	68
SUBTOTAL	839	992	968
ALLIED SERVICES ACT	—	—	20
ASSISTANCE TO CUBAN REFUGEES	139	145	90
SALARIES AND EXPENSES	46	64	79
TOTAL, SOCIAL & REHABILITATION SERVICE	13,498	15,451	14,413

SOCIAL AND REHABILITATION SERVICE

Social and Rehabilitation Service is the agency of HEW that manages the public assistance program, the medicaid program, programs of the Older Americans Act, rehabilitation basic grant program along with other rehabilitation programs, plus the very controversial social services activities under the Social Security Act.

This, as you know, from your past experience, has been one of the fastest growing parts of the HEW budget, having climbed very steeply in recent years. In total, the SRS budget shows a net decrease. The decrease of $1 billion in public assistance maintenance payments is a result of the transfer of aid to the aged, blind, and disabled to the Social Security Administration in January 1974. This is the new supplemental Security Income program enacted last fall in the 1972 social security amendments. Programs for the aging take a big jump from $44 million in 1972 up to $196 million budgeted for this year and for 1974.

Mr. PATTEN. This is the first instance you mentioned the 1972 appropriation. All afternoon you have been quoting 1973.

Mr. CARDWELL. There is a big jump in that one year.

SOCIAL SERVICES

I guess the one item that I would commend your attention to as you go through your hearings and the exploration of the budget would be the social service portion of Public Assistance. That debate, it seems to me, is far from ended. The basic problem that both the Congress and the administration tried to deal with last year, while now under control, it seems to us could still be improved even further. Moving to the next chart, if everybody is ready, Social Security Administration and the social security trust funds.

SOCIAL SECURITY ADMINISTRATION

(IN MILLIONS)

	1972	1973	1974
FEDERAL FUNDS:			
PAYMENT TO TRUST FUNDS	$2,465	$2,377	$3,110
SPECIAL BENEFITS TO DISABLED COAL MINERS	596	1,527	968
SUPPLEMENTAL SECURITY INCOME	—	77	2,212
TRUST FUNDS:			
OLD-AGE AND SURVIVORS AND DISABILITY INSURANCE (RECEIPTS)	42,459	49,201	57,281
(OUTLAYS)	(39,409)	(48,547)	(54,232)
HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE (RECEIPTS)	8,765	11,505	16,196
(OUTLAYS)	(8,819)	(9,573)	(12,096)
ADMINISTRATION (INCLUDED IN TOTALS ABOVE)	1,150	1,403	1,888

SOCIAL SECURITY ADMINISTRATION

Mr. CARDWELL. There are a number of big increases there. They result from the 20-percent increase approved last session. The creation of the supplementary security income program that was discussed earlier this afternoon when we heard the Social Security Administration, an increase in medicaid. The number of beneficiaries will go up in 1974 from 25.1 million to a total of 26.2 million. In other words, 26.2 million Americans will by the end of 1974 be receiving social security checks under the old age and survivors disability insurance program. The number of persons eligible for medicare will go from 21 million people in 1973 to 23.1 million in 1974.

HEW EMPLOYMENT

Going to the last chart—and I hope not the least interesting—the chart of the end-of-year employment as budgeted for HEW in 1973 and 1974.

Mr. FLOOD. What does the phrase "end of year" mean?

Mr. CARDWELL. These figures report the number of permanent full-time regular employees expected to be on HEW's rolls by operating agencies as of June 30.

END-OF-YEAR EMPLOYMENT

	1972 ACTUAL	1973 ESTIMATE	1974 ESTIMATE
FOOD AND DRUG ADMINISTRATION	5,187	6,681	6,215
HEALTH SERVICES & MENTAL HEALTH ADMINISTRATION	26,034	25,555	16,904
NATIONAL INSTITUTES OF HEALTH	11,456	11,538	10,978
EDUCATION DIVISION	2,826	3,608	3,307
SOCIAL AND REHABILITATION SERVICE	1,999	2,777	3,352
SOCIAL SECURITY ADMINISTRATION	53,633	63,657	69,757
OFFICE OF CHILD DEVELOPMENT	374	413	435
OFFICE OF THE SECRETARY	4,255	5,075	5,724
TOTAL EMPLOYMENT	105,764	119,304	116,672

The budget shows an increase in employment in 1973 and then a decrease in 1974. The increase in 1973, as you can see, is in the Social Security Administration, resulting from the social security amendments of last fall and the operation of the new supplementary security income program that was described to you by SSA earlier this afternoon. The decrease in 1974 is related to the proposal to phase out inpatient care at the Public Health Service hospitals and the proposal to shift St. Elizabeth's Hospital to the District of Columbia, the employment being charged to the District of Columbia thereafter rather than the Federal Government.

Mr. Natcher knows about that one.

Mr. FLOOD. Like an old trial lawyer, I happen to hold in my hand here the chart you presented in connection with your 1973 estimate. Your estimated end of year employment for 1973, you told us last year, was 105,032. Now you show us in the 1974 budget that the 1973 estimate is going to come out at 119,304 and that your 1974 estimate is 116,672. Yet the estimate you gave us last year for 1973 was 105,000.

Mr. CARDWELL. That is right.

Mr. FLOOD. Of course, you gave it to us.

Mr. CARDWELL. That was an estimate based on a budget that did not quite materialize. Let us run through the changes. I think there are several. One is the National Institute of Education that went up.

Mr. FLOOD. But not much.

Mr. CARDWELL. The Social Security Administration took a big jump because of the 1972 amendments, which was not included in the figures we showed you last year.

The Office of Secretary took a slight increase growing out of the creation of the so-called PSRO's and the addition of auditors and lawyers to help administer the H.R. 1 provisions and the 1972 education amendments. In general that is what accounts for the change.

Mr. FLOOD. Are you having any trouble getting lawyers?

Mr. CARDWELL. Yes; we are. We are also having trouble having enough lawyers authorized by the Office of Management and Budget. They are tough on lawyers.

Mr. FLOOD. That is understandable.

Thank you, Mr. Cardwell. You were good as usual. What will happen to your minions when they appear is a horse of a different rolling stone.

Mr. CARDWELL. I must say this committee has always treated us very fairly and objectively and I do not think we will come away with too many scars.

Mr. FLOOD. That is a matter of opinion, depending on what you mean by scars.

The committee will recess until tomorrow at 10 o'clock.

TESTIMONY OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

WEDNESDAY, MARCH 7, 1973.

WITNESSES

HON. CASPAR WEINBERGER, SECRETARY OF HEALTH, EDUCATION, AND WELFARE
FRANK C. CARLUCCI, UNDER SECRETARY
JAMES B. CARDWELL, ASSISTANT SECRETARY, COMPTROLLER
STEPHEN KURZMAN, ASSISTANT SECRETARY, LEGISLATION
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, BUDGET

INTRODUCTION OF WITNESS

Mr. FLOOD. We now have the Department of Health, Education, and Welfare to discuss the 1974 budget proposals. The presentation will be made by Caspar Weinberger, the Secretary of Health, Education, and Welfare.

We should have a biographical sketch of you, Mr. Weinberger.

Secretary WEINBERGER. We will submit it for the record.

[The biographical sketch follows:]

CASPAR W. WEINBERGER

Caspar W. Weinberger became the Nation's 10th Secretary of Health, Education, and Welfare on February 12, 1973. He was nominated for the post by President Nixon on November 28, 1972, and took the oath of office at San Clemente, California, his home State.

Coincident with his nomination as HEW Secretary, Mr. Weinberger was named counsellor to the President for human resources. He is responsible, in this post, for the development and implementation of Federal policy in the human resources area.

Secretary Weinberger has served in the Nixon Administration since January 13, 1970, when he became Chairman of the Federal Trade Commission. After 7 months in this assignment, he moved to the newly created Office of Management and Budget as Deputy Director. He assumed the leadership of OMB on June 12, 1972, serving as Director until he was sworn in as HEW Secretary.

Born in San Francisco August 18, 1917. Secretary Weinberger attended public schools there. He was graduated magna cum laude from Harvard College in 1938 where he was elected to Phi Beta Kappa. He received his bachelor of laws degree from Harvard Law School in 1941.

Shortly after his graduation from law school, Secretary Weinberger entered the Army as an infantry private. He served more than 3 years in the Pacific with the 41st Infantry Division and as a member of General Douglas MacArthur's intelligence staff. He was discharged in 1945 as a captain.

Following his wartime service, the Secretary spent 2 years as law clerk to Federal Judge William E. Orr of the U.S. Court of Appeals for the ninth circuit. He then entered private practice.

In 1952, while in private law practice, he was elected to the Assembly of the California State Legislature from the 21st District in San Francisco. He won reelection without opposition in 1954 and 1956.

During his years in the California Legislature, Secretary Weinberger was chairman of both the Assembly Committee on Government Organization and the Joint Assembly-Senate Subcommittee on Alcoholic Beverage Control. His leadership produced a constitutional amendment reorganizing the State's alcoholic beverage control machinery, and the creation of a unified Department of Water Resources.

Newsmen covering the 1955 legislative session in California named the Secretary as the most able member of the State Legislature.

From 1959 to 1968, Secretary Weinberger pursued simultaneous careers as a lawyer, writer, and television moderator. He was a partner in the San Francisco law firm of Heller, Ehrman, White, and McAuliffe, and wrote a twice-weekly column on California State government carried in many State newspapers. He also reviewed books for the San Francisco Chronicle and San Francisco magazine, and moderated a weekly public affairs television show, "Profile: Bay Area," on KQED–TV, the San Francisco educational television station.

Secretary Weinberger headed the Commission on California State government and organization—known as the State's "Little Hoover Commission"—from 1967 to 1968. On February 1, 1968, he was named State Director of Finance by Governor Ronald Reagan, serving in that post until he left for Washington to chair the Federal Trade Commission.

Secretary Weinberger is married to the former Jane Dalton. They are the parents of two children, a daughter and a son.

BIOGRAPHICAL PROFILE OF FRANK C. CARLUCCI

President Nixon nominated Frank C. Carlucci as Under Secretary of the Department of Health, Education and Welfare in December 1972.

Sworn in a month later, Carlucci began the formidable task of helping Secretary Weinberger run HEW, a sprawling human resources agency with 250 different programs and a projected 1974 budget of nearly $94 billion.

He brings to these responsibilities a depth of high-level experience and notable achievements in the Foreign Service and in top-level Washington assignments.

Just before coming to HEW, Carlucci served for 1½ years in the Office of Management and Budget, first as Associate Director and later as Deputy Director. While serving at OMB in August 1972 he was sent by the President as his personal representative to Wilkes-Barre, Pa., where he coordinated Federal relief efforts for flood-stricken victims of tropical storm Agnes, the largest natural disaster in our country's history.

Prior to his stint at OMB, Carlucci was Director of the Office of Economic Opportunity from January to September 1971.

Before his Washington assignments, Carlucci spent 14 years in the Foreign Service, where he continues to maintain career status.

In his second overseas assignment, Carlucci served as second secretary and political officer at Kinshasa in the Congo. He assumed this post in 1960 when the Congo had won its independence from Belgium, an event which sparked bloody political upheavals. Carlucci's sensitive and courageous handling of explosive situations there won him the Department of State's superior service award in 1962 "for ... his outstanding courage in the face of real danger ... and ... his resourcefulness and effectiveness as a political reporting officer."

From 1964 to 1965, he served as Charge d'Affaires, then Consul General in Zanzibar, a newly-independent and leftward leaning African state in political tumult.

Carlucci's next assignment abroad was in Rio de Janeiro, where he served as counsellor for political affairs. While there, he earned the Department's supeerior honor award for his administrative skill in organizing a more cohesive and effective embassy staff.

Carlucci was born in Scranton, Pa. on October 18, 1930. He was graduated from Princeton University in 1952 and attended the Harvard University Graduate School of Business for 1-year. From 1952 to 1954, he served as an officer in the U.S. Navy and from 1955 to 1956, he was in private business with the Jantzen Company in Portland, Oreg.

He and his wife reside in Washington, D.C. with their two children.

Mr. FLOOD. I see you have your flanks well protected, port and starboard, and so on.

Secretary WEINBERGER. That is the idea.

Mr. FLOOD. Some of these people you will want to present.

Secretary WEINBERGER. First, we have Under Secretary Carlucci.

We have Bruce Cardwell, the Comptroller of the Department, and Steve Kurzman, Assistant Secretary, legislation.

Mr. FLOOD. Mr. Secretary, we have been conducting hearings on the HEW budget here in this room since the memory of man runneth not to the contrary. We are pleased to have you with us wearing your new hat as the Secretary of HEW. You have not appeared on the Hill to testify before any congressional committees within the last half hour or so.

Secretary WEINBERGER. It has been at least one-half hour, Mr. Chairman.

Mr. FLOOD. We realize that you are not new insofar as the budget proposals of the Department of Health, Education, and Welfare are concerned. You had the honor and privilege of acting as Director of OMB for some time. During the course of that, there were a few vetoes of the HEW bill which I gather you knew something about en route. So, you are not necessarily a stranger.

As you know, most of these people are old pros here. This is not a very formal operation in this room, as Cardwell and most of the fellows know. If, upon occasion, you feel you want to call upon any of these backup people, do so without hesitation.

The same thing applies to them. If he is not doing so well, you can reach over and whisper in his ear, or you may stand right up and tell us who you are, give us your name, and your title, and rank, if you want to, and sound off upon any of these questions at any time. We prefer it that way.

The idea is to get information. There are no stuffed shirts around here. Sound right off.

All right, you may proceed.

SECRETARY'S PRESENTATION

Secretary WEINBERGER. I will be speaking to you from the height of my 2 weeks' experience in the Department. So, I will frequently take advantage of the offer you made a moment ago to call on assistants.

Mr. Chairman and members of the committee, I welcome the opportunity to appear before this committee to present an overview of the HEW budget for 1974. Because of the broad perspective of the Appropriations Committee, you are in a better position to make a judgment about the major decisions and tradeoffs in our budget request than any other congressional committee. To help you discharge your responsibilities, I would like to lay out the conceptual framework and the key strategic decisions which went into the making of the HEW budget for 1974.

An important consideration which pervaded all of our budget decisions this year was the need to define more clearly the Federal role in general, and the HEW role in particular. The proliferation of Federal domestic programs in recent years has created a good deal of confusion as to what our proper responsibilities are and what kinds of things are more properly left to individual initiative or action by State and local government. A reassessment of what our job should be is long overdue.

The 1974 budget reflects our attempt to redefine the HEW role. Frankly, I cannot say that this job is finished yet, but I think the budget proposals now before you represent very significant progress toward this goal.

The following are the basic concepts and priorities which define the HEW role as it emerged in the development of the 1974 budget:

The primary Federal role in the area of human resources is to provide income support to people in need in a manner which fosters individual independence and initiative. The Federal Government is uniquely qualified to carry out such programs because of its broad taxing powers and its ability to realize the economies inherent in large-scale operations. The principal HEW programs of this type provide income support for retired workers and the poor generally, health care financing for the poor and elderly, and general aid to college students. About 85 percent of the HEW budget for 1974 falls in this category and the largest increases are for these programs. Of particular significance is federalization of the adult categories of public assistance, the extension of medicare to the disabled, and the full funding of the basic opportunity grants for college students.

Another major Federal role is to help State and local governments function more effectively. A long-range objective of this administration is to decentralize decisionmaking to States and localities as much as possible and consolidate narrow categorical programs into broader and more flexible aid packages. Our principal initiative in this area is special education revenue sharing.

Federal support for research is justified because the relatively high costs and long leadtime for producing results of national significance prevent the private market and State and local governments from investing adequately in these activities. The budget endeavors to strengthen HEW research programs within overall budget constraints. The principal areas of emphasis in the 1974 budget are heart and cancer research and the new educational research efforts of the National Institute of Education.

Preventive health and consumer protection activities also have very significant benefits which can only result from collective action. Traditional public health activities, such as the control of epidemics across State lines, are properly a concern of the Federal Government, though we see a very large role for State and local government as well in this area.

Federal support for developing human services delivery systems is also justified, although this support should be provided under strict limitations. Our general principle is that these kinds of Federal interventions in the functioning of social delivery systems should be clearly time limited and aimed at getting new ideas adopted as a part of regular program operations—fostering innovation rather than providing operating subsidies. All of the Department's special projects and demonstration programs have been examined to identify those programs that can continue operations without Federal support, have outlived their usefulness, or show little sign of producing useful results.

The direct provision of services should be undertaken by the Department only as a last resort. Primary reliance should be placed on private and local government service organizations. These considera-

tions lead us to propose the transfer of St. Elizabeth's Hospital to the District of Columbia and the termination of inpatient care in the PHS hospitals.

The administration's general student aid initiative makes it necessary to reexamine the many specialized manpower support programs throughout the Department. Our general conclusion is that we should phase out Federal support for these specialized activities and rely on the general manpower market. The principal exception to this is assistance for expanding the supply of doctors and dentists since the high cost, long period of training, and difficulties in expanding training opportunities make it unlikely that the market will produce the needed supply of trained manpower without special Federal stimulation.

OVERALL BUDGET TOTALS

The President's budget provides $93.8 billion in outlays for HEW programs in 1974. This is an increase of $10.2 billion over the current estimate for 1973 or an increase of more than 12 percent. Likewise, the HEW share of the total budget also increases to 35 percent in 1974, up from 33 percent in 1973. In 1969, the last year before this administration took office, the HEW share of the total budget stood at 25 percent.

This continuing shift is part of a larger overall budget reallocation from Defense to human resources. In 1969, human resources made up 34 percent of the total budget and national defense accounted for 44 percent. This relationship has been completely reversed. Now human resources spending makes up 47 percent of the budget, while national defense has declined to 30 percent. The comparison in dollar terms is also dramatic. Whereas human resources expenditures have increased from $63 billion in 1969 to $125 billion in 1974, spending on defense stands at virtually the same level as in 1969; $81 billion.

My purpose in citing this array of figures is to offset the impression that we are requesting a bare-bones budget in 1974. While we are proposing a number of significant program realinements and terminations, these budgetary changes, both up and down, are being proposed on their merits and not just to stay within a spending ceiling dictated by a responsible fiscal policy. Our intention is to put HEW on a more appropriate and effective course for the present and the future.

INCOME MAINTENANCE

The cornerstone of the Department's efforts to strengthen individual security and initiative are programs which supply cash assistance to people in need. The 1974 budget would provide nearly $61.5 billion in various kinds of cash payments, an increase of $6 billion over our current estimates for 1973. Over 65 percent of the budget is for this purpose.

By far the largest single component of these programs is cash assistance for the aged through the social security system and supplemental security income—the new name for the federalized program of public assistance for the aged, blind, and disabled. We estimate that $43.4 billion will be spent in the form of monthly benefit checks to the aged in 1974, an increase of $4.9 billion over 1973.

There are two major reasons for the expansion of Federal spending for cash assistance for the aged. First, the last Congress authorized a 20 percent across-the-board increase and other liberalizations in social security benefits; 1974 will be the first year in which these new benefit provisions will be fully effective. Second, the federalization of the adult categories of public assistance will become effective on January 1, 1974. We estimate that the net increase in 1974 Federal spending for this new program will be $1 billion, of which $650 million will be for the aged. This results both from the replacement of Federal funds for State matching payments under the old program and from an expansion of the beneficiary rolls under the new national eligibility criteria. The supplemental security income program will add approximately 2.6 million aged people to the beneficiary rolls.

Estimated HEW cash payments to the disabled and their dependents will reach $7.7 billion in 1974, approximately $1.1 billion more than the current estimate for 1973. This increase is also the result of several factors. The number of beneficiaries is expected to increase by about 700,000, of which about 200,00 results from federalizing the public assistance program for the blind and permanently and totally disabled. Further, people receiving disability insurance payments also benefited from the overall increase in social security benefits enacted last year.

The 1974 estimate of payments to coal miners suffering from black lung and other respiratory disorders is estimated at $945 million for 1974, a decrease of $532 million from the 1973 estimate. This decrease results from the fact that the 1973 amount includes $660 million for paying retroactive claims. The 1974 estimate, however, is primarily for current benefits. Partially offsetting the drop in retroactive claims is an increase of 27,000 in the beneficiary population.

The 1974 budget projects one of the smallest increases in Federal matching payments for aid to families with dependent children in the entire history of the program. We are estimating Federal matching payments of $4 billion in 1974, an increase of $97 million over 1973. This slowdown in the increase in Federal AFDC payments is partially the result of a series of management initiatives begun by the Department in 1972. The primary purpose of these efforts is to reduce overpayments and the number of ineligible people receiving benefits. Our most significant initiative in this area is the quality control regulation published in the "Federal Register" last December. This regulation proposed complete withdrawal of Federal matching for overpayments and ineligible beneficiaries as indicated by the latest quality control survey. This part of the regulation has been vigorously opposed by the States. We are currently evaluating State comments and exploring alternatives to the approach in our draft regulation. We expect to publish final regulations on or before April 1. While I cannot say now what the final regulation will contain, I can assure you that we mean business about reducing overpayments and the number of ineligibles on the AFDC rolls. Moreover, I feel that this can only be achieved if there is some significant financial penalty to States which fail to do something effective about these problems. Good intentions are not enough. By the same token, we should not discourage States from finding and reporting errors.

In addition to regulatory changes, the Department is working on legislative proposals to simplify the AFDC program and State management requirements. This balanced approach, relying on Federal action to reduce program complexities and State action to develop improved administrative procedures, should lead to significant reductions in the errors which are damaging the integrity of this program in the eyes of the public.

HEALTH PROGRAMS

HEW's spending for health programs has been increasing rapidly in recent years. Total spending for HEW health programs reaches $22.3 billion in the 1974 budget, $3.9 billion more than our current estimate for 1973 and nearly double the amount spent in 1969. The principal factor in this increase has, of course, been rising health benefit payments through medicare and medicaid. However, many other aspects of the Department's health programs have also been increased significantly. Biomedical research, health manpower training, mental health programs, and food and drug safety are the principal areas of expansion since 1969.

Estimated outlays for medicare and medicaid will reach $17.4 billion in 1974, an increase of $3.1 billion over our current estimate for 1973. This increase is the result of several factors. First, the total number of people eligible to receive medicare benefits will expand by 2.1 million people in 1974, principally as a result of the fact that long term social security and railroad disability beneficiaries become eligible for medicare in July 1973. The medicaid population served will expand by 3.7 million people, one significant factor being the addition of 1.6 million aged, blind, and disabled to the rolls because of the federalization of the adult public assistance categories.

The continuing escalation of medical costs is also a factor in the health financing estimates, even though the rate of increase in medical prices is much lower than it was 2 years ago. The very high cost of medical care points up the need for continued efforts to control utilization so that unnecessary services are not provided. Work has begun to set up the network of Professional Standards Review Organizations required by last year's social security amendments. The budget includes $33 million to finance the PSRO effort in 1974. We are also developing a more vigorous approach to utilization review, which includes a plan to require preadmission certification for elective hospitalization and surgery. State programs which have experimented with this—notably Medi-Cal in California—suggest that substantial reductions in unnecessary utilization may be achieved by this method.

As I mentioned earlier, a national health insurance proposal will again be submitted to this session of Congress. In addition, we believe it is essential to modify our current health financing programs. We will be submitting legislative proposals to revise medicare cost sharing and eliminate Federal matching for adult dental services under medicaid.

As you know, there has been cost sharing in medicare since its inception. Looking critically at how it operates in the hospital insurance portion of the program, we believe that present cost sharing does the wrong things at the wrong time. Except for a first day deductible equal

to the national average cost of 1 day's hospitalization, medicare requires no cost sharing during the first 60 days of hospital stay—when overutilization of services is most likely to occur. High levels of cost sharing are imposed at the end of a long hospital stay, when the beneficiary is least able to afford it. Moreover, the amount the beneficiary now pays bears no relationship to actual costs incurred and services used.

We are proposing that the law be revised to require a uniform 10 percent rate of cost sharing after the first day, based on the charges for actual services used. By requiring cost sharing from the very beginning of a hospital stay, consumer awareness should play a more active role in efforts to control health care costs.

The proposal to terminate Federal matching for adult dental services under medicaid is an effort to target Federal resources on the highest priority needs. In this instance, we believe that the dental needs of children are clearly more critical than those of adults. The early childhood screening regulations place a high priority on the identification and correction of dental problems, especially those which have potentially long term effects. This proposal would not affect the Federal matching for emergency dental services to adults.

The budget for the biomedical research activities of the National Institutes of Health will reach $1,532 million in 1974, an increase of $49 million over our current estimate for 1973. The major priorities in the 1974 research budget will be cancer and heart disease research. The amount for the cancer research will reach $500 million, 34 percent higher than it was in 1972.

The full range of cancer research activities have been expanded, including causation, detection, and diagnosis, as well as prevention and improved methods of treating cancer. The expanded heart disease research will concentrate on arteriosclerosis—the major cause of heart attacks—and on hypertension. Significant emphasis will also be placed on blood diseases and diseases of the lung.

There are reductions in other areas of NIH activity but they result primarily from our decisions to curtail general research support grants and phase out the specialized program to train researchers. The general research support grant program provides untargeted research funds to institutions to strengthen their biomedical research capacity. In our view, direct research activities have a higher priority.

I will discuss our decision to phase out special support for research training in the context of the health manpower budget.

The 1974 budget continues the Department's efforts to help State and local health departments control venereal diseases, particularly gonorrhea. The 1974 program will provide screening for approximately 4 million women and should prevent the occurrence of approximately 100,000 cases of gonorrhea. The budget will also continue the effort to control lead-based paint poisoning and rat infestations.

We believe that there is an appropriate Federal role in preventive health and are attempting to focus Federal resources on the most productive areas. The few reductions proposed in the budget result from either completion of a planned activity—such as the rubella vaccination program which we believe has headed off the predicted epidemic of this disease—or a decision concerning an activity with limited na-

tional significance—such as the highly specialized environmental health research conducted at the Arctic Health Research Center.

The budget makes a substantial departure from past practices of stimulating change in the health service delivery system through various kinds of categorical grant programs. We intend to reform this area of Federal activity so that it is more sharply focused and involves only limited Federal intervention and commitment. We are proposing to terminate several ongoing programs—principally, community mental health centers, Hill-Burton hospital construction, and regional medical programs—redirect others—such as comprehensive health planning and services, and maternal and child health—and have again submitted legislation to stimulate the development of health maintenance organizations.

The HMO legislation illustrates our conception of the proper Federal role in attempting to change the health services delivery system. The proposal provides time-limited Federal assistance to overcome the initial problems of getting an HMO started. Grant funds are provided only for planning and market surveys and special startup costs for HMO's wishing to operate in medically underserved areas. Potential recipients of this aid must clearly understand at the outset, however, that the HMO concept must ultimately prove itself to be viable by operating on its own in the marketplace. If an HMO discovers it cannot compete successfully, we believe it should not be perpetuated through Federal grants.

We are not proposing extension of the community mental health center legislation which expires on June 30, 1973, because we believe this program has proven itself and should now be absorbed by the regular health service delivery system. To date, 515 community mental health centers across the Nation have been aided. The 1974 budget requests adequate budget authority—in excess of $600 million—to honor all commitments which have been made to these centers. We will not, however, make any new commitments. We believe that the current program supports enough community mental health centers for a sufficient time to demonstrate adequately the value of community-based delivery of mental health care. These centers should now face the test of operating on their own without special Federal assistance.

We are also proposing that the Hill-Burton hospital construction program not be extended beyond its expiration date of June 30, 1973. Since this program was first begun 26 years ago, two things have happened which make it unnecessary to continue a special Federal hospital construction program.

First, the country now has a generally adequate supply of hospital beds. In fact, in some parts of the country, a definite surplus now exists. Second, the rise of health financing systems, such as private and public health insurance plans, has made a fundamental change in the way that hospitals do, or should do, their business. Nearly all types of health insurance, including medicare and medicaid, Blue Cross-Blue Shield, and other private plans, recognize depreciation as a valid component in the reimbursement of hospital and medical facilities. This should permit hospitals and medical facilities to either set aside funds for facility improvements or pay back loans for con-

struction over the useful life of the facility. We have estimated that approximately $800 million in depreciation payments will be paid through medicare and medicaid in 1974 and that private insurance will provide over a billion dollars for depreciation. Thus, a special Federal grant program for hospital construction is now unwarranted.

We are proposing the termination of the regional medical program because we believe that it has not achieved its promise in the 7 years since it was enacted, and shows no reasonable chance of doing so in the future. From the outset, the RMP has had great difficulty in defining a clear role for itself.

Originally conceived as covering a limited number of major regions in the United States, a total of 56 regions have been funded, of which 45 are coterminous with or contained within State boundaries. This fact alone brings the program into direct conflict with State-based health planning and service programs, such as comprehensive health planning.

There is no significant evidence that the RMP's have achieved their goal of getting research advances rapidly into regular medical practice. The training programs undertaken are typically of limited scope and duration, and there is no substantial evidence that they have had an effect on actual medical practice. Further, we believe that continuing education for physicians should be paid for by physicians and not by the Federal Government.

A major RMP activity has been the funding of demonstration projects, but many other HEW programs, and many different Federal, State, and local agencies fund similar demonstration projects, thus adding to proliferation of separate projects. In sum, it has become increasingly apparent that RMP's have not succeeded in developing the efficient regional health systems which was their original goal.

The budget is based on extension of all but the graduate training authority in section 314 of the Public Health Service Act. We believe the comprehensive health planning agencies, both State and areawide, must become increasingly effective in the development of health systems which are oriented to their own needs. The budget request for supporting the planning agencies in 1974 is $38 million. This is $3 million more than in 1973 and $12 million more than in 1972 and is in keeping with our efforts to confer more responsibility on these organizations.

Let me emphasize that this increased funding does not reflect complete satisfaction with the performance of comprehensive health planning agencies. Nevertheless, we believe that a properly constituted health planning effort can help to improve the efficiency of the health service delivery system.

The budget maintains funding for neighborhood health centers at current levels, including those centers now supported by the Office of Economic Opportunity. We believe, however, that these centers should acquire a greater proportion of their income through private and public health financing programs. To this end, we will propose an amendment to the Social Security Act to require all State medicaid plans to include reimbursement for free-standing clinics providing

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covered services to medicaid beneficiaries. This should substantially improve the neighorhood health centers bargaining position in dealing with State and local welfare departments.

The funding for maternal and child health programs will remain at the current level of $244 million and, in accord with existing law, the funds for project grants will be made a part of the formula grants, beginning in 1974.

Although the budget simply maintains current levels of funding in the family planning project grant program, including projects formerly supported by the Office of Economic Opportunity, we do expect a substantial expansion in services actually delivered. The social security amendements enacted last year increased the Federal matching rate for family planning services under medicaid and social services to 90 percent and also provided a penalty for any State which failed to establish a family planning program under these authorities.

We believe that this new stimulus will facilitate continued progress toward achieving the President's goal of providing family planning services to all women who want but cannot afford them.

The special efforts under the general leadership of the Special Action Office on Drug Abuse Prevention will be continued and expanded in 1974. Evidence so far available indicates that this effort is having a significant impact on drug addiction. Preliminary indications are that up to 50 percent of drug addicts will volunteer for treatment if adequate services are available, including detoxification, methadone maintenance, rehabilitation, and aftercare services.

Because of the rapid buildup during the last couple of years, the Department's alcoholism program now funds 469 projects in communities across the Nation. These will be maintained in 1974. These projects have gone a long way toward creating the kind of national awareness needed to overcome the problem of alcoholism. They have created a substantial new capacity, but the real test will occur at the local level. We are hopeful that the results of the federally funded projects will be incorporated both in community-initiated efforts and in projects begun with Federal formula grants to the States.

DIRECT MEDICAL CARE

The budget has been prepared on the assumption that our current negotiations with the District of Columbia with regard to St. Elizabeth's Hospital will be successful and that the facility will be transferred to District of Columbia control before the beginning of fiscal year 1974. Given the progress in these negotiations up to this point, I believe that this is a reasonable assumption. The vast majority of patients served by this facility are residents of the District. The national interest which caused the hospital to be established as a Federal facility has all but disappeared. Part of our agreement will be to continue a transitional subsidy until the District Government can integrate the hospital with its other health facilities and absorb the full cost of the hospital in the District of Columbia budget.

As you know, our long-term goal for the PHS hospital system is to turn the hospitals over to community management and use. We believe that the statutory beneficiaries will be better served if care is

provided on a contractual basis with local community hospitals. In advance of working out an agreement for the transfer of the facilities, we are developing a plan for terminating inpatient care by the end of this fiscal year. Again, our main concern is to foster more efficient use of community facilities. In any case, in carrying out these plans, we intend to adhere to the provisions of the Emergency Health Personnel Act, which specify the steps for notifying Congress prior to making these changes in the PHS hospital system.

HEALTH MANPOWER AND SPECIALIZED TRAINING PROGRAMS

In the light of our general student aid initiative—discussed later in the education section of my statement—we have reassessed the need for specialized academic health training programs. This assessment leads us to recommend that the research training program of the National Institutes of Health and the special training programs of the Health Services and Mental Health Administration be phased out. Continuation support for students already enrolled in approved training programs will be provided but no grants will be made to new students. Our broad student assistance programs together with the salary scales in these professions and individual student motivation should produce an adequate supply of this kind of trained manpower.

The budget does retain some special Federal support for the health professions, particularly physicians and dentists. The very high cost of this training and the difficulties attendant upon getting training facilities to expand their capacity justify special Federal intervention, at least until the manpower shortage is overcome.

The 1974 budget continues the current rate of capitation support for schools of medicine, osteopathy, and dentistry. This financial assistance will grow along with the actual increases in enrollment which the Federal program has engendered. We are, however, recommending the termination of capitation payments for schools of nursing, veterinary medicine, optometry, pharmacy, and podiatry. The special programs for allied health and public health would be discontinued when these authorities expire on June 30. In all of these cases, we see the Federal role as limited to special demonstration projects targeted in selected priority areas. The 1974 budget proposes a $35 million increase for this purpose.

We are also recommending changes in the student aid programs for the health professions. Legislation will be submitted requesting an increase in the authorization for National Health Service scholarships. Over the long run, we intend to use this authority as our sole vehicle for providing scholarship assistance to students of the health professions and nursing because the mandatory service provisions will help overcome the maldistribution of health manpower, as well as aid in recruiting staff for the Public Health Service.

EDUCATION

The major initiatives in the education budget are our proposals to fully fund the basic opportunity grant program authorized by the Education Amendments of 1972 and to establish special revenue shar-

ing in elementary and secondary education. These two initiatives are a significant part of our effort to move power and decisionmaking away from the Federal Government in Washington. The student aid program will strengthen individual choice and initiative and special revenue sharing will give State and local government greater flexibility and responsibility in carrying out education programs of national significance.

The 1974 budget contains $959 million for basic opportunity grants. This will provide full funding for this program based on our current estimate of what families should be expected to contribute toward the college education of their children. This constitutes, therefore, the fulfillment of the President's promise to remove financial problems as a barrier to higher education. We estimate that about 1.5 million students will receive a grant from this program.

The basic opportunity grants are focused on families with the greatest financial need. Nevertheless, they are designed to cover only part of the cost of education. The maximum assistance is $1,400 or 50 percent of the annual cost of a college education, whichever is lower. Thus, all students will be required to utilize family savings, to work, or to borrow money to get through school. We believe that this is appropriate since higher education is an investment in the future and increases earning potential.

To insure that all qualified students will be able to earn or borrow the resources needed to fill the gap between the basic opportunity grant and family contribution, on the one hand, and the full cost of education on the other, the budget includes funds for guaranteed student loans and college work study. We estimate that 1,673,000 students will get guaranteed student loans, many of whom will also be receiving a basic opportunity grant. The budget also includes funds to employ 545,000 students in college work study programs. While we are not requesting new capital contributions to the NDEA direct loan program administered by colleges and universities, repayments from prior loans will enable universities to make loans to 259,000 students. All told, over 4 million grants, loans, and work study opportunities will be made available through the fiscal year 1974 budget for higher education. These Federal programs will, of course, be supplemented by State and institutional scholarship and loan programs.

The administration will again submit legislation to authorize a program of special revenue sharing in elementary and secondary education. The President's budget includes $2.8 billion to fund this legislation when it is enacted.

The purpose of the legislation is to consolidate and simplify Federal aid to elementary and secondary education so that State and local officials have greater flexibility and responsibility for programming the funds. Nearly 30 existing formula grant authorities would be merged into special revenue sharing.

While the final specifications of the legislation have not yet been determined, the basic structure of the bill will probably be modeled on the administration's special revenue sharing proposal submitted to the previous Congress. The total for special revenue sharing will be distributed among a limited number of earmarks, but State and local officials will have some flexibility to make transfers among these pro-

gram areas. It is likely that earmarks will be included for the disadvantaged, the handicapped, and vocational education to insure that minimum spending in these areas is maintained. The legislation will, however, place fewer impediments in the way of State and local authorities for carrying out such programs. We believe that this kind of an approach will strengthen State and local initiative and, at the same time, facilitate the attainment of national goals.

In 1974 we are again attempting to cut back impacted area aid. Our approach is twofold and does not require this committee to include any special language in the Appropriation Act. The budget would fully fund entitlements for children whose parents both live and work on Federal property, the so-called "A" children. This is proposed, however, as part of special education revenue sharing and, therefore, we are not asking you to appropriate these funds until this legislation has been enacted. No funds are being requested for children whose parents work but do not live on Federal property, the so-called "B" children. The authorization for "B" entitlements expires at the end of fiscal year 1973 and we are strongly recommending that Congress take no action to extend it. This appears to us to be the most direct approach to remove the inequities in the impacted area aid law.

The 1974 budget provides the second year of funding under the Emergency School Aid Act passed by Congress last summer. The purpose of the program is to help school districts overcome the problems of desegregating while maintaining educational quality. Most of the funds are distributed to the States on the basis of the number of minority group children. We are requesting $271 million for this purpose, the same as the 1973 appropriation.

Our experience with the earlier, much more limited, emergency school aid program indicated that these extra funds can really help to make desegregation less disruptive. We are hopeful that the new program will help the many school districts under actual or potential court orders to develop successful solutions to their desegregation problems.

The role of the Department's education programs, apart from the job in insuring that students have genuine higher education opportunities and providing broad assistance to elementary and secondary education, has become very muddled over the years. Many specialized education assistance programs, narrowly targeted on individual educational problems, have been created, but in a very uncoordinated fashion. We are currently engaged in a process of trying to design a consistent role for the Education Division as a catalyst for change in the education system.

The Education Amendments of 1972 took significant steps to clarify the situation. The National Institute of Education was established and given the charge of bringing new quality and relevance to the effort to discover new methods of teaching and learning. The Institute has now started its operations and many programs formerly administered by the Office of Education have been transferred to it. The budget for 1974 will provide $162 million for the Institute of which approximately $25 million will be available for new research and development projects.

Last year's education amendments also authorized the fund for the improvement of postsecondary education. Although this program is still in the planning stages, it shows great promise for increasing the effectiveness and diversity of postsecondary education. We are requesting an appropriation of $15 million for the fund in 1974, $5 million more than was appropriated for 1973.

The budget request for Office of Education programs which fall into the area of innovation and capacity building reflects the results of a program-by-program assessment to determine which activities are useful and which have either fulfilled their objectives or proved to be basically unproductive. Many programs are recommended for phase-out or outright elimination. Those that remain must clearly demonstrate both effectiveness and relevance to national policy goals.

Our review of education project grant programs indicates that many of these efforts are producing useful results or hold out a reasonable promise of success. These efforts have been maintained and, in some instances, expanded in the 1974 budget.

Typical of these efforts is the program to upgrade the so-called developing institutions, primarily small colleges serving a significant number of minority students. The 1973 budget contained an increase of $48 million to fund a special effort to aid a selected number of these institutions become fully developed and self-sufficient. We are maintaining this initiative in the 1974 budget. Our objective is to get these institutions on their feet as quickly as possible. We are not proposing any kind of long-term Federal subsidy.

We are also requesting $14 million in new funds to test career education techniques and models designed through earlier research efforts of the Office of Education. The models are alternative ways of introducing the dimension of career education at various stages in the educational process. Our objective is to demonstrate effective ways of doing this in all aspects of elementary, secondary, and higher education, not merely in those programs labeled vocational education. It is not, however, our intention to enter into any long-term operational commitment in career education. Rather, we will encourage school districts, colleges, and universities to incorporate validated approaches into their ongoing operations.

We are also planning to maintain the right-to-read and bilingual education programs. The $12 million requested for right-to-read is meant to be used as leverage to influence the use of much larger sums available for reading instruction in other education programs, State and local, as well as Federal. It is only by making these efforts more productive that we can hope to achieve our goal of virtually eliminating illiteracy by 1980. The bilingual education effort has been successful in showing how non-English speaking students can be integrated into regular classrooms without compromising their own ethnic heritage. Such programs have proven beneficial to both non-English speaking and English speaking students.

As I mentioned earlier, a number of educational development programs are being recommended for termination or reduction in 1974 because they have either accomplished what they originally set out to do or show little promise of producing useful results. The follow-through program was begun as an experiment to test various methods

of compensatory education to consolidate the gains which disadvantaged children acquired in Head Start projects. The period of follow-through is defined as kindergarten through third grade. With the funding available through 1973, we have been able to support five groups of follow-through classes. We do not intend to start a new one in 1974. The projects already begun will provide enough data to determine which of the tested approaches to compensatory education have a high probability of success. Evaluations of these experiments will be disseminated to all school districts serving disadvantaged children.

Federal funding for foreign language training and area studies is being withdrawn because in the 15 years of this program's existence, a sinificant capacity for teaching non-Western language and culture has been established in the Nation's colleges and universities. This program has supported more than 100 foreign area study centers and has trained more than 5,000 specialists in non-Western studies. These programs have developed to the point where Federal funding represents less than 10 percent of their annual budgets. It is our opinion that these efforts are now strong enough to make it on their own.

We are recommending the termination of the university community services, environmental education, and nutrition and health projects because they have produced little in the way of useful results to date, and show no sign of doing a better job in the future. I believe that they are not so much mismanaged as faulty in concept. The university community services program from its inception has never had a clear definition of its goals and objectives. It spreads an amount of money thinly over many colleges for the vague purpose of getting the schools more involved with the communities around them. This has led to many meetings and discussion groups but has produced little in the way of improved universities or communities. Similarly environmental education and nutrition and health have resulted in scattered efforts which, while they may have been worthwhile in themselves—such as encouraging high school students to set up a recycling center—have had no lasting effect on school curriculum or educational practice.

SOCIAL SERVICES

The Department's social services programs—including vocational rehabilitation and special programs for the aging—stimulate the provision of services to disadvantaged groups, such as the poor, the aged, and the disabled. They supplement HEW income support programs by providing services which either prevent welfare dependency or help people to leave the welfare rolls. The services for the aged are designed to prevent institutionalization and restore links with active community life. Spending on all HEW social service programs is estimated at slightly over $4 billion in 1974.

The most controversial program in HEW during the last year has been the program of social service for current, former, and potential public assistance recipients authorized by title IV–A and XVI of the Social Security Act. While this program required Federal matching payments of less than $400 million only 4 years ago, 1972

payments reached $1.7 billion and, shortly before Congress enacted a $2.5 billion limitation on Federal matching for this program, it looked as if it could hit $6 billion in 1973. This spurt in Federal outlays resulted primarily from the States' ability to use the vague definitions in law and HEW regulations to reclassify many ongoing State activities as part of their social service plans, thereby claiming Federal matching payments which replaced State funds formerly spent on these programs. Undoubtedly, there has been some genuine expansion of services to the poor, but we believe that a very high percentage of the recent increases in social service matching payments has simply gone to refinance prior State funded activities.

In both 1971 and 1972, the Department sought to limit increases for social service matching payments through general provisions in the HEW Appropriation Act. These efforts were, unfortunately, unsuccessful. Congress, however, did finally take action by including a $2.5 billion limitation on Federal matching for social services as a part of the general revenue sharing bill enacted last summer.

We have followed up on this congressional action by thoroughly revising the implementing regulations. These were published in the Federal Register on February 16.

The purpose of these regulations is to specify clearly the eligible services and target groups for which Federal matching will be available and to close off the loopholes which permitted the massive refinancing of State funded activities. The regulations seek to reduce overlap between this program and other forms of assistance to the poor. Thus, social service matching payments should not be used for subsistance, medical or mental health care, rehabilitation services, or for education programs normally provided through the regular school system. The list of mandatory services is confined to those explicitly mentioned in the Social Security Act, allowing greater State flexibility not to provide services that they judge to be inappropriate or unproductive. The time period during which a former public assistance recipient is eligible for services is defined as 3 months; potential recipients are defined as people who could be on the public assistance rolls within 6 months if services are not provided.

The budget estimate for Federal matching payments for social services is based on State estimates which we received last November. This was after the limitation was enacted but, of course, well before our regulations were published. At this time, the States estimated that they would claim $2,164 million of the authorization for Federal matching payments. When we were putting the finishing touches on the HEW budget last December, we made a preliminary estimate that our final regulations would reduce Federal matching at least $164 million below the State estimates. Thus, the appropriation request now pending before your committee is for $2 billion.

As a further effort to reduce dependency on welfare, the budget is proposing a $243 million increase over our current 1973 estimate for work incentives. This program provides training, child care if necessary, counseling, and job placement services to adults and teenagers on public assistance. By the end of 1974, 156,000 people are expected to be in training, an increase of 18 percent over the current target for the

end of 1973. In addition, the Labor Department expects to have placed 165,000 WIN trainees in jobs by the end of 1974, a 10-percent increase over the 1973 target.

The 1974 budget continues the President's commitment to provide more than $200 million for carrying out the Older Americans Act. This includes $100 million for nutrition services, providing such things as communal and home-delivered meals and nutritional education. The budget also includes $68 million for community planning and service-delivery programs. The purpose of these activities is to reduce the isolation and unnecessary institutionalization of older people throughout the Nation so that they can live meaningful and dignified lives in their own homes.

The 1974 budget request for Head Start would permit this program to operate at current levels, that is, services would be provided to 379,000 children on a regular basis, either for the full year or in summer programs. Of these, 24,000 will participate in experimental projects which include variations of Head Start which the Office of Child Development calls Health Start and Home Start. These activities focus on preschool health problems and developing techniques that could achieve Head Start objectives in the home as well as in formally organized projects. The Department is in the process of implementing the recent legislative requirement that handicapped children make up 10 percent of Head Start enrollment. The program will meet this requirement by the end of 1974.

The program of grants to States for vocational rehabilitation has a proven record of accomplishment enabling physically and mentally handicapped people to lead self-sufficient and productive lives. With the funds requested for 1974, it is estimated that 350,000 people will be rehabilitated, an increase of 10,000 over our current estimate for 1973. We plan to continue the priority of providing rehabilitation services to people on the welfare rolls who could profit from these services. In 1974, it is estimated that 70,000 public assistance recipients will be rehabilitated, an increase of 7,700 over our estimate for 1973. Thus, 77 percent of the increase in rehabilitations planned for 1974 will be for people on public assistance.

In addition, the new supplemental security income program includes special funding for rehabilitating the blind and disabled eligible for this program. The 1974 SSI request includes $39 million for payments to State agencies for this purpose. This will support 142,000 referrals for rehabilitation services.

The budget also continues the program of services to the developmentally disabled, primarily children suffering from mental retardation and other congenital handicaps. This is a relatively new program and the States have had some difficulty in setting it up. We expect, however, that by 1974 all States will be operating programs and that 80,000 people suffering from developmental disabilities will be served.

We plan to resubmit the Department's allied services legislative proposal to this Congress. Currently, the recipient of public services in the area of human resources is confronted by a maze of conflicting jurisdictions and agencies with overlapping responsibilities and requirements. He is often unable to obtain the full range of health and

social services which he needs in order to solve his family problems. Some of these constraints are the result of local actions, others are imposed by the State, and many result from the categorical restrictions inherent in many Federal assistance programs. The proposed legislation would enable States and localities to coordinate and consolidate the planning and provision of human services. The kind of improvements in organization and delivery that need to be made include common intake and eligibility determination, comprehensive information systems, joint planning and budgeting at the State and local level, and personal attention and accountability to the individual to insure that he can find his way through the various systems. The goal of human service programs is to reduce dependency and remove the conditions that foster it. We believe that the Allied Services Act would enable States and localities to achieve this goal at lower cost than would be the case under current categorical rigidities.

SRS is currently engaged in a process of terminating research activities which are marginal, unproductive, or which overlap other projects. The funds that remain will be targeted on projects which are more relevant to the development of policy and the effort to improve the efficiency of social service delivery systems.

The 1974 budget proposes to phase out all special training programs for social workers, vocational rehabilitation workers, specialists in aging, and other social service disciplines. Here again, our view is that the manpower market, stimulated by the general student assistance programs of the Office of Education, will produce an adequate supply of trained manpower to carry out social services programs.

The desire to decentralize decisionmaking has been characteristic of this administration from its very beginning. Significant progress in strengthening the Department's regional offices has been made in the last couple of years. We would like to give this whole effort greater impetus by revising the reporting arrangements for the regional directors. Rather than having the regional directors report through an Assistant Secretary, we are planning to have them report directly to the Under Secretary. This should insure that the regional directors participate more fully in top-level policy decisions at HEW. We are also hopeful that this change in organization will smooth the way for delegating greater programatic decisionmaking authority to the regional directors. This has evolved steadily over the last several years, but I would like to see the Department move faster in this direction.

Full-time permanent employment for HEW is estimated at 116,700 at the end of fiscal year 1974. This is about 2,600 less than our current estimate for 1973 but around 11,000 more than were on duty at the end of 1972. The principal factor tending to increase HEW employment is the federalization of the adult categories of public assistance. This new administrative job has been estimated to add 15,000 employees to the Social Security Administration by the end of 1974. When the job of conversion is finally completed, it has been estimated that the net increase in SSA employment could reach 18,000. However, even if this estimate is right, the job of administering the supplemental security income program will require only half as many Federal employees as it now takes the States to do the same job. But I

still aim to find ways to do the total job with fewer than 18,000 employees. My hope is that we can, over time, reduce substantially the new Federal employment that would otherwise result from federalization of these activities.

The major factors tending to decrease HEW employment are:

Transfer of Saint Elizabeths Hospital, with a staff of about 4,000, to the District of Columbia.

Discontinuation of inpatient care in the Public Health Service hospitals, permitting a reduction in employment of over 3,000.

Program reductions and eliminations in education and health which would reduce employment by about 2,400.

Overall, the Department's staffing proposals are designed to carry out the President's objective of employing only the minimum necessary to discharge legitimate Federal responsibilities.

This completes my prepared statement. My colleagues and I would be happy to answer any questions you may have.

Mr. FLOOD. Yes, indeed.

$31 billion in 50 minutes. I couldn't have done better myself.

You are the former Director of the Office of Management and Budget. Then during the passage of time you acquired a new hat. I do not know what the title is of your special relationship to the President. Is it Director or Special Assistant for Human Resources?

Secretary WEINBERGER. Counselor to the President for Human Resources.

Mr. FLOOD. Counselor to the President for Human Resources, as well as Secretary of Health, Education, and Welfare, et cetera?

Secretary WEINBERGER. No. I think that completes it, Mr. Chairman.

CONGRESSIONAL RESPONSIBILITY

Mr. FLOOD. We as Members of Congress are receiving mountains of mail from people who are telling us how terrible these budget proposals are. We are confronted every day with what is supposed to be the "battle of the budget" between the administration and the Congress. For the reasons I have just stated, you are very much in the middle.

Do you admit the remote possibility that you—I do not mean you personally, of course—that you conceivably may have made a few mistakes in putting this budget together? In other words, I am sure you do not suggest this is a sacred document, inviolate, the Ten Commandments, and cannot be amended, and so on. You do not propose anything like that.

Secretary WEINBERGER. There is always the possibility of human error in an undertaking that large.

Mr. FLOOD. This subcommittee, as you know or at least have heard, has been reviewing the HEW budget for many years. All the members of this subcommittee also serve on other subcommittees under our system here. So, these members consider other parts of the Federal budget.

It is quite possible, highly probable, that we shall reach judgments about the allocation of these resources which are different from those you have reached. If we decide to make some adjustments in it, don't

you think we have not only the right but also the responsibility to do so?

Secretary WEINBERGER. I do not think there ever has been any question about that, Mr. Chairman.

Mr. FLOOD. Of course not. For example, last year Congress increased the HEW budget over the President's request, but this increase was more than offset, you will recall, by cuts in the President's budget for Defense and Foreign Aid.

Secretary WEINBERGER. I did not recall that, Mr. Chairman; no. The increase in the appropriation bills is one part of the total spending program of the Government. While it can be shown that the action on the appropriations bills may have had a net minus or a net plus, the important thing is to look at the overall spending direction.

SPENDING CEILING

Mr. FLOOD. I have before me a copy of the fiscal year 1973 appropriations as approved by the Congress, and here I see a column "over or under fiscal year 1973 budget requests." We have a net minus of $5,322,405,069.

Secretary WEINBERGER. Those are the appropriations, Mr. Chairman. But other actions by the Congress afforded direct spending of $11 billion more than the President felt was a responsible fiscal policy.

Mr. FLOOD. If we do the same thing this year, do you think the President would veto or impound all of the appropriations that exceed his estimates?

Secretary WEINBERGER. Mr. Chairman, I have always refrained from trying to predict what the President would or would not do. I think the best guide is to look at the budget message and the other public statements in which the President has said that he felt that a spending ceiling should have been imposd in 1973.

Both Houses agreed with him but were unable to agree on the details of it at $250 billion.

The President has asked for another spending ceiling in fiscal 1974 in the amount of $267.8 billion, for the same purpose, to try to insure that the total spending, both that put in by the appropriation bills as well as by other measures, does not exceed the budget total. He believes that if it does, the Congress will be forcing a tax increase, which is wrong.

TRAINING OF MEDICAL RESEARCHERS

Mr. FLOOD. Yes. One of the things that concerns us most is that you appear to be closing down, or what is known as phasing out programs.

One subject upon which this subcommittee is very unlikely to agree with you is your proposal to phase out programs for training of medical researchers. We make quite a thing out of this. Our advances in medical research, we believe, has made this country the envy of the world.

We have talked about that in this room for years and years. For instance, take a look at the number of Nobel Prize winners that we have had in recent years on just this thing.

Why do you want to kill the goose that lays the golden egg?

Secretary WEINBERGER. We do not think we have. We do not want to keep on feeding the goose until he becomes ill from overfeeding.

You will recall we continued specialized governmental encouragement in several other educational fields—the production of Ph. D.'s in general, and space scientists and engineers to be more specific. We went beyond the point of the ability of the country as a whole to absorb this. There was serious unemployment due to an overage in those fields.

We also believe that while this work is very important, the indications are now that this specialized form of Government encouragement in the way of subsidies for these particular branches of academic disciplines is no longer indicated nor, indeed, desirable.

Mr. FLOOD. Despite what we are doing in cancer and other areas.

Secretary WEINBERGER. This is not to say we should stop doing that. It is to say we feel now that the supply of people able to do this can well be obtained without the specialized Government subsidies.

Mr. FLOOD. Thereby hangs the tale as between you and these people who are lifetime specialists and scientists and devoted to this thing. Despite what they think or feel or do or say to you or to us or anybody else, that's it.

After weighing all the equities in the scales, there are too many people doing biomedical research?

Secretary WEINBERGER. No, sir; we are not saying that at all. We are simply saying that we believe enough people to fulfill the requirements of the country in all of these highly important fields can be obtained without a specialized Government subsidy.

What we are saying is based also upon the program of the administration which is designed to encourage, to a far greater extent than ever before, general undergraduate training, which in turn leads to specialization in these fields.

We believe there is now a sufficient desire and willingness to proceed with this training, and we have some indirect training opportunities, too, that do not require specialized Federal encouragement in the form of subsidies for these particular purposes.

Mr. FLOOD. Do you have any concrete evidence that you are training too many people for biomedical research?

Secretary WEINBERGER. No. We just believe we have two or three different kinds of indications.

One is that we have substantially increased the supply.

Another is that there seems to be evidence that a great many students would go into these fields anyway, without the specialized Federal encouragement.

As far as the criticism is concerned, Mr. Chairman, I think it is inevitable that whenever any program that has been in force for at least 2 weeks is proposed for any kind of change, termination or reduction, there is bound to be criticism from the people who are participating in it.

Mr. FLOOD. Are you in fact creating a surplus of researchers? If you cut back support for research programs, are you creating a suplus of researchers?

Secretary WEINBERGER. We think there is some possibility that might happen. We also feel that there has been very substantial encouragement given in the past.

We also feel that at a time when we do have to select our priorities, it is a better use of resources to try to focus research and research funds directly, rather than attempting a broadside approach to develop more people in this area when they might very well go into it anyway.

REGIONAL MEDICAL PROGRAM

Mr. FLOOD. You were speaking of phasing out a program which is of great interest to this particular subcommittee, the RMP, the regional medical program, without giving Congress the opportunity to approve or disapprove your action.

Secretary WEINBERGER. We believe we are, Mr. Chairman.

Mr. FLOOD. If you kill the program, how could it be revived if Congress wanted you to continue the program?

Secretary WEINBERGER. The program is in this stage, as I understand it. That is, we are proposing no funding for it. We are making no budgetary request to the Congress.

The termination of the program would be achieved if no funding is voted. So, we do not think we are overriding the Congress in any way.

The authority to continue this program runs out June 30, and we are not requesting a continuation of that authority, nor its funding.

Mr. FLOOD. I understand. If you kill the programs, I repeat, how can you revive them if Congress orders you to continue them? Are you going to wave a wand, or what?

Secretary WEINBERGER. The program does not disappear that fast.

Mr. FLOOD. Of course, thereby hangs the tale. Don't break down and cry.

Secretary WEINBERGER. The budget request provides for a continuation of all commitments. We would honor all Federal commitments that have been made. We are not requesting continuation of the authority, nor the funds. So that it does place before the Congress the issue. There is no suggestion that the program has been killed yesterday.

Mr. FLOOD. I told you of our special concern about the regional medical program. This is just a coincidence because of the change in dates in your appearance here. I dictated a letter and I was going to mail it to you. Since it was dated yesterday, I will hand it to you.

You cannot do this thing overnight or in 5 minutes. I have in my hand here quite a document. It is 10 closely typed—and I mean closely typed—pages, an amazing thing. This is a complex thing.

This has been issued to all local RMP coordinators to tell them how to prepare to phase out this RMP program. I have a copy of the wire. You can imagine I would have, because it was scattered around a couple of weeks ago.

This must have taken hundreds of people 2 or 3 weeks to do what they did. Yet, you direct a closing out of this RMP program in a matter of 14 days.

The reason I have the letter now that I want to hand to you is that I am sure you cannot imagine what has been going on because you are too busy.

This sets March 13 as the deadline to close out this fantastic series of orders. There they are, 10 pages of them; unbelievable. I do not know what those boys sitting in that building over there are doing. If ever I saw somebody mandating waste, which you abhor, this would be the result.

Also, you are starting out to disrupt any communications between this committee and your office before you get off the ground. Under all the circumstances, I cannot see how you can conceivably not extend the 90-day period here in order to have this matter even looked at.

I will give you this, and in due course, probably tomorrow sometime, you will have a chance to make a reply. This is one of our special pigeons, if you know what I mean.

Secretary WEINBERGER. I know what you mean.

Mr. FLOOD. You are speaking of the lady we love, that sort of business. I do not mean you are flying in the face of the gods, but you are flying.

RESEARCH INSTITUTES

Is it not a fact that the increased funds for cancer and heart disease research are, so to speak, coming out of the hides of the other institutes of NIH? What in the world is the justification for that?

Secretary WEINBERGER. What we have in cancer is a very substantial increase, as I mentioned, up now to $500 million, an increase of $75 million or 17 percent over 1973, and a total of 34 percent over 1972.

The National Heart and Lung Institute is up to $265 million, or an $18 million increase, which is again an 18-percent increase over 1972, with particular initiatives in hypertension and arteriosclerosis. There have been some reductions in some of the other institutes.

The total still shows a $50 million increase.

Again, Mr. Chairman, the reductions are in very small amounts; so, practically speaking, what has happened is that the other institutes of the National Institutes of Health are running relatively level. Heart and Cancer are up substantially.

Mr. FLOOD. Yes, I know. The very document you sent to us for the National Institutes of Health shows the National Cancer Institute, 1972, $373 million; 1973, $426 million; and 1974, $500 million. That we know about.

The Heart Institute figures are: 1972, $224 million; 1973, $247 million; and 1974, $265 million.

The other research institutes: 1972, $878 million; 1973, $810 million; and 1974, $767 million. It is out of their hide.

Secretary WEINBERGER. Down about $43 million.

Mr. FLOOD. Just $43 million. We usually talk like that here, but I cannot imagine a budget officer saying that.

Secretary WEINBERGER. There are several institutes over which you spread this amount. We are also talking about a reduction.

The simple fact of the matter is that there has been a major increase in spending for two of the institutes. These are budget authority figures. When you have the budget outlay figures before you, you will see that four of the institutes went up in actual dollars that will be spent in 1974, and the others remained either level or went down by small amounts.

Mr. FLOOD. If you take all the other research institutes, $878 million in 1972, and $767 million in 1974, in a round, fat, ballpark way of talking, that is $100 million for the purposes of our casual conversation here this morning. That is no Beau Geste, even for OMB; is it?

Secretary WEINBERGER. The point that I tried to make earlier is that there has been a more than commensurate increase.

Mr. FLOOD. There is no doubt about that, but the question is: Didn't you take it out of the hides of everybody else?

Secretary WEINBERGER. The point that I tried to make earlier is that we cannot continue to do everything we have done on the scale at which we had previously done it. So, you are maintaining a very high level of expenditure for all of these institutes, but an even higher level for Cancer and Heart.

Mr. FLOOD. In other words, you are quite satisfied with this point of view and you are going to wind up right where you started. Always hovering in the background is the damoclean sword of a potential tax increase.

Secretary WEINBERGER. I think we have to be concerned about that; yes, sir.

Mr. FLOOD. Yes, but it is pretty clear that you are convinced there is no ability in the Congress to take a look at this thing.

Secretary WEINBERGER. No, sir. That is why the budget is in the form of proposals.

NATIONAL CANCER INSTITUTE

Mr. FLOOD. Yes.

I wrote you a letter in connection with the Cancer Institute, since we are talking about NIH. You are aware of those communications I had with you dealing with the Cancer Institute? You probably are not. Whichever one of your people is——

Secretary WEINBERGER. I would be interested in the date, Mr. Chairman. I have not been satisfied, frankly, with our speed in responding to communications. I do not know how long I have had them, but I would like to respond to them if we have not.

Mr. FLOOD. In this case, you did. I think Mr. Carlucci is aware of this.

Mr. CARLUCCI. The letter was referred to me, Mr. Chairman. We are looking into the matter thoroughly.

As you know, the budget does include $84 million for the development of comprehensive cancer detection centers throughout the country. We will be moving ahead on those. Seven of them are in some phase of development.

Your principal concern, as I recall the letter, was to make sure that each center developed a program on how it would reach the practicing physicians to make sure that the practicing physicians were actually brought into the program.

Mr. FLOOD. That is correct.

Mr. CARLUCCI. We are going to require each center to come up with a plan, and we will be responding to you in writing very shortly.

CONTRACTS AND GRANTS

Mr. FLOOD. I am concerned about this built-in practice at the Institute of doing everything by contract—Tinkers to Evers to Chance, if you know what I mean, a nice, very cozy operation dealing with contracts.

Secretary WEINBERGER. We share that concern.

Mr. FLOOD. I believe you do. I have the impression that you do share it.

I think Mr. Carlucci understands this, and I believe you, too, Mr. Secretary, will when you get to it. This is a major matter concerning the way the program to which you are dedicated, the program about which the President is so concerned, is executed.

Secretary WEINBERGER. We certainly would share that concern completely, and also the belief that a program cannot be in any way effective if the results of it do not get out into the hands of the physicians treating the people.

Mr. FLOOD. I am not surprised that you and I can agree, but we certainly do on this, I hope.

Mr. CARLUCCI. May I comment in general on the whole question of contracts and grants?

Mr. FLOOD. This is not one of my bright ideas. This has been going around this table for 4 or 5 years. I am the mouthpiece.

Mr. CARLUCCI. I think it is fair to say that the Secretary and I generally share the concern you have expressed throughout HEW with regard to grant practices and contracting practices. We are going to take some organizational reviews of this.

Mr. FLOOD. That is good. I am glad to hear that.

Let's make exhibit A for this unmasking the Cancer Institute practice on these contracts and get this out where you say it should be.

CONTINUING RESOLUTION

Now that Congress has continued this continuing resolution for 1973 to June 30, are you reviewing your spending plans in view of this for fiscal year 1973? Is there any scuttlebutt about what the President is going to do?

We continued the continuing resolution, and here we are, in limbo, and that makes me ask you at half-past 11 on this date, are you reviewing the spending plans for fiscal year 1973, faced with this awesome thing?

Secretary WEINBERGER. They are constantly under review, not only in this connection but in general, because we want to assure ourselves as well as the Congress that we are spending money that has been authorized already, wisely; and, of course, in this limbo period we necessarily have to be particularly——

Mr. FLOOD. I know, but this is the Appropriations Committee. You are holding back. You have been faced with this thing. You knew what was going to happen. You are holding back right now. We have begun this 1974 hearing. We are talking about 1974.

Secretary WEINBERGER. Yes, sir.

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Mr. FLOOD. What are you doing about 1973? You have been holding back on us. We want to know now.

Secretary WEINBERGER. I do not know what you mean. We have been holding back information or spending?

Mr. FLOOD. Everything. Certainly information.

Secretary WEINBERGER. We are certainly cognizant of the problem involved under the continuing resolutions.

Mr. FLOOD. I know you are.

Secretary WEINBERGER. I spent some time last year before a committee of the Senate which was very critical of the practice of agencies overcommitting during a continuing resolution period, because they felt it frustrated their later authority to make reductions in the totals if they wished to do so.

We tried and are trying to stay within what are identified as the limits of our authority during a continuing resolution period. We are trying to do that. This necessarily may involve some reductions until we get a final definition.

Mr. FLOOD. You are making a review?

Secretary WEINBERGER. Yes, sir.

Mr. FLOOD. Of course, you are making a review. We have to know, if you don't mind, when are we going to have the results of your review?

Secretary WEINBERGER. As soon as it is available, Mr. Chairman.

Mr. FLOOD. How nice.

Secretary WEINBERGER. If you have any specific program involved——

Mr. FLOOD. No. There is a continuing resolution. We are just part of it.

You are reviewing the situation. You have been holding back on us, we think. We would like to know now, if you can tell us this morning, what will the results of the review be?

Secretary WEINBERGER. I do not know what specific program you are speaking of.

Mr. FLOOD. Let us talk about this subcommittee's jurisdiction, our jurisdiction alone.

Mr. MILLER. We have one table which might be of use now, showing our spending plan currently. There is no continuing resolution now, so we are under special controls. But assuming——

Mr. FLOOD. No what?

Mr. MILLER. There is not a continuing resolution.

Secretary WEINBERGER. Not one signed.

Mr. FLOOD. As far as Congress is concerned, there is.

Secretary WEINBERGER. I referred to the limbo period.

Mr. FLOOD. I used the phrase, and you adopted it.

Go ahead.

Mr. MILLER. Before it expired, we were spending at the lower of the 1972 rate or the President's revised 1973 budget.

Mr. FLOOD. That is a good statement. I knew that, or I was pretty sure of that.

What is the earliest possible moment, just for the jurisdiction of our subcommittee, that you will have the review completed?

Secretary WEINBERGER. The earliest possible moment we could give it to you would be immediately after the President's decision on the continuing resolution and the interpretation that we have then as to the spending rate required. As soon as we have that, we would be delighted to furnish it not only to you but to all the constituent agencies of the Department.

Mr. CARDWELL. The assigned deadline is Monday, March 12.

Mr. FLOOD. I thought I could hurry you a little bit.

COUNSELOR FOR HUMAN RESOURCES

Can you explain to us how your role vis-a-vis the President differs now from what we have had sitting in that chair with other Secretaries? You are a nice guy and we like you, but I cannot see what hat you are wearing.

Secretary WEINBERGER. I am here as Secretary of the Department.

Mr. FLOOD. You are here as Secretary of HEW. You are not likely to become something else any minute?

Secretary WEINBERGER. No, sir.

Mr. FLOOD. I do not want you to, all of a sudden, become Human Resources Counselor or something like that.

Secretary WEINBERGER. I am here as Secretary of the Department.

Mr. FLOOD. You are sitting there as Secretary, but this is also the subcommittee for Labor. While you are there, I am going to put another hat on you because we would like to know this: You are the President's chief adviser on human resources. Does that mean that you are going to review the Labor Department's budget before it goes to the President?

Secretary WEINBERGER. Not all of it, sir; no.

Perhaps I could say just a word about the role of the Counselor for Human Resources, which is a new position and is still in what might be called the developmental stage.

In general, the President's desire is twofold or threefold. In the past, there has been the habit, as you know, of creating specific Cabinet committees to cover problems that cut across the boundary lines of the existing departments.

I think the President feels that in the human resources field it would be desirable to have a standing committee rather than a series of ad hoc Cabinet committees. I think the Counselor for Human Resources would conduct a kind of standing committee on problems of the kind that cut across departmental lines.

Some of those, for example, involving Labor, as you mentioned, would be employment security, unemployment insurance, and manpower training programs. Because those areas have a human resources aspect, my job would be, not to operate these programs, fortunately, but simply to meet with the people who do operate them and have them meet with the people who operate similar income security or other programs, and discuss whatever common problems there might be, to try to insure that the President's goals in this field are carried out in a unified and coordinated way, and to convey the concerns of the people running the departments about changes or recommendations in policy.

This is that kind of thing. It is not operations. Operations are confined to this.

Mr. FLOOD. That is all you are going to do. You ought to read what you just said.

Secretary WEINBERGER. I am familiar with the scope of it.

Mr. FLOOD. It is not really Olympian, after all.

Secretary WEINBERGER. But it is a large responsibility.

Mr. FLOOD. The reason I asked you about the Labor thing is that this is the Labor-HEW Appropriation Subcommittee.

Secretary WEINBERGER. I understand.

Mr. FLOOD. We consider the budget for the Department of Labor, as well as HEW.

Secretary WEINBERGER. With respect to this year's budget, of course the Counselor's Office was not created at that point, and the budget of the Labor Department has been prepared in completely the normal way and submitted to you as a separate document.

Mr. FLOOD. But you were at the OMB when the Labor budget was done.

Secretary WEINBERGER. I was, indeed.

Mr. FLOOD. In your capacity now as this human resources type, you will only do that and no more?

Secretary WEINBERGER. It is not in the nature of things. It is a consultative, counseling, liaison, communications kind of role with respect to the desire of the President to insure that matters that have a generally common base, that is, embodying human resources activities, are carried out and managed, even though a number of different agencies are involved, in a way that is coordinated and consistent with his polices. That is the basic idea.

Mr. FLOOD. All those things being true, and they are awesome, do you expect to devote less time to the administration of the Department of HEW than the other Secretaries have done?

Secretary WEINBERGER. I have no idea what other Secretaries did, Mr. Chairman. I intend to devote all of the time to it that I possibly can, and that will be practically all the time.

Fortunately, I will be aided by the extraordinarily able Under Secretary that we were fortunate in having confirmed by the Senate, and who has been working in these areas with me.

Mr. FLOOD. You mean Mr. Carlucci?

Secretary WEINBERGER. I mean Mr. Carlucci.

EDUCATION SPECIAL REVENUE SHARING

Mr. FLOOD. One of the most significant proposals in your budget is this business of the special revenue-sharing. We agreed here yesterday that we would use the phrase "general revenue-sharing" on the one hand and "special revenue-sharing" on the other, so we might have some idea what we are talking about.

With reference to your education programs, including title I of the Elementary and Secondary Education Act, vocational education grants, impacted area grants, and all that, has there been any bill incorporating this proposal sent to Congress?

Secretary WEINBERGER. Not yet. We are working on it as a very high priority. We hope to have it up to you as soon as possible.

We are perfectly aware of the fact that time is going by and you need it. We want to get it up very soon.

Mr. FLOOD. Therefore, no hearings are scheduled?

Secretary WEINBERGER. Not as yet, because the bill is not in. We believe that will be corrected in a very short time.

Mr. FLOOD. Do you think there is any possibility, the way you are working, of any special revenue-sharing for education being enacted before July 1 or by July 1?

Secretary WEINBERGER. I think it is entirely possible; yes, sir.

Mr. FLOOD. You are concerned about that?

Secretary WEINBERGER. Yes, sir.

Mr. FLOOD. Keeping in mind where we are, if it is not enacted by July 1, what would you recommend the committee do about appropriations for the existing education programs? Should they be continued at the current level?

Secretary WEINBERGER. Mr. Chairman, I have scrupulously avoided making any predictions or recommendations based on failure. I would regard failure to enact special revenue-sharing by July 1 as a failure.

The President does not have contingency plans for failures. He wants to get that measure enacted. He thinks that it will do a far better job. It will fold in all of the authorities and outlays that are provided in the programs that we have indicated broadly in the budget.

I do not see any reason it would not be enacted.

Mr. FLOOD. We still have the idea bouncing in the back of our head of a separate education appropriation bill

Secretary WEINBERGER. We do not have the bill, but we have a hearing date set, March 19, by Congressman Perkins' committee. We hope to get that in.

EVALUATION STUDIES

Mr. FLOOD. There has been a lot of rhetoric lately about Federal programs that have failed to accomplish their objectives. We have been appropriating a great deal of money for the last several years for studies to evaluate these HEW programs. We would like to know what the results of these evaluations are. Could you give us a list of the HEW programs that you believe or conclude have failed to meet their objectives—not something from the top of your head, not just likes and dislikes, because we have those, too. We appropriated all this money for all these studies. You wanted evaluation studies. We want the evaluation studies to support that judgment.

Do you have an example right now of an evaluation study here?

Secretary WEINBERGER. The impacted aid study. I think that is a program that is clearly at the top of most people's lists.

NOTE.—The information requested was not provided in time to be printed at this point in the hearings, but may be found beginning on p. 610.

Mr. FLOOD. Mr. Michel.

Mr. MICHEL. Thank you, Mr. Chairman.

COMMENT ON THE SECRETARY'S PRESENTATION

Mr. Secretary, we have heard over the period of the last 15 years a number of Secretaries of HEW who have given their testimony before this committee, both as newly initiated Secretaries and as those who spent some period of time there, and we have observed an improvement in their capacity to deliver after they have actually been subjected to the Department for a considerable period of time.

I must confess that you, as one who comes to us for the first time, are giving us one of the most comprehensive and concise pictures we have had. Even though it does cover 40 pages, there is not a lot of loose rhetoric in it, as far as I am concerned. There is a lot of meat here.

There are so many initiatives being proposed to change direction, throw off the old and begin anew in a number of programs.

You are up against it, as you already have been in your appearances before a number of other committees on the Hill. We hear so much about special interests on the outside that influence the Congress. The Congress itself is just as guilty of having its own built-in special interests as the various groups on the outside.

There are those of us who have been around here for many years who have become just so darned wedded to a program that 15 or 20 years ago we cosponsored that we can't bear the thought of changes. It has our name on it, or we have been talking about it for so long, we get to the point that we hate to admit that maybe we will have to talk about some other things.

Hill-Burton was a great program. We extolled Senator Hill for many years while he was here. I suspect part of it was because the old gentleman was still here, and it was one of those things. The Congress gets to be a kind of club.

I just want to say from the beginning that I do not find myself wedded to the past here. If there are good arguments for change—and the chairman has asked you to specify a list of those programs that you think are bad or that have outlived their usefulness—we have it spelled out for us here, and I think rightly so. We do not want to be changing simply for the sake of change, but because we think there is a better route.

PROGRAM TRADEOFFS

You began somewhere in your testimony by talking about tradeoffs. When I think of tradeoffs, I think of "you give and we take," and then "you take and we give." There is an area of compromise.

But I am wondering, from the presentation you have made here, living within the constraints of the budget's overall ceiling, is there any opportunity for any tradeoffs, as far as our committee is concerned?

Secretary WEINBERGER. I think we would certainly be very interested in hearing any specific proposals. I take it you mean a reduction in some of the requests, and additions in others, something of that kind.

Mr. MICHEL. Yes.

Secretary WEINBERGER. I know of no one who would not be interested in looking at any proposals of that kind. The President has submitted

a budget. He has submitted a detailed justification for it. He submitted a long list of program terminations and reductions, and the reasons therefor in the budget.

It starts around page 51 of the actual budget document.

This represents his best judgment and his best thinking as to the way in which the Federal resources should be directed and focused at this time. I am certain that any specific proposal would be looked at carefully, and some kind of position reached as to whether the administration could support it.

HEALTH RESEARCH

Mr. MICHEL. Let me take some of the items in the same chronological order as the chairman addressed himself to them.

For example, the health researchers and the decline in the Federal role of supporting health research as reflected in the budget you present.

I gather that you take the position that because there is really so much in the pipeline, a precipitous cut in this year really is not all that disastrous; that many of the research activities will still go on, but at a slowly declining rate.

Secretary WEINBERGER. Yes; there is a lot in the pipeline. All existing commitments would be fully honored under the requests presented to the Congress. No new commitments would be made under these proposals because of the basic feeling that I mentioned to the chairman as to what led us to the recommendation. We would honor existing commitments.

This means that a very substantial amount would continue to be spent for all of these purposes. In many cases, the reductions are simply a reduction in the rate of expected increase. There is still a very large amount being funded in all of the National Institutes. The National Institute of Neurological Diseases and Stroke still has $108 million as opposed to $100 million in 1973. The National Institute of Arthritis, Metabolism, and Digestive Diseases had $141 million in 1973 and $135 million in 1974, a drop of $6 million, but still a very large amount.

Again, I do not think we should be misled into judging the effectiveness of everything by the amount of money that we request for it.

Mr. MICHEL. As a matter of fact, our standard of measurement up on the Hill has been too much locked into the expenditure of dollars. If there has been a requested or appropriated increase in any given Department or Agency, that automatically meant everything was rosy, and it was an expenditure well spent. I do not happen to take that position.

You would not want to go so far as to say, however, that the Federal Government does not have a continuing role in funding research activities out at NIH?

Secretary WEINBERGER. No. We have indicated that very clearly by our request for $1.531 billion, if we only use the dollars as a measurement. So, there is a very substantial amount of Federal resources being devoted to this purpose.

We are talking about the special training of researchers and their special encouragement by the Federal Government which we think is

no longer required in the volume and degree it was before; and also, we are talking about trying to focus the research rather than simply responding to applications for a particular contract or grant. We are trying to insure that basic objectives that seem important are being pursued.

Mr. MICHEL. The educational institutions around the country obviously are distressed about this, because in many cases we have been subsidizing our institutions of higher learning by way of our research programs over a period of years. There is no question about it.

What kind of input have they had, if any, to this decision? Are they to expect, if your position is sustained and you can pursue this policy, conceivably, through the life of this administration, 4 years, that every young person anticipating or desiring a role in medical research particularly would have to cut it strictly on his own; that there would be no resources available to him?

DIRECT STUDENT ASSISTANCE

Secretary WEINBERGER. There would be resources available. What we are talking about is a shift from the provision of Federal aid to institutions to Federal aid to individuals. So, we can, indeed, have a provision, as we have in this budget, so everyone, if he or she is otherwise qualified for admission, can get into college and not be barred by a lack of funds from completing that or from going on for additional work.

We do feel there has been a substantial loss in the effectiveness of the dollar, because when Federal aid is granted entirely through institutions, a certain amount is lost through administration or overhead. The President's feeling is that all the available dollars should go to the students themselves. That is the thrust of this budget.

That is a new direction, without any question. Institutions which have benefited primarily from institutional aid are distressed and concerned. I do not think there is that much reason for it, because the funds given to the students will be spent at the institutions without the loss of Federal funds for overhead or administrative purposes.

INTERNATIONAL STUDIES

Mr. MICHEL. Closely akin to that, in the international studies field there was a dramatic drop from $15 million down to $2.3 million. Secretary Marland and Dr. Ottina were testifying on that, and I got on that subject, as did several other members of the committee.

There, of course, you have a highly selective group of studies. Not every institution is able to provide that kind of training, nor do we want every one of the institutions of higher learning to offer that kind of training. Young kids choose this or that school over another because they have an opportunity to train in one field or another to a greater extent.

It seems to me if the program or the end result is desirable and it is a national resource to have these people, then we do have some responsibility, even an obligation, in effect, to give the institution some

kind of support, because it cannot be financed solely through the student's tuition. In one area you have only 4 or 5 or half a dozen students who have the inclination and desire to participate in that kind of program.

You could say, well, they live in California, and the only school is in New York. They have to go to New York to get that kind of training.

We like to have them more geographically spread around the country so there isn't this tremendous burden, in this case on the student, to pay so much to get the kind of training he thinks will be valuable for him.

Secretary WEINBERGER. This is one of the programs that we believe has done a good enough job in its area. In doing that job, a very substantial capacity for teaching nonwestern languages and other things has been established. We have more than 100 foreign area study centers. We have trained some 5,000 specialists. Federal funding at this point is less than 10 percent of this effort.

If this is regarded as a high priority by the institutions, we think spread out among 100 centers, this is not a very large additional amount.

Mr. MICHEL. We were talking about a precipitous drop, because in building a faculty for a program, you just don't turn the spigot on and off. These are highly specialized people, as in the space program and some of the others. We could not say overnight we have to have them.

Secretary WEINBERGER. It is not a large part of the spigot. It is a small part of the total. Again, it is a matter of selection of priorities.

Mr. Carlucci has, I think, special knowledge of this subject because, of course, as know, he was in the Foreign Service.

Mr. CARLUCCI. We have talked to the State Department about this. All the indications are that they have an abundant supply of people with this kind of expertise.

A real issue arises: Is there a national need to continue funding these particular organizations, particularly, as the Secretary has pointed out, now that the Federal funding represents less than 10 percent of their budget?

In effect, we have produced almost an oversupply.

Mr. MICHEL. If that is the case, that is a good enough argument for me. At one time we were encouraging people to get into the teaching profession by the forgiveness of loans, and we found the stimulation there got us enough teachers to the extent that an oversupply developed.

If this really can be substantiated by hard, cold figures, you do not really need to say too much more to sell me, notwithstanding the special pleadings we get on the outside for continuation of a program that might enhance that institution that offers that particular program. I am not wedded to that. I want it to be proved to me that this is the case.

Mr. CARLUCCI. The best evidence is that the State Department is not having any trouble at all attracting this expertise.

Mr. MICHEL. The next question arises: Is it only the State Department that we are supplying with people here? We keep talking in this

country about the need for expanding trade, not only to our traditional trading partners, but to countries we are not so well acquainted with. We have the wherewithal to produce and overproduce and outproduce. Is it not a financial resource to have the kind of people who can be our ambassadors in the private sector to develop business in foreign countries?

Mr. CARLUCCI. I think we can extrapolate from State Department experience the fact that other organizations will similarly be able to pick up whatever kind of expertise they need. Generally, these people who come out are indepth scholars in this particular program, and would not normally go into the exporting business. They have traditionally engaged in academic pursuits and the foreign service. I think there is a sufficient supply.

REGIONAL MEDICAL PROGRAM

Mr. MICHEL. Let us get to the regional medical program. The chairman referred to the regional medical program as our special pigeon. I can recall when that proposition was first being talked about by the late President Johnson, establishing a heart, cancer, and stroke center.

The initial proposition was to establish some 28 centers around the country. Ninety-nine percent of the Members of Congress were under the impression that this meant the establishment in geographical balance of the 28 centers around the country to combat heart, cancer, and stroke, or to deal with the problem.

But, when it goes through all the legislative wheels and one thing and another, it does not turn out to be that at all. They find the only way they can really have these things to be meaningful and purposeful is to have them gravitate around existing medical centers. You just could not go out in the desert and set up this fancy enclave as you had in Philadelphia, Chicago, New York, and existing places.

It turned out to be something completely different from what was originally conceived.

Then over a period of testing—you say we have 56, in excess of the number of States—you get this conflict between other programs in a given State and this program. I get conflicting views in my talks with medical professionals. I get the impression that there are several good regional medical programs, and I suppose on the other side of the spectrum you could talk about several pretty bad ones.

Is there an opportunity here for tradeoffs or compromise?

Secretary WEINBERGER. I think the simple fact of the matter is that the program did not live up to its original purpose, which was a perfectly worthy one. It broke down into a situation where most of the 56 centers are within State boundaries; and, therefore, they overlap frequently and conflict with comprehensive health planning.

The biggest expenditure has been in two areas—for administration of the program itself, and for continuing education, the so-called upgrading of training of health personnel.

As I mentioned in the opening statement, in fiscal year 1971, 60 percent of the people have been receiving training in a project that lasted 1 day or less.

Typically, this is the kind of thing that will be done on a Friday or Saturday morning. Doctors from various areas will come and sit in a medical school and will have a course in some subject which either is newly developed or can be more intensively presented by an expert.

It is a very good thing. Typically, however, a course charge is made, $25 for the day, or something of this kind. You get the benefits of this training and some written materials are issued. You go back home and, presumably, are a better lawyer or engineer or doctor. I think there is a lot of value to it.

The problem is that in a year when we are looking at the necessity of focusing Federal funds, there does not seem to be any reason to continue paying such a large amount for a program, 39 percent for staff activity and the balance mostly for so-called continued education and manpower training, which the doctors might well pay themselves. That is the point.

It isn't that the program is all bad. It is simply that it has not in any way reached its purpose of disseminating medical knowledge. The necessity of transmitting to all areas of the country the latest developments and technology is a very valid and extremely important point. The National Library of Medicine at the NIH does extremely valuable work in this area. They have people who digest and paraphrase the findings that have been made and reported in thousands and thousands of medical journals all over the world. They put this on tape and it is entirely possible for a doctor in the remotest part of the country to telephone in a request and have a computerized printout of all of the requested material in a very short time.

Mr. FLOOD. We will adjourn now and come back at 2 o'clock.

AFTER RECESS

Mr. Michel.

Mr. MICHEL. Thank you, Mr. Chairman.

RMP DOCUMENT

As we broke this morning, we were on a discussion of regional medical programs, what the Department was and was not doing.

You had some additional comments you wanted to make, Mr. Secretary.

Secretary WEINBERGER. Yes.

This is a memorandum of February 22 that went out to all the regional medical program coordinators and grantee officials.

The purpose of this letter is to refine and clarify points in the telegram sent to you on February 1.

Mr. FLOOD. Is that the 10-page document?

Secretary WEINBERGER. It is quite a long document. I thought I would read a couple of pertinent points from it. I shall not read it all. It says:

Because no funds for regional medical program services have been requested by the Administration for fiscal year 1974, a phaseout plan had to be developed by Regional Medical Program Service—that is our Washington office—and a maximum termination date, February 15, 1974, set for the regional medical pro-

gram. Immediately upon receiving approval from HSMHA for this plan, a telegram was sent to you on February 1 indicating that each region should submit two written plans, one for phasing out all regional medical program services by June 30, and a separate plan and set of forms for activities proposed for continuation beyond June 30 but in no event beyond February 15, 1974.

Then there are a couple of sentences:

The February 15 date is merely the last possible termination date for any regional medical program, and none can be extended beyond that for any purpose except where funds are previously obligated or under contract which are subsequently approved during the forthcoming review.

Then on page 3, it says:

Thus, in view of the uncertainties, it is our judgment that regional medical programs should realistically consider June 30 or soon thereafter as the likely termination date, with perhaps only the regional medical program under exceptional circumstances continuing its activities in fiscal year 1974 for a limited time.

All of that is to indicate that these instructions that went out were based upon the fact that the President was not requesting continuation of the authority or funds beyond the end of this year, and that we were going to try in an orderly way to give notice in order to get plans ready to deal with it.

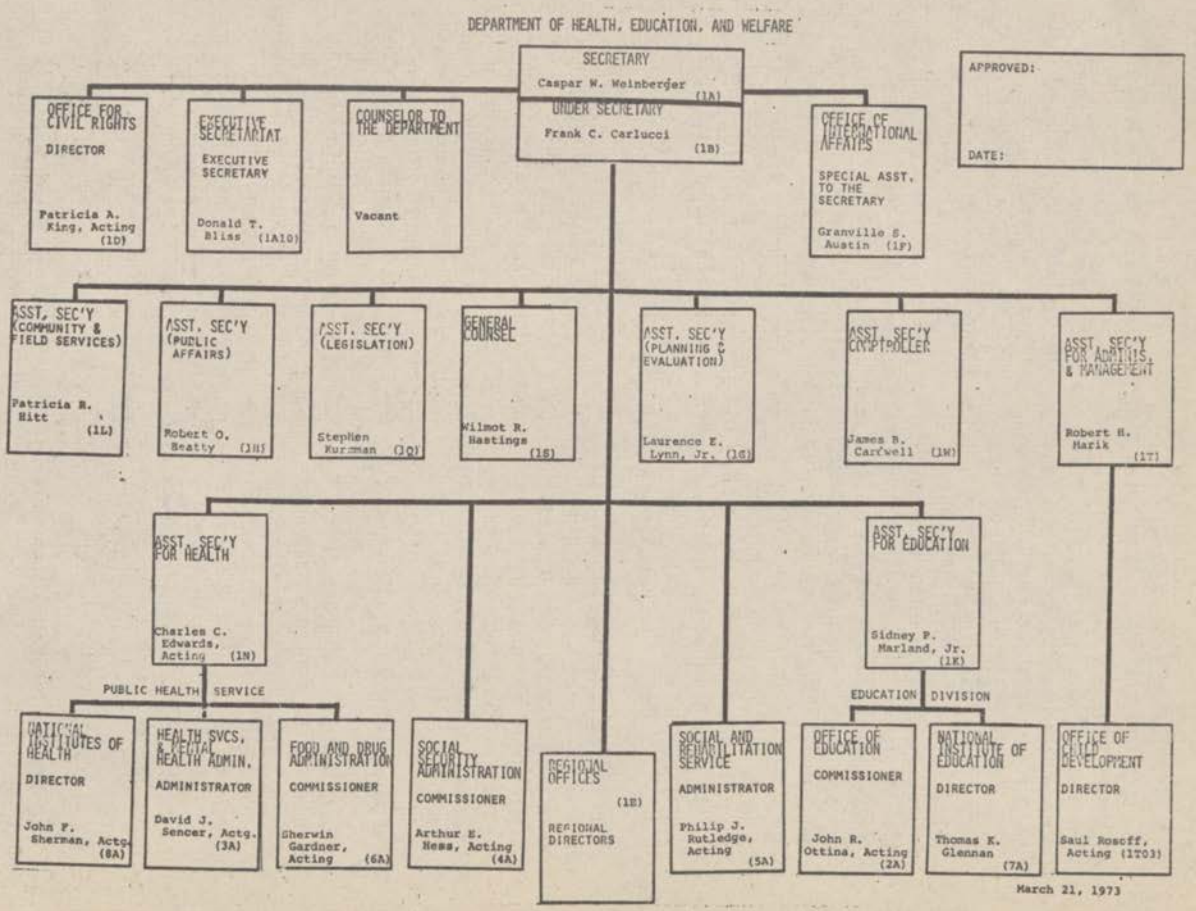
I do not think this can be properly described as dismantling or crippling the programs in advance of congressional determination. We do feel we have an obligation to notify the grantees, the coordinators, officials, and so on, that the President is not requesting funds and that this will require certain actions on your part.

ORGANIZATION OF THE DEPARTMENT

Mr. MICHEL. Mr. Secretary, could we have an organizational chart of your Department, the names of the people as well as the offices they hold?

Secretary WEINBERGER. Yes, sir. I do not have it with me, but we will supply it.

[The information follows:]


DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SECRETARY
Caspar W. Weinberger (1A)
UNDER SECRETARY
Frank C. Carlucci (1B)
APPROVED:
DATE:
OFFICE FOR CIVIL RIGHTS
DIRECTOR
Patricia A. King, Acting (1D)
EXECUTIVE SECRETARIAT
EXECUTIVE SECRETARY
Donald T. Bliss (1A10)
COUNSELOR TO THE DEPARTMENT
Vacant
OFFICE OF INTERNATIONAL AFFAIRS
SPECIAL ASST. TO THE SECRETARY
Granville S. Austin (1F)
ASST. SEC'Y (COMMUNITY & FIELD SERVICES)
Patricia R. Hitt (1L)
ASST. SEC'Y (PUBLIC AFFAIRS)
Robert O. Beatty (1H)
ASST. SEC'Y (LEGISLATION)
Stephen Kurzman (1Q)
GENERAL COUNSEL
Wilmot R. Hastings (1S)
ASST. SEC'Y (PLANNING & EVALUATION)
Laurence E. Lynn, Jr. (1G)
ASST. SEC'Y COMPTROLLER
James B. Cardwell (1M)
ASST. SEC'Y FOR ADMIN. & MANAGEMENT
Robert H. Marik (1T)
ASST. SEC'Y FOR HEALTH
Charles C. Edwards, Acting (1N)
ASST. SEC'Y FOR EDUCATION
Sidney P. Marland, Jr. (1K)
PUBLIC HEALTH SERVICE
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NATIONAL INSTITUTES OF HEALTH
DIRECTOR
John F. Sherman, Actg. (8A)
HEALTH SVCS. & MENTAL HEALTH ADMIN.
ADMINISTRATOR
David J. Sencer, Actg. (3A)
FOOD AND DRUG ADMINISTRATION
COMMISSIONER
Sherwin Gardner, Acting (6A)
SOCIAL SECURITY ADMINISTRATION
COMMISSIONER
Arthur E. Hess, Acting (4A)
REGIONAL OFFICES (1E)
REGIONAL DIRECTORS
SOCIAL AND REHABILITATION SERVICE
ADMINISTRATOR
Philip J. Rutledge, Acting (5A)
OFFICE OF EDUCATION
COMMISSIONER
John R. Ottina, Acting (2A)
NATIONAL INSTITUTE OF EDUCATION
DIRECTOR
Thomas K. Glennan (7A)
OFFICE OF CHILD DEVELOPMENT
DIRECTOR
Saul Rosoff, Acting (1T03)
March 21, 1973

CONTROLLABILITY OF THE BUDGET

Mr. MICHEL. How much of your budget is actually uncontrollable this year compared to last year?

Secretary WEINBERGER. There are varying estimates. It depends upon definitions. The figure we have been using lately is 85.7 percent of the 1974 budget outlays. 1973 was 85.2 percent.

Mr. MICHEL. Those are percentages?

Secretary WEINBERGER. Percentages of uncontrollables.

Mr. MICHEL. In terms of dollars?

Secretary WEINBERGER. It would be 85 percent or $80.6 billion.

Mr. MICHEL. Actually, there is a pretty good piece of the action here that we can affect one way or another.

Secretary WEINBERGER. Yes; and you can affect the whole thing, because "uncontrollable" means uncontrollable in the sense that we continue to follow the same statutory rules that are in effect now. By changing statutes, of course, the whole thing becomes controllable; although social security, medicare, and medicaid, which are considered uncontrollable and unchangeable, constitute a large part of it.

GENERAL MANPOWER MARKET

Mr. MICHEL. I would like to turn to the policy on which your manpower and student aid proposals are based. You concluded that the specialized manpower support programs should be phased out, and that we should rely, instead, on the general manpower market.

Secretary WEINBERGER. Yes.

Mr. MICHEL. What do you mean by general manpower market?

Secretary WEINBERGER. By general manpower market we mean that rather than use categorical specialized student support programs to meet the demand for the cost of postsecondary education we use the general student assistance programs to finance the cost of higher education. Federal categorical or specialized assistance should only be used when there is evidence that the marketplace cannot provide the necessary manpower in areas that are of national priority and where intervention will appreciably affect the supply of that manpower.

We believe now that Federal support for specialized activities is no longer necessary. Our broad student assistance programs together with income potential and individual motivation should produce an adequate supply of trained manpower.

HEALTH CAPITATION GRANTS

We are still providing special institutional capitation grants for medical and dental training. The very high cost of this training and the difficulties attendant upon getting training facilities to expand their capacity justify special Federal intervention, at least until this manpower shortage is overcome.

Mr. MICHEL. I was going to ask you something about that later, but since we are on that subject, may I ask here what was the rationale for continuing the current rate of capitation support for medicine, osteopathy, and dentistry, and then terminating it for nursing, veterinary medicine, optometry, pharmacy, and podiatry?

The chairman touched on this in a very cursory fashion, maybe for the purpose of expediting the hearing, but he and all members of the subcommittee have an interest particularly in nursing. That is one area in which we will get, I am sure, a lot of flack. I know the gentleman to my right has been very active in support of veterinary medicine, and several others on the subcommittee, too.

Can you give me something more than your general statement to support that position? I think it fair to predict that we are going to run into some flack on that.

Secretary WEINBERGER. Let me say initially that the medical, osteopathy and dental seem to be well established, and we are continuing the capitation grants for that purpose.

With respect to the subsidies that have been going into nursing education, these subsidies have been roughly at about $300 per student. The actual cost of the nurse education is somewhere between $2,000 and $3,000 a year. So, the problem, again, is similar to the one I mentioned in another connection in the statement. That is, that it is a comparatively small amount of money, $16 million in 1973, spread so thinly that it does really very little good or very little in an effective way toward producing an additional supply of nurses.

Mr. MICHEL. You are not telling us that we have a sufficient supply of nurses?

Secretary WEINBERGER. It is awfully hard to give any categorical answer to that, because you have different kinds of descriptions of need. A lot of it depends on the various levels of service continuing to be supplied under medicare and medicaid. A lot of it depends on what utilization is made.

We believe that in some areas of the country and for some kinds of care, there may not be enough nurses. In others there may be close to enough right now and, given the lag in the time it takes to train, there may well be a situation in which Government stimulation could provide an oversupply.

Right at the moment, I think there is considered to be a need for additional nurses. We have 1,400 nurse training schools in the country, and only 950 of them last year even applied for the capitation grant.

So, this kind of level of support of around $300 does not seem to be significant in increasing or decreasing the supply of nurses.

Mr. CARDWELL. Before you leave that, I think we ought to comment on the other three professions.

I think they reflect a choice as to priority and a general conclusion in the form of a question as to whether it is proper public policy to finance directly and subsidize the training in those particular disciplines—pharmacy and veterinary medicine.

I would call your attention to the fact that this issue has been raised before, with previous administrations and previous budgets having made exactly the same proposal, and largely for the same reasons. This is not a new issue. It is an issue which has come before us several times.

Mr. SHRIVER. Is not the education of veterinarians in the national interest? They have been extensively used by the Federal Government. They are used in connection with our defense efforts and are quite important.

There are only 18 or 19 schools in the country, and they are supported by those 18 or 19 States.

Veterinarians trained in Kansas do not remain in Kansas. Most of them go out to the rest of the country. Therefore, there is a national interest, I think, in connection with the training of these people.

Mr. CARDWELL. I do not think the data are conclusive, but there are some data, I have been told about, that suggest that in specialized disciplines, graduates do tend to stay in the same general area where they went to school. It is particularly true of physicians, and I assume it to be true of veterinarians.

Mr. SHRIVER. In your statement, Mr. Secretary, you say the principal exception to this is assistance for expanding the supply of doctors and dentists, since the high cost—that certainly applies to veterinarians and osteopaths—and the long period of training make it unlikely that the market will produce the trained manpower needed.

The same thing applies there. The reasons you have given would apply to these others.

Secretary WEINBERGER. I think, as Mr. Cardwell said, that this is certainly an important point. The important part of it is the fact that we felt the Federal Government would have to select, with considerable care, the things that it does, and that while a lot of things are desirable, it is not possible to fund all of them.

So, we are trying to select the things that seem most important. There are higher rewards in many of these professions, and that opens up, of course, the possibility of borrowing to enable completion of education, and repaying as earnings commence. Types of programs of this sort, both public and private, as well as those run by the schools, are available. It is desirable and necessary to have Federal encouragement in particular kinds of shortages.

Again, we just feel we cannot do them all. So, we have tried to pick out the ones that, in the national health picture, seemed the most important.

Mr. SHRIVER. You will find most States have a medical school and a great number of them have dentistry schools. You find very few of these other schools throughout the country that are serving the needs and demands of the country as a whole.

LEGISLATIVE PROPOSALS

Mr. MICHEL. Mr. Secretary, how many legislative proposals do you have in the making, that have already been submitted or are on their way up to the Hill?

Secretary WEINBERGER. I do not have an actual number. There are a lot of them, of course, because we have a lot of authorities running out in June. There will be reauthorizing legislation needed in those cases where the President wants to continue the program.

We have a major initiative in health and a major initiative in education, both of which, as I mentioned earlier this morning, we are working on.

Mr. MICHEL. Yesterday when Assistant Secretary Marland was here, as we broke the hearing I tried to emphasize the importance of getting that thing up here pronto.

Secretary WEINBERGER. I agree completely.

Mr. MICHEL. The legislative committees of both Houses have to act, we have to go to conference, and all that routine. We are just out in the cold unless we have something specifically to tie to. In the absence of having something rather promptly, then we have just to go the old route. I do not think we can emphasize that too much.

Secretary WEINBERGER. I think every inducement and every reason argues in favor of moving it up promptly. We agree completely, and we have every inducement to do so, because it is our program and we would like to get it here just as quickly as possible.

I do not like to make a flat prediction and then miss on it, but I do not see anything that will prevent that coming up in the next few days.

Mr. MICHEL. That is better than what we heard yesterday. We heard that it might be 2 weeks.

Secretary WEINBERGER. You appreciate there are a number of people to be consulted. Since it is the President's legislation, we like to consult him on it. We also have to consult with a lot of the educational groups and States and local school districts that will be affected, and who resent very much not having an opportunity to put their say into it.

That process is under way now, and that is why I am a little hesitant to give you a definite date, because we just might not get their recommendations in time to include the whole thing.

It is not a small job, but it is also a very important one, and speed is a highly important factor in it.

Mr. MICHEL. You will be submitting legislative proposals to revise the Medicare cost-sharing and eliminate the Federal matching for adult dental services under Medicaid, as you said in your statement.

Secretary WEINBERGER. Yes.

MEDICARE COST SHARING

Mr. MICHEL. Can you give us some further indication of what you are looking to with respect to revision of medicare cost sharing?

Secretary WEINBERGER. Yes. We have set this forth in some general detail in the budget.

First of all, I might say there is nothing new about this. Cost sharing has been a part of the medicare program since the beginning. What we are talking about are differences in degree.

The thing that has bothered our people and has led to this legislation primarily is the fact that we believe the present system encourages doctors and providers of health services to utilize the hospital as the first resort rather than as the last resort. We are trying to provide a cost-sharing formula that would make it apparent that the use of the hospital is going to cost somebody something and, therefore, it should be avoided unless it is absolutely essential.

Mr. MICHEL. Would you say we are going to triple or quadruple the cost as a means of barring people from hospital care?

Secretary WEINBERGER. No. The thing is, we think you get two or three other beneficial results out of it. We are saying that doctors and or medical services have every inducement, really, to overutilize hospitals, whereas we think the inducements ought to be the other way.

There is no cost-sharing factor at the present time, aside from the

first day, for 60 days. This means even in diagnostic services which sometimes take 3, 4, or 5 days, or observation cases, it is much easier in every way for providers, doctors and others, to say, "You had better go in the hospital and have all those tests made," rather than talking about some less expensive kind of facility which would not be covered as the hospital is. So, we are talking about a cost sharing that starts the first day, but diminishes and eventually ends after prolonged periods of stay when the patient can least afford charges. Whereas, the present system has practically nothing for the first day, and then builds up to a high charge in the latter days, after a long period of expensive illness.

We are really trying to redesign the system. We would keep the cost-sharing feature in, as it is at present. We think the cost-sharing feature has desirable and necessary results in preventing an overutilization of this most expensive facility, and that if we are able to do this, we can diminish somewhat the tremendous inflation that has been built into hospital costs. They have been rising faster than any other item in the CPI.

HEALTH CARE COSTS

Mr. MICHEL. That probably had some bearing on why in phase 3 the medical profession and hospital care across the board, for that matter, were singled out. Did you have some input in that particular decision?

Secretary WEINBERGER. It is hard to know. We had a lot of meetings and a lot of people expressed their ideas. I am frank to tell you that I have felt that health care costs in general have risen much too steeply in recent years. In fact, it is one of the things that stands out completely when you look at any charts or any studies of what has happened to prices.

I think we have induced a lot of this ourselves. I think we have a system which now guarantees payment from groups that had not paid at all for their medical services. It guarantees whatever charge is made, practically speaking.

It has a feature—I referred to it a moment ago—that encourages the use of the most expensive kind of health care facilities. I think we have contributed a great deal to it.

In addition, all this was taking place at a time when there was a definite shortage of medical providers, medical personnel, doctors and others.

I think all of these things contribute in a completely classical economic way to pushing the price up.

Mr. MICHEL. You can say anything you want to, I guess, with figures, but we have been inclined at times to say the per capita cost per day in the hospital is *x* number of dollars.

Secretary WEINBERGER. It is $105.70 nationally, but there is a tremendous variety up and down. In New York City it is about $130. In some places, as in Massachusetts and Illinois, it is about $50.

Mr. MICHEL. Then there is another factor in that which disturbs me. When people return from Europe, for example, they say the medical costs on a comparable basis are not what they are in this country. What they forget is that the stay in the hospital in the United States is about one-third of the average stay in the hospital in Europe. When

you take these computations, it stands to reason that the first several days in the hospital are those that will be the most expensive. You have had an accident or something tragic or you would not be there.

If that stay in the hospital is 21 days as against 7 days, you will get, obviously, a lower cost per day average. We tend in this country to speak in averages so much that it is a little bit distorted picture.

Have you had any problems expressed by the hospitals because of the imposition of phase III? All the costs are increasing, but they cannot pass that on.

Secretary WEINBERGER. Yes; there have been protests from them. They felt it was unfair and that they should have been treated in phase III as other major industries were.

We felt that there had been a very sharp and continuing rise in health care costs, and that it was not an appropriate time to move, even to the somewhat more flexible system of phase III. Phase III is not all that flexible. It still involves very substantial controls. It was simply felt that the record of our attempts to reduce and hold the inflation back in health care costs had not been as successful or effective as in some other fields and that, therefore, it was quite proper to continue this for a time.

But both the doctors and the hospital organizations have protested.

You have another factor here. You are always told by the hospitals that it is not fair to compare it because a greatly increased quality has gone into this now, and that you now get two aspirin tablets instead of one. You have all of this very substantial equipment and intensive care units and tremendously costly installations. This is another reason for stopping Hill-Burton, we already have a good supply of beds, and new facilities with their higher costs simply contribute to the higher cost.

We have had a lot of protests from the hospitals, who feel they should be allowed to increase their prices to meet what they feel is an increase in quality.

There are a lot of people on the other side who feel that an excess of quality is there, and it is an excess which does not add materially to the safety or comfort or treatment of the patient.

Mr. CARDWELL. With the Secretary's permission, could I take you back to your comments about the problems we run into sometimes by using averages.

Apropos of that is the fact that the cost-sharing proposal on health insurance would switch from the use of average daily costs to actual charges that the patient incurs. That is part of the concept of cost awareness on the part of the patient. He then begins to realize what it is costing him. He understands what the figure is related to. Otherwise, a national average is something he rarely understands.

Secretary WEINBERGER. That is a valid point which I had overlooked. That is another of the changes we are trying to make and will propose in our legislation.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Mr. MICHEL. Let me turn now to where you are with regard to setting up the professional standards review organization required by last year's social security amendments.

Secretary WEINBERGER. We have the director of that office on board now. We have not announced his appointment because the formalities are not complete. He is working, and we are assembling a staff.

We have not appointed the council yet, but we have received a lot of suggestions and proposals for membership on that council.

I think it reasonable to say we are generally on schedule with that. It is required to be in place by January 1, 1974. It will be a very expensive operation.

The first job will be to draw the boundary lines of the regions and get them to qualify various professionals standards review groups within each of those regions.

Mr. MICHEL. Do you know yet how many regions there will be?

Secretary WEINBERGER. We are talking roughly in the 200 range in order to be sure that we will have an area of the country in which there is a recognized kind of uniformity of practice and standards. This involves a great many different parts of the country.

Mr. MICHEL. How many people will be on the council?

Secretary WEINBERGER. Eleven, I believe it is.

Mr. MICHEL. Is that by statute?

Secretary WEINBERGER. Yes.

Mr. MICHEL. Is there any provision for the distribution?

Secretary WEINBERGER. There isn't any required distribution, but naturally, as with any of these groups, we would want to make sure that all portions of the country are represented. I think that goes automatically with any appointive process.

We would also have very high hopes for this. We believe that not only can it improve and refine the quality of medical care, but it can result in substantial cost reductions for some of the public medical programs.

Again, there hasn't been any really effective examination or limit on the charges that can be made. We have had a lot of insurance schemes and we have had a lot of reimbursement schemes. They all involve insuring or reimbursing or paying the charge, whatever it happens to be.

We think that there has been a rather wide variation of charges and standards, and that it is important for both quality as well as quantity that we get some kind of handle on this.

I think it is important, too, that the medical profession itself be instrumental in setting these standards of care. I do not think anyone in Washington, certainly not I, feels competent to tell a doctor how to practice medicine. We do think it important to get a procedure in place under which there will not be an overuse or an overemphasis on, for example, taking four X-rays when one might do perfectly well. Things of this kind, we think, have contributed to shooting the costs up.

I do not say this in any sense of blaming or criticizing anyone, but I think it is essential that we have the profession itself represented through these councils, boards and organizations and that it look very critically at the type and quality of care and at the cost of it.

There are many problems within the medical profession itself that have given rise to very proper concern. Individual doctors are making $200,000 or $250,000 a year entirely from medicare patients. There

may be nothing wrong with this, but the medical profession itself is properly worried about the impression that this may give the public.

They are anxious, as I understand it, to join in this effort to assure that there is quality without an attempt to overload the system.

Mr. MICHEL. Is there a legislative timetable in which these are to be done?

Secretary WEINBERGER. January 1, 1974, is the time at which the organization is supposed to be complete, the regions drawn, and the certification of the units in the country that will be sort of self-governing units.

Mr. MICHEL. There will be a considerable time, even after that, before you get some feel for it?

Secretary WEINBERGER. I hope not too long. If we can get the right kind of organizations, I would think we could start seeing some results, I would hope, in fiscal year 1974, certainly right beyond that.

I think it is a very necessary thing, because I think the whole system has been designed simply to reimburse whatever was charged. I think we are beyond that now.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. MICHEL. On HMO's, do I detect any kind of change of direction or emphasis or feeling?

Secretary WEINBERGER. I do not think so. We had a desire last time and have a desire this time to test that. We have money in the budget to test it on a fairly extensive basis, I think $60 million.

Mr. MICHEL. Will that be limited to testing?

Secretary WEINBERGER. In the nature of things, it will be limited to establishing these organizations and seeing how they work.

Mr. MICHEL. That is a lot of money for testing.

Secretary WEINBERGER. There are different varieties, different models. You have situations in which there are low-income people who would have difficulty in maintaining payments. You have problems of locating them in areas where the medical personnel are not in large supply.

I assure you, if we do not find we can usefully use this amount to test and demonstrate the effectiveness of it, we will turn it back to the Treasury, and gladly so, if it seemed this was more than is required for an actual test.

Mr. FLOOD. Are you aware of any legislation this year in either the House or the Senate on HMO's as such?

Mr. CARLUCCI. I testified on that legislation yesterday before Congressman Rogers' committee.

Mr. MICHEL. Is it significantly different from last year's proposal?

Mr. CARLUCCI. The basic difference is that last year it was envisaged as an operational program. This year we have decided it would be better to have it as a demonstration program so we can thoroughly test the viability of the concept.

Mr. MICHEL. Last year, you may recall, at least on this subcommittee, we had quite a numbers game being played. It was pretty hard for

me to nail down how many we were really talking about. It went up from 20, 30, or 40 up to the hundreds. Then I think it finalized itself into maybe no more than some 100.

If we are experimenting and testing with $60 million, that will be confined to how many?

Mr. CARLUCCI. As the Secretary indicated, it is hard for us to tell just how many HMO's that would be used to fund. In the past, we have used existing R. & D. authority to fund only the planning aspect of the HMO. We have not gotten into the operational aspect. Some 84 HMO's were funded for planning grants. Of those, I think about 14 have spun off on their own and become fully operational.

There was a figure which you probably referred to of 110 bandied about last year. That also includes HMO's that received technical assistance rather than just planning grants.

We are envisaging under our legislation that for those HMO's that wish to extend their operations into medically underserved areas, we would provide operational money, and that is the essential difference between what we are doing now and what we would do under the legislation.

Mr. MICHEL. You spoke of being spun off and on their own. Does that mean they are absolutely free of Federal assistance?

Mr. CARLUCCI. There may be some residual planning money, but it means they have attracted sufficient private capital to become self-sustaining.

Mr. MICHEL. Could we at this point in the record have a résumé or listing of those, with maybe a couple of sentences about how they were conceived?

Secretary WEINBERGER. We do not feel this is the kind of thing the Federal Government ought to subsidize year after year. There are startup costs. There are variations in different parts of the country, and with different income levels.

Generally speaking, the whole idea is that it is to be a self-contained, self-continuing kind of thing that has emphasis on preventive medicine.

In the long range, I think it has very real hope. There are so many different kinds of them that I think it quite proper to try to demonstrate how well they work, if at all. That is what the direction is this year.

[The information follows:]

OPERATIONAL HMOs RECEIVING PLANNING FUNDS OR TECHNICAL ASSISTANCE

Rural Health Associates, Farmington, Maine
This group, providing health services to the poor under a million dollar OEO grant, received an HMO grant to extend these efforts to the middle working class population of West Central Maine.

Rhode Island Medical Society Physicians Service, Providence, Rhode Island
This project is a prepaid group practice experiment in an urban setting.

Penobscot Bay Medical Center, Rockport, Maine
The contractor planned to provide for 40,000 coastal poor people of Penobscot Bay a prepaid group practice option as a permanent activity of the current OEO health network project. OEO had funded a 15 month capitation health plan for 2,000 poor people. The Penobscot Bay Medical Center hopes to turn this into a community-wide self-sufficient HMO.

Geisinger Medical Center, Danville, Pennsylvania
This large multi-specialty medical clinic located in rural Central Pennsylvania has operated for years as a fee-for-services clinic. It partially converted to an HMO which it felt would better serve the area's population. The emphasis of the project is to reduce cost of health care, consumer education, prevention and treatment.

Ramsey County Hospital, St. Paul, Minnesota
A 515 bed teaching hospital of the University of Minnesota which launched an HMO plan on October 1, 1972 with the technical assistance of Group Health Plan Inc. of Minnesota.

Group Health Plan of Northeast Minnesota, Virginia, Minnesota
A rural consumer based plan assisted by Group Health Plan, Inc. of Minnesota which began January 1, 1973 to deliver services on a prepaid basis through two physician groups.

Medical Center Health Plan, Minneapolis, Minnesota
A large, well-established, multi-specialty clinic that began in December 1972 to deliver health service on a prepaid basis to enrollees of the Minneapolis area. This group received technical assistance from the American Association of Medical Clinics.

Lovelace Foundation for Medical Education and Research, Albuquerque, New Mexico
This combined urban-rural HMO in Northern New Mexico and Southern Colorado was funded to serve metropolitan Albuquerque as well as Anglos, Chicanos, and Indians in an area of sparse population and poor transportation in the north.

New Mexico Health Care Corporation, Albuquerque, New Mexico
This physician-hospital organization developed an HMO to service the Albuquerque area. There are two cooperating hospitals in the service area--St. Joseph's and Presbyterian Hospital Center. The services are aimed at all segments of the population with emphasis towards low income groups.

Hawaii Medical Services Association, Honolulu, Hawaii
This insurance-based plan was founded in 1936 to market comprehensive health plans emphasizing outpatient services. Grant funds helped to develop an umbrella HMO and market the HMO plan as an option to their present service plans which now provide service to over 76% of Hawaii's total population of 768,000. The Plan will serve isolated island groups as well as urban centers through scattered group practices belonging to the HMO.

Medical Care Foundation of Sacramento, Sacramento, California
This project was funded to expand the medical care foundation of Sacramento to a health maintenance organization.

South Los Angeles Community Health Plan, Los Angeles, California
This project was funded to develop an HMO in Los Angeles within a black disadvantaged community.

Watts Extended Health, Inc. Los Angeles, California
An administrative umbrella-type HMO serving the Watts area. A high percentage of the area's population is living at the poverty level.

Group Health Cooperative of Puget Sound, Olympia, Washington
This project was funded to expand the services of the group health cooperative to the residents of Olympia.

Mr. FLOOD. What is the professional reaction to it, if you know of any?

Secretary WEINBERGER. I am not able to answer you on that, Mr. Chairman. There may be others who have had some professional reaction. I have had comparatively little.

I think there is some interest in it, but I have not heard anything. I think, however, that if the idea were that the Government were going to run them all, there would be plenty of professional reaction.

Mr. FLOOD. At first, there was a great deal of widespread objection, but it seems to have simmered down in the last year.

Secretary WEINBERGER. I think there may have been misconceptions on both scale and scope, and the idea that the Federal Government was going to run them all.

Mr. MICHEL. I think, too, part of the apprehension was that we were rushing headlong into something we did not know about, and how much we were obliging and obligating ourselves in this room to sustain these things over an extended period of time.

Mr. FLOOD. As a matter of fact, I heard HMO translated about nine different ways by nine different people.

Mr. CARLUCCI. I think it fair to say, Mr. Chairman, that Congressman Rogers' committee yesterday generally endorsed the demonstration approach. I think they share your caution. I think there is some question whether the other body would share your caution, but Congressman Rogers' committee does.

Mr. MICHEL. Is it fair to assume that it is an impractical thing in a confined, inner city area, to have an HMO as a viable operation?

Mr. CARLUCCI. We are particularly interested in seeing if the demonstration would succeed in medically underserved areas, such as inner city operations. In such areas we have the medicaid option to HMO. A number of HMO's have contracted with State medicaid operations. This is a way of using existing financing methods to develop good preventive health care.

IMPACTED AREA AID

Mr. MICHEL. Just one final question, Mr. Secretary.

I am a little puzzled over the relationship of impact aid to revenue sharing. You say the budget would fully fund entitlements for children whose parents both live and work on Federal property. Yet this program is to be folded into revenue sharing.

Secretary WEINBERGER. Yes.

Mr. MICHEL. Do you mean, then, even as a part of revenue sharing, the impact aid program would retain its separate and individual identity?

Secretary WEINBERGER. We have not completely drafted the educational revenue sharing, as we mentioned, but we do plan to put into revenue sharing the category A children. We do not plan to put in the B category, because that is a program we are recommending for termination. That is a part of the educational revenue sharing proposal.

At this point, I am very doubtful that we want to continue the A portion precisely as it is now. We would like to try to get the funds

into the school district and let them make decisions as to which is the best way to go.

It is conceivable that it would be part of the formula for computing the amounts of aid that would go in. As I say, we have not completed drafting the educational revenue sharing measure.

Certainly, the outlines, I think, are clear.

Mr. CARDWELL. Also, as we mentioned the other day, the approach that we are recommending to Congress is that the Congress allow the so-called B authority to expire, and that Congress then deal with the A authority when the special revenue sharing legislation is considered.

Mr. MICHEL. I understand.

Thank you.

Mr. FLOOD. Mr. Natcher.

Mr. NATCHER. Mr. Secretary, we want to welcome you before our committee. Certainly, we wish you the best of everything in your new assignment.

Secretary WEINBERGER. Thank you, sir.

Mr. NATCHER. I believe you occupy the most important Cabinet position in the President's Cabinet, and I think the next 5 years will prove that to be true.

REDUCTIONS MADE BY APPROPRIATIONS COMMITTEE

Mr. Secretary, from time to time we hear statements to the effect that the Committee on Appropriations in the House is unable to deal with matters pertaining to the budget, that there are a lot of people downtown who know a whole lot more than the Committee on Appropriations do about budget matters generally.

I have completed 19 years as a Member of Congress, and for 20 consecutive years the Committee on Appropriations in the House has reduced the President's budget. If the Congress generally had followed the recommendations of our Committee on Appropriations and gone along with the $30 billion that we reduced the budgets over the past 5 years, we would have been in much better shape than we are today.

During the past 5 years, as you know, the Congress has added, through backdoor spending and through other methods, the sum of $30 billion to the budget requests.

I just wanted to call that to your attention.

HEW BUDGET VERSUS DEFENSE BUDGET

On our Committee on Appropriations, we have a number of people who have been here a long time. They also know quite a bit about this budget generally, and they are able to locate hidden funds and to understand how trust funds can be used to make budgets look better.

Last year Secretary Richardson appeared before our committee, and in his general statement he stated in part as follows:

> We are also beginning to gird ourselves for new tasks in the temper of a changing time, and have begun to shift our priorities accordingly. Since the present administration took office, human resources expenditures have risen from 34 percent of the total Federal budget to 45 percent, while national security expenditures have declined from 44 percent to 32 percent. HEW's budget mean-

while has been rising at an annual rate of 14 percent, nearly twice the average rate of increase in the total Federal budget. In the next fiscal year, Department outlays will approach $79 billion, roughly one-third of the Federal budget.

Mr. Secretary, when Secretary Richardson used the figure $79 billion, of course he knew that included $46 billion of trust fund money. As far as the bill itself was concerned, we had only about $33 billion in the bill.

In discussing this matter with the Secretary last year, we went into detail somewhat. Mr. Cardwell was here, and he probably remembers the colloquy that we had with the Secretary. I said to him and I quote:

Mr. Secretary, as far as saying to the people in this country that we are going to increase Defense and it must be increased and we are going to have to hold down HEW and the domestic programs, you will have a hard time selling the American people on that. The majority of the people in this country who think are very much in favor of a Defense budget that absolutely secures this country from the standpoint of security. There is no question about that. As far as saying we are going to have to increase Defense appropriations at the expense of the domestic programs, you may have a hard time selling the people on that.

Mr. Secretary, I want to read a part of your statement to the committee that you made this morning. I quote:

This continuing shift is part of a larger overall budget reallocation from Defense to human resources. In 1969, human resources made up 34 percent of the total budget, and national defense accounted for 44 percent. This relationship has been completely reversed. Now human resources spending makes up 47 percent of the budget, while national defense has declined to 30 percent. The comparison in dollar terms is also dramatic. Whereas human resources expenditures have increased from $63 billion in 1969 to $125 billion in 1974, spending on Defense stands at virtually the same level as in 1969, $81 billion.

This is true, Mr. Secretary, but why didn't you go on and state as far as the $81 billion is concerned that the budget for fiscal year 1973, that we are now operating under, the Defense appropriation totaled $74,372,976,000?

That sounds real good when you say spending on Defense stands at virtually the same level as in 1969, $81 billion, which is a $6 billion-plus increase in the budget for 1974. Is that not correct?

Secretary WEINBERGER. Congressman, it is the difference between budget authority and budget outlays. The budget outlays of the Department of Defense, which is the figure I concentrate on primarily because I am interested in dollars out of the Treasury—and that was also true when I was at the Budget Office—varied from 1969 to 1973 somewhere about $3 billion, around $79 billion to $76 billion.

In 1974, DOD outlays are estimated at an increase primarily $79.8 billion in outlays, because of the increases in pay and prices.

There have been four increases in military pay since 1971. That is what is reflected. It is not an increase in activity of the Defense Department. It is a major decrease in activity.

Mr. NATCHER. Mr. Secretary, would you agree with me that in the budget for fiscal year 1974 we have a $6.6 billion increase in defense?

Secretary WEINBERGER. No, sir, I am talking, again, in outlays. We have about a $4 billion increase in outlays in DOD. That is entirely related to pay and price increases, and represents a decrease in activity.

Mr. NATCHER. Let us take your figure, then, of a $3.9 billion increase in defense.

Mr. CARDWELL. In Defense Department outlays; yes.

Mr. NATCHER. In 1973, the budget estimate for HEW was $33,798,189,500. As far as the 1974 budget estimates, we had $31,064,803,000. This means $2,733,386,500 under the 1973 estimate, and $3,014,111,500 under the continuing resolution.

Do you agree with those figures?

TRUST FUNDS

Secretary WEINBERGER. No, sir. We have problems with those figures because you are disregarding, I think, the trust funds, which we think cannot be disregarded. I think that is money, and a very important part of the Government's program.

I do not think you can just wave aside social security and medicare and say that isn't real money or that it doesn't count. Federal funds are one portion of a very large budget.

But the HEW budget will have increased in total, between 1973 and 1974, just a little over $10 billion. I think that is not an increase that we can disregard.

Mr. NATCHER. Mr. Secretary, do you consider trust fund money outlay money?

Secretary WEINBERGER. I certainly do; yes, sir.

Mr. NATCHER. In other words, as far as trust fund money is concerned, from time to time we see borrowed money out of trust funds, $10 billon for instance to put the budget in a position where it is not too much on the deficit side.

When you come to this committee and present your budget request, you have your authorization for the use of your trust fund money, but as far as trust fund money is concerned. it is not a part of new money before this committee from the standpoint of overall appropriations.

TOTAL SPENDING

Secretary WEINBERGER. That is one of the problems we have with the figures you have been citing. Your figures are completely correct as far as the appropriation action is concerned. I share with you the feeling that the Appropriations Committee, out of its enormous experience, which far exceeds mine, is perfectly capable of dealing with the budget, and has dealt with it on a very constructive and able basis over the years.

Our problem is that the appropriation action is by no means the whole story. The whole story is what we have to look at when we are interested in the taxes and the inflationary effect of governmental spending.

I think, Mr. Natcher, we have to consider the entire action of the Congress. As I mentioned at the beginning of the hearing in response to a similar statement by the chairman, our feeling is that the Congress as a whole did not cut the President's request. The Congress directed or purported to direct about $11 billion more in spending than the President felt was a fiscally sound goal, $261 billion as opposed to $250 billion.

I do not think we can disregard any part of the spending. I do not think we can compartmentalize it and say, "This is the Appropriations Committee, and we don't have to think of anything else," or "This is trust fund, and we don't have to pay attention to it."

I think the Appropriations Committee has done a fine job in making reductions in many cases, but the Congress as a whole has made substantial additions.

The black lung bill is the best example. That bill was not in the budget, but it required $1 billion of additional outlay.

DEFENSE SPENDING

Mr. NATCHER. That is a part of the $30 billion added in the last 5 years. Of the overall budget of $269 billion, would you agree with me that you have an increase in defense expenditures?

Secretary WEINBERGER. Yes; there is an increase in defense expenditures, but it is an increase associated entirely with pay and price. It means a substantial decline in activity.

Mr. NATCHER. It is an increase in money.

Secretary WEINBERGER. Yes.

Mr. NATCHER. Do we have an increase in the budget for space?

Secretary WEINBERGER. I do not recall exactly. I think it is almost level or a little decline.

Mr. NATCHER. Is there any increase in it?

Secretary WEINBERGER. Budget authority is down about $40 million and outlays are up about $75 million.

HEW BUDGET

Mr. NATCHER. As far as HEW is concerned, are we up or down over the 1973 budget?

Secretary WEINBERGER. HEW is way up.

Mr. NATCHER. How much is the figure?

Secretarly WEINBERGER. HEW's budget is $83 billion in 1973; $93 billion in 1974.

Mr. NATCHER. You still have to have those trust funds in there, don't you, Mr. Secretary? Why don't you just talk about the new money that is in the bill, and leave the trust fund money out? How much difference do we have in the 1973 budget and the 1974 budget?

Secretary WEINBERGER. Excluding payments to the trust funds, we have $2 billion in new money, in outlays of Federal funds, and we have $8 billion new money in trust funds. We have almost $10 billion in additional spending in the HEW budget.

"New" or "old" are not terms that mean very much to me. Total funding is what I have to be interested in, both in this Department as well as in my budget responsibilities.

Mr. NATCHER. In the budget we have before our committee, the budget estimates for 1974, is the figure $31,064,803,000 correct?

Secretary WEINBERGER. That is the budget authority. The outlays under that are $30.6 billion, and the outlays for 1973 were $27.8 billion. We have just about a $3 billion increase in outlays, and about a $2 billion increase in budget authority in Federal funds.

But in trust funds, we have a $13 billion increase in authority, and in outlays we have about an $8 billion increase.

Mr. NATCHER. Would this be $2,733,386,500 under the 1973 estimates?

Mr. MILLER. The difference is that you are using the budget that was submitted by the President in January 1972.

Secretary WEINBERGER. We have made some revisions since.

Mr. NATCHER. I understand.

CONTROL OF TOTAL BUDGET

Mr. CARDWELL. Mr. Natcher, would you indulge me in a comment. I have observed this process for a long time. My experience is not as extensive as yours. I care a lot about the process. I have watched the Committee on Appropriations just as I think the Committee on Appropriations has watched me.

I think what you are really pointing out is that the budget of the Federal Government is no longer under the direct control of the Committee on Appropriations.

Mr. NATCHER. I do not agree with you, Mr. Cardwell.

Mr. CARDWELL. I think what you are really establishing is that the budget of the United States is no longer under the control of the Committee on Appropriations.

Secretary WEINBERGER. That is a very fundamental and important point.

Mr. CARDWELL. You cannot disregard the trust funds.

Mr. NATCHER. It is no longer under the control of the Committee on Appropriations? Go ahead and tell us who it is under the control of, Mr. Cardwell. When we mark this bill up, you may change your mind. Go ahead and tell the committee who is in charge of it.

Mr. CARDWELL. I am not sure anybody is. That may be our problem.

Mr. NATCHER. Go ahead and explain to us who you think is in charge of the budget.

Mr. CARDWELL. On the issue of the trust funds, they represent, from the standpoint of their impact on our economy and our citizenry, the second largest source of revenue coming into the U.S. Treasury. They are second only to individual income taxes.

They are almost double, in 1974, the corporate tax rate.

You cannot ignore that much of our economy and say it does not count.

The Congress in its wisdom and through its various voices has in the last 2 years increased social security benefits 70 percent. They have to be financed. They are financed out of those revenues.

This committee, as you point out, deals with a total budget of about $93 billion. You will deal with about $30 billion.

I ask you, who will deal with the rest of it? What unit of Congress will make conscious decisions this year to spend or not spend the rest of it? They will not make conscious decisions. Those decisions have already been made by prior Congresses.

That faces every President, whether he is a Republican, Democrat, conservative, or liberal. I do not really understand how we can continue to ignore it.

Mr. NATCHER. Programs have been deleted and others cut back drastically. Congress will not approve of a number of your suggestions, and time will show as to how our people feel about your proposals concerning Hill-Burton funds, library services, mental health programs, vocational education, and other reductions in welfare. I yield, Mr. Casey.

Mr. CASEY. Mr. Secretary, you were using as an example of the possible irresponsibility of the Congress the black lung bill, because it would not be subject——

Secretary WEINBERGER. I did not characterize it. I said it was totally outside the appropriation process.

Mr. CASEY. You also, I think, used it as an example of what built up spending as being uncontrollable.

Secretary WEINBERGER. That is right.

REVENUE SHARING

Mr. CASEY. The biggest item we had last year in that same category was asked for by the administration—revenue sharing.

Secretary WEINBERGER. I do not think it was as large as the social security increases that were voted.

Mr. CASEY. I am not talking about social security increases. They are in the trust fund.

Secretary WEINBERGER. It was asked for in the context of a budget that was $246 billion; and it was asked for in the context of a 3-year appropriation.

Mr. CASEY. You cannot on the one side say the Congress passed these things that did not go through the appropriations process, and then ignore the fact that the biggest thing we had, which is about $30 billion, I believe, is this general revenue sharing. You are coming back with another one this year called special revenue sharing.

Secretary WEINBERGER. The thing we are coming back with is a measure that is designed to eliminate 30 categorical authorities and provide a single program and the same amount of money.

Mr. CASEY. The general revenue sharing was $3 billion, and social security was only $2.8 billion. The biggest thing was what the administration itself asked for.

Secretary WEINBERGER. But it asked for it in the context of a budget that was overall fiscally responsible.

Mr. CASEY. Now you are talking about special revenue sharing, and all those who came up and hammered on our door for general revenue—understand, I did not vote for it—it has soured on them like nobody's business.

Secretary WEINBERGER. I have not encountered that, sir.

Mr. CASEY. Haven't you been reading the paper?

Secretary WEINBERGER. Yes.

I tell you what has soured, and that is the suggestion that there be special revenue sharing with some of the programs that they are presently having no longer being funded.

Mr. CASEY. You may have them hammer on the door for special revenue sharing, but it will sour in their mouth, too.

Secretary WEINBERGER. I hope not. I think it is a better way to go than 30 separate programs in which they attempt to make a national school board out of the Congress. That is, in effect, what the 30 programs do. You are in the position of trying to tell some schools whether they should or should not have overhead projectors.

Mr. CASEY. I will tell you the same thing I told the Secretary of the Treasury. I think you both have had the same hat at different times.

Secretary WEINBERGER. We have followed each other around quite closely; yes, sir.

TAX CREDIT

Mr. CASEY. That is, if you want to turn them loose, why do you not suggest a tax credit against Federal taxes for local taxes, and let them raise it? If they are going to spend it, let them raise it, instead of coming up here and just beating on our door, and all they do is say: "We would give more local service if the Congress would share more of the revenue."

Secretary WEINBERGER. We are suggesting a tax credit in connection with the assistance.

Mr. CASEY. I am talking about the tax credit. So they can go down there, if they want to raise local taxes they can say, "Get some credits against your Federal taxes."

Thank you.

TRUST FUNDS

Mr. PATTEN. Would you yield?

When you throw in the trust funds compared to these other expenditures, don't leave out the fact, according to your own chart, that you are going to collect $22.3 billion under social security taxes we levied. You are not hit from a revenue point of view because we voted a little increase in social security. We provided the money. You are going to take in $23 billion more in social security.

When you speak of the trust funds you have to tell us you are going to collect $23 billion more, and that does not put you behind the eight-ball in trust funds. In the things we are talking about, trust funds should be omitted. We should have last year's budget set up categorically to make the proper comparison because I think you have cut out the programs that I love.

Secretary WEINBERGER. We have certainly made reductions in programs. We had to. Otherwise we would have been spending at $11 billion over the amount that would have enabled us to get along without inflation and more taxes. We have done that. There has been an increase in revenues from the trust funds but it is still not emphasized in Mr. Cardwell's point. They have an enormous impact on the economy and the taxpayer. Those revenues are being paid out in benefits but they cannot be disregarded in considering the total effect of the Government's spending and the effect on the economy of that spending.

OVERALL LOOK AT THE BUDGET

There is no slight suggestion that there are not revenues in the trust funds. Fortunately there are or we would all be in trouble. They are

part of the spending program of the Government. I think the best way to emphasize the problems associated with an overall look at the budget is that I doubt if there were five or six people in the Congress who knew the day before adjournment last October that the total spending directed by the Congress was about $261 billion instead of the $250 billion both Houses agreed to in the President's ceiling request, but couldn't agree to on the final form of the bill.

HEW REQUEST

Mr. NATCHER. Mr. Secretary, what is the amount of the request before this committee at this time for HEW?

Secretary WEINBERGER. The request for Federal funds is for $31.5 billion in budget authority and $30.6 billion in outlays.

Mr. NATCHER. Is this figure high in your opinion?

Secretary WEINBERGER. I think it is a very substantial figure. I think, given the uncontrollable nature of many of the expenditures, it is an amount that is proper to carry on the work of the agency.

Mr. NATCHER. Do you feel that this figure should be reduced by the Committee on Appropriations?

Secretary WEINBERGER. I have not made any such recommendation. I have not been in place long enough to see if the administration of these programs can be carried on with less funds. We are requesting the amount that is in the budget because, when I was in the Office of Management and Budget and when the President completed his examination of it, this is the amount that we all concluded was necessary to operate these programs. We are not asking for less nor more.

Mr. NATCHER. Generally speaking, Mr. Secretary, from your knowledge of HEW—and you have not been here too long.

Secretary WEINBERGER. I am speaking to you from the heights of 2 weeks' experience.

Mr. NATCHER. From your experience now with HEW, are you in favor down through the years of reducing the overall amount in this department? What is your attitude?

Secretary WEINBERGER. I don't have any real goal or aim that is based on dollars, Congressman. I would like to do the job and I would like to do the job with as few public funds as possible. If we can do it for less. I would like to do it for less. That is one of the reasons PSRO's seem to me to be an attractive and useful investment. I think by investing funds in that, we may well end up with a system in which we can get better medical care for less cost to the public under the medicare and medicaid programs.

Mr. NATCHER. I yield.

Mr. FLOOD. Mr. Secretary, look, you have been down in OMB. Here is Caspar and here is Frankie there and there you are for a couple of years during which time we were faced with a series of Presidential vetoes. I have reasonable cause to believe you are a good lawyer and journalist and so on, and you know what I mean. Anyhow, this went on. You do remember these things because I was the guy down in the well of that House with this veto and that veto and override this one and that one. There is Caspar and Frank, and next year there is Caspar and Frank, and again and again, four of them.

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I wake up one Sunday morning and who in the world is over at HEW—Caspar and Frank. What would you think?

Secretary WEINBERGER. I would think that is the way a self-governing democratic system works.

Mr. FLOOD. That is just the point I was going to make. That is a self-governing operation, no question about it. The only trouble is that the self is on the wrong side of the table.

Secretary WEINBERGER. There are all kinds of self-government, and I think both Frank and I have given up trying to predict what happens next.

Mr. FLOOD. With your marvelous sense of humor, wouldn't this appeal to your sense of humor, if nothing else?

Secretary WEINBERGER. That is a point I raised earlier in higher quarters.

Mr. NATCHER. Mr. Secretary, as I understand now, you are in favor of carrying out the programs in HEW and getting the most for the dollar. I don't think anyone falls out with you about that.

Are there additional programs in the bill that you believe should be reduced?

Secretary WEINBERGER. There may very well be.

Mr. NATCHER. Any that would be deleted that you can tell the committee about?

Secretary WEINBERGER. I am not prepared to say that at this point. I have only been there a very short time. During the budget examination of these programs there were ones we felt fully justified and warranted, reducing or eliminating. There might be others also for which I would recommend reduced or terminated, but we are not prepared to make any additional recommendations of that kind at this time.

The ones that we felt should be terminated or reduced, have been so recommended. They are before you in the form of requests for reduced or zero funding and a request not to extend the authority. Those are the ones that we have examined and acted on. I am not prepared to say that everything else is precisely as it ought to be. I am fully prepared to stand behind this budget request and ask that the committee fulfill it but not exceed it.

Mr. NATCHER. Mr. Secretary, at the time you were named Secretary of HEW and before you were confirmed by the Senate, you read articles, and I read them, to the effect that you were being placed in this assignment for the purpose of cutting this budget for HEW. You read those stories?

Secretary WEINBERGER. I read those stories but I read my answers.

Mr. NATCHER. Did they make any impression on you?

Secretary WEINBERGER. Those stories did not because I also read my answers to them.

Mr. NATCHER. What did you say?

Secretary WEINBERGER. I said that I had received no specific instructions from the President to do anything other than try to operate the assigned programs in the best way possible and try to insure that the Federal dollars went to the people most in need. That is my charter, so to speak. It is a broad one and we are trying to carry it out. I have never been able to control nor be responsible for appellations that the press gives us.

Mr. NATCHER. Mr. Secretary, prior to your assignment in the Office of Management and Budget, what was your occupation? What assignment did you have in California?

Secretary WEINBERGER. I was an attorney at law in California. I was the director of finance for 2 years for Governor Reagan.

Mr. NATCHER. Did you ever have an assignment comparable with the one you have now?

Secretary WEINBERGER. No. I have had no assignment comparable to this. I have had no assignment comparable to the Federal budget prior to the time I took that. I am not sure there are comparable ones.

Mr. NATCHER. We still wish you the best of everything.

Secretary WEINBERGER. I need it.

Mr. NATCHER. Mr. Secretary, thank you. Again I want you to know that, as one member of this committee, I wish you the best of everything in your new assignment. We are going to try to help you, Mr. Secretary.

Secretary WEINBERGER. I need it and appreciate that very much.

Mr. NATCHER. Thank you.

Mr. FLOOD. There are not many amateurs around this table.

Secretary WEINBERGER. It is a very pleasant hearing so far, Mr. Chairman.

Mr. SHRIVER. Thank you, Mr. Chairman.

Mr. Secretary, I want to express my own personal appreciation for your forthright answers. I recognize that you have a most responsible and complex job and probably one of the most difficult in the Federal Government. You are to be commended, especially for your courage.

COUNSELOR FOR HUMAN RESOURCES

How do you view the dual role that you have, as Secretary and as counselor? How do you look at your responsibility?

Secretary WEINBERGER. Congressman, I am hopeful it will be a helpful duality. I think the basic idea arose from the fact that the President, as you will recall, submitted, about 2 years ago, a plan to consolidate the functions of the executive branch into four main divisions. One of the four he wanted to consolidate was Human Resources. The feeling that he had at that time, and insofar as I know it has not changed, was that there are similarities in function, in activities, and in programs that transcend the existing boundary lines of various departments and agencies created many years ago. There was a good chance of waste and duplication if each of these agencies were operated separately without an overall realization or examination of the similarities of the program.

For example, in manpower training we have, as I recall, something like 13 separate programs scattered through five agencies working on various phases of manpower training. Rather than have that continued, the desire of the President was to have those pulled together even though they might cut across existing department lines, so that not one person would be operating them—the Counselor for Human Resources does not operate anything except HEW—but, to insure that there was a coordinated approach and a proper utilization of all of the resources so we wouldn't get into duplicate or quadruplicate over-

heads and things of that kind. That is essentially what we are trying to do now with the counselor's role, trying to achieve administratively some of the advantages that the President sees from this sort of unified operation.

The principal role of the counselor, as I see it at the moment, is a kind of communications role; to insure that there is lateral, upward and downward communications between all of the agencies working in things that affect or are involved in human resources. Income security, manpower training, nutritional programs—some of these are in Agriculture, some in HEW, some in HUD. We are trying to deal with all of these on a unified basis, unified in the sense that they try to get at things that have basic similarities. Human resources is one of those fields. Natural resources is another. Urban and rural community development is another. These are the counselor's roles, in addition to having the direction of some of the major departments.

As I say, I think the only way in which this can be really worked is to have extraordinarily able and dedicated people working with us in these endeavors. I feel particularly fortunate, as I mentioned this morning, in having Mr. Carlucci as the Under Secretary. I think in other administrations or in other sections, the Under Secretary's role has not been utilized as a true alterego of the Secretary. There may have been sometimes a tendency to establish the Under Secretary as in charge of a specific program. We are not doing that. We are completely interchangeable, and I think it has to be that way.

PUBLIC ASSISTANCE TAKEOVER

Mr. SHRIVER. When the Federal Government takes over the added categories of public assistance next January, this will presumably free up a considerable amount of State funds. Do we have any idea of how much?

Secretary WEINBERGER. We have the exact figures. The estimates are that we would add 18,000 employees. I think the States are using approximately 24,000 or 25,000 people for these tasks now. It would be my hope we would do it with fewer than 18,000 new employees if we get the advantages of consolidation with our existing social security system. My worry about it, frankly, is that not all of the State people whose duties will be replaced will be off the State payroll. I have a feeling some may stay on. That is one of the problems with transferring a function of this kind. This is a——

Mr. SHRIVER. You don't have anything to say about that?

Secretary WEINBERGER. Not at all.

Mr. MICHEL. They are going to be relieved of their responsibility and the Federal Government is going to assume that?

Secretary WEINBERGER. That is the direction of the Congress and we are approaching and addressing that right now.

MEDICARE COSTS

Mr. SHRIVER. In an effort to hold down medical costs, you are planning to require preadmission for elective hospitalization and surgery. How will that work?

Secretary WEINBERGER. I would ask one of the people here who is more familiar with that than I am. The general idea is that there has been quite a cost that has been racked up over the years with elective surgery and elective procedures of all kinds. I think what is desired here is to have some kind of medical examinations and certification as to the desirability and necessity of hospitalization well in advance of admission to hospitals. We believe there is a $100 million saving that can be obtained from this.

Is there anyone that wants to take up that?

Mr. CARDWELL. I would comment it does involve the design of a regulation. That regulation is not yet finished. At the time the Social Security Administration arrives for their testimony, I hope they will describe it to you. It really follows one of the basic traditions of the medicare program, which has from its inception involved a utilization review after the fact by looking at norms. This would be an effort to take the norms that have been identified and to apply them in advance by having the hospital, admission staff, and physicians in the community made aware of what the norms involve, and to test their own proposals against those norms.

Secretary WEINBERGER. The overall intent of the program, Congressman, is to get away from insuring a Government payment for whatever the charge might be. We are trying to look back and see if the charge itself is reasonable and if it can not be reduced before we agree automatically it will be governmentally funded.

COMMUNITY MENTAL HEALTH CENTERS

Mr. SHRIVER. You are proposing no extension of the community mental health center legislation. You say this program should now be absorbed by the regular health service delivery system.

What do you mean by that?

Secretary WEINBERGER. We now have 515 of them that have been federally aided across the country. There are several States that provide for these themselves out of State funding. Our budget request provides enough authority to honor all commitments; and, the commitments was that they would be federally aided for 8 years. This involves a continuation of funding, for many, for several years. We don't believe we should make any more commitments. The idea was to demonstrate that a community mental health center could work and this involved being financially self-supporting.

Mr. SHRIVER. Does this mean that you support the inclusion of mental health care in the national health insurance program?

Secretary WEINBERGER. We are working on the national health insurance proposal that we are going to submit. We may well get into that kind of a provision. I am personally familiar with how they work in some parts of the State of California. They have opted to reduce the need for large State institutions, to keep patients much closer to home, and to get them discharged to happy and useful lives and to their families sooner. This is all good.

By definition they are community operations, and we think it is entirely proper for the Government to start them out, help them, see if they can work. We believe that that has now been demonstrated

and that it is time for the Federal Government not to start new commitments of this kind, but to complete their old commitments, even if they take 6 or 7 years. We have asked for authority to do that, but have informed them with plenty of notice they are to be self-supporting or supported within their own communities or States.

Mr. CARDWELL. Mr. Shriver, there are a couple of other points that might be of interest and useful as you evaluate this proposal. One is that as the program has evolved and you take a picture of it as of today, you find the HEW financial support accounts for about 23 percent of the total support. There is another 7 percent coming in in the form of other direct Federal dollars. The rest of it is coming in either through State and other political subdivision support or through third-party pay systems.

The second point I would like to make is when the program was originally conceived and passed and established by the Congress, the third-party pay system was just barely getting underway. That was clearly evolved. There are cases where medicare will cover some mental illness, and mental illness is also an option of some of the State medicaid programs. As you look down the road, it is pretty clear third-party pay systems will begin to come more into play.

The final issue, as you talk to the mental health people when they come to testify, is the fact that the day of the warehouse, large institutions is past. As the Secretary pointed out, the demonstration has been already made. The concept of providing mental health in the community is well established in this country. The basic issue is, should the Federal Government continue to finance what has become a local operation, particularly considering the movement into third-party pay financing mechanisms?

SPECIAL PROGRAM FOR ALLIED HEALTH

Mr. SHRIVER. You want to discontinue the special program for allied health. Some of these schools are just getting started and certainly there is a shortage in this area for that kind of help. Is the same reason the matter of priorities?

Secretary WEINBERGER. Yes; I think it is fair to describe it as a selection of priorities. This program is designed to support improved training and utilization of allied health, paramedical personnel. We have made grants to various training centers that do this and have encouraged them to increase their enrollments, and so on. We will continue to have special project grant assistance under very flexible educational programs.

Student assistance will be available also. Again I think we have to bear in mind the point quite similar to the ones made in previous programs. Federal funding is not really a very crucial factor in substantial growth of these paramedical personnel. Federal spending and support has been quite small in relation to State, local, and private spending. We figure again it is an appropriate time to move out of this field with Federal financing.

Mr. CARDWELL. There are two other points. One is that we are not backing away from a concept of trying to produce additional skills

and new kinds of skills for the delivery of health care. We are saying we would like to concentrate that support in the special project authority that was included in the health manpower amendments of last year. That authority permits a better direction of how you go about that task rather than spread money among all institutions on an institutional support basis. On the institutional support idea, there is an alternative which we think has come into play and should be allowed to takeover. This is the movement of the community colleges into the teaching and training of paraprofessionals. This is really the thing that the community colleges are clearly doing best. It is the thing that they are moving more rapidly into than any other form of curriculum.

Secretary WEINBERGER. There are about 1,200 of these programs in junior and senior colleges; 3,200 separate sorts of programs in these 1,200 and less than a third of them have received Federal support and are receiving it now. Private schools, State and local governments are supporting them, and again Federal support does not seem to be an instrumental factor.

IMPACTED AREA AID

Mr. SHRIVER. Getting to a noncontroversial part of your testimony, that relating to impact aid. I have been on this committee since 1965 and I have heard similar statements to cut back on impact aid made before. We have had impact aid, as I said, a long, long time in all parts of the country.

Let me tell you about one school district just outside of my home city. In that community we have a large airplane factory with the real property used by the industry owned by the Federal Government, so that school district receives no real property taxes from this one industry. It is the only large business in the school district. Of course, the community has grocery stores; it is a bedroom community primarily.

The community school district also educates children from an airbase, except most of the citizens live in this little community and not on the airbase. So practically all of the school support comes from the "B" students under impact aid, which you would eliminate. We are rather late into this year, and they have already made their plans based on what they thought they were going to get and what they have received from Federal impact aid in the past many, many years.

What would I tell this school district as to how they are going to finance the finishing of this school year and another year based on that kind of fact I have discussed. The situation is not like Montgomery and Fairfax County. That is all I have heard about in explanation of what is wrong or inequitable about the so-called inequitable program of impact aid.

Secretary WEINBERGER. Congressman, the problem, of course, is that of the very substantial amount of Federal funding of about $126 million, something over $26 million of that does go into the three Maryland counties that you mentioned. What has happened in many parts of the country has been that there has been a large amount of Federal funds put out without any particular relationship to need. The school districts themselves will not be surprised at another attempt to end this program because this is, I suppose, the fifth President of the United States who has tried to end it. It is not a novel proposal in any sense.

As far as the timing is concerned, that is the same problem we have with the timing of all educational appropriations. School districts start planning these fall expenditure program now; and, usually by now the Congress has not had an opportunity to act on the educational appropriations requested. To that extent there has been the same uncertainty. To the extent that the parents live and work on a Federal post, there would be a continuation of the program recommended. To the extent the parents live off the post and therefore contribute through property taxes and other purchase taxes to the community, there seems to be no reason to put out a special Federal subsidy that has no relationship to need at a time when the President has felt the full focus of Federal funds should be on those who do stand most in need.

Mr. SHRIVER. Except that the whole thing was started by the Federal Government?

Secretary WEINBERGER. Yes. There were different conditions at that time.

Mr. SHRIVER. The board has relied upon this?

Secretary WEINBERGER. They have relied on it, but each year for pretty close to 20 years it has been challenged.

Mr. SHRIVER. Practically the only source of real property support in this particular instance that I told you is a nontaxable, federally owned property.

Secretary WEINBERGER. There are many States which have attempted to equalize their educational revenues by recognizing that this kind of disparity exists, and some States are pretty close to 60 percent owned by the Federal Government with large national forests and national parks. There are some counties that I am familiar with where the Federal ownership is something like 90 to 95 percent. The State equalizes the educational expenditures in these areas because the tax base is so small. There cannot really be any contention that there has not been either warning or the possibility of change of this system because President after President has recognized what seemed to be the inequities of putting out the Federal funds where there is no relationship to need. There have been many——

REVENUE SHARING

Mr. SHRIVER. We are putting our money into revenue sharing where the need factor is not there. Under this program there has never been a string attached to it. The money goes back with no strings, the same as intended under revenue sharing.

Secretary WEINBERGER. We think there is a need factor with general revenue sharing because we believe the provision of different general revenue-sharing funds can be of substantial assistance to State and local governments in preventing the necessity for them to raise taxes.

Mr. SHRIVER. The school district, as I described?

Secretary WEINBERGER. General revenue-sharing funds are available indirectly in the sense that they free State and local governments from other requirements, and free their local revenues for additional education purposes. They could be used for this if they so desired.

Mr. SHRIVER. I yield to my colleague from Massachusetts.

Mr. CONTE. Mr. Secretary, how much of the special educational revenue sharing will be attributable to impacted aid?

Secretary WEINBERGER. We would plan to fold in the A category children, $227 million in 1973. That would be that portion of the $2.5 billion that we would have in mind for the program.

Mr. CONTE. In other words, nothing else?

Secretary WEINBERGER. That is correct. We would not propose, Congressman, to fold in category B children because we think that is not a justified program. We are requesting termination in the sense that we are not asking a renewal of the authority of that program.

Mr. CONTE. I want to be absolutely clear on this. I think a lot of people back home think that the special revenue sharing for education will include aid to impacted schools. If they are getting impacted aid, are they going to get that money?

Secretary WEINBERGER. They are going to get the A but not the B.

Mr. CONTE. Then, as I understand it, there will be absolutely no money for the category B children.

Secretary WEINBERGER. That is correct. We are recommending that the category B program be terminated.

Mr. CARDWELL. I think one reason the idea of impacted aid being specifically identifiable exists is that the special revenue-sharing proposal last year for education did have a special passthrough for impacted area aid. In other words, you could identify specific amounts of money and it could only be applied to impacted area aid. The question remains as to whether the proposal presented this year will have the same kind of passthrough. That has not been decided yet.

Mr. SHRIVER. The general revenue sharing, you indicated that might be available?

Secretary WEINBERGER. Indirectly, because it would free State and local governments from the need to use their own revenues for various purposes. Therefore, they would have those revenues and could use them for school purposes. General revenue sharing had a prohibition against the use of these funds for educational purposes locally.

Mr. SHRIVER. That is what I am talking about.

Mr. MICHEL. Not for the State?

Secretary WEINBERGER. Not for the State. Also, as I say, if you get some, as some States did, $100 million or $200 million or $500 million more than you had before, indirectly it enables you to do so because it gives the additional money which can finance permitted activities and free up funds for other activities.

Mr. SHRIVER. In reality, I can tell this school district to go to the State and get some of their general revenues?

Secretary WEINBERGER. I think that probably quite soon all States will be required to have some kind of an equalization factor for educational expenditures. I think that will be the effect of the Serrano case which will be probably decided by the Supreme Court fairly soon. It is never safe or permissible in my business to try to predict what courts will do; but, on a direct, specific case, I think without any question you are going to have a situation in which States will be equalizing the amount of educational funding that they have, to take into account the differences in tax base.

I think the basic idea is that it is not considered fair for children to have less available State funds or be penalized because of the area of the State in which they live.

Mr. SHRIVER. Thank you, Mr. Chairman.

Mr. FLOOD. Mr Casey?

Mr. CASEY. Thank you, Mr. Chairman.

Mr. Secretary, I apologize for not being here this morning, but I have a subcommittee which I chair which takes care of the salaries of my colleagues and takes care of the House. They always want me to get my bill out first.

Mr. FLOOD. You see the College of Cardinals here. These guys are all chairmen.

Mr. CASEY. I get in trouble if I don't get my bill out first. They don't want to operate on a continuing resolution.

I want to welcome you as the new Secretary of HEW.

Secretary WEINBERGER. Thank you.

APPROPRIATIONS PROCESS

Mr. CASEY. It has already been stated and everybody recognizes that HEW is the most important Cabinet position and gaining more prominence all the time.

Mr. Secretary, one thing that distresses me is this attitude to try to blame Congress for all the trouble we are in fiscally. The executive branch has a very nice way of dodging the issue, lay it on us real well, because they say—

> The Congress passes these bills that have automatic appropriations, do not go through the appropriation process. The Appropriations Committee is very responsible but the Congress passes these bills that do not go through the appropriation process.

Then the executive asks for revenue sharing which does not go through the process, and when I try to put it on you, you say the Congress adopted it. There we are. We are the guilty parties.

I would say that if we had been delinquent in that respect the executive has contributed to our delinquency by asking for additional types of this kind of legislation. I don't think that you ought to wrap it all around us.

Mind you, I think this has been healthy for the Congress in jumping on us because there is going to be more responsibility on the part of the Congress as a whole in looking spending over and doing its part. In fact, I was shown a statement in which you stated that there should be a closer working relationship between the Executive and the Congress.

Secretary WEINBERGER. Very much so.

Mr. CASEY. In tightening up the expenditures, seeing a little more responsibility in that regard.

Secretary WEINBERGER. Yes, sir.

Mr. CASEY. I think it is equal.

Mr. CARDWELL. I would think, I don't know about the Secretary, but we would concede there has to be a greater awareness on the part of the executive on creating new open-ended programs.

Mr. CASEY. I think when you start throwing bricks around, some of them are going to boomerang on you. The Congress passes bills, sets up programs, but they are administered by the executive. Somebody says, "Look what you set up and how sorry it is operated."

We don't operate them. I think we all have our share in some of these programs that have gone sour. Sometimes about the time that you get a program worked out to where it is kind of responsible it is abolished and you start a new one with a new name and practically the same objectives. About the time you get the kinks worked out here we go.

We get a new Executive, President, and Secretary, and here we crank up again, and they pick out their own name and head in the same direction with a whole new crew with a few changes.

I just want to say that I voted for some programs and I voted against others, but I stuck by the idea the Appropriations Committee ought to review programs and I still do. As a Member of the legislative body, as a whole, I must take some of the blame. I don't think Members of Congress are entitled to all of the blame that the news media is heaping on them at the moment by means of editorials, cartoons, etc.

Along that line, on the priorities, such as the revenue sharing, it was a priority of the executive department so you all think it is great. We as a Congress as a whole happen to think that black lung had a priority, but that is bad. I think that each has some right to pick priorities in that regard, but by the same token we must tighten up and have the opportunity to oversee them. I would think the appropriation process on all spending that we possibly can, so that we can have year-to-year restraint. Revenue sharing has a 3-year restraint, as I understand it.

Mr. CARDWELL. Black lung is appropriated, but still open-ended, because you pay based on the number of beneficiaries.

CALIFORNIA'S DEPARTMENT OF FINANCE

Secretary WEINBERGER. I always favored a situation in which there were no uncontrollables and the Congress and the executive had 100-percent review through the appropriations process each year. I favored that in California and tried to get away from the highway trust funds and all the other dedicated funds, but it is a very difficult thing to do because individual groups get individual protections and fences built around their favorite appropriations; and, they prefer it that way because they prefer to remove it from legislative or congressional consideration.

Mr. FLOOD. Is the budget office a part of the legislative branch in the State of California?

Secretary WEINBERGER. No. There is a department of finance that is part of the executive branch.

Mr. FLOOD. The so-called bureau of the budget is in the legislature?

Secretary WEINBERGER. No. They don't have a bureau of the budget. They have a department of finance that has the budget and audit function as well as some of the revenue functions.

Mr. FLOOD. Do you think we should have the same thing here that the legislature has in California?

Secretary WEINBERGER. The legislature in California has a staff that serves a joint budget committee, and that joint budget committee examines the Governor's budget that is submitted each year.

Mr. FLOOD. Pretty good thing?

Secretary WEINBERGER. It works out reasonably well; yes, sir. They have the staffs that Congress doesn't have; and, the size of apropriations committees doesn't seem to me to be in any sense inadequate or too few. I think what is needed is more of a total jurisdiction to examine the entire budget rather than just the appropriation bills. I think there needs to be some central point in the Congress, and I am pretty presumptious in saying anything about how the Congress should carry on its business, but it seems to me there is a better result to be obtained if you had 100 percent of the budget under your review rather than about 30 percent.

NONAPPROPRIATION ITEMS

Mr. CARDWELL. While we are on the subject, I am not sure I should say this, but as you look down the road at the kinds of public policies that are to be considered next, for example, health insurance, if we follow past practice we will create another open-ended nonappropriation budget item of great significance.

Mr. CASEY. That is true, but by the same token there you have an actuarial type of slide rule operation, I think.

Mr. CARDWELL. One of our problems is people coin these terms trust funds and dedicated funds, and then legislators and executors somehow condition themselves to believe that that sets them apart from all of the decisionmaking. That really is a fundamental mistake in Government. We keep making it over and over again, in my judgment. They are such a significant part of our public policy. We make very deliberate and important choices and then we turn around and pretend that that is something else. "That is in a trust fund so we don't have to worry about it." Yet our capacity to pay, capacity to make other choices has already been affected and in some ways preempted. The U.S. Treasury is not a bottomless pit filled to the brim.

Mr. CASEY. Is that right?

Mr. CARDWELL. That is right.

We certainly feel that way. It is a non sequitur.

Mr. CASEY. I agree with you wholeheartedly, but by the same token I am in sympathy to a great degree with the fact there has been an awakening of the fact that the Federal Government should not be in everything. I do have a quarrel with the idea that the way you are going to get out of it is all of a sudden whack everything off.

Mental health was mentioned a while ago. We get elected not on general broad policies, but we get elected by what is interesting for our constituents and those who have helped us get where we are. It is that basic.

I had a gentleman walk into my office. He said "I am for the President's idea to cut down on this spending, but."

Secretary WEINBERGER. That is very familiar.

Mr. CASEY. You very adroitly say that revenue sharing can pick this up if they want to and it can give local authorities responsibility.

I assure you that if anyone is doing the same thing I am doing, making a tabulation of what is being cut out in my particular area, revenue sharing and what they will get back will not begin to cover it. Yet you say this will help them in preventing higher taxes. If they try to maintain the types of services they have had in the past it will not do this.

Incidentally, I am from Houston.

Secretary WEINBERGER. Yes, sir.

Mr. CASEY. They are really excited about the cuts. In fact, I have to be there the last Friday of this month. They want us all down there to tell us how this is affecting them. There is not that much revenue sharing going back into that area to pick up the slack. That is one of the problems.

HILL-BURTON

For instance, you want to cut out the Hill-Burton funds. The hospital beds have been built up to some degree. However, by the same token the Federal Government comes along and says, "If you want to operate a particular hospital or a home for the aged, you have to have certain standards." All right. In my own area here is a black nursing home. It was all first built by local contributions. Perhaps some Federal money went into the first one. This was some 20 years ago.

They have now been put on notice "You have to either upgrade or close down." They applied for some Hill-Burton funds. They have been approved all the way up. They now have no money. What do they do—close down? What other alternative have they?

Secretary WEINBERGER. The Hill-Burton commitments which have been made would be honored. We have pointed out in the statement that there are $1,800 million in depreciation costs from third party and insurance financing sources, which provide a basis for seeking construction financing.

Mr. CASEY. Insurance financing? You mean insured loans?

Secretary WEINBERGER. No; it breaks down this way—the medicare-medicaid program of the Federal Government reimburses hospitals for their expenditures. One of the elements of reimbursement is depreciation. That can provide $800 million annually in financing which can be set aside and used for renewal or restoration or improvement.

Third party insurance, outside of the Government, will pay an estimated $1 billion next year for the same basic purpose so that you have a fund both from Government as well as private insurance sources of about $1.8 billion over the whole Nation, which is much more than Hill-Burton ever paid for improvements or for modernization or expansion if any is needed. Therefore, we think with this kind of available financing, with an overall surplus of beds in many parts of the country——

Mr. CASEY. I am talking about this one little institution. How long will it take them under this depreciation allowance to build up this reserve?

Secretary WEINBERGER. They have been receiving payments from these funds. Certainly the existence and availability of this kind of repayment can furnish the basis for a private loan. They can borrow against this with no real problem.

Mr. FLOOD. With regard to Hill-Burton, keeping in mind two or three different things, you spoke of bricks and mortar, new construction.

Secretary WEINBERGER. Yes.

Mr. FLOOD. I am glad you are getting to modernization. This has been badly neglected by everybody. This is of great importance.

Now here is a town with two hospitals. They are obsolete. Now they want to build a new hospital, bricks and mortar, the construction of which will in the long run be quite a fund saving and delivery saving, a saving in every facet of the entire spectrum of medical delivery. This I have not heard mentioned. Why not?

Secretary WEINBERGER. I don't know how frequently this situation arises——

Mr. FLOOD. It is occurring very frequently now, more frequently.

Secretary WEINBERGER. With the effort of the Federal Government in helping finance comprehensive health planning, we hope there will be an end to duplicating hospital facilities and hospital facilities which tend to overlap and which are therefore inherently more costly.

Mr. FLOOD. That is not quite what I mean. Hospital *A* has an open heart surgery unit. If one has one, the other must have one, too.

Secretary WEINBERGER. This is what I am talking about.

Mr. FLOOD. You are right about that. I am not talking about that. The older cities throughout the country and these great old places which have been in decline finally have gotten together. Now they want to build a new hospital, but they need new bricks and mortar money to eliminate the other two. It will be a saving in dollars and delivery. I have not heard about this.

Secretary WEINBERGER. The reimbursement payments that those hospitals get from both private carriers as well as Government medicare-medicaid carries with it a sum for the replacement of these facilities. I have no idea how long it would take to amass that kind of sum but it is the kind of guaranteed annual payment that will support a loan. I would think this would be one of the ways they would want to investigate for building the kind of single facility you are speaking about.

Mr. FLOOD. Can you have somebody take a much better look at it?

Secretary WEINBERGER. I would be glad to, sir.

HOMES FOR THE AGED

Mr. CASEY. I am more concerned with the home for the aged. This country has been very far behind in that respect. When you have a nonprofit organization willing to take it on they should be helped. Right now it takes a pretty wealthy man to keep someone in a home for the aged.

Of course, it is true it would be better if they were home, but by the same token why force somebody to wreck their own home to try to look after an invalid father or mother when all they need is custodial care.

I am not talking about the hospital now. Here is a nursing home which in my opinion is getting very little medicare and medicaid. It is primarily old age assistance checks. A lot of the maintenance is done

by contributions from the local community fund, the United Fund, donors, individuals, and so on. When they go to make capital improvement they have to come up with some money, even to get under Hill-Burton. You say it has been approved. It is only up to the State level.

Secretary WEINBERGER. I see.

Mr. CASEY. The States have no more money.

Secretary WEINBERGER. Hill-Burton in many States previously cut out the States' one-third. They are requiring two-thirds private financing to cover the Federal one-third. The Hill-Burton program itself was not anything which would provide free facilities or even low-cost facilities. We think it was one of the major contributing factors to the very high cost of hospital and nursing home care.

Mr. CASEY. Forget about the hospitals. I am talking about the aged. This is not a hospital.

Secretary WEINBERGER. This is not a kind of program that——

Mr. CASEY. Very low-income people, blacks.

Secretary WEINBERGER. Hill-Burton would not directly affect that. Hill-Burton produced very high cost facilities and was one of the factors in pushing the prices of daily care up. The provision of homes of the kind you describe are not under Hill-Burton.

Mr. CASEY. Like where? They said it was under Hill-Burton.

Secretary WEINBERGER. I think there woud be very little advantage to using Hill-Burton for that.

Mr. CARDWELL. It is a tough problem. It is pretty well established, though, that the commercial homes can obtain financing on the open market. They are doing it every day.

Mr. CASEY. This is not a commercial home.

Mr. CARDWELL. One of the problems is that the privates and nonprofits have not learned how to use the money market.

Mr. CASEY. Can somebody advise them on how to use the money market? I will take any help I can get.

Secretary WEINBERGER. There is $971 million in Federal matching funds under the medicaid program, almost $1 billion, for nursing homes.

Mr. FLOOD. Let us make a guinea pig out of Mr. Casey.

Mr. CASEY. I am willing if you are talking about this particular project.

Mr. FLOOD. We do that frequently on other things.

Secretary WEINBERGER. If you would like to submit the details of this, the town and all the rest.

Mr. CASEY. I would be pleased to.

Secretary WEINBERGER. We will do our best.

Mr. FLOOD. Don't make it a secret now. We would like to know about this, too.

Mr. CASEY. I think you will run into it throughout the country.

Secretary WEINBERGER. I didn't think continuation of Hill-Burton will be particularly useful in the case you cite.

Mr. CARDWELL. I doubt it, too, under present arrangements.

Mr. ROBINSON. In part answer to Mr. Casey's question, most States today have State nursing home associations. In Virginia this is where that advice is coming from, from the Virginia Nursing Home Associa-

tion—where the money is, what the source is, what the terms are, how to go about the financing. I am sure there must be one in Texas, too.

Mr. FLOOD. Have your man run that down.

Mr. CARDWELL. We are about to come out with a new set of standards on extended care facilities.

Mr. CASEY. They are on probation right now. This is because they thought they would get a grant to start the new building and wreck the old one.

Mr. Secretary, I will not take any more of your time now. We will have the heads of your various sections. I do appreciate the opportunity to talk to you about this and I want you to know we have problems, too. It is not always our fault.

Secretary WEINBERGER. I understand, sir.

Mr. FLOOD. We will resume at 10 o'clock tomorrow, gentlemen.

THURSDAY, MARCH 8, 1973.

UNIFIED BUDGET

Mr. FLOOD. The committee will come to order.

Mr. Conte, the witness is yours.

Mr. CONTE. I want to join the other members of the committee in welcoming Secretary Weinberger here. Having been on the job only 2 weeks, he is certainly doing a great job in handling the varied questions that have been posed to him.

Yesterday when the chairman was asking you about the time when you were head of the budget in California some of the points you were making were very interesting. One is that you established a unified budget in California, and that it worked out very well.

Secretary WEINBERGER. Yes, it did.

Mr. CONTE. I feel very strongly, not to get into budgetary policy here, that the only answer here in the Congress is to bring out a unified budget, rather than bringing it out in piecemeal. You do not get an overall picture.

Secretary WEINBERGER. A single budget bill, Congressman, goes in by the Governor early in January. The legislature then considers that single bill. They have subcommittees of ways and means and Senate finance. They take action on it almost always prior to June 30. Once in a while they miss it by 2 or 3 days. Usually, though, they are well in advance of June 30.

Then they also have a provision that no other spending bill can be considered in advance of the budget without a formal letter from the Governor that he substitutes that consideration for the budget. So, they have no other financing and no other spending bills possible before the committees, and all spending bills have to go before the ways and means, which is equivalent to the Appropriations Committee here. They are held until the budget itself is passed so they have an idea how much they are going to be spending and how much revenue will be left.

Of course, there is a constitutional provision that the budget cannot be unbalanced.

Mr. CONTE. It makes a lot of sense. If each subcommittee reported out a bill which could be considered in 1 or 2 days of a full committee hearing, the Appropriations Committee could come out with a unified budget. I voted for that this year for this simple reason.

Every subcommittee feels its bill is sacrosanct. This makes it very difficult to get the whole budget picture. I do not see how you can have a balanced budget under this system.

Secretary WEINBERGER. I think it is difficult for anybody in the Congress to know the total appropriations at any point. The committee staff keeps running totals, but generally it is very hard to know, because you are acting on 13 spending bills, 14 in some years, and in addition there are all kinds of bills outside the budget process.

I gather that one year, 1946, the Congress tried a single budget bill, and it has never gone back to it. I do not really know what the history of that was.

It has been in use in California for some years, and they seem very happy with it.

ADULT DENTAL SERVICES

Mr. CONTE. Yesterday, Mr. Michel asked you about the proposal on page 12 to terminate Federal matching for adult dental services. In the last sentence of that paragraph, you say: "This proposal would not affect the Federal matching for emergency dental services to adults."

That really struck me. Will this open a Pandora's box to all kinds of abuses? Who will determine whether a dental operation or any other dental service is an emergency? He could say everything is an emergency.

Secretary WEINBERGER. I think this is in the category of grants to the States for the purposes of providing emergency health services of all kinds. I think the statement refers to the fact that that would not interfere with that portion of the emergency grants that goes to dental services. Medicaid dental services to children continue, of course.

Mr. CONTE. Are we speaking of medicaid?

Secretary WEINBERGER. Yes. But the regulations would be developed in order to specify that these emergency services for adults could be continued.

Mr. CARDWELL. I think your question is a good one. It is a problem we constantly run into in the management of the public assistance and medicaid program. The proposal suggests that we would establish, say in the provision of medical services, regulations that define what an emergency situation is. Otherwise, the State bears the full cost.

Under our proposal, the States may continue on their own, without any Federal intervention, to provide dental services of all kinds. We will match those that clearly fit in the concept of "emergency."

Of course, the program would be subject to audit to determine whether or not their claims were valid. There is an inherent management problem whenever you try, particularly from a long distance, to establish criteria and then assume that the States and the local agencies administering the program will follow them. That is our assumption.

Mr. CONTE. A lot of dentists have really made a killing under medicaid. I think that this is another big loophole.

You state that the Federal role in developing human services should be one of fostering innovation rather than providing operating subsidies. Would you please explain this?

Secretary WEINBERGER. Yes. I think the administration's position is pretty settled on this, Congressman. The President has felt right along that the Federal Government should not provide direct medical services; that we had a perfectly valid role in looking at new things and encouraging experimentation and research and new applications or techniques, and trying to put out money for that purpose; but we should not run hospitals, we should not run clinics, we should not provide a direct medical service in any form.

DEMONSTRATION PROJECTS

Mr. CONTE. What about those programs that you have found to be successful? What incentive is there for State and local governments to support programs which they decide they do not want but which the Congress feels should be implemented nationally?

Secretary WEINBERGER. That would again be a matter that I suppose would have to be settled between the Congress and the Executive. As far as States taking on programs or what incentive there should be to take them on, I think the incentive would be a successful demonstration.

For example, in the community mental health clinics and services, we have, I think, demonstrated that communities can run mental health facilities; that if they do, they can relieve the State and sometimes the county of very large expenditures for very useless treatment and prevent people from being kept in huge institutions with no real possibility of cures.

It is much better from all points of view. I think we have demonstrated that the community can deal with these cases in community centers close to the patient's home.

I think the Federal Government, with some 530 of these established around the country, has demonstrated that this can be done and that this is a much better way to do it.

It seems to me the incentive to the States, cities, and counties, to pick this up is simply that it is a far better, a far less expensive, and a far more effective treatment. The Federal Government having demonstrated this, can now step out; it will, of course, complete its commitments. The commitment was 8 years' Federal support. In the case of a community mental health clinic that was started 2 years ago, there would be 6 years left. We ask for authority to complete those commitments.

We think no more new starts are necessary. No more new or continuing demonstration programs are necessary. From here on, we are simply providing a subsidy to complete our current commitments. That is the rationale.

I would think if a State did not want to pick it up, that would be a pretty good evidence of the fact that as far as that State was concerned, it had a low priority, and we should not interfere with their determination and, in effect, force it on them.

In the case you pose of a State not wanting to pick it up and the Federal Government wanting to provide it, I suppose we could simply go in and force it on the community, but the President's philosophy is very much opposed to doing that.

He would like the priorities to be set locally and the decisions to be made locally. He would like the Federal Government to help where necessary, and to step out once the demonstration is complete.

CONTROLLABILITY OF THE BUDGET

Mr. CONTE. Mr. Secretary, what part of your budget is uncontrollable and what part of your budget is relatively uncontrollable?

Secretary WEINBERGER. Of the whole Federal budget, 74 percent is uncontrollable in the sense that we have to continue programs that are presently in effect.

As far as the HEW budget is concerned, we have 88 percent in 1974 classed as uncontrollable; 87 percent last year. That runs out to about $82.5 billion, in budget authority.

Mr. CONTE. How about the relatively uncontrollable part of the HEW budget?

Secretary WEINBERGER. This is the whole uncontrollable thing. We have not broken it down between relatively and not.

FORMULA GRANTS

Mr. CARDWELL. I think there is another category. That figure excludes the so-called HEW formula grants, which have in the past been reasoned by some to be relatively uncontrollable in nature, in that once the formula is set, then the funds are distributed by just applying the formula on a ministerial basis.

Secretary WEINBERGER. They are controllable in the sense that we can control them up to the amount that is put into them. Once that amount is determined by appropriation and signature of the President, it becomes uncontrollable, because then the money has to be spent.

Maybe that is the category you were referring to.

Mr. CARDWELL. I assume that is the one.

Mr. CONTE. Would you supply a breakdown of those programs for the record?

Mr. MILLER. There is about $5.4 billion in formula grants.

Secretary WEINBERGER. We will get a breakdown for you.

[The information follows:]

The mandatory formula grants for the Department of Health, Education, and Welfare amount to $5,399,264,000 in fiscal year 1972, $5,559,603,000 in fiscal year 1973, and $5,443,863,000 in fiscal year 1974. The breakdown of these programs is as follows:

EALT NVICES AND MENTAL
HEA. ADMINISTRATION

DEPARTMENT OF HEALTH. ..UCATION, AND WELFARE

Programs in the 1973 budge. .or which State allocations, once an appropriation has been made, are mandatory

(in thousands)

Appropriation/Program	1972 BA	1973 BA	1974 BA
Mental health			
Alcoholism formula grants (Section 301, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970)	30,000	30,000	30,000
Drug abuse - grants to States	---	15,000	15,000
Health services planning and development			
Medical Facilities construction grants (Section 601 - PHS Act)	197,200	2,000	---
Comprehensive health planning (Section 314(a), PHS Act)	7,600	9,000	10,000
Health services delivery			
Comprehensive health services (Section 314(d), PHS Act)	90,000	90,000	90,000
Maternal and child health services (Section 503 - Social Security Act)	59,250	60,778	153,051
Crippled children services (Section 504 - Social Security Act)	62,272	64,900	64,900
Total, Health Services and Mental Health Administration	446,322	271,678	362,951

NATIONAL INSTITUTES OF HEALTH

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Programs in the 1973 budget for which State allocations, once an appropriation has been made, are mandatory

(in thousands)

Appropriation/Program	1972 BA	1973 BA	1974 BA
Health manpower			
Institutional support:			
Conversion of 2-year schools (Section 771(b), PHS Act)	2,500	6,000	6,000
Capitation grants:			
Medical, dental and related (Section 770, PHS Act)	155,200	152,200	152,500
Nursing (Section 806, PHS Act)	31,500	16,800	---
Direct loans:			
Medical, dental and related (Section 742, PHS Act)	30,000	36,000	36,000
Nursing (Section 824, PHS Act)	21,000	21,000	21,000
Scholarships:			
Medical, dental and related (Section 780, PHS Act)	15,500	15,500	10,000
Nursing (Section 860, PHS Act)	19,500	19,500	11,000
Total, National Institutes of Health	275,200	267,000	236,500

OFFICE OF EDUCATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Programs in the 1973 budget for which State allocations, once an appropriation has been made, are mandatory

(in thousands)

Appropriation/Program	1972 BA	1973 BA	1974 BA
Education Revenue Sharing			
Programs to be included in revenue sharing:	---	---	2,527,366
Educationally deprived children (Title I, ESEA)	1,597,375	1,585,000	---
Supplementary services (Title III, ESEA)	146,248	146,168	---
School assistance in Federally affected areas (P.L. 874)	189,300	227,150	---
Education for the handicapped basic grants (Part B, EHA)	37,500	37,500	---
Vocational education basic grants (Part B, VEA)	468,497	468,497	---
Adult basic education (Adult + Education Act)	51,134	51,134	---
Subtotal	2,490,054	2,515,449	2,527,366
School assistance in Federally affected areas (P.L. 874)	403,280	187,850	41,500
Emergency school aid	---	186,911	204,131
Higher education:			
Grants and work-study	646,900	872,000	1,209,000
Direct loans (Title II, NDEA)	316,584	292,970	5,000
University community services (Title I, HEA)	9,500	5,700	---
Library resources			
Public libraries services (Titles I and III, Library Services and Construction Act)	58,709	32,730	---
School library resources (Title II, ESEA)	90,000	90,000	---
Total, Office of Education	4,015,027	4,183,610	3,980,997

SOCIAL A[illegible]HABILITATION SERVI[illegible]

DEPARTMENT OF HEALT[illegible]DUCATION, AND WELFARE

Programs in the 1973 budget for which State allocations, once an appropriation has been made, are mandatory

(in thousands)

Appropriation/Program	1972 BA	1973 BA	1974 BA
Grants to States for public assistance			
Child welfare services (Title IV, Social Security Act).....	46,000	46,000	46,000
Social and rehabilitation services			
Rehabilitation services and facilities: Basic State grants (Section 2, Vocational Rehabilitation Act).....	560,000	590,000	610,000
Grants for the developmentally disabled, State grants.....	21,715	21,715	21,715
Special programs for the aging: Community planning and services and nutrition (Title III and VII Older American Act of 1965).....	35,000	179,600	179,600
Total, Social and Rehabilitation Service.....	662,715	837,315	857,315
Grant Total, Department of Health, Education, and Welfare..	5,399,264	5,559,603	5,443,863

Mr. CONTE. You state that, with the federalization of public assistance for the aged, blind, and disabled, the supplemental security income beneficiary rolls are increasing. You also state the rolls of the aged will increase by 2.6 million people.

How does this number compare with the number of people receiving assistance from the States themselves?

Secretary WEINBERGER. Let us see if we can get that for you.

Mr. CONTE. Provide that for the record.

Secretary WEINBERGER. Yes, we will.

Mr. CONTE. Could you also provide for the record the same figures for those who fit in the categories of blind and disabled?

Secretary WEINBERGER. Yes, we will.

[The information follows:]

The number of people receiving public assistance payments from the Federal Government compared with those who receive only State supplemental payments, according to categories, is as follows:

FY 1974
Supplemental Security Income

(in millions)

Recipients	Aged	Blind and Disabled	Total
Converted from State roles.....	2.0	1.4	3.4
Newly eligible.....	2.6	.2	2.8
Total.....	4.6	1.6	6.2
Receiving Federal Payments.....	3.7	1.5	5.2
Receiving State supplemental payments only.....	.9	.1	1.0
Total.....	4.6	1.6	6.2
Benefits			
Regular Federal Benefit Payments....	$1,100	$600	$1,700
Federal "Hold Harmless" portion of State supplemental payments....	100	50	150
Total.....	1,200	650	1,850
State Supplementation			
Number of States whose payment levels are above the Federal standard.....		28	
Current estimate of number of States likely to be eligible for "hold harmless" payments.....		16	

Mr. CONTE. The regulation you proposed in December is ostensibly designed to reduce the number of overpayments and the number of ineligibles who are receiving aid to families with dependent children.

Are there plans to provide States with technical assistance to comply with these regulations?

Secretary WEINBERGER. Yes, there are. It is very much to our interest as well as to the States' interest that we not pay, and the taxpayers' money not be used, for overpayments or to pay people who are ineligible. I think everybody is in agreement on that.

There has been disagreement and there have been some proposed changes in the regulations that were submitted by the Department in December, the so-called quality control regulations. We are receiving comments and we are considering revisions in the original published version.

The basic objective remains exactly the same. I am persuaded it is the objective of everybody in the country to try to cut down and eventually eliminate the overpayments and the payments to ineligibles. Those run as high as 30 percent in some States. The averages run roughly around 19 or 20 percent. That is a very large amount.

We would certainly be very interested in helping with technical assistance, both in the gathering of these statistics, in the monitoring of them, and in procedures to help the States correct some of the mistakes in administration that they are making.

Mr. CONTE. Will there be an increased cost in State administration of these facilities?

Secretary WEINBERGER. There should not be. We will have in place the guidelines for this kind of information gathering. When it is working, there should be a substantial savings, because the States themselves pay out a lot.

As you know, the actual administration is by the counties. There would be very substantial savings to the States if they could eliminate ineligibles or overpayments. We are also working on different methods, including such things as the flat grants, to try to get at many of the principal causes of overpayments.

Mr. MILLER. I would mention that the Congress has approved in the past several years about 500 additional positions directed just to that kind of technical assistance and administrative oversight. Our 1974 budget contains over 700 positions just for that purpose, to effect those economies, even though many of our requests for HEW employment are reductions for fiscal year 1973. So, technical assistance capability will be there if the Congress approves the request.

Mr. CONTE. When will the administration's proposed legislation on AFDC be submitted to the Congress?

Secretary WEINBERGER. We are working on 2 levels, Mr. Conte.

We have some immediate proposals in mind, and some of them are along the line that I mentioned a moment ago. We will try to reduce

the amount of error and will try to simplify the requirements so the amount of error will be reduced. Other management improvements, including the change in regulations, that we think would bring about a reduction in errors that occur in the State and county administration will be proposed.

On another level, we are working on a longer range kind of program that would insure there is no inducement for anyone to go on welfare, no inducement to stay on and every inducement to try to get off. We believe the ultimate solution is jobs. That is the only kind of activity which will in the long run solve this problem.

Through our economic policies, we are trying to encourage employers of all kinds to take people who have been on welfare. We have been trying to encourage through manpower training, through WIN, a whole series of programs that could get people into permanent, useful, satisfying jobs.

We are also trying to insure that we do not have any inducement for people to go on or to stay on welfare or anything that would make it more attractive to be on welfare than to be on the job. That is a longer range effort.

One of the things the President has asked me to do is to meet with leaders of Congress who are interested in these proposals and try to get their ideas and try to put them all into a program that will have a longer range effect in reducing the rolls.

Mr. CONTE. When do you foresee this coming up to the Congress at the present time?

Secretary WEINBERGER. I would hope we could get it up sometime, with any luck, toward the summer. I think we could iron out enough of the difficulties and objections that blocked the previous plans.

I think even if it came up then, there might be time enough to have it enacted. I think anything can be enacted if you have enough basis of agreement and consensus behind it. That is what we are hunting for.

Meantime, what we do plan to do administratively is not only what I have described, but also to try to distill the best experience of the States in reducing rolls, in providing work incentives, and in providing work requirements.

CALIFORNIA PLAN

We have a new man on board, Mr. Carlson. He was the head of the social welfare department in California, and has developed a number of imaginative plans which have had the result of reducing the rolls in California by 265,000, while at the same time freeing some money that has been used to increase the awards and benefits to people who are permanently disabled and the other groups unable to work.

So, we plan to have him go around to other States and explain what he did in California—he is also familiar with some projects that have been tried in New York and two or three other States—and encourage

the States to use this kind of change in program if they wish to do so, and make available to them all of his experience, and regulations, and proposals.

All of this, I think, would be very helpful in getting at the problem of eligibility determinations and in the work incentives at the State level.

We are also embarked on a program of much freer use of waivers of Federal regulations to enable the States to try out experiments. My understanding and my impression is that there was considerable reluctance in the past to grant any waivers on the part of the Federal Government. We are now taking the opposite tack and urging and encouraging the granting of waivers so States can try these experiments and see if they can make reductions of the same kind that California has.

There is one interesting thing about the California experiment. A lot of people said, "You get them off the AFDC, and they will simply turn up on some other relief roll or something. They will go on the county general relief or something of that kind."

This has not happened in the State; 265,000 people are off the welfare rolls. No other rolls or comparable programs have increased.

It came in, almost simultaneously, with a rather stiff work requirement. In many cases, checks are being held and are piling up in some of the State and county offices. They are just not calling for them any longer.

Mr. FLOOD. Is this Californian on board and functioning now?

Secretary WEINBERGER. Yes, sir. His name is Carlson.

Mr. CONTE. Is he coming before our committee?

Secretary WEINBERGER. He had not planned to. He is not up for confirmation. However, he would be available. We plan to use him to go around and serve as a man who would demonstrate and explain to other States the changes in the plans that were put in effect in California, and offer that in the form of technical assistance if a State wishes to use it.

There obviously is not only no authority but no desire to force a State to do so.

The results there, and in some other States that he is familiar with because he has membership in national associations, have been sufficiently interesting as to offer them to other States and in effect to say to them, "This is how they are doing it in States A, B, and C. You might want to try it. If you do, we will be glad to help with a team of people who are familiar with it."

SUPPLEMENTAL SECURITY INCOME

Mr. CARDWELL. I do not want to break your chain of thought or questions, Mr. Conte, but I thought it might be helpful if we went back and touched on one of your earlier questions. We will put the full data in the record on the supplemental security income, but I thought it would be useful to put some salient points in.

You asked the question how many aged, and so forth.

This year it is estimated we will go into 1974, the year in which the conversion takes place, with about 2 million older people on the public assistance rolls.

The supplemental security income authority liberalizes eligibility, and another 2.6 million would become eligible, for a total of 4.6 million.

Of that 4.6 million, the Federal payments will cover about 3.7 million, and about 900,000 would be paid out in State supplements. That is because in the case of the 900,000, their States now provide benefits that exceed those that they would be eligible for under the Federal programs. The law says in those cases the States must continue payments in the form of a supplement.

FAMILY ASSISTANCE LEGISLATION

Mr. CONTE. Mr. Secretary, some of us were disappointed that the administration decided to drop the proposed family assistance legislation which was passed by the House during the 92d Congress. I felt this was a step in the right direction, and it would have helped to get a lot of people off the welfare rolls.

Do you feel the proposals you were just speaking about will have the same impact?

Secretary WEINBERGER. I think the longer range proposal that I described at too great length and too discursively a moment ago, is what the President has in mind and what might be called the substitute for or the offset for that particular plan.

Mr. CONTE. Do you feel it will have the same impact?

Secretary WEINBERGER. I would certainly hope so, yes. When that plan was submitted, the President felt as you did. The problem, however, became increasingly complicated with the parliamentary situation in the Senate. The House, as you say, passed it, and I believe passed it twice.

Mr. CONTE. Yes.

Secretary WEINBERGER. By a substantial margin. The Senate divided into three camps. The President became convinced and is convinced that those three camps remain, and that it would be an impossibility to get a bill of that kind through the Senate.

For that reason, he wants me to try to see, by conferring with congressional leaders here and in the Senate, if we can devise some kind of program that we can live with fiscally and that can do the basic kind of things that it was hoped the family assistance plan would do.

There are a lot of differences now, a lot of the various benefits have been added since the family assistance plan was first submitted. There are a lot of changed conditions.

The President is interested in results, and I do not think he wants to have the entire subject bog down again in a 3-way fight in the Senate. So, we are trying to find some kind of effective ground that can secure necessary support in the Senate and at the same time retain the support that it had in the House.

That is why I am reluctant to give you a timetable, because I do not know just when that can be put together. That is the kind of thing we are working on.

Mr. CONTE. As I understand the problem, the conservatives felt the guaranteed annual wage went too far, and the liberals felt it did not go far enough.

Secretary WEINBERGER. Right.

MEDICARE

Mr. CONTE. It has been estimated that the proposed changes in Medicare will raise the cost of average patient stay in the hospital from $90 to $220. Will people with social security as the sole source of income be able to shoulder this increase?

Secretary WEINBERGER. I am afraid I did not quite get that. Does this relate to the cost sharing we propose?

Mr. CONTE. The proposed changes in medicare.

Mr. CARDWELL. Yes; the question pertains to that, I am sure.

Secretary WEINBERGER. The basic principle of medicare remains, that is, if people become medically indigent within the definitions of that program, their expenses will be covered.

Mr. CONTE. I will pursue it later.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

You have spoken of further efforts to try to implement control of the costs and utilization of hospital care at the institutional level. What are these efforts?

Secretary WEINBERGER. The PSRO effort is a major one. As we mentioned yesterday it will be in place by January 1, 1974. I think we are on schedule on that.

We need to set up the professional standards review organizations as a network through the country, manned and operated by the physicians themselves. We will develop nationally, standards of care and utilization so we can measure whether or not there has been an excessive use of it, and whether or not there has been the necessary quality of medical care supplied.

We also have in place, of course, as part of the whole economic stabilization program, the cost of living council program, the attempt to hold down health care costs nationally, which I think is a tremendously important effort.

We have the cost-sharing provisions that we are recommending and will send legislation up embracing those. They are designed to prevent and discourage overutilization, which we think has been a very large factor in pushing the costs of health care up so much more rapidly than other elements in the CPI.

HEALTH MAINTENANCE ORGANIZATION

Mr. CONTE. You indicate the health maintenance organization proposal is designed to operate in medically underserved areas. What does

the Department view as an underserved area? Can it be in a section of a city, for example?

Secretary WEINBERGER. Yes; it might be. It is basically an attempt to try to analyze the number of physicians who are actually available and on whom low-income people can call and be served.

There are formulas that produce clear indications that there are areas of underservice in the rural areas or in remote parts of the country, parts remote from the cities or medical facilities.

I think they could well show that there are also certain city areas that are in this category, and the HMO program is designed to try to provide preventive organizations in these areas where ordinarily it would be hard to get them. The doctors may not want to practice there or the people themselves may not have the money, frequently, to make the advance payments to the HMO's.

Mr. CONTE. The demand is great enough in the particular area you speak of now.

Do you have any alternative to serve these people?

Secretary WEINBERGER. Yes; speaking specifically of the HMO's, which we would like to see established in those areas, initially there would be startup costs paid by the Government. Then we would hope a broad enough base of membership could be obtained so there would be funds to continue to operate successfully.

That is what some of the demonstration projects would be designed to show.

As far as people well below the poverty level, we, of course, have the medicaid program, and that would be a matter of just insuring that there was enough medical manpower in the areas to serve them. That, again, would be primarily a matter of State administration with medicaid. We would hope that they would be minimal, and that they would be provided for locally. We would try to secure that result through grants and continued operation of the OEO services which are coming over to HEW.

NEIGHBORHOOD HEALTH CENTERS

Mr. CONTE. You are proposing amendments affecting neighborhood health centers designed to improve their bargaining position with State and local welfare departments. Will these amendments enable them to bargain effectively, and will the proposed legislation contain a vehicle to oversee this operation and to assure that they, in fact, are able to deal effectively with these welfare departments?

Secretary WEINBERGER. The proposal would be for free standing clinics and would require reimbursement for that.

Oversight, would have to be built into the program, and we would have to satisfy ourselves that it was accomplishing its objective. If it did not, we would want to change it, because the whole point of it would be to have that kind of service provided.

This raises a somewhat broader point, and that is the whole evaluation effort of the Department. We feel now we have to improve the evaluative abilities of the Department, because we are going to be

called on constantly, we think correctly, to justify continuation of some of the things we are doing with comparatively limited resources. We want to be sure we can assure this committee as well as others, that what we are doing is effective and useful and, if it is not, that it should be stopped and we turn to something else.

The only way we can do that, is to have a constant oversight and monitoring of these programs in an effective way. That is what we would want to get installed.

If we are not able to have that, if we do not have that capability now, we would certainly want to build it, and that is one of the principal efforts we are engaged in throughout the Department. We have to be able to satisfy ourselves and then come up here and satisfy the appropriate committees of the Congress that when we recommend continuance of a program, we are basing our recommendation on its effectiveness.

If we recommend termination of a program, we ought to have the evidence to show that it is not working and that the reason for termination is to free some funds to start something more creative and more effective.

DRUG REHABILITATION

Mr. CONTE. In regard to your statement on drug addiction, you say 50 percent of the addicts will volunteer for treatment. What will this cost in the next 5 years?

Secretary WEINBERGER. We have in the budget a 5-year estimate of the cost of the programs we are proposing. I do not have it with me this morning, but we will supply it.

[The information follows:]

We have included in the budget request for fiscal year 1974 funds to continue Federal support for existing project grants which were authorized under the Community Mental Health Centers Act. This authority expires and the appropriations requested will provide the resources to fulfill commitments for the duration of the approved grant period. The following table indicates the costs associated with these grants.

Drug Abuse Community Programs—Funds Requested for Years Beyond 1974

Fiscal year:	*Thousands*
1975	$50,719
1976	45,640
1977	41,937
1978	34,745
1979	24,995
1980	7,164
Total	205,200

Mr. CONTE. How about the other 50 percent?

Secretary WEINBERGER. Again, drug addiction arises from a combination of a great many problems. We are very hopeful that with the war over and with that particular portion of the reason for increased addiction gone, we might have a reduction in total number of cases.

For one thing, there are very few reliable statistics in this field.

Mr. CONTE. That was my next question. How successful have you beenwith this 50 percent?

Secretary WEINBERGER. I am not sure that anybody is in a position to tell you at this point, because there has not been a proper follow-up or a proper monitoring of the effects of a particular kind of treatment.

There are a lot of new treatments now. There is a lot of reliance being placed on methadone and things of that kind. Dr. Jaffe might be able to supplement this, and send up a statement, or we could put it in the record. I am not aware of sufficiently reliable follow-up studies on methadone, or some of the newer forms of treatment, to be able to tell you that they work or that they work pretty well or that they don't work at all.

That has been one of the troubles. Usually, the typical pattern has been that a person is treated and it is hoped there has been an improvement. He disappears, and may turn up later.

We do not have any basis or method of following through on trying to determine whether one particular form of treatment, the use of control groups, or anything of that kind, is more effective than the other. We need to do this. That is one of the things I think we are most interested in pursuing.

We believe that ultimately, with enough education and enough knowledge and enough new forms of treatment, we can get well into that second 50 percent. We are not even sure what happens to the first 50 percent yet. The figures in this are very soft, I regret to say.

Mr. CONTE. There is one thing that bothers me. With all the money the Congress appropriates for NIH—maybe I am oversimplifying—why haven't they had a crash program to learn to treat drug addicts? No one who ever has appeared before this committee has come up with an answer or any reasonable solution to meet this problem.

I also have another question. I wonder if you could have someone from your office give me some statistics on how many of the drug addicts that you are treating in this 50 precent have moved over to alcoholism.

Secretary WEINBERGER. I will certainly try, but I could not guarantee that we could get any answer. The next question would be: Which is worse?

Mr. CONTE. That is right.

Secretary WEINBERGER. I have been through this before. I just do not think there is a statistical base for answering you with any confidence at all. I am sorry that there is none. I think it is one of the parts of the problem.

I do not think anybody knows enough about what causes it, or what happens when a person has been theoretically detoxified or run through one of the clinics, and so on. I think we are starting to get it. I think some States perhaps are further ahead than others, and some may be ahead of the Federal Government.

In constructing the budgets—I went through the budget hearings with Dr. Jaffe and others—you cannot get answers when you ask why this amount is necessary and what effects you have had from last year's.

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We have to have some kind of answers to satisfy ourselves, you, and the public. We are not in a good position in this field.

Mr. MILLER. Mr. Conte, I think we have as much money in the program for research programs in drug abuse as the state of the art will permit. There have been major increases over a period of 3 or 4 years.

Mr. CONTE. I am not concerned with that so much as I am concerned with coming up with the answer on how to treat these people.

Secretary WEINBERGER. Let me point out one thing Mr. Miller has put before me which illustrates it.

On research and training, we will move up from $36 million in 1972 to $51 million in the 1974 budget request.

In the community program, which is experimental, we have moved up from $81 million to $381 million between 1972 and 1974.

These are, of course, total funds that would be available to try out different kinds of projects around the country.

ALCOHOLISM

Mr. CONTE. Are you maintaining the same level of funding on alcoholism?

Mr. MILLER. We are continuing our level of funding for alcoholism to the States in terms of the formula grants.

Mr. CONTE. I am speaking of total money for all programs.

Secretary WEINBERGER. Research, training, and community effort are generally at the same level.

Mr. CONTE. Do you think we can meet the challenge by maintaining the same level of funding?

Secretary WEINBERGER. I think the way Mr. Miller phrased it is probably correct, that we have not had any indication that spending a great deal more would make any material difference yet.

We do have some organizational changes in mind in the department so as to place alcoholism in a different area where we can get more emphasis on research.

I do not have any doubt in my own mind that it is an extraordinarily serious problem, perhaps as serious as the drug problem. It is part and parcel of the same thing. We are certainly aware of that, and I think the funding levels are those that, as far as anybody can tell based on an insufficient foundation of figures, are about all that can be profitably spent this year in trying to develop new techniques and trying out techniques that are proposed.

Certainly, if anything resembling a major breakthrough appeared on the horizon, I would want to fund it, as we are trying to do with cancer.

Mr. CARDWELL. You may have read the other day the report—I am not familiar with the phenomenon at all and you may want to ask Dr. Brown, the director of the National Institute of Mental Health, when he comes before you—in the press of the NIMH-financed researcher's conclusion that he had isolated that part of the brain that is affected by heroin.

The basic problem in finding a workable treatment has been that science does not understand the process of addiction, whether it be

from heroin or other drugs. The press suggested this was a significant finding. You might want to talk to them about it.

Mr. CONTE. I was interested to read in the Washington Post that they have found brain damage is caused by heroin addiction. We will develop that later.

ST. ELIZABETH'S HOSPITAL

What do you intend to accomplish by transferring St. Elizabeth's Hospital from HEW to the District of Columbia? It is like taking that money out of one pocket and putting it in another pocket.

Secretary WEINBERGER. No, not really, sir. The District raises its own funds, a considerable number of them, from District residents through property tax, sales tax, and so on. The Federal Government does supply a fair amount of money for the District. There is no question about that.

The main thing is that the hospital itself no longer has any distinctive Federal characteristic, it does not have any demonstration or research capability that is particularly unique to the Federal Government, nor does it serve a group of patients that has any special unique Federal characteristic.

We feel it is part of the general plan of taking the Federal Government out of the direct delivery of medical services. There is no longer any justification for running a hospital where 86 percent of the patients are local residents.

It is not so much a dollar saving. We think the District will be able to operate it. We are working on contracts and negotiations for that purpose.

We think they probably will be able to do it at perhaps the same or maybe a little lower cost than the Federal Government. It is not a cost matter, though. It is the matter of an improper role, as we see it, for the Federal Government in accordance with the principles we outlined yesterday in the statement.

Mr. CONTE. I think Mr. Natcher and I will share a bottle of champagne if that is true and it is operated at a lower cost than it is now.

Mr. NATCHER. I agree.

[Off the record.]

NURSING FUNDS

Mr. CONTE. Mr. Secretary, you indicate the administration is planning a substantial cutback in the support of health manpower programs. Are salary scales in the nursing profession, for example, sufficient to draw a sufficient number of students who can afford the cost of an education after these programs are terminated?

I notice in your testimony that you have programs for doctors, dentists, and everybody who can afford it, as I see it, except the poor nurses. I do not think this is right.

Secretary WEINBERGER. The rationale for that, Congressman Conte, is that we believe that there will be a sufficient encouragement, not through the salary scale so to speak, but on the basis of the number of people entering nursing schools, to close most of the gap that appears to exist.

We also think that it is possible to eliminate in the future what presently appears to be the need for nurses by greater use of paramedical personnel, nurse's aides, nurse's assistants, and so on.

We feel, finally, that we do have to get the Federal Government out of encouraging special groups of students where there isn't any demonstrated need on a priority basis.

I am not saying there isn't a need for more nurses. I think there is. But I think there is a greater need for some other portions of the medical profession. I think those are the ones who at this point have to be set out for receipt of Government funds that encourage the entry into these fields.

The nursing incomes are better now. They were extraordinarily low for many years.

I still think there are a lot of people who go into nursing without regard to the salary scale. I think that is a fortunate thing for the country. I think there has been some marked improvement in the salaries, and I think that is an absolutely essential thing.

We had nurses in some of the San Francisco hospitals who were getting less income than the gardeners around the hospital grounds. I think this was very obviously, not only an inequity, but a foolish thing, because I think it was something that perhaps at that time did tend to discourage more nursing entrants.

I think there has been some improvement in salaries. I think we can modify some of the views as to long-range needs if we get into a greater reliance on paramedical personnel, nurse's aides, and assistants of that kind.

Mr. CONTE. Let me tell you something I have found in my district that you might think about. Many hospitals have nursing schools, and the cost of the nursing school is passed on to the patient. This cost of educating nurses is a great cost to the hospital itself. Then upon graduation, sizeable number of these women go into the Federal service, such as the Air Force, the Army, or the Navy, or they go into public service working for the Federal Government. One of the big reasons for this is that the Federal pay scale is much higher than it is back home.

I wonder if you would give some thought to reimbursing those hospitals for those nurses that go to the Federal Government. They have subsidized them and cared for them for 3 or 4 years. When they graduate, instead of going to work in the hospital where they need them badly, they go to the Federal Government.

You cannot blame these women. The pay is a lot better and the fringe benefits are much better than they would get back home.

Secretary WEINBERGER. I think that is an interesting suggestion. I had not realized that there was much movement that way. Usually, it is the other way: a person is trained by the Federal Government and then is very uninterested in doing any Federal service.

I had not realized there was some the other way. That would be a very interesting proposal, and one we certainly would want to look at.

Mr. CONTE. Both Mr. Robinson and I married nurses.

Secretary WEINBERGER. You are talking to a man who married one.

RESEARCH TRAINING

Mr. CONTE. You state that the reductions in the NIH activity generally fall in the category of generalized research support grants and specialized programs of training researchers. Will this not have a generalized effect on the level of biomedical research over the long term?

Secretary WEINBERGER. In my statement I was referring to the reduction in general research support grants from $55 million in 1972 to $17 million in 1974. These are untargeted funds which have been distributed by the National Institutes of Health for the purpose of strengthening the general capability of university and other research institutions. Traditionally, most of the funds have been distributed on the basis of the success of the institution in competing for regular research grants. The institutions receiving the most research grant funds also received the largest share of the general research support money.

In reviewing the budget for 1973 and 1974, we came to the conclusion that such untargeted general purpose funding was of a lesser priority than grant and contract funds focused on the direct conduct of research. We do not believe that reducing it will have a deleterious long-term effect on the Nation's research capability.

I would point out that the portion of the program which focuses on helping the weaker, developing institutions has not been reduced and has, in fact, been increased from $4 million in 1973 to $7 million in 1974. These funds are not distributed on the basis of past success in competing for research funds and are designed to help developing institutions compete on a more equal footing with the larger and more experienced universities and research organizations.

Mr. CONTE. Is it believed there will be an adequate supply of qualified medical research scientists following the cutback in programs designed to train them? What will be the sources of funding to support this kind of training?

Secretary WEINBERGER. There is no evidence to indicate that the overall quantity of biomedical researchers will be significantly affected by the withdrawal of Federal funds for research training. There may be some shifts in where these researchers receive their training The State-supported schools will probably train a larger share of the biomedical researchers in the future than they do now. It is difficult to say this with any kind of firmness, but this is the general feeling at NIH.

Looked at another way, we believe that the special training grant and fellowship programs of NIH, for the most part, are used to support activities which would be carried out by the students or universities themselves in the absence of Federal assistance. As long as training money is made available by the Federal Government, students will avail themselves of it. But this does not mean that when Federal funds are no longer available, students will not seek other means of support.

The source of funding would be made up of university scholarship programs, borrowing, family contributions, and part-time employment on the part of the student. In other words, the traditional means by which students support themselves while they are in school.

While the basic opportunity grant program administered by the Office of Education does not cover graduate training, the fact of the much larger grant support for undergraduate training should have two long-term effects which should tend to increase the output of biomedical researchers. First, a larger number of students will be attaining the undergraduate degree and become potential graduate students. Second, because a larger proportion of the disadvantaged student's costs have been fully paid for through grants, the students, once graduated, should be in a relatively good position to incur a debt to support graduate education. Thus, the administration's general student aid initiative will probably have an indirect effect on professional training such as biomedical research.

Mr. CONTE. You indicate that the broad student assistance programs will be part of the reason why some of these health manpower programs are no longer needed. How does the amount of student aid that is proposed to be available under the fiscal year 1974 budget compare with that which existed before, taking into account all the student assistance programs which are and were in the HEW budget?

Secretary WEINBERGER. We have made an analysis of all of the Department's training programs, including both the broad student assistance programs and the specialized programs focusing on training for specific professions. In 1972, the last year before funds were requested for the basic opportunity grant program, total HEW funds for training activities and student aid were approximately $2.4 billion. In 1974, this total is nearly $3 billion, about $600 million more than was spent in 1972. Thus, increase in general student aid programs, such as basic opportunity grants, more than offsets the reductions in the specialized training programs. These figures exclude health manpower construction grants, for which $162 million was appropriated in 1972 and spent over a 2-year period. Even if construction is included, the departmental totals would still show a net increase of more than $400 million.

I would like to offer a table for the record which breaks down these figures by HEW operating agency and type of assistance provided.

[The information referred to follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Student Aid and Training Programs, Fiscal Years 1972 and 1974

(Amounts in thousands)

SUMMARY	1972	1974
Health Services and Mental Health Administration:		
Fellowships	$ 9,697	$ 4,394
Scholarships	---	22,100
Training grants	148,348	110,832
Training contracts	341	---
Total, HSMHA	158,386	137,327
National Institutes of Health:		
Fellowships	46,709	30,341
Training grants	198,744	160,893
Scholarships	35,227	21,270
Capitation and other operational support	322,251	264,000
Total, NIH	602,931	476,504
Office of Education:		
Fellowships	65,267	38,198
Training grants	21,201	14,380
Direct loans:		
Federal capital contributions	291,000	5,000
Repayments available for new loans	(125,502)	(180,883)
Subsidized, insured loans:		
Interest on insured loans	196,600	310,000
Loan volume subsidized	(3,478,624)	(4,733,000)
Basic opportunity grants	---	959,000
Supplementary opportunity grants	210,300	---
Work study	270,300	250,000
Other grants in aid	5,316	14,750
Total, OE	1,059,709	1,591,328
Social and Rehabilitation Service:		
Fellowships	103	75
Training grants	37,331	16,925
Total, SRS	37,434	17,000
Social Security Administration:		
Special educational benefits	521,000	758,000
GRAND TOTAL, DHEW	2,379,460	2,980,159

MEDICAL SCHOLARSHIPS

Mr. CONTE. You indicate that the proposal you will make for national health service scholarships will contain mandatory service provisions to overcome the maldistribution of health manpower. What form will these service provisions take? Will they be geographically directed as well.

Secretary WEINBERGER. There are already mandatory service provisions in the Emergency Health Personnel Act. The current provisions require service in the Public Health Service Commissioned Corps or as a civilian member of the National Health Service Corps. Scholarship recipients have a service obligation of 1 year for each year of training supported by the Federal Government and at least half of this time must be spent in medical shortage areas now served by the National Health Service Corps. We are proposing to raise the authorized amount from $3 million to such sum that may be necessary, so that we can request $22.5 million for this program in 1974.

We will also request that the mandatory service be defined as including work with any Federal health service program. We see this program as helping to overcome recruitment problems in PHS generally as well as the maldistribution of health manpower.

EDUCATION PROGRAMS

Mr. CONTE. In the higher education area, you indicate that 1,673,000 students will get guaranteed student loans. Might there be some problems getting enough banks who are willing to make enough loans if the interest rates continue to climb? Do you have any proposals as to how to deal with this problem should it arise?

Secretary WEINBERGER. The guaranteed student loan program has grown steadily during the last several years. Our latest data show that about 1.3 million loans were guaranteed for the school year now underway. I don't think that the growth to 1.7 million by the academic year 1974–75 should present any special difficulty or administrative problems. While there was some reluctance on the part of banks to participate in the first few years of this program, this has been overcome.

With regard to interest rates, the authorizing legislation provides a special allowance to lenders for keeping the guaranteed student loan interest rate competitive when there are fluctuations in the prime interest rate. I think this should be adequate to meet any fluctuations that we can anticipate.

Mr. CONTE. The administration has proposed educational revenue sharing to supplant some 30 formula programs in elementary and secondary education. What does the administration propose to do if educational revenue sharing is not enacted in time for the beginning of fiscal year 1974?

As a secondary question, what if the Congress decides to enact the extension of the Elementary and Secondary Education Act that is now pending in committee?

Secretary WEINBERGER. As I said earlier, we are not making our plans on the assumption of failure. We are committed to special education revenue sharing and all of our plans are predicated on its success. We do not have a contingency plan in case it fails. I will be testifying

shortly before the legislative committees and I will do my best to persuade them that education revenue sharing should be effective during fiscal year 1974. Since this is not the first time they have seen such a proposal—we submitted one to the last session of Congress—I think it is reasonable to expect expeditious action.

Mr. CONTE. With regard to your proposals on impacted area aid, how much of the $2.7 billion for educational revenue sharing will be attributable to the impacted aid?

Secretary WEINBERGER. About $232 million will be for impacted area aid. This is the estimate of what full entitlement would be for so-called A children, those children whose parents live as well as work on Federal property.

CHANGING FEDERAL ROLE

Mr. CONTE. The administration has made a significant number of judgments regarding the effectiveness of programs and whether or not they have completed their goals. In light of these judgments, it is recommending significant changes in the budget. The question I have is, Why has the administration undertaken activities to phase out some of these programs before the phaseouts were approved by the Congress and, in many cases, without its consultation?

Secretary WEINBERGER. I believe that we are consulting with Congress. This hearing is part of that consultation process. The phaseouts and program terminations are submitted as proposals in the President's budget and it is up to Congress to review them. It is not our intention to act unilaterally. I would hope that, after you have seen our arguments for making these reductions, you can support the President's proposals.

Mr. CONTE. Under the administration's conception of the Federal role in education, among other things, its role is viewed as one of research, development, and demonstration. As I understand your intentions, once a development is found to be a validated approach to ongoing operations, the administration intends to encourage their incorporation into the appropriate educational system. What form is this encouragement to take? Will this be effective?

Secretary WEINBERGER. This kind of encouragement can take many forms. It can result from simply the dissemination of information about successful practices and techniques. It can flow from technical assistance which staff of the Office of Education provide to school districts which request consultation. It can also be encouraged by Federal support for one-time startup costs to spread the idea until is has built up enough momentum on its own. After education revenue sharing is enacted, I believe that this sort of activity would be the most appropriate role for the Office of Education.

FOLLOW THROUGH

Mr. CONTE. With regard to the proposed phaseout of Follow Through, when will the evaluations of the tested programs be available?

Secretary WEINBERGER. Some should be available later this year. One of the groups of Follow Through students completed their par-

ticipation in the program last June. Further evaluation reports will be available and published as each of the classes completes its 4 years in the Follow Through program.

Mr. CONTE. What do you believe will be the source of continued support for programs of this type?

Secretary WEINBERGER. Primarily the regular school budget, supplemented by the special education revenue sharing funds. In many cases the new techniques discovered and tested through education research and demonstration projects do not cost any more than the conventional approaches to elementary and secondary education. The basic thrust very often is simply to try to get school districts to make better use of the resources at their disposal. It should not be viewed necessarily as an add-on to what's being done now, but as a replacement.

Mr. CONTE. Does the administration plan to cut out any Follow Through projects in fiscal year 1974?

Secretary WEINBERGER. No. We have adequate funds to continue all of the existing projects which have not yet completed their 4 years of activity.

FOREIGN LANGUAGE TRAINING CENTERS

Mr. CONTE. The budget proposes that foreign language training and area studies under NDEA title VI be terminated. Many people involved with these programs have indicated that these programs are, for the most part, very small, and that the schools have already indicated a reluctance to continue their programs without the Federal assistance. What is the administration's response to this?

Secretary WEINBERGER. I'm not aware of this. In fact, the indications we have are that most of these programs have quite a bit of support from university and private sources. I believe there are about 100 of these centers now in existence and nearly all of these should be able to survive the withdrawal of Federal support.

Mr. CONTE. When you say that the Federal funding under this program amounts to only 10 percent of their annual budgets, is this 10 percent only of those funds which go directly to the schools to support their operations, or does it include something else? If so, what?

Secretary WEINBERGER. The 10 percent refers to the budgets of the foreign language programs, not the total school budget. In includes the tuition receipts for students participating in the program, as well as special individual or institutional contributions or endowment income devoted to the program. The percentage would be much lower if we considered all the income of the university.

SOCIAL SERVICES

Mr. CONTE. You say that there undoubtedly has been some genuine expansion of services under the social services program during its recent meteoric climb before the limitation was enacted with the revenue sharing bill. Do you have any idea as to how much of an increase there was? What is the basis for your supposition?

Secretary WEINBERGER. We don't have any really definitive figures on this situation. After looking at a number of proposed State plan changes, an estimate was made that approximately 80 percent or more of the increase was due to refinancing rather than increase in services.

We know, for example, that in Alaska much of the increase was accomplished by real expansion of services. This was made possible because of the new income available to the State of Alaska from the offshore oil leases. Other States were not as fortunate in opening up new sources of revenue whereby they could dramatically increase State matching for covered services. Instead they redefined State supported services as being in the social services plan and withdrew three-quarters of their State support and substituted Federal matching for it.

ELDERLY NUTRITION

Mr. CONTE. You have proposed $100 million to be spent on the nutrition services under the Older Americans Act. This is the same as the level of the fiscal year 1973 request. In view of the rises in the cost of food, will this be sufficient?

Secretary WEINBERGER. I'm not sure what you mean by sufficient. If you mean we will be able to feed all elderly persons, the answer of course is no. Nor would $4 billion be sufficient for that purpose, $100 million will be sufficient, however, to demonstrate methods of providing food and more nutritious meals to the elderly through various kinds of community arrangements, including communal meals and special deliveries to the aged who are incapacitated. Our main intention is not to subsidize a vast on-going service, but rather to build capacity for States, localities, and private groups to do the job themselves.

Mr. FLOOD. Mr. Smith.

Mr. SMITH. First of all, Mr. Secretary, I want to extend to you my condolences and sympathy on your shift from a well fortified dugout at OMB over to this new position which is exposed to the prevailing winds on a daily basis.

Secretary WEINBERGER. I do get a lot more experience on the Hill in this business. I have already had it in the first 2 weeks.

Mr. SMITH. I guess by now you know you have been chosen by your friends and neighbors and the President to head the greatest conglomeration of little fiefdoms that were ever put together in one office in the history of mankind. None of your predecessors ever got completely on top of the job. I hope you do. Of course, your predecessors served back in a time when we still had a republic. Perhaps it will be easier now.

PARAPROFESSIONALS IN HEALTH DELIVERY

I want to ask you something which I asked Secretary Richardson last year and the year before which I think is terribly important. It will be hard to answer, I guess, because you cannot use the excuse of inflation or taxes or anything like that, because it does not cost any money.

I really think Secretary Richardson was very sympathetic to the idea, but somehow it never got done. That is, I am convinced that if we do not reform the delivery system, there are not enough dollars in Europe and Kuwait together to pay for some of these plans that are being promoted.

It seems to me that one of the first things to do is to get the States—this is in their jurisdiction at this time—to change their rules of practice and regulations so that doctors can legally delegate some of their authority, all of which they are not able to use anyway, or else if they are, they are wasting their time on something they should not be doing, to some nurses or nurse practitioners.

We have been talking about this for a long time, but it just isn't being done. There have been all kinds of committees to try to define what kind of services can be delegated, but they never get it done.

We have wasted valuable time, because some of these people who have come back from Vietnam and have been doing that kind of work could not get jobs. So, they are no longer interested in securing the training for this kind of job.

It seems to me that the one thing the President could do that might be of greater benefit than anything else is just to get some people together on top of the mountain some weekend, from the various professions, and get them in a room, as we do with labor negotiations when they break down, and say: "Listen, you people get together and come up with some kind of formula for delegating some of this authority so we can get more out of our delivery system."

I do not think it will be done at anything less than the Presidential level.

Secretary WEINBERGER. Congressman, I do not have any argument, at all. That is one of the reasons I am so hesitant to agree that there is a shortage of "X" thousands of doctors or "X" thousands of nurses, because this is all based on the assumption that we continue what we are now doing.

When you project this out to 1980 or 1990, I am reluctant to agree because it seems to me that we need to move in the general direction you are talking about.

It is one of the reasons I was not particularly concerned, as one of the other committees seemed to be, that we have an increasing number of foreign-trained doctors being admitted to practice. This does not really bother me because I think what we need to do is not only increase the supply, but examine increasingly the utilization and the need for some of the existing practices.

That is one of the things I am very hopeful this PSRO effort will produce. I think it is quite evident we cannot continue with the existing trends and requirements and projections. I agree with you, I do not think we will be able to get into satisfactory agreement of what now appear to be the future needs.

I would like to see it. It isn't anything that can come very quickly, because we do not presently have in training numbers of people in paramedical categories or nurse practitioners. But I think there are some hopeful trends in some of the medical schools, and I think that we just have to encourage this as much as possible, and perhaps the solution you suggest would produce results.

I am not sure it would, because there are a lot of different factors that would be involved in that closed room that you postulate that come out of labor-management negotiations. But, we have to move in this direction.

Mr. SMITH. We do have a lot of people who can do these things right now.

Secretary WEINBERGER. Yes, we do.

Mr. SMITH. I am saying it may be desirable to have some additional training but a lot of doctors are now illegally delegating authority, otherwise they could not serve all their patients.

Secretary WEINBERGER. That is true.

Mr. SMITH. The least we can do is make it legal. In many instances they are stopped from furnishing services because the doctor cannot claim the nurse is in his presence when he prescribes aspirins or she is serving a patient in a town away from his main office. So, he cannot send her out there to perform the same services she would perform in his office.

Secretary WEINBERGER. The first thing we have to do is try to sort out the protections that exist to protect the public and the protections that exist to protect the professions.

There are some in both categories. I think we would have to be, obviously, assured that a delegation of the type you describe is not one that is going to injure the public. I think there is no question that we have to move in this direction.

I think some of the new hospitals are being constructed so that a minimum of medical manpower is required. But we are a long way from the kind of result that I think you and I both want to see.

HMO'S IN RURAL AREAS

Mr. SMITH. I hear a lot of talk about HMO's, and I think that is great. But in all of these hearings that have been held, I find a dearth of understanding of what the real problem is in rural areas.

Secretary WEINBERGER. Yes.

Mr. SMITH. These people may live in a town that may be 15 miles from a group practice office or whatever you want to call it. As a practical matter, they cannot get there. What they have to have is some professional help in the local town. That could be the nurse practitioner with a direct telephone line to the doctors.

Secretary WEINBERGER. This is not a new concept. Years ago, the visiting nurse in slum areas of the cities used to be the best doctor in town, in many situations. An extension of this kind of thing is certainly possible and I think will be necessary.

Mr. SMITH. They talk about quality medical care, but these people by the thousands do not have any medical care now, so the quality could not help but improve.

Secretary WEINBERGER. That is right.

Mr. SMITH. Some are elderly people in some of these towns who have not seen a doctor in 10 years. If a flu epidemic comes through, they cannot go 15 miles over to the HMO office and get taken care of that way; they need for the nurse to come around and see them and at least get some advice.

Anyway, I think that is something that can be done, that can be done now without money, to start a movement in that direction. I just do not think it will be accomplished unless you can convince the President that he needs to do it.

The other thing I wanted to ask about was the breakdown of controllable compared to uncontrollable programs.

Now that you have reduced substantially in the budget some of the uncontrollable items, if the definition of control remains the same, such as, for example, impact aid, and the Congress goes ahead and appropriates a substantial chunk of money, which I assume they will do, for uncontrollable items, we are going to have a crunch on controllables like you never have seen before; is that not right?

Secretary WEINBERGER. Well, I think that would certainly be true. There will be an increasing need to try to follow the exercise I put in at the Budget Office which was called controlling the uncontrollables.

Mr. SMITH. So you are getting by this year somewhat a little easier; the full impact is not being noticed because we are under a continuing resolution. In effect, that has changed some definitions of what is controlled and uncontrolled.

Secretary WEINBERGER. Some of the reductions, Congressman, that are put forth in the budget and some of the terminations get into the uncontrollable sector. An expenditure is uncontrollable by our definitions if all the ground rules remain the same.

You can control some of the uncontrollables by trying to change the ground rules or by trying to change the existing programs or terminating them. So some of the terminations have come in the uncontrollable category.

Mr. SMITH. That gets to the nub of my next question: Are you attempting to change the definition of "controllables"?

Secretary WEINBERGER. Well, we are recommending to the Congress that authority to continue a lot of programs not be renewed. We are recommending no funding for many of these programs.

Mr. SMITH. That is not what I am talking about. I mean are you redefining some of these items——

Secretary WEINBERGER. No.

Mr. SMITH [continuing]. As not controlled that were controlled?

Secretary WEINBERGER. No, I do not think so, sir.

For example, take regional medical programs. This is a controllable. The authority for that program expires June 30. We are not requesting a continuation of funding for that program. If there is a continuation of formula grant funding then it would remain as a relatively uncontrollable portion of the budget.

Mr. SMITH. I think you ought to take a look at that list, because when the administration came out with a new list 2 or 3 years ago, it is difficult to understand how some of those items could be considered to be uncontrollables.

Secretary WEINBERGER. Well, they are uncontrollable in the sense that if the statute remains on the books, the formulas require that certain amounts of money be paid out to the States or the counties. All we have to do, then, is simply receive the request from the counties of States and respond with a check. That is the list that we are using. Now there are some that we can control in the sense that we do not put in a certain amount of money that the formulas call for.

The social services program is in that category. That was uncontrollable, and that moved from less than $500 million to potentially $6 billion, just last year.

The Congress controlled that in one sense by saying the ceiling is $2.5 billion—you cannot spend any more than that.

Mr. SMITH. What is on that uncontrollable list makes a whale of a lot of difference on what the controlled items are eventually going to end up with, it seems to me.

Secretary WEINBERGER. True. Not so much what is on that list, but the amount of money that is required to fund uncontrollable programs determines what you have left as controllable.

Mr. SMITH. Assuming we have a normal situation and do not operate under continuing resolution, it is going to bring a crunch this year.

Secretary WEINBERGER. Right.

Mr. CARDWELL. What does or does not go on that list depends on how one interprets the mandatory formula grants.

Mr. SMITH. That is right.

Mr. CARDWELL. Are they properly interpreted as being mandatory? Because if they are not, then they are not on the list. The issue is, does the executive have any discretion to set spending levels once appropriated? That is one class. That is the class on the so-called list.

Then there is the other class, made up of public assistance and trust fund activities, for example, where the authorizing statute sets up an entitlement to classes of individuals. Expenditures are based on the number of people who will be in that class at any one time and will claim that entitlement. That is the other type of uncontrollable.

Mr. SMITH. If that list is not changed, I would be surprised if you do not find yourself going back over to OMB in another 8 months with your hat in your hand asking them to cancel one of those aircraft carriers and give you a little more money.

Secretary WEINBERGER. That would be a sad day for me, not to cancel the aircraft carrier but to ask for more money.

Mr. SMITH. It would be hard for you, because you have to keep in mind that defense might be your next job.

Secretary WEINBERGER. There are limits.

Mr. SMITH. That is all I have, Mr. Chairman.

Mr. FLOOD. Mr. Robinson?

Mr. ROBINSON. Thank you, Mr. Chairman.

DEFICIT BUDGET

Mr. Secretary, I, too, would like to congratulate you on your forthright and articulate presentation which you have given us here. But I think we have to acknowledge when we look back over the period of the last couple of years that you probably had a very signficant impact not only on the budget process for HEW, but on the budget process as it applies to the entire country as a whole and all of the programs.

I find myself concerned by the fact that in the consideration of the full employment budget concept we are considering a budget this year which is in the red by almost $13 billion, at a time when we obviously are looking for a very prosperous year, when unemployment rolls are

dropping, when we have almost gotten to the point where the full employment level has been reached and yet in the budget presentation that was made to us in the full committee, it was simply acknowledged that it was necessary to spend $13 billion more than we were taking in order to keep the economy running.

Secretary WEINBERGER. Congressman, I have very little argument with you, but I would like to be allowed a couple of comments right at this point, because you touched a raw nerve.

I do not like that $12 billion deficit there either. That is a function of using the budget as I think it probably had to be used, to stimulate the economy when we were as far down as we were 2 years ago. The budget was used in a conscious decision by the President at that time to stimulate the economy. The full employment concept which involves and permits spending more than you take in was adopted, but a ceiling on how much more is needed and that ceiling, as you know, is the amount of revenues you would get if you were at full employment. The problem with a budget that is 75, 74 percent uncontrollable is that when the economy no longer requires deficit spending, it becomes very difficult to move back. You cannot unwind it all in one year. That is the reason why there is so much outcry this year. The President is trying to move back to the point where the budget will not be overstimulated, where it will not start another wave of inflation. Even with a budget with a $12 million deficit there has been a great deal of outcry—it is to austere, we have reduced things drastically and ruthlessly, and all the rest. Yet that is literally the only way it can be done.

That budget of 1974, with its $12 billion deficit, represents a budget that is approximately $22 billion, if I remember correctly, less than it would have been had we not made the cuts that brought us back to $250 billion for fiscal 1973. It is a budget which would permit us to be at actual balance in 1975 if we hold the line in the 1973, 1974, and proposed 1975 budgets.

That is why the budget for this year shows a 1975 budget in the $280 billion range instead of $315 billion, which is what would have been required if we allowed the $250 billion to go to $261 billion in 1973. This has a tremendous ballooning effect each year.

You have a budget this year that has a deficit of $12 billion. It is a major fiscal accomplishment to get it back that low, because it would have been well above $20 billion, close to $30 billion again, had we let things go from $250 billion to $261 billion. That is the reason the President was so insistent on a $250 billion ceiling and on taking all steps to get to $250 billion. If we do not hold the line with the 1974 budget, at $12 billion deficit, we will have a deficit in fiscal 1974 and fiscal 1975 that is completely unacceptable from every economic point of view, and we will have been the cause of starting more inflation.

We will also have to have a tax increase of about 20 percent, unless this line is held. That is why it is so extremely important that we do that.

Now we made every effort to see if we could not anything about getting the 1974 budget any lower. Frankly, this was not possible. So that $12 billion represents real progress, when you had $24 billion the previous year, when you have a 75-percent uncontrollable budget and when there is a need to get back to balance because the economy

shows that you are going to have an inflationary effect if you keep on with deficit financing. You cannot get a balanced budget when you have 75-percent uncontrollable and when you have had to use the budget to stimulate the economy in 2 previous years.

Mr. ROBINSON. I recognize the argument because we heard all the same statistics, of course, once before from Mr. Ash and Secretary Shultz.

Secretary WEINBERGER. We all use the same textbook.

Mr. ROBINSON. That is exactly right. I have an idea that you had a pretty good hand in writing it, as a matter of fact.

SECRETARY'S IMPACT ON HEW BUDGET

What concerns me is how do you apportion out this planned deficit, how much of this planned deficit is in this HEW budget?

Secretary WEINBERGER. I do not think there is anything that operated that way, Congressman. As we said a moment ago, about 86 percent of HEW is uncontrollable.

You do not plan part of your deficit in that kind of an agency. What you plan is to try to hold those programs which have less demonstrated value, terminate programs which have demonstrated that they have completed their mission or are not effective at all, and put what increases you had into programs that do appear to be effective or, more likely, that are required by the formulas to increase.

Social security in HEW is increasing somewhere in the neighborhood of about $6 to $7 billion. That is part of that deficit, too, not because it is not financed—there is financing coming in from increased payroll taxes—but it is part of the total.

Mr. ROBINSON. But nevertheless, in the face of the facts that I have already stated, and in the face of the statement which you have made in the article which recently appeared in Readers' Digest in which you say:

> The more I probed, the more apparent it became that throwing the taxpayers' money at one problem after another does not guarantee solutions.

Then you go on to recite a number of statistics which already appear in the record.

Secretary WEINBERGER. Yes.

Mr. ROBINSON. Including the fact that your Department, HEW, is going to outstrip the Department of Defense this year, largely as you have just said, because of huge increases in social security.

Secretary WEINBERGER. Right.

Mr. ROBINSON. I wonder if up until that point this statement reflects the thinking of those that have been serving in the position that they now serve in and that are sitting around the table here, rather than something to which you have made any significant contribution, because you have not been there very long. I would be totally sympathetic if such is the case, but this is the way the statement reads.

Secretary WEINBERGER. Well, I take responsibility for all statements that have come out under my name, whether I write them or not. I take full responsibility for this statement and for the material in it. It is meant to be explanatory and illustrative of some of the things that are in our budget request.

I was familiar with the things that went into that budget request, of course, or at least the things that came out of it.

I stand behind the entire statement. As far as the latter part is concerned, we will have a very large new duty which was laid on us with the federalization of the adult categories.

As I say, here, the estimate is that it can be done with no fewer than 18,000 new employees and I believe it can be done with fewer than 18,000 new employees, and also, we are going to try to make reductions elsewhere wherever we can so that the totals will stay within the ceilings which the OMB put on the budget.

Mrs. GREEN. The present Secretary of HEW would never be guilty of this, but I well remember when Secretary McKay appeared before the Interior Committee, he read the statement. When he had completed it, he looked up at Congressman Engle and said, "Now, Mr. Chairman, if I may add a few words of my own."

Secretary WEINBERGER. There are not enough hours in the day, Congressman, to do everything and I do rely on a very able staff, but I will continue to impose my own ideas on my opening statements and any other documents that come out over my name.

Mr. ROBINSON. The point I would like to make before going on is that I would hope that your economic philosophy will have more impact on the operation of the Department of HEW than is reflected in the statement which has been read and I believe that most of it was written by others than you, even though I realize that you have to stand behind it.

FOOD STAMPS

Before getting into any specific points, I would like to refer to something in which you have an ancillary interest and responsibility, and that is food stamps.

Secretary WEINBERGER. Yes.

Mr. ROBINSON. We have had the statement of the Secretary of Agriculture before the committee which funds USDA. I brought to his attention this statement in a document which we have, which says that the major change included in the 1971 amendments was the establishment of uniform—this refers to food stamps—uniform nationwide eligibility standards based on income and other resources available to be determined jointly by the Secretaries of Agriculture and HEW.

It is my personal belief that the program for the assistance of the needy and the poor that is most abused of all that we have is the food stamp program. I think if you want to get information to that effect, all you have to do is talk to any neighborhood grocer today.

The Secretary of Agriculture indicated that he was willing to consider modifications in these requirements, in the eligibility standards, in terms of trying to reduce the amount of money that we are putting into that program which this year is budgeted to be $2.2 billion. This is not your department. This is Agriculture money, as you well know.

He said the only reason it had not been done before now is because of the pressure groups that exerted so much pressure on them that they decided to back off and that at present nothing was under consideration.

My question of you, Mr. Secretary, is whether or not in view of the fiscal situation that we face, you would be willing to consider such a

consultation in line with cutting down on these eligibility standards, tightening up on the requirements and making this program make some sense, instead of being the boondoggle it is today.

Secretary WEINBERGER. Well, Congressman, we are certainly examining every program.

I, as you have indicated, have an ancillary interest in that, because it is one of the programs assigned for coordinative purposes to the counselor for Human Resources. So I would have an interest in it, and I would certainly examine it along with the others, to insure as I said a moment ago that when we report to the Congress that an amount is required, it is an amount truly required, and when we report to the Congress and to the President on the efficacy of particular programs or anything else about them, that we have full facts and have also the knowledge sufficient to recommend any changes that may be indicated.

We have a full-scale evaluation and examination of all of these programs under way and we are going to extend it to those that are involved in the counselor's role.

Mr. ROBINSON. As you know, there is a growing strong sense of objection to these open-ended programs.

Secretary WEINBERGER. Yes, indeed.

Mr. ROBINSON. The food stamp program is in this category of being absolutely overfunded——

Secretary WEINBERGER. The budget charts that you have there indicate the growth of the program in recent years. It has been very spectacular.

Mr. ROBINSON. It has been spectacular and frightens me very much.

SUPPLEMENTAL SECURITY INCOME

You mentioned the 18,000 additional employees that will be necessary to administer the program of the shift from the States to your agency of the adult assistance program. Now is there any danger, Mr. Secretary, that this is going to be another layer of bureaucracy with which we will have difficulty?

Secretary WEINBERGER. Well, I certainly hope not.

There are somewhere in the neighborhood of 22,000 to 23,000 State employees performing this service now. Once the service is transferred to the Federal Government, the estimate is that, if and when it is, we can do it with about 18,000.

My concern is, and we will have no control over it, that some of the 23,000, 24,000 people in the State governments doing this may not be terminated.

There is no reason for them to continue in State employment if they have been full time on this work because this work will be transferred to the Federal Government.

But we would hope to do it for less than the 18,000 estimate. That 18,000 is considerably less than the number of people presently doing it. We would hope the States would find that once this function is transferred the people presently handling it would not have to be retained in the State departments, certainly not for any purpose connected with this transfer.

Mr. ROBINSON. Would any portion of those people be the same people in HEW?

Secretary WEINBERGER. They might very well be. There is a lot of interest in doing that. Certainly the people doing this are experienced in it and we would want to utilize their experience.

I do not think there is a one-for-one transfer, we hope to do it with a lot less. Certainly some of the people who are presently doing it would be most welcome.

COMMUNITY MENTAL HEALTH CENTERS

Mr. ROBINSON. I would like to ask a few more that pertain to matters in general.

You mentioned in your statement regarding the status of the community mental health centers and their continuation. You make some mention of an 8-year period. I did not exactly understand what that inferred.

Secretary WEINBERGER. That is, by statute. When the community mental health centers started they were supposed to be funded for 8 years by the Federal Government—actually, initially, it was 5, then the period was extended to 8 years by a change in the statute.

Each center was to be assured that if it was started it would have 8 years of Federal funding, Federal assistance. Our proposal is that we should honor that commitment. A center that was started 6 years ago should get 2 more years of Federal funding, a center that started 7 years ago should get one; there is supposed to be a declining Federal share each year and we are proposing to continue doing that.

A center started last year would have 7 years of declining Federal aid. That is a commitment and we propose to honor it. We do not propose to start any new ones. That is the exent of the program.

Mr. ROBINSON. I understand. I just wanted to understand what that number inferred.

FAMILY PLANNING

To what exent do you find States cooperating with your family planning programs in which you infer that penalties will be applied if they do not in time go along with the program?

Secretary WEINBERGER. I do not have information on that. I will ask anybody here from the agency.

Mr. CARDWELL. That is a legislatively imposed requirement. It is not something that we invented.

Mr. MILLER. I think it is too early to tell, too. It is just being proposed. I do not think we have had a chance to get any experience.

Mr. ROBINSON. You have not received any reaction from the States that is significant at this point?

Mr. MILLER. No.

MENTAL HEALTH FUNDS

Mr. ROBINSON. I am concerned about an item in the budget that does not seem to me to be adequately covered in terms of your testimony, whereby you do not go into the tremendous increase in 1974 in the amount that you want to appropriate for mental health, which is under your health programs.

You go up from $640 million to $1.32 billion.

Secretary WEINBERGER. That is the matter we were talking about just a moment ago. That is the authority to continue to fund the 8-year commitment. It is not an outlay figure. The outlay figure would be much lower. That is the one that gives us the authority to complete all commitments and nothing more. Since we will not be asking the item in subsequent years under the present plans, we wanted the authority to complete it.

Mr. SHRIVER. Would you yield? But why are you doing it all in 1 year?

Secretary WEINBERGER. Just to get the authority this year. We would not be spending it this year.

Mr. SHRIVER. But it does increase the budget that much?

Secretary WEINBERGER. It does.

Mr. SHRIVER. More than if you would give it out each year?

Secretary WEINBERGER. Not really. I know the Congress is in the habit of using budget authority as their measure. But I have always used, as I have used previously, the budget outlay figure and that will remain a decreasing, declining basis as the years go on and we get near the end of honoring the last of these 8-year commitments. On a year-by-year basis, the outlays will be the same. But the authority has all been requested in this year.

Mr. FLOOD. We will reconvene at 2 o'clock.

AFTERNOON SESSION

Mr. FLOOD. Mr. Robinson, you have the witness.

AID TO BLACK COLLEGES

Mr. ROBINSON. Thank you, Mr Chairman. Mr. Secretary, with reference to the funds for developing institutions of higher education, I gather from your statement that there will be at least as much emphasis and, as a matter of fact, increasing amount of emphasis as compared to 1972 on aid to black institutions.

Secretary WEINBERGER. Yes. We plan to hold that——

Mr. ROBINSON. $100 million, I believe it is.

Secretary WEINBERGER. Yes, sir.

Mr. ROBINSON. I certainly approve of this as an objective. We have a number of them in Virginia, but I wonder if the overall objective of widening educational opportunities for the underprivileged is being approached in an unbalanced way by going down this direction in terms of encouraging black institutions to stay black, because that is exactly what this program does in all too many instances.

Secretary WEINBERGER. There is not any desire to do that, nor any feeling that that is the proper way to go. As far as I am personally concerned, we are after integration. I have no desire to see separateness maintained on either side.

Mr. ROBINSON. Well, there are a great many institutions in my own district that are making intensive efforts to increase their black enrollment.

Secretary WEINBERGER. Yes.

Mr. ROBINSON. And yet, they are not making much headway. And as a matter of fact, I objected to a statement that was made by Dr. Ottina, which I will repeat again, when he referred to the seemingly hostile middle-class environment found on most campuses, with regard to the blacks.

Secretary WEINBERGER. I did not hear his testimony and I did not——

Mr. ROBINSON. I think it is unfortunate that that appears in the record.

Mr. MILLER. I think Dr. Ottina also, when it was called to his attention, indicated he would not have submitted it. In fact, he changed it.

Mr. ROBINSON. I insisted on it being done. I believe as I indicated at that time and I would like to repeat to you, some of this money should be directed to assisting and orienting the blacks before they go to college rather than simply funding the black colleges to which they gravitate because, when they go to the white ones, the higher dropout rate they suffer discourages additional blacks to come to the same college.

I think we are misspending some of this money in that regard and I frankly have somewhat of the same criticism with regard to the $271 million that is proposed to be spent to help these desegregating high schools or public schools that are either under order or, I believe as it said there, either under order or potentially under order.

I would like to know how much of that money, of the $271 million that is proposed, would actually get to the schools themselves and how much of it is for administration of the program in terms of people that circulate and attempt to define where these problems exist.

Secretary WEINBERGER. It is a perfectly valid question. I do not have the information here on that kind of breakdown, but I would be very glad to get it for you.

Mr. MILLER. That program goes out to the States as a formula grant. But each project, which presumably would be submitted by a school or by a school district would have to be approved at the Federal level, probably in the regional office.

Mr. ROBINSON. I wonder how much of the total funds go to help a school district that is under order to bus that had not been previously busing, for example.

Mr. CARDWELL. On that first item you discussed, the so-called developing institutions, it is true the preponderance of that money will go to black schools, but it all does not go to black schools. It is a matter of economic status and potential for self-development rather than the color of the schools' student body.

Mr. ROBINSON. The way you put it, you say it goes primarily to small colleges serving a significant number of minority students.

Mr. CARDWELL. I agree.

Mr. ROBINSON. I would like a definition of a significant number of minority students.

Mr. CARDWELL. Let me go back.

It is not the number of minority students that determines whether an institution would be eligible, it is the economic status of the institution that determines whether they are eligible.

It just so happens that most of the schools that would be eligible because of lack of economic capacity are either black or other predominantly minority student body. Some of them are Mexican Americans, as a matter of fact, but not too many.

Mr. ROBINSON. Can you give me a percentage as a significant number?

Mr. CARDWELL. We will do that. I do not have it here.

Mr. ROBINSON. I would like to see a further definition of what "significant" means.

[The information follows:]

Generally, a significant percentage of low-income students denotes a minimum of at least 40 percent of the institutions annual enrollment made up of students coming from homes where the family income is less than $7,500.

In the average developing institution, this means 400 students in a total enrollment of 1,000.

In the predominantly black institutions, this proportion is, on the average, 80 percent.

In those institutions having at least 100 Mexicans-American students, the low income percentage is between 60 and 70 percent.

Institutions serving no less than 100 American Indian students can usually report that at least 90 percent of the Indian students are from homes where the income is less than $7,500.

In many instances, this low income figure exceeds 40 percent because it is often true that institutions having this proportion of low-income students serve more than one minority.

SELF-DETERMINATION

Now, Mr. Secretary, the President recently indicated that in his view the Government perhaps, and I cannot quote his words and I cannot quote the source, but I recall it quite definitely, the Government in his view was taking too great a role in determining for people decisions that they should more properly make themselves in some very important areas, such as this question of the diet-cholesterol problem, the family planning area, the exercise conflict, as to whether or not you exercise, whether it is good for you or bad for you; and that there is an amount of guidance here that may be undesirable in terms of our democratic system.

Do you have any particular thinking on that subject with regard to the programs that are in HEW?

Secretary WEINBERGER. Well, I do not have any specific examples to mention to you, Congressman, but the statement you paraphrased of the President I think is from the inaugural address.

The general feeling he has, that Government services should be necessary and should benefit people who are most in need and that while other services of the kind you described may have had some basic usage earlier, now is the time when we have to select the priori-

ties and when we have to insure that the Government dollars go to the people most in need and for projects and programs that have been proven to be effective.

With respect to the cholesterol in the diet, that is a form that would come out of a research program based upon some of the work that the National Institutes are doing in connection with the heart study. I think that kind of work would certainly continue, because if we can identify any of the causes of arteriosclerosis or heart disease through diet, and there have been a lot of projects in this category for a long time, that would be helpful and useful. But generally speaking, I think the President feels that programs that have a marginal value or are designed to do things that people might well do for themselves or other governmental units should do, are programs the Federal Government should start backing out of. That is essentially what we tried to say in the principles that I cited here in the opening statement, what the budget has been based on, and what the Federal role should be confined to.

Mr. ROBINSON. In other words, you are redefining——

Secretary WEINBERGER. We certainly are trying to.

Mr. ROBINSON [continuing]. Your position with respect to this?

Secretary WEINBERGER. Yes, we have to, because the dollars are just not there to continue doing everything we have done in the past on the increasing scale that seems to be required every year.

WASTEFUL FEDERAL PROGRAMS

Mr. ROBINSON. In your article in the Reader's Digest, you quote the fact that the catalog of Federal domestic assistance lists more than 1,000 different programs, and you are further quoted to the extent that many of these, of course, are exceedingly wasteful in your view.

What are the most wasteful programs in your view, Mr. Secretary?

Secretary WEINBERGER. The most wasteful ones are the ones we tried to identify on pages 50 and 51 in the budget document. They involve in many cases not just waste, but things that have been finished, that could be terminated, things that the Federal Government no longer need do.

I have in mind, with respect to some of the areas not involved in HEW, programs like the REA loan guarantees at 2 percent, the Rural Environmental Protection programs, where farmers are paid something like $230 or $240 a year for following such environmental practices around their home as they would normally follow anyway.

I regard the impacted aid program as in that category because it is not focused. There is a whole list of them from various departments that are set forth on those two pages. Those are the ones we feel should be terminated. Sometimes it is not that they are wasteful, they are either unnecessary or the Federal Government is playing an inappropriate role in them. But there are a great many. They have been identified from time to time.

The President's second budget identified about $3 billion worth of programs that he felt should be terminated. Very little results flowed

from that, although he did manage to get some administrative costs down. We are still running a steamship line down in Panama, and have been running a railroad in Alaska for close to half a century.

I think these are the things that the Federal Government could terminate now.

Mr. FLOOD. If the gentleman will yield, what is the status of the Panama line?

It used to run from New York to Baltimore down to the zone. Then that was discontinued and passenger ships were taken off. They started to run from the gulf coast down.

Secretary WEINBERGER. It is interzonal mostly, but there are some additional areas served right in and around the periphery of the canal.

Mr. FLOOD. Does that line still transport passengers?

Secretary WEINBERGER. Yes, sir; so far as I know.

Mr. FLOOD. It does. Where is the U.S. port, down in the gulf coast?

Secretary WEINBERGER. Yes. I think it is Galveston. I am not sure.

Mr. FLOOD. Thank you.

AFDC PROGRAM

Mr. ROBINSON. With reference to the quality control program aimed at waste in the aid to families with dependent children—and I certainly endorse such an effort—I wonder if you could indicate how much this monitoring is going to cost?

I note that you have not decided just how to penalize States which do not seem to be tightening up their eligibility procedures. Will this result in another sizable bureaucratic unit devoted to policing the States?

Secretary WEINBERGER. This effort will be under the leadership of the Social and Rehabilitation Service. We are proposing an increase in staffing directly related to our efforts to improve the management of public assistance. These would be a net increase of about 600 jobs in SRS, bringing their staffing up to about 3,400 people. The increase would cover medicaid and social services as well as the quality control effort in aid to families with dependent children. I do not believe that this constitutes a particularly large Federal bureaucracy, especially considering the fact that approximately 240,000 State and local staff are employed to administer the various public assistance programs.

The additional people should more than pay for themselves through savings in Federal matching and more efficient State and local operations. I believe that Charlie Miller has the figures on how much this operation costs.

Mr. MILLER. Mr. Robinson, the total budget for the salaries and expenses of the Social and Rehabilitation Service comes to about $79 million in the 1974 budget. Of this amount, approximately $47 million is devoted to the administration of the public assistance programs. This will support Federal employment of 2,295 people in 1974.

Mr. ROBINSON. I should be interested in your experience with the quality control procedures in Virginia.

Could someone supply an indication of how Virginia stands as to compliance with the standards, or guidelines?

Secretary WEINBERGER. I have some data here on the results of a quality control survey which the Virginia Welfare Department conducted covering the months of July through December 1971. It indicates that the rate of ineligibility in the AFDC program was 4.4 percent, that 22.1 percent of the people on the rolls received overpayments, and 19.1 percent received underpayments. In contrast, the national average shows a 6.8 percent rate of ineligibility, a 13.8 percent rate of overpayment and a 7.6 percent rate of underpayment. These figures show that Virginia is showing a lower ineligibility rate than the Nation as a whole, but a much higher of incorrect payments.

I think that it would be reasonable to expect that more vigorous management on the part of the Virginia Welfare Department could make very significant improvements in this performance. We are hopeful that the figures now being compiled for 1972 will show some improvement.

MEDICARE CLAIMS

Mr. ROBINSON. We certainly need to concentrate on ways to hold down the costs of the medicare and medicaid programs, and I noted with particular interest your plans in this regard.

Particularly as to medicare, however, I have great sympathy with the many elderly citizens who have communicated with me in regard to long delays in processing of claims, and inadequate explanation furnished them when part or all of a particular claim is turned back by the carrier.

Will you be giving attention to this?

Secretary WEINBERGER. Yes I will. I believe that the beneficiaries deserve prompt action on their medicare claims and a proper explanation for the denial of any claim which they feel entitled to. The Medicare Act is quite complicated and I believe that the Social Security Administration and the intermediaries that process medicare will have done a generally good job of making its intricacies understandable, both to the providers of medical care and public at large. I believe, however, that this performance can be improved and I will expect to see continued progress in this area.

I understand that there have recently been some abnormal delays in processing claims in the State of Virginia. During 1971 and part of 1972, the Travelers Insurance Co., which is responsible for processing claims in many areas of Virginia, was consolidating its three offices into one location in Richmond and installing a new computer system. A backlog of unprocessed claims developed during this period, but once the new system was in operation, performance improved rapidly. The latest data which the Social Security Administration has indicates that Travelers' claims processing performance compares favorably with regional and national averages. I can supply a table for the record which shows the extent of the processing problems and the recent improvement.

[The information referred to follows:]

Period	Weeks' work on hand			Percent claims over 30 days		
	Traveler's	Region	National	Traveler's	Region	National
July to December 1971	5.9	2.2	2.4	29.3	27.7	20.4
January to March 1973	5.2	2.3	2.4	46.6	30.0	19.6
April to June 1972	3.7	1.8	2.1	43.8	27.0	18.3
August to September 1972	3.0	1.7	2.0	30.4	24.2	18.1
October to December 1972	2.8	2.3	2.2	19.0	16.6	15.5
January 1972	2.2	2.7	3.2	14.1	21.0	16.4

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Mr. ROBINSON. I have a particular interest in the PSRO program because what I understand to be one of the pioneer efforts in this field has been operating in Albemarle County, Va., under auspices of the Albemarle County Medical Association.

What has been the impression gained from the pilot efforts of this kind? Has the Albemarle County effort been productive, in your view? What has been the degree of acceptance in the health professions?

Secretary WEINBERGER. I can't say that I have had a personal opportunity to examine the PSRO efforts of the Albemarle County Medical Association. I understand, however, that the people in the Office of the Assistant Secretary for Health who are implementing the PSRO program have a very high regard for the accomplishments of the county medical association.

The association has received a grant from the National Center for Health Services Research and Development to establish an experimental medical care review organization under the overall leadership of Dr. James Respess. The initial reports from this project indicate that the Albemarle County experience will prove of great value to future PSRO efforts. They appear to be far ahead of comparable efforts in other areas in developing criteria for appropriate levels of medical care.

HEALTH DELIVERY CENTERS

Mr. ROBINSON. I am having some difficulty in understanding which of the community health delivery programs will be continued.

In my congressional district, for example, there is an agency known as the Central Virginia Community Health Center, which has been funded by OEO.

My understanding, from the Department's congressional liaison people, is that it may expect to receive continued funding.

Not far away, there is an agency known as the Center for Delivery of Health Care, a program established pursuant to title V of the Social Security Act of 1965.

This agency, as I understand it, is engaged in programs of maternal and infant care, children and youth health care and children's dental health.

I am informed that its future is in question, and that a paper identified to me as interim policy statement (IPS No. 4) of the Administrator of HSMHA, proposes to phase it out.

Could you clarify the difference in treatment of these programs?

Secretary WEINBERGER. I believe that your understanding is correct about the center being funded by OEO. The transfer from OEO for neighborhood health centers should be adequate to support all of the existing centers at current levels of operation.

I also believe that Virginia should have no trouble continuing its maternal and child health programs. In 1974, the funds formerly budgeted for the maternal and child health project grant program will be added to the formula grant allocations to the States. This is required by title V of the Social Security Act and our budget plans are based on carrying out this law as it now stands. The discontinuation of the project grant program in favor of a larger formula grant does result in some State-by-State reallocations. Some States gain funds and other lose. In the case of Virginia, it would gain approximately $1 million over what it received from formula and project grants in 1973. Because of this, the Virginia Health Department should have no difficulty continuing all of its previously supported projects and even starting some new ones. It's really up to them to make this determination.

The policy statement you refer to is an effort by the Health Services and Mental Health Administration to define its role more clearly in health delivery and the development of health services resources. It establishes general guidelines applying to all HSMHA programs which are very similar to the principles which I discussed at the beginning of my opening statement. One important aspect of the interim policy statement is the goal of encouraging all federally supported health centers to become self-sufficient through tapping public and private third party payment systems and other State and community resources. This is, of course, quite consistent with overall departmental policy and the assumptions behind the 1974 budget request.

EMERGENCY SCHOOL AID

Mr. ROBINSON. In the item for emergency school aid, directed toward special costs incurred in the effort to advance desegregation, I note that you intend to maintain this assistance at substantially the same level as in the current fiscal year.

This suggests that not much progress has taken place in adjusting these special problems, or that the program is getting established as more or less permanent.

Why should not this money be placed in the special revenue sharing pot?

Secretary WEINBERGER. I think that in the long run it would make sense to do this. The emergency school aid effort should last only a limited number of years and when this job is complete, it would seem reasonable to devote these funds to improving the education for all disadvantaged children. I can't say right now, however, how long it will

be necessary to keep a program going which is specifically directed at helping schools overcome the problems of desegregation. We are considering these factors right now in the development of our education legislative proposals. It may be necessary to request a continuation of the emergency school aid effort beyond the 2 years currently authorized for it.

Mr. ROBINSON. That is all, Mr. Chairman.

Mr. FLOOD. Mr. Patten?

LETTER ON STUDENT ASSISTANCE

Mr. PATTEN. Mr. Secretary, Mr. Chairman, on the supplemental I have a letter from my chancellor of education of the State of New Jersey, who comments on our supplemental, especially the basic opportunity grants.

Will I get an opportunity sometime to put this in the record?

Mr. FLOOD. You can do it now.

Mr. PATTEN. That will be swell.

He comments. They all support the basic opportunity grants. He said last year New Jersey was only able to satisfy approximately 20 percent of the HEW panel approved requests under the former program.

He says that $7,500 family contribution schedules, that schedules set at $7,500, works adversely against us in New Jersey because of our high cost-of-living level. We find this at every turn. So that I would like to put this in the record.

Mr. FLOOD. Without objection, it is so ordered.

[The information follows:]

STATE OF NEW JERSEY
DEPARTMENT OF HIGHER EDUCATION
TRENTON, NEW JERSEY

OFFICE OF THE CHANCELLOR

February 27, 1973

The Honorable Edward J. Patten
U.S. House of Representatives
Room 2332
Rayburn House Office Building
Washington, D.C.

Dear Ed:

It is my understanding that your Subcommittee on Labor, Health, Education and Welfare Appropriations is now beginning to consider the Supplemental Appropriations Bill for FY73.

There are several items under discussion in that bill which affect postsecondary education in New Jersey. I thought it might be worthwhile to provide you with some additional background information on our priorities, and particularly on our student aid needs in the State. Because of the lateness of the passage of the new EDUCATION AMENDMENTS OF 1972, higher education issues have not really been dealt with in great depth this fiscal year. It is extremely important for us to have some of those new programs implemented, as well as to see adequate support provided to the priority programs which serve New Jersey. Following is a list of just a few of the State's highest priority programs:

Basic Opportunity Grants and Supplemental Educational Opportunity Grants

In New Jersey in FY72, the State was only able to satisfy approximately 20 percent of its HEW panel-approved request under the former EOG program. When the Basic Opportunity Grant Program, which we supported, was proposed and the decision reached to have a balanced approach to student aid through the new program in combination with existing student aid programs, we believed that New Jersey might better be able to serve its lower income students.

With the Basic Opportunity Grant program alone, there is some concern that New Jersey might not lose even more of its basic student aid support, especially now that the institutions and the Federal programs are serving a much-expanded postsecondary student population which includes the proprietary institutions (a policy with which we do concur). However, with the population to be served greatly increased, and the number of alternative student aid programs with which can service their needs, New Jersey will not be able to adequately serve lower-income and lower-middle-income students in a high-cost State such as New Jersey.

Almost none of the State colleges were able to meet even 50 percent of their EOG requests; requests which had been approved by HEW panels. The State University could

satisfy only 65 percent if its needs. The two new State colleges serving new populations and areas in the State were only able to satisfy an average of 35 percent of their EOG panel-approved needs. While some of the community colleges did fare slightly better, Middlesex County College was only able to satisfy 31 percent of its EOG needs. The panel approved $39,500 in EOG grants for Middlesex College, after the College had requested an amount totaling $49,500 in EOG funds. HEW was only able to provide a total of $15,150. Middlesex County College has now filed a request for funding from EOG totaling $63,700, with $36,700 of that amount being for new EOG grants.

To reiterate, we strongly support the initial implementation of the Basic Opportunity Grant Program for the coming academic year, and we again endorse the concept of aid provided directly to the student, along with a balanced program of student assistance provided the institutions with which to work, to design more effective and adequate "student aid packages" and to attract students. We do have some concern for the lateness of the year; already any implementation of the BEOG program will cause some confusions within the States. On the other hand, we have been assured that if action is taken before early April, the student financial aid community would still be able to implement it for the academic year 1973-1974. I feel it is important to begin BEOG at least on a pilot basis this year. I also feel that the funds should be secured for the Supplemental Educational Opportunity Grant Program, to ensure that the intent of the EDUCATION AMENDMENTS OF 1972 is fully carried out, and to enable the financial aid community and the institutions an opportunity to coordinate the programs and develop a balanced approach.

Furthermore, with the allowance for assets in the family contribution schedule and regulations set at $7,500, New Jersey could again be adversely affected, it is a relatively low asset level when you consider the higher State and regional cost-of-living. Since there would be no minimum guarantees of aid flowing to any one State through the BEOG program, we could end up facing severely inadequate student assistance funding resources, despite the fact that New Jersey maintains the fourth largest student aid program in the nation, and is on its own making an outstanding effort to support student aid needs.

In turn, I realize the tremendous economic and budgetary pressures under which your Committee is working and I would like to suggest that if a ceiling on appropriations is to be assessed, that the level of funding of other programs, such as BEOG be reduced in order to free up funds for some funding of the SEOG program at at least last year's level of approximately $250 million, and that College Work Study be restored to at least a funding level of $270 million. (Under the present estimate for Work Study of $250 million, New Jersey stands to lose almost $4 million in funds. New Jersey has a strong Work Study program, and it would be most unfortunate to have it weakened at this point in its development.) If, for example, the level of funding now proposed for the Basic Opportunity Grant Program by the Administration, $622 million, were reduced by $300 million, there would be enough funds "freed," so to speak, to ensure funding of the Supplemental EOG program, and to restore some funds to College Work Study. This would still leave funds to establish the Basic Opportunity Grant concept as a pilot program this year, until the regulations, delivery process and system are more thoroughly worked out over a longer period of time before full funding is applied to the program.

Fund for the Improvement of Postsecondary Education

There is a second new program recently authorized in the EDUCATION AMENDMENTS, which I would like to mention briefly, and that is the Fund for the Improvement of Postsecondary Education. This fund will give higher education an opportunity to explore new trends in the field, to improve the management and planning aspects of postsecondary education, and to examine ways to expand access to postsecondary education to new kinds of students, making postsecondary education more meaningful to them.

I do serve on the national advisory board for this new program, and have been impressed with the degree to which the administering agency has gone to great lengths to determine what is going on in higher education, what some of the major problems and areas which need changing, improvement and strengthening are. I am confident that the Fund will be able to effectively use the $10 million appropriated for its activities in FY73, and I am hopeful that the Fund will continue to receive your support.

Cooperative Education, Developing Institutional Support, and TRIO-Special Services

New Jersey strongly supports several of the requests for increased funds for higher education programs such as Cooperative Education, Title III, Developing Institutions, and TRIO (Upward Bound and Special Services, Talent Search).

To provide you with some background on these three programs, New Jersey is a particularly strong Cooperative Education State. Through the State Department of Higher Education we are trying to coordinate a State-wide effort in Cooperative Education; with State funds we are supporting almost a dozen institutions to develop their own programs; and now Federal funds are supporting Cooperative Education programs at two new community colleges, a state college, and a private four-year institution. The concept is a good one, combining academic and professional work with an academic program making postsecondary education more realistic and more effective. The budget requests a funding level of $10.7 million for Cooperative Education; without new funds the USOE will only be able to fund perhaps five new programs nationally, and will only be able to give reduced support to renewed programs.

We also support the Administration's request for additional funds under the Title III program, "Developing Institutions." We do question the "new thrust" use of these funds, but feel, at the same time, that this program can be of extreme value to the community colleges in New Jersey as they become of age and eligibility. To date, the State of New Jersey has only had one Title III program funded, which meant support of only about $140,000 per year of a $50 million program. We are concerned that these funds have not been chaneled more effectively into New Jersey, and would hope that this issue might be raised. However, we would still support the Administration's one effort in the budget to provide for some targeted institutional aid.

Third, we want to strongly support the increase requested for TRIO programs, from $50 million to $70 million. Once again, while the Northeast region has not been receiving an adequate level of funding from this program, we still view the TRIO programs as one of the most student assistance and student-service oriented programs operated by the U.S. Office of Education. The demand for these funds

each year is outstanding. If there is no increase provided for, there will be no new programs in New Jersey under any of the three categories, just at a time when a number of institutions were becoming firmly committed to the idea of reaching out to the high schools, to deal with the dropout problem, to provide greater access to the disadvantaged into college, and to providing students with the skills and assistance they need to remain in postsecondary education. Following the funding of student aid programs (SEOG, BEOG, Work Study, and NDSL) TRIO programs, especially Special Services and Upward Bound are a very high priority for the State.

There are two additional programs for which I would like to specifically request support, which are not included in the Administration's plans for FY73.

EPDA V-E

One of these is the higher education component of the Education Professions Development Act, Title V-E, which supports a number of critically important training programs and institutes to prepare faculty serving special needs and problems--the urban areas, the disadvantaged, the students seeking non-traditional ways of completing a postsecondary education. Title V-E was provided only $5.1 million in the Supplemental Appropriations Bill passed in October, 1972. This level of funding was the amount finally requested for training institutes by the Administration, although the original budget request for FY73 funding levels was to have been increased to $13 million for training institutes and fellowships. The program is slated to be phased out, as are all of the component programs of EPDA. While we concur that there must be some serious reassessment of training needs and trends, there are still shortages of more specialized educational personnel; and Title V-E was addressing these needs, and should not be allowed to be lost along with other programs being phased out because of fear of a "teacher surplus." EPDA V-E does not just produce more general-skills teachers. New Jersey has been heavily involved with the V-E program, and we would be extremely unhappy to see it lost at this point in time.

EOC

Next, we would like tp propose that you do all that may be possible to see that some funding is provided for the Educational Opportunity Center concept. With as little as $3 million, at least 8-12 pilot Educational Opportunity Centers could be initiated which would serve a number of different kinds of populations--urban and rural. The Centers would become the focus of an effort to coordinate educational services, information, counseling, tutoring, and assistance to disadvantaged students to further enhance their chances for pursuing the appropriate postsecondary education and training opportunity. The EOC is related to the TRIO programs, and could operate in coordination with them, supplementing their impact at existing institutions. EOCs, however, would be community-based educational centers and networks employing the resources, materials, and staff of all possible education groups, community groups, and facilities, coordinating them, and therefore, hopefully, more effectively utilizing them. I would like to request that you consider, and ask that others on the Subcommittee seriously consider providing funds for this concept recently authorized in the EDUCATION AMENDMENTS OF 1972.

There are, of course, other programs for which I would like to express support -- such as Right-To-Read, which has been so terribly effective in New Jersey, and the need to provide some initial implementation funds for the Occupational and Adult Education Act. I have tried, however, to give you some idea of the top priorities of New Jersey.

As usual, I appreciate your sincere concern about support for postsecondary education; and I know that you will do all that is possible to provide appropriate and adequate support.

Please let me know if there is any additional information with which I can provide you. I would like to ask that this statement be included in the written Record.

Sincerely,

Ralph A. Dungan

Ralph A. Dungan

Mr. PATTEN. He does ask for support on some programs which I think are going to be aborted.

I do not think there is much point in covering some of the grounds the others have. This is the fourth committee you have appeared before. We read the newspapers.

As you sit here, it strikes me you are pretty confident of your position. I am not sure, myself, but we will see.

I like to feel, as a bank attorney for over 25 years, I have a deep sense of fiscal responsibility as a member of this subcommittee. That goes for most of the members. So I am in no position to take up a big spending cry as far as my people are concerned. They would rather see me support the administration policy in a lot of respects.

My new community mental health facility in Perth Amboy is being aborted, and we just about got the bricks laid. You would think that was the cause of inflation. I cannot buy that at all.

I know enough about beef and veal and a lot of other things to know why we have this situation. We have $25 billion in here for increased interest rates, which is inflationary.

Secretary WEINBERGER. You know that facility was just started and will have Federal funding for 8 years.

Mr. PATTEN. We had a big field called Kilmer Field, 40,000 men embarked there in World War II in 1 week. So it was only farmland and the United States gave it to Rutgers.

Because of legislation we passed here in 1965 and 1966, I look out there and I see a big medical school, the first time in the history of our State that we built a medical school, the richest State in the Union. We only did it because of the Federal program. There is not a dime in here to help us continue to make that a medical center.

We have a pharmacy school, a medical building; library; that money is being eliminated. My hopes were that our people in the State would have a real medical center like so many other parts of the country; Houston, Duke, Boston, Scranton, Wilkes-Barre, the Mayo Clinic, and others.

We were on our way. One of your best men was dean of Rutgers Medical School, Dr. Stetten. So I look out there at that pharmacy school, the new School of Engineering, all brand new, we are building an educational center. I feel badly as I sit here and read this budget because I do not see how we are going to continue as we increase the enrollment with these programs. I do not know.

Well, here is what I want to say about inflation. When I came here to the Congress in 1962, the budget was $92 billion. The Federal Government took in a like amount. You say in this budget that you will collect—the President says in his message right here, $31 billion in revenue more this year than last year.

Well, last year we collected $25 billion more than the year before.

Secretary WEINBERGER. I thought we had gone up $25 billion. That is why I was trying to recall the exact figures. The revenues went up about $25 billion as I remember.

Mr. PATTEN. I just read it here that they thought our revenues will increase $31 billion. A total of $256 billion.

Secretary WEINBERGER. I am sorry, I thought you meant from 1972 to 1973. From 1973 to 1974——

Mr. PATTEN. We anticipate you will collect $31 billion more?

Secretary WEINBERGER. Right.

Mr. PATTEN. In other words, that is three times as much money as when I took my oath of office here in January 1963. That is a tremendous sum of money. We must remember we have 50 million more people.

My figures may not be accurate. We have a lot more people in the last 10 years. So I sit here as a Member of Congress, and never voted for a new tax. I always voted to cut taxes. And I had the pleasure, because of the postwar period, of voting to cut taxes seven times. I voted to cut a lot of excise taxes on the girls' pocketbooks and their cosmetics, the theater, music, auto tax, et cetera.

So that we did not increase the Federal taxes, but because this country has an economy going at over $1,200 billion without increasing taxes, this Government is going to collect something in the neighborhood of $260 billion or $270 billion this coming year, compared to $90 billion when I came to the House in 1962.

I think we have a right to ask for the correct priorities. Now, rather than revenue sharing, I had a deep feeling we should have cut taxes again. I voted with the chairman of this committee against revenue sharing. I am more proud of it now than I was last year.

As I sit here with you, knowing the New Jersey State Legislature, knowing city hall as I do—I was a mayor for 8 years—I know revenue sharing will not finance these educational and health programs.

MODEL CITIES

The director of my hospital told me Friday morning that our storefront, our neighborhood medical facility up on Hall Avenue, is doing a marvelous job. It is a store. We have a doctor and a nurse in there. The poor people go in.

Now the man who is head of our hospital is new and he is a professional. They sought him out, they brought him in on a professional basis. He told me that my neighborhood health facility, which is under my model cities program, is doing a terrific job.

So as you arrive at these decisions as to what we need for our people, and what we do not need, I am really upset and I am lost, because I see my problem. I do not think we can neglect some of these health areas. I do not think I can forsake my model cities program.

The lunch program, I have checked it out. I gather the lunch program might be on the way out.

Secretary WEINBERGER. No. I think the school lunch program has been increased very substantially.

Mr. PATTEN. There is a footnote in one of these charts—all right, I did not want to be specific on programs. I just want to generalize.

Secretary WEINBERGER. I want to mention on the model cities that I think your experience almost unique and very fortunate. The evidence we had is that there is a tremendous amount of money being wasted in model cities, through administration, overhead, and organizational expenditures and very little of it is reaching the people in the way you described, which I think was the original intent of the program.

The formula gives funds to cities, to counties, and to States.

Mr. FLOOD. Model cities?

Secretary WEINBERGER. No; not the model cities program, but an urban community development special revenue-sharing fund. The decision would be up to the communities rather than our forcing it. That is what we hope to do.

Mr. PATTEN. You know, we should not lose faith in our country. I have one company that sponsors and encourages us in this nursing work. In fact, they spent a lot of their money.

In 1963 they did $100 million worth of business. Last year they did 13 times as much, $1.3 billion. It has 11 plants in my district. They sponsored more funding for the nurses. They made brochures and sent people down here. They spent quite a few dollars to acquaint the Congress and your administration with it.

I have heard the director of our State institutions say, over a Christmas weekend, he was short over 500 nurses. We had 30,000 people in our institutions. The man cried. He said if the people only knew how little help he had. He told employees he would pay them double time and cash if they came in over the 4-day New Year's holidays.

We always had a problem with help. Especially nurses. We are always short. In fact, today's paper has the VA hospital report where they had one nurse for 200 patients.

What I am trying to say is that I marvel at our free enterprise. I came from Leningrad last month; they lined up to get their 2 pounds of potatoes. It takes them 3 hours to shop for their daily bread.

I love, I thrill at our system. I never believe my country would grow like it has in the last 10 years. I am happy that we are here when we are producing a GNP of $1.2 trillion.

While we sit here, England is tied up with strikes. Their hospitals are in crisis. I was in Italy where you could not get near an airplane because of strikes. They voted 30 percent Communist last time.

What I am saying is that I am close to the senior citizens, the elderly in my district. Some of them cannot buy a pair of glasses, they cannot buy teeth, hearing aids; just the common things, not to mention their more serious problems. Some have $125 social security a month to live on.

So the little bit of housing we put up for our senior citizens is a Godsend. The biggest problem in my district is the rent squeeze. Today's Washington paper says that the Council of Living says there is a 14-percent increase in rents since January. Food prices are criminal. No voice downtown cries out.

So when we talk about inflation, we cannot wholly blame the HEW budget. I do not want it said that this whole question of inflation is related to the few dollars we gave Rutgers University for their medical school or for the nurses program or mental health facility, because I do not believe that. If we want to keep America and protect our system, we have to have some services for our people.

I am really afraid, Mr. Secretary, that some of the services that are reaching our people are going to be eliminated in this budget. I would love to maintain our system of democracy.

I am going to conclude with just one observation.

Speaking of respect for us as Congressmen, I do not believe there are five free parliaments left in the world. Certainly I was over in Greece, where they abolished the Parliament. That is what one ruler thought of fellows like us.

I saw Willy Brandt dissolve parliament and call a new election. Canada had to have a new election, Ireland had to have a new election, all because the parliament voted "No confidence." The Korean President is about to appoint many to the House of Delegates. That is a pretty good system. Maybe the people downtown would like that. But the best guy is Franco. He has the Cortes; he appoints 400 out of 600.

I said to the fellow in the Cortes, "How often do you meet in plenary session?"

He looked at me in amazement. They met last year eight times.

I said, "Do you debate? Do you fight?"

He looked at me. "No," he says, "the Government gives it to you, you pass it, you approve it, see."

I met the parliamentarian from Bulgaria, if you think that is not a free parliament. Now that Finland bit; you would like this system. They just elected the president. His term has 2 years left, but just to keep the big bear quiet, they have elected him for 6 more years, I think. So that is a free parliament, right?

The truth is, few parliaments are free. Take Taiwan—you know what they have there. They were elected back in 1940, representing all China. They are still the Parliament at Taiwan; they are all over 80 years old.

Secretary WEINBERGER. It is a very stable government.

Mr. PATTEN. Incidentally, Franco yielded a little bit, married women who are heads of family were allowed to vote for about 100 members of the Cortes.

Secretary WEINBERGER. He is slipping.

Mr. PATTEN. Well, in every place you find a parliament abolished, you find there is no newspaper, no freedom of the press. In Sofia, you could not find one paper except what the government printed.

In Finland the Government owns the radio, TV, and the press.

All through Korea, Taiwan, Vietnam, the Philippines, Morocco, Lebanon, all those Arab people we like to be friendly with have no freely elected parliaments. There is no freedom of the press, there is no freedom of radio or television. They do not have much television. They do not even have electricity, most of them. So when I come back and put my foot in this Capitol, it is with a source of pride.

The President quotes the Constitution, saying that all power that is not given to the Federal Government is reserved to the States. That is how I started in politics, a Democrat, a States-rights advocate. It is old hat with me. There is another part of the Constitution which the Founders very wisely put in, that the duly elected representatives of the people—that is me, we are always running, every 2 years.

The Senators were appointed like lords originally. The President was elected by some delegates. We are the people's representatives. They said we shall lay the taxes, we shall appropriate the money.

Mr. Secretary, if you sit in the council down there, as I know you do, I speak for myself—that when the duly elected Congress appropriates

money and the President signs the bill for water quality and sewage disposal plants and the law is not carried out, I become frightened.

I feel very seriously about it. I do not think the Constitution or the law of the land is being followed. I do not think anyone has the right downtown to do that, spoil my government. I do not want to wind up like a lawmaker in Chile I spoke with—they live under physical threat, under all kinds of threats. They are not free parliamentarians.

I hate to see us go the way of many other countries where we have no free press, no free parliamentarians. I am afraid some of us do not realize that. I am scared. I want to copy what somebody else said. I feel this deep down in my heart, when our law says we appropriate money, it become law, especially if we pass it over the veto; I do not know by what right people do what they do and still say they follow law and order.

But on fiscal responsibility, I admire and I like many things that are said and done.

I saw it in Greece, in Athens last month, the students were out. I heard what they said. Can it happen here? I do not know.

I just want you to know I am going to fight for my rights as a Congressman under the Constitution insofar as we have that constitutional power.

I do not know how well we can fight, but I would just like to have a little more respect and a little more admiration in certain quarters than what I am now getting. I feel a little bit hurt in some respects.

I know this, that revenue sharing is not going to go for the programs we helped initiate here. My people are going to suffer as a result of it.

Mr. FLOOD. Mr. Obey?

REVENUE SHARING

Mr. OBEY. Thank you, Mr. Chairman.

I guess it has been the style the last 2 days for people to get a few things off their chest before they ask any questions. Just two observations I have before I start with just a very few questions.

First of all, going back to this little ping-pong game we have been having on revenue sharing for the last 2 days, I recognize there are some advantages to it, but what strikes me, for instance, is what we have done with municipal workers, for instance. The Congress managed to get away from being a participant in the setting of the salary for postal workers.

Now we are right back at it for policemen, firemen, and I expect that is going to be worse, not better. I bring that up because of your remark, Mr. Secretary, about our becoming a national school board, because of title I and some of the other programs.

We may not be a national school board when we get done with revenue sharing, but I am afraid we are going to be a national wage center for almost every worker in local government, and I think that is mighty unhealthy.

Secretary WEINBERGER. Are you speaking of the economic stabilization program?

Mr. OBEY. No, I am talking about revenue sharing, the fact that many police and fire groups in my State were on me last time, saying, "Hey, we want you to support revenue sharing, because we want our salary increased."

Secretary WEINBERGER. You appreciate there is nothing the Federal Government does to indicate how the money should be used, for local salaries or anything of that kind?

Mr. OBEY. I understand that.

What is going to happen, what happened last year, from talking with my colleagues, mayors were telling their police and fire people: "Well, we agreed to give you that salary increase, but it was contingent on revenue sharing passing and we do not know what is going to happen, so we do not know what we are going to be able to do with you."

That is the kind of thing developing at the local level that I do not like to see.

Secretary WEINBERGER. Pressure from firemen, police, and teachers for increased salaries is nothing new. I used to encounter it in the California Legislature and it is a standard feature of local government.

Mr. OBEY. So did I in the Wisconsin Legislature.

Secretary WEINBERGER. Yes.

Mr. OBEY. I think it gets to the absurd level when people at the Federal level start to get letters from local police and fire people saying they want revenue sharing passed so they can get the wage and salary increases that they have been negotiating. That should be handled locally.

DEFENSE SPENDING

One other point—I notice Mr. Ash did it, too, when he was before our full committee meeting. I notice all the time when we talk about defense, people say, "Well, you have to remember the fact that that is so much manpower cost."

The fact is that in this budget, according to Mr. Ash at any rate, there is $1 billion more this year than last year for weapons purchases. I'm not smart enough to figure out why peace should cost more than war.

I would think the first year of peace—and I give the President full credit for his achievement, but in the first year of peace we ought to be able to cut back somewhat on our hardware purchases to free up some additional money for the crying needs that I certainly see all around my district.

Secretary WEINBERGER. Of course, there has been a very substantial reduction in the Defense activities and if there were not, we would have a Defense budget of over $90 billion. But there has been a very substantial reduction and that has brought it back to $79.8 billion. Even though that represents more dollars than in 1973, almost all of it is pay and price increases caused by the all-volunteer Armed Forces program which, in turn, I think has removed a lot of the trouble that we had in the cities and colleges in the last few years.

Mr. OBEY. Well, we could get into another debate on the volunteer Army, too.

I would like inserted in the record at this point, and I will supply the clerk with the page, the report of the full committee last year which inventoried in great detail weapons systems which were purchased and paid for by funds appropriated by our committee, since the Vietnam war began.

I think it indicates——

Mr. FLOOD. By our committee, do you mean the full Appropriations Committee?

Mr. OBEY. The full committee, that is right.

[The information follows:]

MODERNIZATION OF OUR MILITARY FORCES

New weapons and new equipments have been provided to all of the military services in recent years even though we were funding the war in Southeast Asia.

During the Vietnam war years, as has been true during all war years, new concepts have been developed and modernization has moved forward at a rapid pace. The following are examples of new and improved weapon systems and related military equipment which have completed development, been deployed, or developments initiated during the Vietnam war years.

ARMY

CH–54 heavy lift helicopter
OH–6 and OH–58 light observation helicopters
UH–1 Huey tactical transport helicopters
CH–47 Chinook cargo transport helicopter
U–21 Utility aircraft.
OV–1 Mohawk STOL observation aircraft
AH–1 Cobra helicopter gunships
Safeguard antiballistic missile system
Improved Hawk antiair missile
Chaparral/Vulcan antiair system
Dragon antitank missile
TOW antitank missile
Shillelagh antitank missile
Lance surface-to-surface missile
M551 Sheridan tanks
M60A1 and M60A2 tanks
M16A1 rifles
Improved trucks
Night sight devices
New rangefinders
Various electronic sensors
Automatic data-processing equipment expansion
New radios and radars
New transportable bridges
New field hospitals
Satellite communications

NAVY

A–6E attack aircraft
EA–6B electronic warfare aircraft
A–7E attack aircraft
F–4 Phantom fighter/attack aircraft
F–14 fighter aircraft
RH–53D mine countermeasures helicopters
P–3C ASW patrol aircraft
S–3A ASW patrol aircraft
E–2C early warning aircraft
Polaris/Poseidon missiles
Condor air-to-ground missile
Harpoon air-to-ground missile
Improved Sparrow air-to-air missiles

Improved Sidewinder air-to-air missiles
Phoenix air-to-air missiles
Agile air-to-air missiles
Shrike antiradiation missiles
Standard antiradiation missiles
AS submarine tenders
AD destroyer tenders
SSBN conversions to Poseidon
Three nuclear-powered Aircraft carriers
SSN–688 class nuclear attack submarines
DLGN–38 class nuclear frigates
DD–963 class destroyers
LHA helicopter/amphibious ships
SCS sea control ship
PHM patrol hydrofoil missile ship
PF patrol frigates
AOR fleet oiler ships
T–AGOR oceanographic research ships
T–AGS surveying ship
NR–1 nuclear submersible research ship
DSRV deep submergence rescue vehicles
DSSV deep submergence search vehicle
ATS rescue and salvage ship
Conversion/modernization of fleet
Antiship missile defense system
Point defense missile system
LAMPS ASW helicopters
Sonobuoys
Optical (TV)/laser-guided glide bombs
Various drone vehicles
Ship antimissile integrated defense
Navy tactical data system
Automatic data processing equipment expansion
Satellite communications
Trident (ULMS) submarine

MARINE CORPS

A–4M attack aircraft
AV–8A Harrier V/STOL attack aircraft
AH–1 Cobra helicopter gunships
OV–10 observation aircraft
UH–1 Huey tactical transport helicopters
CH–46 cargo transport helicopters
CH–53 cargo transport helicopters
F–4 Phantom aircraft
Improved Hawk antiair missile
LVT–7 family of amphibious vehicles
M16A1 rifles
New radio/radar/electronics equipment
New field hospitals
Automatic data processing equipment expansion

AIR FORCE

A–7D attack aircraft
A–37 attack aircraft
B–1 bomber aircraft
E–3A airborne warning and control system (AWACS)
F–111 attack aircraft
FB–111 bomber aircraft
F–4 Phantom fighter/attack aircraft
F–5B/E fighter aircraft
F–15 fighter aircraft
C–5A cargo aircraft
C–9A aeromedical evacuation aircraft
C–130E cargo aircraft
Minuteman II ICBM missiles
Minuteman III ICBM missiles

Minuteman modernization and update
Improved Sparrow air-to-air missiles
Improved Sidewinder air-to-air missiles
Shrike antiradiation missiles
Agile air-to-air missile
Maverick air-to-ground missiles
Various drone vehicles
Satellite communications
Rockets
Cluster bombs
Optical (TV)/laser guided glide bombs
Automatic data processing equipment expansion
Bare base sets
New radio/radar/electronics equipment
Various electronic sensors

The foregoing litany of weapons systems and other military equipment, while not complete, makes it abundantly clear that modernization of our military forces has continued during the Vietnam war years. Our military forces can be truly described as the most modern in the world today.

That report indicated that the service had done very well in terms of modernization, in terms of additional weapons purchases. I think that ought to be inserted here so that in this context anyway that portion of the argument is also seen.

Just a few questions, Mr. Secretary.

INCOME SUPPORT

On page 2, you indicated that the primary Federal role, in your statement, in the area of human resources is to provide income support to people in need.

I agree with that, and I am somewhat persuaded by the argument that it is better to rely more heavily on an income policy rather than a service policy in terms of meeting the needs for the people. I think you have to have a balance, but I am in agreement that we have gone too far in one direction as opposed to the other.

I regret that the administration did not come down with something similar to their welfare reform of last session. I thought the President was right on it. Even with all the difficulty we had in the Senate, I think that argument is worth going through again.

Especially in the light of your statement that the primary role is to provide income support, I am regretful that approach has been abandoned, at least insofar as H.R. 1 is concerned.

MEDICARE

On your medicare costs, you say you will want to increase the medicare beneficiary's out-of-pocket expenses for hospitalization, and you justify it by saying on page 12 that by requiring cost sharing from the very beginning of the hospital stay, consumer awareness should play a more active role in the effort to control health-care costs.

I was under the impression that your own Department's statistics had indicated that in fact there had been a decline in the average stay by individual medicare recipients.

Secretary WEINBERGER. I think there probably has been some decline in the average stay, but there has been an excessive usage, not by the

individual but by the doctors and providers who order them to the hospitals. So, you had a much larger number of shorter stays. The total cost of the program I think has increased rather markedly.

Mr. OBEY. As I understand, you want the medicare patient to pick up a larger share of his initial stay in the hospital. How long would an average person have to be hospitalized before he comes out ahead?

Secretary WEINBERGER. You mean comparing the previous system with the proposal? I think somewhere in the neighborhood of 75 to 80 days. The basic proposal is premised on the idea that the doctors and other providers of the services, because the system is so designed, have every encouragement to order a patient in and order some fairly elaborate services for him for diagnostic or other purposes as a course of first resort.

We believe that if there were cost-sharing features imposed during the earlier days in the hospital, there would be a lot less usage made by the doctors of this most expensive form of facility as a first resort, and that there would be more resort initially to less-expensive health care facilities.

We think the percentage figure of the people who have long stays is very small now because the system——

Mr. OBEY. That is the point I am getting to.

Secretary WEINBERGER. I know. I am sure you are about to make the point that a very small number of people stay 60 or 70 or 80 days. We think the reason that is true is not based on medical need. It is based on the fact that it then becomes very expensive for them under the present system, they have used up their resources and, therefore, the doctor moves them, regardless of medical need, to some other kind of facility.

That is why the statistics show a very small number of people apparently in the hospitals. It does not, we think, trace back to medical need. It traces back to the system which encourages early use of the hospital and discourages or almost prevents a person who may need long hospitalization from actually getting it.

Mr. CARDWELL. Over half the people who go in the hospital under Medicare stay less than 10 days.

Mr. OBEY. It was my impression that it was a very small percentage that stayed 70 or 80 days, and my point is that you can have your theoretical justification for it if you like——

Secretary WEINBERGER. It is much more than theory, because if you have overusage in the early days——

Mr. OBEY. I have one of the biggest insurance companies in my hometown. It is a responsible company. At least in my own area. I have noticed doctors become more responsible in the way they assign patients to hospitals versus other kinds of institutions, too.

Secretary WEINBERGER. We hope so. That is what the PSRO program is for, and that is why we have kept controls on health care costs equivalent to the phase 2 type.

Mr. OBEY. Is this not an awfully brutal way to approach it?

Secretary WEINBERGER. It certainly is not intended as such, and I do not believe it will work out as such.

Mr. OBEY. Is there not some way, for instance, that you could make that kind of arrangement for the kind of illness where a person is

referred to a hospital by the doctor or kept there on a judgmental basis, and not apply it to somebody, for instance, who requires immediate hospitalization for something very serious which does not involve judgment on the part of the doctor that he might or might not be better off in the hospital?

Secretary WEINBERGER. At the moment, there is no way of going behind a doctor's direction that a patient be hospitalized. A very large number of patients are hospitalized, we believe—and I think the figures bear it out—almost as a matter of routine. That routine kind of hospitalization, even for a few days, because your most expensive stay in the hospital is the 1st, 2d, and 3d day, has tended to put an enormous demand on the hospital charges.

Mr. OBEY. Then why do you not come in with a recommendation which limits the increase to the first 5 or 6 days, rather than stretching it out?

Secretary WEINBERGER. Again, it is a matter of trying to take away the inducement to use the hospital, the most expensive kind of facility, as a matter of first resort.

The basic point we had in mind in designing the program was to try to discourage providers from ordering their patients into hospitals as a matter of first resort, feeling that they were perfectly content to leave them there because, after the first day, there is no charge and there is no factor which tends to discourage the overuse.

Mr. OBEY. What about the man who does not go to a doctor for consultation? What about the guy who drops over on Third Street in Wausau, Wis., with a heart condition, and has to be taken into a hospital in a very serious situation, and has to stay there 30 or 40 days? There is no overutilization on his part. He is being asked to absorb the cost for others who might engage in that practice.

Secretary WEINBERGER. We are trying to discourage the ones who do not need it. There is no suggestion what ever that a doctor not order a patient to the hospital when the medical need is there. We think that there are a great many cases in which, because everything after the first day is free, there has been a tendency simply to say, "Put him in the hospital" and leave him there for a few days.

Mr. OBEY. I have counties in my district where the average income for a family is $4,000 or $5,000.

Secretary WEINBERGER. They would qualify for medicaid then.

Mr. OBEY. I understand that.

I have counties where there is 17 or 18 percent unemployment. I have counties where there is very little in the way of an opportunity even to get to a hospital, let alone overutilize it. With the income level that many of my people have in my district, they are not going to come out very well under your proposal. I think it is a mistake.

MEDICARE SAVINGS

Mr. ROBINSON. This program was listed as one of those, when I asked you the last question with regard to the most wasteful programs that we have. Your budget documents reflect a saving of $616 million through the implementation of this program in 1974, and $1.3 billion in 1975.

Secretary WEINBERGER. Not all of that is from charges, Congressman. A large part of that is from improved administration, and from changing the reimbursement provisions and getting rid of some of the advance payment provisions that are presently in the law.

A comparatively smaller amount of the latter sum that you gave would be attributed to this.

Mr. CARDWELL. $345 million is related to the item we have just been discussing, offset by an increase of $44 million in medicaid; medicaid would go up.

Secretary WEINBERGER. A little less than $300 million.

Mr. ROBINSON. The point is that in your Department of HEW, this is by far the biggest item in terms of where you hope to save money.

Secretary WEINBERGER. That is right. It has been growing rapidly.

I think part of the objection that is coming in—and there certainly is criticism of it, as Congressman Obey has indicated—stems from the basic idea that every time we have found an area that we thought was possible for savings without injuring the essential priorities, there is a tremendous built-in objection. Any kind of change or termination or slowing down brings a very substantial objection.

I understand it and I know pretty much why, but it is one of the reasons why the programs keep on growing rather than getting examined carefully and reduced when we think the facts warrant it.

Mr. OBEY. My point is that I would think these are things that could be handled by an administrative belt-tightening type of measure. You are very talented at that. I would think this kind of program would be best approached along those lines, rather than——

Secretary WEINBERGER. We are doing that, and the great bulk of the savings we anticipate would come from that. We think there is no question there has been, with a system that provides, in effect, free hospital care for everything after the first day, a tremendous overinducement to doctors to utilize it rather than using it only in situations where it is medically required.

Mr. OBEY. I come back to my original point. If you are trying to prevent people from being moved into a hospital every time they cut a finger, if you are interested in that, rather than just a budgetary transaction on paper somewhere, it would seem to me you could accomplish the same purposes by limiting that penalty, so to speak, to a 5- or 6- or 15-day period so you do not really sock the middle ground of people who would have to stay 30 or 40 days and cannot afford it.

I was not here then, but when medicare was passed, one of the reasons it was passed is so you could get away from the means test type of operation. You are suggesting now, I guess, that the people in my district on very low incomes go back to that to supplement their medical benefits.

Secretary WEINBERGER. There is a medicaid provision for the medically indigent. I think with the range and scale of expenditures we are in now, we are at the stage where we have to be sure the Federal expenditures are focused on and reach the people who are most in need.

Mr. OBEY. I agree with that, but I do not think this does it.

Secretary WEINBERGER. We believe it does. We recognize there is a lot of controversy about it.

Mr. CARDWELL. May I bring out one bit of information that I think might help our understanding of this issue? There seems to be an impression that these cost-sharing proposals will require the patient to pick up a major share of his hospital charges. In point of fact, his out-of-pocket expenses for services of the type covered by medicare will actually average less than 10 percent of his bill. The rest of it will be picked up by medicaid, private insurance, or medicare.

The out-of-pocket cost is simply not as significant as everybody has characterized its being.

Mr. OBEY. It depends on your definition of significant. Where 20 percent of the population gets some kind of social security benefit—I have one county where over 20 percent get social security checks—that means for that population a decision like this, while insignificant in the total picture, is damned significant as far as they are concerned.

Mr. CARDWELL. In the case where the individual is very poor, where he does not, for one reason or another, desire to become a welfare beneficiary, or has no private insurance, yes. Medicare today is not going to do much for that patient, either.

Mr. OBEY. I understand that. In spite of medicare, out-of-pocket expenses for people over 65 are still very high. I do not see why we should add to it.

MENTAL HEALTH

On community mental health centers, I am just curious, are my figures right? I am told that in 1970, private and voluntary insurance paid only about 6.4 percent of the costs incurred for mental illness.

Secretary WEINBERGER. I think there has been a growing addition to that. I do not know, but I would think those figures may have been right. They may have been a little low for 1970.

I think there has been a growing acceptance of the fact that this is a risk which also ought to be covered, and I would suspect the figure was much higher now.

Mr. OBEY. What would your guess be? You indicate you are relying heavily on third-party payments in this area.

Secretary WEINBERGER. No, we did not indicate we plan to rely heavily on third party payments in the community mental health centers. We indicated we had already funded and promised to continue to fund, for the full amount of the 8-year commitment, a great many community mental health centers. We indicated that they were, indeed, by definition, to be community-oriented and community-operated, and that it was time, now that the demonstration was complete, for communities to plan to run these themselves.

This is one of the things that I think does now have to be stopped. It is another one of the difficulties that is encountered whenever you try to terminate or slow down a program.

Mr. OBEY. Somewhere in your statement, there was a reference to increasing reliance on third-party payments.

Secretary WEINBERGER. I think increasing reliance is a fair way to put it, but I do not say we necessarily place heavy reliance.

In many States now, direct appropriations are authorized. Indeed, almost exactly one-third of the cost of these centers is coming from the States now, and another 10 or 11 percent is coming from local community funds.

Mr. OBEY. I am interested in the specific thing I asked. I would like to know what percentage of those costs you think will be borne by third-party payments in the 1980's.

Secretary WEINBERGER. I would be guessing, but if we have our HMO program established, if we have other forms of national insurance and private insurance, I would guess it would be very much higher than 6 or 7 percent. I would think it probably would be closer to maybe 25 percent.

It could easily be supplemented by the medicare-medicaid portion and State payments and local government payments.

Mr. OBEY. I hope you are right, but I remember going through this in the legislature back in the early 1960's, when we were told that there was going to be a great move in this direction, and it did not materialize.

Secretary WEINBERGER. I guess we were the first State to adopt the bill that authorized the community mental health treatment. We had great success with it in California. We managed to reduce substantially the number of beds required in the State hospitals.

Mr. CARDWELL. Actually, the largest source of financing in the long term has to be the shift that has been occurring in almost every State. The State-borne costs should shift to the community.

NDEA TITLE VI

Mr. OBEY. Mr. Secretary, on page 22 you discuss the manpower and specialized training program. You indicate: "Continuation support for students already enrolled in approved training programs will be provided, but no grants will be made to new students."

My question is, "Why was not the same kind of procedure applied to NDEA, title VI, if you did want to phase it out assuming that were wise—why was it not at least phased out that way rather than being cut off immediately?"

Secretary WEINBERGER. I think NDEA was a 1-year commitment, and it has been fulfilled by the initial grant.

In these special training programs and some of these generalized research training programs, the commitment was for more than a year. In all cases our policy has been to honor the full commitment when we are planning to terminate a program. If we had a 1-year commitment and that was granted last year, there would be no commitment beyond that, so there would be no phasing out required.

Mr. OBEY. It is true, it is not, that you have a very high percentage of those kids applying in the second year? Once they get in, they have a tendency to keep getting that fellowship?

Secretary WEINBERGER. I think there are some in that category, yes.

Mr. OBEY. It would seem to me to be much easier and more sensible, if you felt that was something that had to be done to phase it out gradually to reduce the effect on individual fellowship holders.

EDUCATION FINANCING

On page 23, you say that at least one of the major initiatives in the education budget is your proposal to fully fund BOG. I discussed this with Dr. Marland a couple of days ago. He indicated in testimony before this committee a year ago that he expected that we would be making faster progress in elementary and secondary than we would in higher education.

We have had a lot of talk around the table about priorities, and I wonder why it is that the administration seems to indicate that higher priority ought to be given to higher education than elementary and secondary.

Secretary WEINBERGER. I do not think that is the case. Based on just dollar measurements, which is what most people seem to use these days, the elementary and secondary special revenue sharing that we are asking for is in the range of $2.5 billion, and the basic opportunity grants are a little under $1 billion.

Mr. OBEY. I am talking about increase over last year.

Secretary WEINBERGER. Increases over last year are relative. We have an increase in the basic opportunity grants of something in the neighborhood of about $350 million from 1973 to 1974. We are suggesting reducing the direct loans so the total increase is about $75 million.

In the elementary education, it runs just about level, $2.5 billion.

I do not believe we should place so much reliance on the dollar increase as the measurement. I think the concern of the administration for students in both categories is demonstrated in proper priority by these two requests.

Mr. OBEY. I do not mean to imply that higher education ought to take the last spot, and again I do not know much about anyplace but my own, but it seems to me at least in my own area the most serious problems are found in the elementary and secondary areas.

I do not see any sense of urgency reflected in this budget in terms of either the quality of elementary and secondary education or, for that matter, the inequities of financing of elementary and secondary education.

Secretary WEINBERGER. We think the concern is amply demonstrated by a request of this size, and we think the concern will be demonstrated if you put it in the form of special revenue sharing and give the school districts $2.5 billion without breaking it down into the 30 categories that the present $2.5 billion is. We think they will get a lot more use out of it, that they will save all the dollars they have to put in application forms and matching funds.

Mr. OBEY. I understand that. I agree that it is wise to try to broaden those programs.

I come back to my point. I thought a year ago when I read Dr. Marland's statement in the newspapers and when I heard the President's statement about his plans to bring down a bill which would provide some substantial effort to balance the inequities, in financing elementary and secondary education, and I was enthusiastic.

I thought there would be action.

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Since then, I do not know what has happened, but there is no sense of urgency.

In my State, we have some very serious problems caused by underfinancing of some of the poorest areas of that State, and they will not be solved until the Federal Government gets involved.

Secretary WEINBERGER. I would have to differ with you, because I think the fundamental solution for elementary and secondary education will have to be found at the local and State level. I believe that there has to be a lot of realinement within the States as to how the dollars are raised and spent, and I think some of the court cases will well force that.

I think we cannot look to the National Government to provide the basic elementary and secondary education financing. I think it can fill out and supplement; and, I think that is exactly what is being done with the educational special revenue-sharing proposal.

Even on that basis, we are spending more and have a much greater increase in elementary and secondary education in the form of Federal outlays in 1974 than in higher education. The figures show a $156 million increase for elementary and secondary in 1974 over 1973, and $56 million increase for higher education.

I think that is a proper allocation of the Federal resources in those two areas. We will never solve the financing inequities of elementary and secondary education unless we have some revisions within the States.

Mr. OBEY. My point is, I think the Federal Government, especially if the *Serrano* decision becomes final, has an obvious obligation to try to balance inequities between States, very much the same as the States have an obligation to try to balance inequities between localities.

Secretary WEINBERGER. That issue certainly is not involved in the *Serrano* case. The *Serrano* case simply goes to the proper allocation of funds within the State.

Mr. OBEY. That is right, but if you can philosophically say it is unfair for a kid in a poor area of Wisconsin to have a tougher time financing his education than a kid in a wealthy area. By the same token, it can be argued that it is just as inequitable for a kid in Mississippi or some of the other lower income States to have his education financed on a State basis when other States are doing quite well.

Mrs. GREEN. I may be entirely wrong, but it seems to me if the lower court decisions are upheld by the higher courts on the question of the equity and use of the property taxes as a means of supporting education, there is bound to be a case from Mississippi or Alabama saying that the constitutional rights of our children are being violated because of what is being done in Montgomery County or Westchester County, and, if upheld, the question Mr. Obey raises probably will revolutionize the financing of elementary and secondary education more than anything that has ever happened.

Secretary WEINBERGER. It would also revolutionize the education, I would suggest, Mrs. Green. I am not sure it is as desirable as working out the financing arrangements within the existing framework.

I would hate to see the Congress become or try to become a national school board. I am very much afraid that that would follow if these

two trends, maintaining 30 or more categorical programs and attempting to redress all financial inequities through Federal financing, come together.

Mrs. GREEN. I completely agree with you. In fact, I think that if those cases are upheld in the higher courts, we will have nothing but mediocrity, because if an individual local group of parents decide this is not a high enough quality of education for our youngsters in this district, and we wish to voluntarily assess ourselves $300 or $400 more to supply other things for our children, if the court says, "Yes, you may do it," then you go back to the same inequitable distribution of funds as before the first suit was filed.

If they say, "No, you cannot," it seems to me there is nothing but mediocrity for the future.

Secretary WEINBERGER. The effect of a lot of this is a complete leveling process. Certainly, it does not sound as if it would be any kind of improvement, and I think it would be quite the contrary.

Mr. CARDWELL. Mrs. Green knows a lot more about this than I do.

Mrs. GREEN. I have heard this before.

All I can say is if this statement be true, we are launching an amazing number of programs on an ocean of ignorance.

Mr. CARDWELL. I am trying to observe what I think has happened thus far through public policies, and I think the budget reflects it. If you examine the decisions on Federal assistance to higher education and elementary and secondary education, as I read the evolution of public policy, it does not seem to me that the makers of public policy in the Congress have decided to go as far as you say we have and must go.

Mr. OBEY. I did not say they have.

Mr. CARDWELL. If you sort out the elementary and secondary educational authorities, you will find that there are very few of them that are really directed toward general aid. They are all directed toward some kind of special problem or benefit—standardization, some special experiment.

Mr. OBEY. I am trying to lead to a question which I would like to get at, if I could.

Dr. Marland, testifying before this subcommittee a year ago, indicated he thought the day would come when the Federal Government was supplying 25 to 30 percent of the cost of education.

Secretary WEINBERGER. That may have been against the background of a happier fiscal situation.

Mr. OBEY. I would like to know your attitude on this. Do you think that is desirable?

Secretary WEINBERGER. Not with the degree of control that I would see almost automatically associated with that. I think we have a bad enough situation now with the 30 categorical programs. We are at the point now where a lot of school districts feel that they have to have overhead projectors because there is a categorical program that allows them to put in a matching program for that amount. If they do not do it, they get criticized, because there are all these free Federal funds around that they do not apply for.

I would not like to see a quarter to a half of the elementary and secondary schools of this country financed directly by the Federal Government, because I think it is inevitable that control of a very undesirable nature would be associated with that. I just do not think that we in Washington have the knowledge of the diversity in this country or the ability to apply that diversity, as Mrs. Green suggested a moment ago, to warrant such a change in the system.

Frankly, I do not think that we have had all that bad a result to warrant considering junking the kind of system we have had for such a very long time.

Mr. OBEY. I just wanted your statement on it, for the record.

BASIC OPPORTUNITY GRANTS

Since you brought up the question of student loans, would you mind explaining to me—I frankly am not that familiar with all of the arguments that are used to imply the BOGs are much preferable to EOGs and the other old programs—I would like you to restate for me why BOGs are so superior.

Secretary WEINBERGER. I am not prepared to denounce or criticize other programs, but I am prepared to support the basic opportunity grants.

I think on the scale that we are talking about, they offer us for the first time the opportunity to be able to say truthfully that any qualified student can now have a college education and need not be deprived of it because of financial reasons.

We are working out a family contribution scale.

Mr. OBEY. Would that statement apply to the sons and daughters of farm families?

Secretary WEINBERGER. Oh, yes, it certainly would.

Mr. OBEY. That is not my understanding. It is my understanding the guidelines you have laid down for BOGs might make it difficult for farm youngsters to obtain the kind of help that they need. You have a more difficult capitalization situation for farms and small businesses than for others.

Mr. CARDWELL. The asset part of the equation?

Mr. OBEY. Yes.

Secretary WEINBERGER. We also have to bear in mind that farm income is not only higher than it has been ever before——

Mr. OBEY. And so are expenses.

Secretary WEINBERGER. And expenses are high, too. The simple fact of the matter is that we believe this family contribution scale—which certainly will have to have some adjustments made in it if it turns out to be incorrect—will enable students to receive up to $1,400 a year, which, on the average, is a very substantial portion of the total college education cost.

This requires and implies that the student raise some of his funds himself, either through family contribution or through work or scholarship or through private loan from the college, and there are a great many of these programs available.

Taking this together with the massive infusion of student aid, the State scholarship programs and all these other sources, we think it can

now safely be said that no student need be deprived of a college education because of finances. If there is some inequity in the family contribution scale, then we would change it.

Mr. OBEY. I talked to Congressman Quie today, and he gave me at least some tentative indication that he had the impression that there might be some readjustment going on.

Mr. CARDWELL. Let us see if we can clarify this.

First of all, let us try to establish whether I am correct in presuming that you are concerned about the fact that assets owned by farm——

Mr. FLOOD. That is the key word.

Mr. CARDWELL [continuing]. Assets owned by a farmer and necessary to the pursuit of his business are counted too heavily in the equation that determines the family contribution.

I think that is the only way the question arises.

Mr. OBEY. Mr. Smith brought it up here today.

Is that being reexamined? That is my question.

Mr. FLOOD. You have stated the question. You have repeated the gentleman's question. We did not get an answer to the question.

Mr. CARDWELL. The answer is that it is being reexamined, and we can put in this record what seems to be the proper answer. Then you can draw your own conclusion.

Mr. FLOOD. You develop it in the record, but in a paragraph can you say something now specifically to the word "assets"?

Secretary WEINBERGER. The family contribution schedule as a whole, including the definition of assets, is before the legislative committees. They would have to approve it. It is being debated there.

If we feel some changes should be made, they will be taken before that committee.

The final schedule, including assets will have to come out of that process. We have submitted in a short time, under forced draft, our belief as to what is a proper family contribution schedule.

Mr. FLOOD. Then you will develop for the record at this point a clearcut answer to that issue?

Mr. CARDWELL. We will include specific recommendation of the Office of Education in this regard, and will clarify the opportunities that still exist for further negotiation of that particular formula.

Mr. OBEY. That would weigh very heavily in my judgment whether I would support any basic opportunity grant.

Mr. CARDWELL. The truth of the matter is that the President has set a policy which we are trying to carry out. He wants to create the opportunity for any and every student, including students of farm families, to get a college education.

If through some technical error that would not be possible, it would be our responsibility to try to correct it.

Mr. FLOOD. That is why we are holding the hearings.

Secretary WEINBERGER. The goal is the one we described, and if we have not reached it, we can certainly try again.

[The information follows:]

PROPOSED TREATMENT OF FARM ASSETS UNDER THE BASIC GRANT PROGRAM—DESCRIPTION AND RATIONALE

For the purposes of the basic grant program, assets mean such items as cash on hand which includes checking and savings accounts and such sums as may be set aside in trust funds. Included also are the curent market value,

at the time a student applies to have his family contribution determined, of any stocks, bonds, any other securities, real estate, home (if owned), income producing property such as farmland, and business equipment, and business inventory which are owned by the student and/or the student's parents. Consumer durables such as automobiles, furniture, and household appliances are not considered as assets. This meaning closely corresponds to those used by the two major needs analyses agencies, American College Testing and the College Scholarship Service.

Assets are treated in the calculation of a family's expected contribution from income and assets as follow: Once gross assets are known, outstanding liabilities (indebtedness) against such assets are deducted to determine the net worth of the assets. The next step is to subtract the asset reserve of $7,500 from the net worth and then multiply the balance by 5 percent to determine the expected contribution from assets. Farm assets are assessed in the same manner as nonfarm assets.

It has been suggested that a farm family typically has low income associated with large net assets. In fact, the incomes of farm families are neither so low, nor so dependent on ownership of farm assets. Indeed, precisely those families with low farm income are most likely to have off-farm income. Charles Schultze in a Brookings Institution staff paper entitled "The Distribution of Farm Subsidies" shows that 50.8 percent of all 1969 farms had sales of less than $5,000. Between 70 and 90 percent of the total income of these farmers was derived from nonfarm sources.

Figures of net worth of farm families also need to be taken into consideration. There are large numbers of rural farm families who are not owners or operators of farms, and a great many of these families will be eligible for basic grants, with the proportion varying from region to region. Farm net worth statistics have often excluded this type of farm family; 1970 census data classified 40 percent of all farm personnel in the category of farm labor or farm foremen. In Minnesota, for example, 20 percent are in this category. Exclusion of such farm families greatly exaggerates the net worth of rural families.

A second factor also contributes to exaggerated estimates of the net worth of farm families. Too often the statistics which deal with farm net worth are those which average the many small properties with the relatively few large ones. For purposes of determining the impact of basic grants on farm families a more reasonable measure of typical net worth is the median, not the average. For example, a Department of Agriculture survery conducted in the mid-1960's indicated that average net worth of farm operator/owner families was almost twice the median net worth.

STUDENT LOANS

Mr. OBEY. Let me move to the student loan situation for a minute.

If I understand the thrust of your planning, you are moving to greater emphasis upon guaranteed as opposed to direct loans. Is that right?

Secretary WEINBERGER. Yes, we are.

Mr. OBEY. The interest rate paid for guaranteed loans is what?

Secretary WEINBERGER. I do not know what it is at the moment.

Mr. OBEY. Somebody must have an idea of the range that is being paid.

Secretary WEINBERGER. We would be glad to get that and put it in.

Mr. OBEY. Is it not near seven?

Secretary WEINBERGER. Yes; for the guaranteed loan program.

Mr. OBEY. What is it under the other programs?

Secretary WEINBERGER. The direct loan made by the Government is 3 percent. The direct loan made by the Government at 3 percent is one program.

In place of that, we have moved to a very heavy reliance on straight grants at zero percent.

Mr. OBEY. I am trying to get at this: Can you tell me the average amount that a kid would borrow in this country if he goes to 4 years of undergraduate and 2 years of graduate school?

Secretary WEINBERGER. No; I cannot give an average, because it depends on how much the student is able to work, how much his family is able to contribute, and how much of a loan he is able to get.

Mr. OBEY. What is the maximum he could owe?

Secretary WEINBERGER. I suppose he could borrow the full cost of his education if he did not want to work and he could not get a scholarship. It may vary very widely.

Mr. OBEY. Let us say he is a well-motivated student who has to work hard to get his grades, and if he has to do an awful lot of work he won't make it through school.

Mr. FLOOD. There are such figures available, even if they are not precise figures.

But in answer to that question, there are figures available which you can supply for the record as to what he would have to borrow for 4 years, and what is the average for 1 year. You have a set of figures like that.

Have the record show that in direct answer to that question.

Mrs. GREEN. Would you want to include in that request the total amount that the student would have to pay, including the interest?

Mr. OBEY. Yes. That is what I am leading to.

Mr. FLOOD. You understand that question has several facets. I have seen this, and so have you. Just see that the four or five facets are included.

Secretary WEINBERGER. I think we have the question. We will provide it for the record.

Mr. OBEY. I would like to know what the average amount is that is borrowed each year now by students, what it is over a 4-year period and, as Mrs. Green suggested, what it would cost in principal and interest for the total period.

I also would like to know what the maximum is that can be borrowed.

Secretary WEINBERGER. That can be borrowed under the direct loan program, or privately?

Mr. OBEY. Direct loan.

Secretary WEINBERGER. We will get all of that for you and get it in in the order in which you requested it. Under the guaranteed loan program, it is $10,000.

Mr. FLOOD. You know the whole cycle of that series of questions. That will be a good thing to have in the record.

Secretary WEINBERGER. I will be glad to provide it.

[The information follows:]

The average size of loan in the guaranteed student loan program to date has been $965. Using this average, the student who borrows for each of 4 years as

an undergraduate would have to repay $3,860. The total for the student who also borrows for 2 years of graduate school would be $5,790.

The total principal and interest would be as follows:

	Principal	Interest	Total payment
Amount borrowed (4-year student) $3,860:			
If repaid in 5 years	$3,860	$709	$4,569
If repaid in 10 years	3,860	1,384	5,244
Amount borrowed (6-year student) $5,790:			
If repaid in 5 years	5,790	1,064	6,854
If repaid in 10 years	5,790	2,176	7,966

Mr. OBEY. My point is that kids will wind up finishing school who will owe as much in student loans as a fellow who had a mortgage on a house in my hometown when I got out of school in 1962.

Secretary WEINBERGER. We think if the basic opportunity grant program is put in as we are requesting, it will reduce substantially the amount that will have to be borrowed.

Mr. OBEY. Why do you move from the direct loan to the guaranteed loan?

Secretary WEINBERGER. We are continuing the guaranteed loan at the same general levels. We are moving from the direct loan to the grant for a number of reasons, one of which is that with a grant program you do eliminate the large repayment of interest that has to follow.

Mr. OBEY. For half of what he needs. My point is, are you not going at cross purposes when on the one hand you say you are not going to owe as much because you will get a BOG, and then you say, but the money that you have to borrow you will have to borrow at 7 rather than 3 percent?

That kid will be paying through the nose eventually, anyway.

Secretary WEINBERGER. I think the difference in interest, on the amount that would have to be borrowed is not going to be enough to hamper his ability to realize the very real gains that come from an investment in education.

Mr. OBEY. The repayment could be $500 a year.

Secretary WEINBERGER. It might be $500 a year.

Mr. OBEY. Or more.

Secretary WEINBERGER. I would think not. But around that range. We would certainly think that an investment in higher education, if it has any of the value that we all think it has, would make that more than worthwhile.

Mr. OBEY. Surely, except that the payments start immediately after graduation and on the first few years he may repay with great difficulty.

Secretary WEINBERGER. There is great flexibility in the educational loans. The grant program that we have recommended would remove a large amount of the interest problem, particularly if the student had some opportunity to work, and almost all colleges make that opportunity available. State scholarships, parental contributions, and loans could supplement the grants.

I think when you get all of these other factors into it—employment, State scholarships, college loans at very low rates of interest. Fed-

eral grants—you are reducing substantially the amount of money that would have to be raised by the loan program.

Mr. OBEY. I still am not persuaded that it is wise public policy to require students to take out loans that will be repaid at 7 percent when they could just as easily take out loans that would be repaid at 3 percent. I think that would be a much more reasonable position for you to take.

Secretary WEINBERGER. We think it is even more reasonable to move to a program that has nearly a billion dollars for direct opportunity grants.

Mr. OBEY. Just one other question.

CONGRESSIONAL RESPONSIBILITY

We were talking some about congressional irresponsibility.

Mr. CARDWELL. Could we stipulate we did not say that Congress has been irresponsible.

Mr. OBEY. I think it has been implied in a lot of statements that have come out of the executive branch.

Mr. FLOOD. Is that for the record? It is not clear who "we" are.

Mr. CARDWELL. Those of us sitting on this side of the table.

Mr. FLOOD. You have to speak pretty much for yourself there. I am not sure you speak for all.

Secretary WEINBERGER. Sometimes, in the heat of a trial, stipulations are offered which are beyond the scope of the evidence.

Mr. FLOOD. I know about that. That is what I was wondering.

Mr. OBEY. I agree; I think Congress has in some instances been irresponsible fiscally. I think, very frankly, one of those times was when it followed the recommendations of the administration and supported the last tax cut. I did not vote for that, nor did I vote for revenue sharing, because what we have done is eliminate about $16 billion in revenues.

I recognize the arguments about how that money may have helped the economy. It will be much more difficult to get those revenues back than it was to let them loose in the first place.

Frankly, I am not all that impressed with statements that if we do this and if we do that, we are going to necessitate a tax increase. I think, had we done the right thing 3 years ago, we would not have voted for those tax cuts for accelerated depreciation and unlimited investment credit for business in the first place, and we would not be in a position quite as serious as it is today.

I want to ask you one question.

Secretary WEINBERGER. I am sure the record will show I disagree with that without my saying so.

DEFENSE BUDGET

Mr. OBEY. I am sure.

Mr. Ash addressed himself to this somewhat. We did not get a clear answer from him on it. Mr. Whitten asked a number of questions about the intent of the administration if Congress did certain things.

I would just ask you this, because I would like to get your definition of what would or would not be responsible conduct on our part.

If this committee decided that we ought, as Mr. Natcher suggested the other day, to trim $2 or $3 or $4 billion from the Defense budget, and if we used that, instead, to fund additional programs within your Department, would you define that as being responsible or reasonable, or how would you define it?

Secretary WEINBERGER. I would define that as irresponsible, Congressman.

Mr. OBEY. I would like to know why.

Secretary WEINBERGER. Because I do not think we can safely cut $4 or $5 billion out of the Defense budget. I think if the Defense budget is inadequate, we are risking a great deal more than further experimentation with some of the domestic programs which have already proven to be quite ineffective. For that reason, I think we have reached a nice balance at this point.

We have reduced the Defense activities substantially. The pay increases that have been voted, three or four in 1½ years, make it necessary to increase the total, even though you reduce the activity called for by that total.

We have increased the human resources side of the budget in HEW by about $10 billion. I think that represents a proper allocation right at the verge of the ability of the Federal Government to meet it.

So, I would define that as irresponsible, and I would feel I could not be bound by Mr. Cardwell's stipulation if that kind of action took place.

PRESIDENT'S BUDGET

Mr. OBEY. OK. I disagree with that but I am glad to get that on the record.

Secretary WEINBERGER. I have said it many times publicly.

Mr. OBEY. What would your recommendation be for the President in terms of spending additional moneys we might choose to appropriate if we did not go above the budget in total, but within the President's budget added something to your Department? Would you be enthusiastic about that?

Secretary WEINBERGER. I never discuss my recommendations to the President with anybody except the President. I do not invoke executive privilege, but I think you can appreciate that if the President wants someone around to give him recommendations, he would correctly anticipate that those recommendations would be given to him and not otherwise.

I think I have already indicated my personal beliefs on these matters as straightforwardly as I can.

Mr. OBEY. I think we have a right to know whether in fact this whole exercise is meaningful or whether it is a charade. It seems to me that if we——

Secretary WEINBERGER. I have not come up here for 2 days on any charade. I came up here because I anticipated this as a meaningful and significant portion of the governmental process. I assume that it will be carried out in that way.

I am certainly not prepared to make some hypothetical guesses as to what will happen if some committee or some branch of the Congress

does or does not do something 6 or 8 months down the track. I am just not going to guess with you because I do not have any idea.

I am certainly not going to discuss recommendations that I might make to the President under those circumstances, because they are too hypothetical, and they would violate the duties that I think I assumed when I was asked by the President to serve him.

Mr. OBEY. But your budget request is hypothetical.

Secretary WEINBERGER. No. That is very concrete. That is as specific as you can get.

Mr. OBEY. It is hypothetical to us because, as Mr. Michel pointed out the other day, so much of this is based upon the assumption that certain things will happen and that Congress will pass certain recommendations such as special revenue sharing.

Secretary WEINBERGER. It is a concrete, specific proposal, and it is most concrete and specific to meet a deadline.

The budget is a thing that drives more decisions than anything else. If it were not for the budget and the deadline you gentlemen have set, I suspect we would have a great many more task forces studying things than we have actual decisions.

So, I do not think there is anything hypothetical or tentative about the budget proposals. They are in black and white, and they are there before you. What you do with them is, obviously, a totally different matter.

ALTERNATIVE TO EDUCATION SPECIAL REVENUE SHARING

Mr. OBEY. Do you think, for instance, that additional moneys in any area of elementary and secondary education, for instance, could usefully be spent if this committee appropriated them?

Secretary WEINBERGER. Certainly not under the categorical programs that are in place now. I think that would be compounding a serious error that we made for a long time.

Mr. OBEY. So it would be your personal position then that if revenue sharing comes down too late and we cannot act on it——

Secretary WEINBERGER. It will not come down too late for you to act on it.

Mr. OBEY. I hope you are right, but it would be your position that if we do not—if the Congress chooses not to enact it, it would be your position, your personal feeling anyway that you would not want to spend any more money for education even if we appropriated it?

Secretary WEINBERGER. We have made only one proposal, that is, that the appropriated money for education go out in the form of education special revenue sharing. I do not have alternative suggestions or a fall-back position.

Mr. OBEY. What is our choice? What if we decide we do not like it?

Secretary WEINBERGER. The President has made a single specific proposal. He has not suggested any alternatives. I have no authority to speak for him beyond the proposal he has made. I agree with it. I think it is the proper proposal and I would like very much to see it enacted.

Mr. OBEY. That is all.

Mr. FLOOD. Mrs. Green?

Mrs. GREEN. Thank you, Mr. Chairman.

The other day we were talking about two items and I could not put my hands on them at the moment. In the hearing I believe on Tuesday, I made reference to an in-house document where OE is recommending that the interest rate on the National Defense Education Act student loans be raised to 7 percent.

I would ask unanimous consent, Mr. Chairman, first: that paper be placed in the record at this point and that, also, I be allowed to include it in the record the other day, because when I asked the question, I believe Dr. Muirhead replied—and I believe Dr. Marland was here—he said he knew of no such document at all. This in-house document——

Mr. FLOOD. I recall that discussion. Without objection.

[The information follows:]

A memorandum, November 17, 1972 on the subject fiscal year 1974 funding strategy for the national direct student loan program contains an in-house discussion of three possible funding strategies for the NDSL program to reduce its budgetary impact to a minimum. One of the strategies referred to a proposal to consider the advisability of increasing the NDSL interest rate to 7 percent, the same as the guaranteed insured loan program rate.

UNITED STATES GOVERNMENT

Memorandum

TO : Dr. Joseph P. Cosand
Deputy Commissioner for Higher Education

DATE: November 17, 1972

FROM : Acting Deputy Associate Commissioner
for Higher Education

SUBJECT: FY 1974 Funding Strategy for the National Direct Student Loan Program

We have considered three possible funding strategies for the NDSL program to reduce its budgetary impact to a minimum. The three strategies are as follows:

1. To provide no funds for the program except those required by present legislation for teacher cancellation payments to institutions. This approach, if continued in future years, would result in the eventual elimination of the NDSL Loan Funds now existing at participating institutions.

2. To provide off the budget funding for the Loan Funds by amending existing legislation to permit institutions to sell NDSL Loan paper to the newly authorized Student Loan Marketing Association. This approach would require continued funding of teacher cancellations as described in strategy #1 and would require additional funding to cover interest subsidies which would be required by this funding mechanism.

3. To amend existing legislation to provide for full reimbursement of teacher cancellations for all loans regardless of when they were made and for defaults on loans which go into repayment after June 30, 1973. Current legislation provides for reimbursement for teacher and military cancellations only and at the 100% rate only for loans made after June 30, 1972. We would also propose increasing the interest rate to 7% and changing the program guidelines.

After carefully reviewing all three of these strategies, we have decided to recommend strategy #3. We have rejected the first approach because we feel sure that it would have no chance of Congressional acceptance and because it would lead to the eventual elimination of the existing Loan Funds, which in our judgment can still serve a valuable purpose as explained below. We have provisionally rejected strategy #2 because we do not think it can obtain support in either the Congress or the academic community at the present time. After SLMA is in full operation and has had a chance to prove its effectiveness, let us say after at least a full year's operation, we may wish to reconsider this approach.

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

The third strategy, which we have chosen to recommend, will permit us to preserve the integrity of the existing Funds for a relatively modest outlay of federal funds; it will provide for a clearer definition of the purpose of this program, which will be consonant with the Administration's overall student aid strategy; and it will emphasize and make more real the similarity of this program to the Guaranteed Loan Program, which should make it easier to obtain congressional support for the SLMA approach should we decide to go that route later on, as well as making it more likely that Congress will approve the proposal we are recommending here.

Specifically we propose that:

1. Legislation be amended to fully reimburse the Loan Funds for all losses through cancellations, defaults, bankruptcies, and death and disability. Reimbursement for defaults would apply only to loans which go into repayment status after June 30, 1973. These legislative changes would also be necessary should strategy #2 be chosen.

2. That the interest rate be increased from 3% to 7%, the same as the Guaranteed Loan Program;

3. That institutions be asked (or required) to give preference for NDSL Loans to students who are unable to obtain a Guaranteed Loan.

We believe that this approach has much to recommend it. It makes the program virtually identical to the Guaranteed Loan Program except for the Teacher Cancellation provision. This will make it easier to convert to the SLMA approach later on and would eliminate any unfair advantage for NDSL borrowers. Now that the Guaranteed Loan Program is expected to provide loans to large numbers of low income students, there is no longer any reason to provide NDSL borrowers a lower interest rate than GLP borrowers. This approach will also strengthen the Loan Funds, which can still fulfill a valuable function by providing loans to students unable to obtain Guaranteed Loans and by providing a source of loan funds to institutions which may be unwilling or unable to participate as lenders in the Guaranteed Loan Program.

It should be emphasized to the Congress that the NDSL Funds at the institutions presently have a net worth of $2.2 billion and are capable of generating $150-$200 million in loans per year if all future losses are fully reimbursed by the Federal Government. With such a vast Loan Fund already in existence, it does not seem at all unreasonable to cease providing additional Federal Capital. This is especially true now that the Guaranteed Loan Program can be expected to make loans to many students who would have formerly had to borrow from the NDSL program.

Page 3 - Dr. Joseph P. Cosand

The five-year projection of the appropriations needed to fund the recommended alternative are as follows:

	For teacher and military cancellation	For defaults	Total
1974	55	4	59
1975	60	5	65
1976	70	7	77
1977	75	9	84
1978	70	11	81

There is an additional source of leakage from the Fund which is different in nature from those for which appropriations are proposed. This involves institutions which choose, for one reason or another, to discontinue participation in the program, in which case their Funds are liquidated. In such cases, the Federal share of collections is currently reverted to the Treasury as repayments are made. The liquidation of a particular Fund may take many years. It is proposed that the legislation be amended to provide that collections of loans made from Funds which are liquidated in future years be made available for reallocation by the Commissioner to other institutions.

It is anticipated that liquidations will become a serious source of leakage from the Fund if new Federal capital contributions cease, particularly among those institutions whose funds are still so new that the volume of collections is so minimal that few or no new loans can be made from current collections. As many as 400-500 institutions have Funds of such a minimal size. While the amount in any one institution may be small, in the aggregate several tens of millions of dollars could be involved.

(Sgd.) S.W. Herrell

S.W. Herrell

Mrs. GREEN. It clearly says they recommend it be raised to 7 percent.

Secretary WEINBERGER. May I comment on that?

I have not seen a document of that kind. Having been there such a short time, I am not aware of its existence. I do not doubt for a moment that there is probably a document of the exact kind Mrs. Green has described, because she has described it. I am sure she has stated it accurately.

I do question the characterization of it as an in-house document because it sounds as if it has a highly official status. There are hundreds of thousands of pieces of paper of this kind that I have seen floating around that could not remotely be considered as, nor resemble, policy positions. The fact that one way or another someone obtains possession of a document of this kind is one reason that we advise the newspapers, that come to us with leaked information, that chances are 90 to 1 it is not an accurate statement.

Mr. FLOOD. That has nothing to do with the document. Frequently these documents speak for themselves.

Secretary WEINBERGER. It may speak for itself, but it may also be only one man's suggestions to another man, neither of whom have authority to do anything.

Mrs. GREEN. This is a memorandum from the Acting Deputy Associate Commissioner for Higher Education to Dr Joseph P. Cosand.

Secretary WEINBERGER. Dr. Cosand is no longer with us, of course.

Mrs. GREEN. Yes; I am aware of that, but the memorandum was not written by him—but to him. May I finish? I do not mean to be rude.

But the recommendation is made that the interest rate be increased to 7 percent and the answer from Dr. Muirhead—and I think Mr. Ottina and Mr. Marland were both there—they did not contradict him when he said they had heard of no such discussion in the Office of Education. This answer strikes me as strange. So, I would ask that this whole document be placed at this point in the record and the correction we made the other day.

My question I would ask Dr. Weinberger, following up, and you do not need to take the time——

Secretary WEINBERGER. Sadly, I am not a doctor, Mrs. Green.

Mr. FLOOD. We can arrange that.

Mrs. GREEN. My question: Has this policy been decided?

Secretary WEINBERGER. Not to my knowledge; no.

Mrs. GREEN. Not to your knowledge?

Secretary WEINBERGER. No; and Dr. Cosand, who apparently was one of the recipients of that document, is no longer with us.

Mrs. GREEN. Yes. I understand.

SOLE SOURCE CONTRACTS

Second, Mr. Chairman, I could not locate the statement to which I referred, that indicates the sole source contracts for the year 1972 had increased to 95 percent; in the years 1967, 1968, 1969, within the Office of Education (and I am talking about discretionary funds only) 90 percent of all contracts and grants were on a sole source basis, and I refer to page 32 of the hearings before the subcommittee which I

chaired last year; on that page is a table that we asked Mr. Ottina to provide, and while this is incomplete for contracts and grants, for that year the sole source percentage had increased to 95 percent.

If I may have that in the record.

Mr. FLOOD. Without objection.

You indicated the other day that would be so, so there they are; yes. Do you want those at this point in the record?

Mrs. GREEN. I would like it at the time of the discussion.

Mr. FLOOD. I think that is better.

PRESCHOOL EDUCATION

Mrs. GREEN. At this point in the record today, I would like to have inserted an article from Harper's magazine which I think really should be read by everybody who is talking about preschool education, and it is called "The Dangers of Early Schooling."

It seems particularly appropriate for me to be offering this at this moment, because at 4:30 in Portland, Oreg., a demonstration is scheduled in front of my office for a tremendously expanded preschool program or day care centers. This is a very scholarly article—presenting at least one viewpoint—pointing out the problems and that we had better go a little bit slow and that some of the things we are doing for children at an early age may not be helpful, but may have the opposite effect. I suggest this viewpoint at least needs to be considered.

Mr. FLOOD. That is certainly a timely insertion then, at 10 after 4, it is pretty good.

Mrs. GREEN. Yes.

Mr. FLOOD. I think the record should show that you are doing it at 10 minutes after 4.

Mrs. GREEN. That is right.

Mr. PATTEN. Eastern daylight saving time.

Mrs. GREEN. Yes.

[The article follows:]

[From Harper's Magazine]

THE DANGERS OF EARLY SCHOOLING

(By Raymond S. Moore and Dennis R. Moore)

Raymond Moore is professor of education at Andrews University and chief executive officer of the Hewitt Research Center. Dennis Moore, his son, is a graduate student at the University of Colorado and a member of the teaching staff at Walnut Hills Community School, in Colorado. A full scholarly version of this essay will appear in the fall Teachers College Record.

The idea that "the earlier a child starts school the better" is well on the way to becoming an unquestioned tenet of the conventional wisdom. Educators and legislators across the country are pressing for earlier and earlier schooling for *all* children, on the assumption that schools and teachers can do more for the child than parents can or will do. Parents themselves, bewildered over how best to meet their children's needs, not only have accepted this formulation but have agitated to be certain *their* children will not be left behind in the race to the schoolhouse.

In the face of this growing movement—and after exhaustive review of the research concerning early-childhood education—we contend that sending 4-year-

olds off to school results in far more harm than good. In fact, we argue that children probably shouldn't attend school until they are 7 or 8 years old.

There is simply no conclusive proof that even the best known early-schooling plans are working, and there is considerable evidence that most are not. Studies show that most of the extensive projects such as Headstart and Great Cities have failed to produce the expected growth in scholastic achievement. Furthermore, there is an impressive body of research indicating that the late starter generally does better through school than the child who starts early.

It may be that the sheer volume of professional and political propaganda—along with parental complacency and uncertainty—will sweep all 4-year-olds into school regardless of what the facts are. Already there is considerable momentum: the National Education Association's Educational Policies Commission has called for public-supported education beginning with 4-year-olds; the New York State Regents have recommended generalized schooling down to age 3, to be achieved by 1973 or 1975; and California's State school superintendent is currently seeking legislation to authorize schooling for all 4-year-olds. While the price to the taxpayer for such programs would be high, the costs could be even greater in damage to the very children who are supposedly being helped.

Most plans for early-childhood education seem to grow out of a genuine concern for children. The high caliber of people historically appointed to the Educational Policies Commission, for example, would suggest that only the highest motives stand behind its conclusions. Yet some of the older hands fear that many educators and media firms are moving rapidly into the field because, in the words of a key researcher, "that's where the money is."

Even the National School Public Relations Association might be forgiven for placing the movement for early-childhood education in a highly favorable light in its recent report, *Project Breakthrough*. Yet these leaders should be expected to provide hard evidence for their conclusions and recommendations, lest it be suggested their interest lies more in creating teacher jobs and government projects than in assuring the welfare of the child and his family. Indeed, one California State staffer has expressed concern about teacher employment if research pointed away from early schooling.

Advocates of early schooling usually start from two well-proved points: the fact of incredibly rapid growth in the child's intelligence between birth and age 5, and the need for the child's social development to keep pace with his intellectual maturity. But then they go on to make unfortunate twin assumptions: that a child's intelligence can be nurtured by organizing it, and that brightness means readiness for the world of schooling. In short, their happy vision is that early schooling offers the best garden for a child's budding intelligence and developing social awareness.

These assumptions, however comforting or promising, are contradicted by clear-cut experimental evidence. A wealth of research has established that one of a child's primary needs in these formative years is for an environment free of tasks that will tax his brain, and an equally important need is for a setting that provides warmth, continuity, and security. That normal school experience does not successfully meet these needs has been established by three different kinds of studies: those that compare early and later school entrants; those that explore important but little understood changes in the young child's brain; and those that compare the effectiveness of parents and teachers in the development of young children. All three lines of investigation point to a common conclusion: early schooling, far from being the garden of delights its advocates claim, may actually be a damaging experience.

TOO MUCH TOO EARLY

Investigators who have studied very young children in school overwhelmingly present a grim picture. The child too often stumbles insecurely through kindergarten and the early grades. His friends who were delayed a year or so quickly catch up and pass him—and usually become more stable and highly motivated. His learning retention frequently remains lower than that of his later starting peers, regardless of how bright he is. In other words, it is hard to escape the conclusion that early schooling is little short of crippling. A few indicative studies by well-regarded researchers give a sense of the situation:

In an American Educational Research Association experiment with two groups of children matched by sex, age, intelligence, and home background, H. M. Davis

reports: "One group began reading at the age of 6, the other at the age of 7. In 2 years the late beginning group had caught up with the early beginning group. After the first 2 years, these two groups were joined in classes. At the end of their seventh school year the children who began a year later were 1 year ahead of the early beginners."

In Chula Vista, Calif., Margaret Gott compared kindergarten children who were about 4 years, 9 months of age when enrolled, with those who were about 5 years, 7 months. She found that, after six grades of schooling, the younger group achieved less well than the older group in all subjects at each grade level (except in one case where achievement was equal).

In Oak Ridge, Tenn., Inez King reports, 54 children who were under 6 when they started school were compared with 50 children who started after age 6. Stanford Achievement Tests at the end of grade 6 showed a distinct difference, strongly in favor of the older group.

Studies on how long and how well very young children retain their learning have been conducted in virtually all grades and socioeconomic levels with remarkably uniform results. B. U. Keister reported that even 5-year-olds who developed enough skills to finish first grade reading generally did not retain the learning through summer vacation. Other comparisons of reading achievements of early and late starters at third- through sixth-grade levels all found that later entrants significantly excelled those who started earlier.

In Grosse Pointe, Mich., Paul Mawhinney describes a study of children who were selected by psychologists because they were considered mature enough or bright enough to be admitted to kindergarten before age 5. An evaluation of all those children remaining in the school system after 14 years showed that more than one-fourth of the select group were below average or had repeated a grade.

Years ago, pioneer child researcher Arnold Gesell noted that school tasks such as reading, writing, and arithmetic "depend upon motor skills which are subject to the same laws of growth which govern creeping, walking, grasping." The awkwardness a young child may exhibit, he noted, "is often sadly overlooked by teachers and parents"—who should be as flexible in their attitudes toward the child's readiness to read as toward his readiness to walk.

ON THE HOME FRONT

The third, and possibly the most important, conclusion to be drawn from research is that when a child is taken from the home for early schooling—or remains at home without loving care—he is vulnerable to mental and emotional problems that will affect his learning, motivation, and behavior. While many proponents of early schooling insist that the young child needs social contact outside the home—namely in the school—the lesson of numerous investigations is that this need ranks far behind the child's need for close parental contact. The teacher, in general, does not make a good surrogate mother.

Maternal deprivation, in the words of John Bowlby, a world authority on the subject, describes the extent to which a child does not experience "a warm, intimate, and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment." As part of a 1951 World Health Organization study, Bowlby noted that "a child is deprived even though living at home if his mother (or permanent mother-substitute) is unable to give him the loving care small children need [or] . . . if for any reason he is removed from his mother's care." Today, he points out that in the Western world early childhood problems commonly result from "too little mothering, or . . . [from] mothering coming from a succession of different people." While a child is most vulnerable until age 5, he can experience the effects of maternal deprivation until age 8.

In an experiment conducted in Uganda, Marcel Geber demonstrated that children who do not have continuous warm mothering are less sociable than those who do. Using standardized tests, Geber worked with babies from poor tribal families in which the mothers were child-centered, providing continual caressing, cuddling, and attention to their babies. He found these infants to be superior to Western children in sociability as well as in physiological maturation and coordination, adaptability, and language skills. While African children frequently

mature earlier than Westerners, Geber also reported that babies from relatively well-to-do Uganda families, with less maternal contact but more formal training, were much less mature in these areas than the babies of poor families.

A more personal perspective on the socializing experience of early schooling is provided by M. W. Sullivan, a well-known educational programer. He recalls that kindergarten only caused him to wet his pants. When the teacher sent him home he was so happy that he decided to keep on wetting his pants in school—until he was sent home for the year.

On the basis of such findings, it seems clear that for a child of this age, development at home is far more important than development in school. And if the parents' acceptance of their role is a key factor in the child's development, then it makes a great deal more sense to educate the parents to fulfill their proper role than to hire teachers to do an inadequate job of trying to substitute for them.

Traditionally, of course, school people have argued that parents simply don't care or are too ignorant or too obsessed with the desire to protect their own freedom to fulfill the needs of their children. Parents, for their part, have seldom contested this view, possibly out of feelings of uncertainty or inadequacy when confronted by the opinions of these professionals. The facts, however, as determined by a number of investigations of parental willingness to aid the development of their children, run counter to this conception. The vast majority of parents, regardless of socioeconomic status, stand ready to help their children in terms of home-education programs. While much of the justification for early-childhood education has grown from the belief that children from disadvantaged backgrounds in particular will benefit, studies have repeatedly shown that the home provides resources that should not be lightly dismissed.

On the basis of several studies, Bowlby insists that "children thrive better in bad homes than in good institutions." He goes on to observe: "It must never be forgotten . . . that even the bad parent who neglects her child is nonetheless providing much for him. . . . Except in the worst cases, she is giving him food and shelter, comforting him in distress, teaching him simple skills, and above all is providing him with that continuity of human care on which his sense of security rests."

In Flint, Mich., Mildred Smith found that when she took study-help materials into disadvantaged homes and asked for parental help, 90 percent of the families responded, and of these 99 percent of the parents asked that the program be continued.

Burton Blatt and Frank Garfunkel found it necessary to reject the operating hypothesis of their own study—that preschool might be good for disadvantaged children who "were at least 2 years away from entering the first grade." They concluded that (1) the home is more influential than the school; (2) the school can do little without strong home support; (3) disadvantaged parents "are often anxious to cooperate"; and (4) school organization and requirements are often "foreign" to these parents, who in turn are blamed by the school for not readily accepting them.

In all the investigations of early schooling, the only clear evidence proving its value is in the case of special child-care needs that are not common to most children—and even here the home should be the center of operation whenever possible. Special and early education is a benefit when it provides therapeutic help for the handicapped child—those with problems of vision, speech, hearing; or cerebral palsy, severe mental retardation, neuroses, psychoses, and advanced emotional problems. Likewise, in cases where the child may be severely deprived because his parents are mentally, physically, or emotionally unable to care for him, early schooling may provide an advantageous alternative to the home.

Yet one of the clear dangers of attempting to provide early schooling for all 3- or 4-year-olds is that these programs for the handicapped child, which are desperately needed, will be watered down Sheldon White, a developmental psychologist at Harvard, fears that the early-schooling movement "will work itself into so much trouble within 6 years or so that it will wipe out the gains special education has made and possibly ruin the future of early-childhood education."

Most disturbing of all, the volume of research work that stands opposed to early-childhood education appears to have made hardly a dent in the enthusiasm of its proponents. The report of the California task force on early childhood edu-

cation, for example, loftily recommends early schooling as a way to prevent future "crime, poverty, addiction, malnutrition, and violence"—without pausing to notice that some of the studies it quotes in its support actually contradict its recommendations.

It appears, indeed, that many of the problems early schooling is supposed to solve actually exist because children right now are being forced into schooling too early Throughout the experimental work in this area there is considerable evidence that early schooling and parental deprivation together are prime contributors to childhood maladjustment, motivational loss, poor retention, deterioration of attitudes, visual handicaps, and a wide variety of other physical and behavioral problems.

SCHOOL IN THE HOME

The question remains, of course, what is the alternative to early schooling? How are a bright child's enthusiasms and eagerness for learning to be met before he is 8 years old and ready for school? The most promising practical solution emerging from current research points to home-centered educational programs.

Susan Gray and Phyllis Levenstein, among others, are now experimenting with "home schools," the latter by means of a "mother-child home program." In this plan, teachers visit homes at regular intervals to work with parents in assessing a child's development and suggesting appropriate ways of nuturing his growth without taxing him. Essentially these visitors function less as traditional teachers and more as consultants or resource personnel, providing ideas and directions for the parents to use as they choose; in fact, to overcome parental fear of professional teachers, these visitors freqeuntly refer to themselves as "toy demonstrators."

In terms of funds required, home-teaching programs avoid the need for heavy taxation to cover capital and operating costs that, for example, the California early-school proposal is certain to bring. The California planners are projecting a cost of $500 to $600 per child per year. New York State experts, however, point out that such programs must be funded at the rate of at least $1,800 per child annually, and that truly effective programs will cost "much more."

A central spokesman for the home-school approach is Earl Schaefer, Professor of maternal and child health at the University of North Carolina and former chief of early child-care research at the National Institute of Mental Health. In a recent interview, Schaefer called home-centered programs, and particularly the work of Levenstein and Gray, "the current most likely solution" to the child-development dilemma. To its credit, the Office of Child Development in the Department of Health, Education, and Welfare is embarking on a new project called home start, intended to redirect the focus of early-childhood education from the school to the home.

The home-school concept can be adapted to meet the growing national concern for children of working mothers. Neighborhood home centers could be established where the mothers (or other adults) providing care would be selected for their warmth, continuity, and dedication to the welfare of children. Where parents cannot afford the entire cost of these centers, the difference could be subsidized by the States. Traveling teachers or "toy demonstrators" on State or local payrolls could monitor these home "schools" to see that each was providing adequate care and equipment, and to coordinate them with existing social-service programs.

While the proposal is sketchy—and in any case may not provide the only answer to the country's child-care problem—it does establish a fruitful direction for exploration. After all, social policy must be a product of our best knowledge on public issues, or it runs the risk of plunging us even deeper into the problems we are attempting to escape. The clear lessons of scholarly research in the field of child development are that we must worry less about exploiting the child's intelligence and more about understanding it, and that schoolmen must realize that there is less value in attempting to substitute for the parent than in helping parents to help themselves and their children.

EARLY STRESS CAN INJURE

A second series of arguments against early schooling emerges from the studies of neurophysiologists, psychologists, and pediatricians concerned with the delicate harmonies at work in the development of the young child's brain. These

investigators are in remarkable agreement in their timing of the stages at which children are normally ready to think abstractly, to organize facts, and to sustain and retain learning without undue damage or strain.

Research on brain development indicates that important changes are constantly underway in the normal child from birth into adolescence, including the shifting of control from the emotional centers to the reasoning centers. The period at which "reason" develops, and the ability to organize facts emerges, normally comes between ages 7 or 8 and 10 or 11.

Numerous studies support the idea that the young child cannot meet the demands posed by schooling prior to the level of development usually achieved by age 7 or 8. At Harvard, the work of Paul Yakovlev has shown that the nerve fibers between the thalamus and the cortex in a child's brain are not finished or fully insulated until after age 7. Likewise, it is only between the ages of 7 and 10 that the cerebral commissures (brain paths between the lobes) and the reticular formation (a primary arousing system) are fully developed.

A number of other studies have established that a child's visual and auditory systems reach maturity only gradually. This is of enormous consequence for tasks such as reading, where there are high demands for discrimination in sight and sound.

Luella Cole has observed that some children are unable to focus on objects at close range—as required for reading—until they are 7, 8, or even older. She reports that not more than 10 percent of 5-year-olds can perceive the difference between "d" and "b" or "p" and q." Not until children are 8, she says, is it possible to "be perfectly certain the eyes are mature enough to avoid such confusions."

Hearing presents a similar situation. Luella Cole notes: "If [a child] has normal 6-year-old ears he will still be unable to distinguish consistently between the sounds of 'g' and 'k,' 'm' and 'n,' 'p' and 'b' or any other pair of related sounds."

Dr. Henry L. Hilgartner, a Texas ophthalmologist, offers evidence of eye damage from early schooling. Noting that the eyes of young children focus better on distant objects than on close ones, he reported that the State's record prior to 1930 was 7.7 farsighted children to every nearsighted child. After 1930, when the Texas school-entry age was lowered from 7 to 6, the ratio shifted to five nearsighted children for every farsighted child.

Swiss psychologist Jean Piaget, one of the world's leading students of child development, long ago urged educators to concentrate on maximizing a child's development, not on accelerating it. He found that a child under age 7 or 8 relates quantity to shape and form of objects, but if the shape or form is changed, he becomes confused, assuming the quantity must also change. For instance, the 4- or 5-year-old seldom understands how a low, wide glass can hold as much water as a tall, narrow glass. Even after the water is poured from the tall glass into the wide one, he will usually insist that the tall one is larger and holds more. Not until he is 7 or 8 or older does he become a fully "reasonable" creature, able to reason abstractly instead of dealing solely with direct relationships.

Mrs. GREEN. To go to other matters; first, Mr. Weinberger, I do want to join my colleagues in welcoming you. I must say I agree with the gentleman from Illinois; I thought your statement was one of the, if not the most concise, helpful and well put together statements that I have heard a Secretary of HEW give in the years I have been in the Congress.

Secretary WEINBERGER. Thank you.

Mrs. GREEN. Second, I would like to comment on the appointment of Mr. Carlucci as the Under Secretary.

As I see it, Mr. Carlucci was by far the best Director of OEO during the years of its existence. I intend to support the administration's efforts to dismantle OEO. I know there are no budget requests before this committee at this time.

A question on OEO, Mr. Chairman, if it is in order.

I do not expect you to have the answers to this today, but if you would put it in the record at this point.

The last study I made was that we have at least, at least, 75 Federal programs that are designed exclusively for the poor. Not all of them in OEO—a very large number are in many other departments and agencies.

I am told now that the number is about 100. Could I ask that a list of all of the present programs that are exclusively designed for the poor be placed in the record at this point with the dollar amount, and then, beside it, the number of programs exclusively designed for the poor that will remain in operation if the administration's recommendation for dismantling of OEO takes place?

Mr. FLOOD. Exclusively designed for the poor?

Mrs. GREEN. By that I mean, restricted to——

Mr. CARDWELL. You mean——

Mr. FLOOD. Just a moment, she is entirely capable of answering the question.

Mrs. GREEN. A program to which only a person living at the poverty level or below is eligible and to which no middle-income family or upper-income family is eligible, even though they are paying for it. That is what I mean "exclusively designed".

Mr. FLOOD. That is what I thought you meant, but I wanted to make sure.

Mrs. GREEN. That is what I meant by "for the poor." I will say in support of that position that I asked the Library of Congress to do a study on the amount that might be received, in cash and in kind, for a family of five—a mother and four children on ADC who have taken advantage of all OEO and other programs outside of OEO; and their income might be over $11,000 in cash and in kind, without working a day and without paying a cent in taxes; we also asked the Library of Congress to do the same study for a mother and either eight or nine children, who took advantage of all the innumerable programs for the poor; and they could have an annual income of over $21,000 in cash and in kind, without paying a dime in taxes and without working a single day. This list of programs includes some manpower training. This is not all theory. We have, also, Mr. Chairman, identified families in my State who have received these amounts.

One of my colleagues told me on the floor this week that a family has been identified whose members are enrolled in 11 of the programs designed for the poor and that they are collecting $24,000. Such instances are the basis, plus a lot of other reasons, why I cannot quarrel with the administration on bringing some order out of the chaos, the overlapping, the duplication—the waste we have seen in OEO for so long a period of time:

[The information follows:]

POVERTY PROGRAMS

Following is a list of HEW programs, with funding levels for 1973 and 1974, specifically designated to serve the poor—primary criteria for eligibility is low income. Also shown are poverty programs identified in the "Catalog of Federal Domestic Assistance" for 1972 for other Federal agencies.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

	(in thousands) FY 73 Budget Estimate	FY 74 Budget Estimate
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION		
Mental Health		
Community Mental Health Centers	$125,100	$125,250
Health Services Delivery		
Dental Health of Children	1,180	(a)
Family Planning Projects	101,615	116,615
Health Care of Children and Youth	47,400	(a)
Maternity and Infant Care Projects	42,940	(a)
Migrant Health Grants	23,750	23,750
Indian Health Services		
Indian Health Services	169,590	178,518
Indian Health Facilities		
Indian Sanitation Facilities	35,745	36,179
NATIONAL INSTITUTES OF HEALTH		
Health Manpower		
Health Professions Scholarships	$ 15,500	$ 10,000
Nursing Scholarships	19,500	11,000
Health Manpower Education Initiative Awards	31,759	46,500

	(in thousands) FY 73 Budget Estimate	FY 74 Budget Estimate
OFFICE OF EDUCATION		
Elementary and Secondary Education		
Bilingual Education (Title VII)	$ 35,080	$ 35,000
Educationally Deprived Children - Migrants	58,380	(b)
Follow Through	57,700	41,000
Educationally Deprived Children - Special Grants for Urban and Rural Schools (Title I ESEA - Part C)	28,064	(b)
Educationally Deprived Children - Special Incentive Grants	8,215	(b)
Vocational and Adult Education		
Vocational Education - Special Needs	20,000	(b)
Vocational Education - Work-Study	6,000	(b)
Higher Education		
Higher Education - Work-Study	252,785	250,000
Educational Development		
Dropout Prevention	8,500	4,000
School Health and Nutrition Services for Children from Low-Income Families	2,000	---
SOCIAL AND REHABILITATION SERVICE		
Grants to States for Public Assistance		
Child Welfare Services	$ 46,000	$ 46,000
Medical Assistance Program (Medicaid - Title XIX)	5,183,899	5,902,862
Social Services	2,135,927	2,163,864
Maintenance Assistance	6,615,335	6,119,664
Work Incentives		
Work Incentive Program	291,920	534,434
Social and Rehabilitation Services		
Comprehensive Social and Rehabilitation Research	68,563	47,063
Assistance to Refugees in the United States		
Refugee Assistance - Cuban Refugees	145,000	90,000

	(in thousands) FY 73 Budget Estimate	FY 74 Budget Estimate
OFFICE OF CHILD DEVELOPMENT		
Child Development		
Child Development - Head Start.....	$ (c)	$ (c)

(a) Funds for 1974 are included under Maternal and Child Health Services formula grants.

(b) This program is included in the proposed Special Revenue Sharing program.

(c) No projections are possible, but amounts are anticipated not to fall below FY 1972 levels.

BUREAU OF INDIAN AFFAIRS
DEPARTMENT OF THE INTERIOR

Indian Education - Adults
Indian Social Services - Child Welfare Assistance
Indian Agricultural Extension
Indian Tribal Government Operations
Indian Community Development
Indian Education - Contracts with Indian School Boards
Indian Engineering Technical Assistance
Indian Employment Assistance
Indian Education - Dormitory Operations
Indian Education - Federal Schools
Indian Forests - Fire Suppression and Emergency Rehabilitation
Indian Forests - Management, Protection, and Development
Indian Social Services - General Assistance
Indian Education - Colleges and Universities
Indian Housing - Development
Indian Housing - Improvement
Indian Industrial and Tourism Development and On-The-Job Training
Indian Investments - Tribal Trust Funds and Individual Indian Monies
Indian Lands - Range Management
Indian Lands - Real Estate Appraisal
Indian Lands - Real Estate Services
Indian Roads - Reservation Roads and Bridges
Indian Loans - Claim Assistance
Indian Loans - Economic and Social Development
Indian Roads - Maintenance
Indian Lands - Soil and Moisture Conservation
Indian Property Acquisition - Transfer of Federally Owned Buildings, Improvements and/or Facilities
Indian Lands - Irrigation Construction, Maintenance, Operation, and Related Systems
Indian Property Acquisition - Transfer of Indian School Properties
Indian Accounting Services for Tribes
Indian Education - Assistance to Non-Federal Schools
Indian Judicial, Prevention and Enforcement Services
Indian Social Services - Counseling
Indian Tribal Affairs Management

FOOD AND NUTRITION SERVICE
DEPARTMENT OF AGRICULTURE

Food Distribution
Food stamps
Special Food Service Program for Children (Nonschool Food Program)
School Breakfast Program
National School Lunch Program

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Public Housing - Acquisition and Construction
Public Housing - Home-Ownership for Low-Income Families
Public Housing - Modernization of Projects
Public Housing - Leased
Rent Supplements - Rental Housing for Lower Income Families
Very Low-Income Housing Repair Loans

MANPOWER ADMINISTRATION
DEPARTMENT OF LABOR

Concentrated Employment Program
Manpower Development and Training - Institutional Training
Public Employment Program
Job Opportunities in the Business Sector
Neighborhood Youth Corps
National On-The-Job Training
Operation Mainstream
Public Service Careers
Job Corps
Migrant Workers (Last Yellow Bus)
Farm Labor Contracto- Registration
Work Incentive Program - Training and Allowances

ACTION

Foster Grandparents
Volunteers in Service to America

APPALACHIAN REGIONAL COMMISSION

Appalachian Health Demonstration

OFFICE OF ECONOMIC OPPORTUNITY

Community Action
Comprehensive Health Services
Family Planning
Migrant and Seasonal Farmworkers Assistance
Older Persons Opportunities and Services
Drug Rehabilitation
Emergency Food and Medical Services
Legal Services
Special Impact

SMALL BUSINESS ADMINISTRATION

Economic Opportunity Loans for Small Businesses

To some specific questions, Mr. Secretary. Why, with the teacher surplus, does the administration recommend a continuation of the Teachers Corps?

Secretary WEINBERGER. I think it is primarily a matter, Mrs. Green, of trying to insure that areas of the country that are underserved will be served. I think there is some concern about the distribution of teachers, and the feeling is that through the continued operation of the Teachers Corps we might be able to get teachers into areas that do not now have an adequate supply.

Mr. CARDWELL. You know the program is designed to develop teachers of the disadvantaged, usually, in urban school systems, the hard to teach.

Mrs. GREEN. As the Federal Government views it. But it seems to me this is one area which is in violation of the administration's general policy. I have not talked to a school superintendent yet who, if given the alternative of taking some Teachers Corps people or being given the identical amount of money that would be paid to those Teachers Corps members—I have not had a single superintendent who has not said, "Well, I would much rather hire my own teachers and train them for the problems in our city than to accept a Federal Teachers Corps enrollee who has been trained according to Federal ideas or standards."

Mr. CARDWELL. Of course, it is a good question; it has been considered several times. The training programs that the Federal Government finances, as you know, are conducted at colleges and universities and are usually tailored there. As far as I know, there is no Federal standard.

Mrs. GREEN. I introduced an amendment a long time ago that would allow a school district to have the funds instead of a university and then they could shop around at the universities within their area for curriculum which would be beneficial for teachers in the difficult schools in that particular district.

Mr. CARDWELL. They would buy their own.

Mrs. GREEN. And have some say about the curricula that we're going to be provided to train teachers to meet their problems.

When you give it to a university, they may give you the same old classes that they have taught for 50 years and it may or may not be relevant to the problems within that school district.

Secretary WEINBERGER. Mrs. Green, I might say that your amendment sounds as if it would be very much in keeping with the basic administration philosophy as to students versus institutional aid. Offhand, without knowing nearly enough about it, it would certainly sound much more attractive to me than the other system you described.

Mrs. GREEN. I still really do not quite accept the philosophy for continuing Teachers Corps with the tremendous surplus of teachers we have. I think districts, if they have the money here, would much prefer to select and hire the ones most qualified.

Also, Mr. Chairman, you raised a question the other day about the Commission, under section 1202. We had an exchange with Commissioner Marland. One of my specific questions directed to him was that if the legislative branch of the Government decides to add money for title 10, would we not then need the Commission?

He agreed we would.

Then he stated that he had sent out a letter to every single State saying that they had decided to not have any State commissions.

I would like to have at this point in the record that full colloquy with Mr. Marland inserted here before it is cleansed.

Mr. FLOOD. Before what?

Mrs. GREEN. Before it is cleansed, either by myself or anybody else, just exactly as it appeared the other day, just that short colloquy.

Mr. FLOOD. You mean you want the colloquy with Dr. Marland repeated again at this point?

Mrs. GREEN. Yes; it was just in regard to this particular question.

Mr. FLOOD. I see. Because if I recall it, I believe I asked Dr. Marland to be sure and insert at that point in the record a copy of that letter, did I not, that was being sent to the various jurisdictions. Do you recall?

Mrs. GREEN. Yes.

Mr. FLOOD. Then you would want that, too?

Mrs. GREEN. If I may try to make one more point, you will understand why I am requesting this.

Mr. FLOOD. Nothing wrong with that. We will do that.

Mrs. GREEN. The reason I am asking this, I said: "Dr. Marland, in that letter that you sent to the States, did you also advise them of a possible contingency that Congress might appropriate funds under title 10?"

Mr. FLOOD. That was proper interrogation.

Mrs. GREEN. He said, "Yes, we did, we included it in the letter."

That is why I want that colloquy without it being changed by myself or by him.

Mr. FLOOD. That is proper.

Mrs. GREEN. Because the letter, which I did not have at the time—and it is over Mr. Ottina's signature—has absolutely no reference to the fact that there might be the possibility of Congress appropriating funds and thus requiring State commissions. Ottina was sitting beside Dr. Marland when he answered that question.

I will read only one paragraph of this, but the whole letter, as you say, will be in the record.

Mr. FLOOD. Yes.

Mrs. GREEN. "Under the circumstances, it has been determined that we should indefinitely defer our plans for the distribution of the revised report of the task force and suspend all activity relative to the establishment of the section 1202 State commissions."

There is no reference, and it seems to me it is a great disservice, because you cannot organize State commissions overnight. I would like

my State to know that there is the possibility Congress might add funds and they ought to be thinking about establishing a State commission. It takes time.

Mr. FLOOD. We will have to do this. No objection, that is quite proper.

But of course, Mr. Secretary, when that is done and you see that record, then of course you have a right, if you are so inclined, to reply directly to this presentation.

Secretary WEINBERGER. Very good.

Mr. FLOOD. I think perhaps you would.

Secretary WEINBERGER. I appreciate that.

[The information follows:]

The authority here is very free authority, consciously so. Again, I would return to the testimony before Mrs. Green's committee a year ago. We want it to be free. We want to give a high order of creativity to Columbia and other institutions across the land that want change.

I would guess while we are saying we want a 50-percent increase at a time of scarce resources, we would like to see it more, Mr. Chairman.

Mr. FLOOD. The law requires that all projects be submitted to the State higher education commission for comment and for recommendation. Knowing States as we do, have all the States set up these commissions? What is the role of these commissions?

Dr. MARLAND. That will require a careful response, because the condition is changing.

Mr. FLOOD. Have all the States set them up?

Dr. MARLAND. The quick answer is, no. The quick answer also says none may be required to do it. The longer answer says this, and Dr. Ottina may wish to amplify this because the 1202 commissions are under his jurisdiction——

Mr. FLOOD. You say none may be set up. The law requires that they be set up.

Dr. MARLAND. We are modifying that.

Mr. FLOOD. You are modifying the law?

Dr. MARLAND. We are modifying our instructions at this time to the States as to how they may operate with this authority. Let me continue.

The law authorized the 1202 commissions to be set up, but they were optional. But the law also said that if the State wished to have moneys under new authorizations and the Education Amendments of 1972 to include community college authorization and occupational authorization at postsecondary level, those two authorities would indeed have to be approved by the 1202 planning commission.

We have subsequently learned from general counsel that the testimony that you have just cited, namely, that applications to the fund have to go through those commissions, is not so. The counsel has ruled that that is not contained in the law, and it was gratuitous on our part in contemplating the function of those commissions.

Since both of those programs in which Congress mandated that the funds would be approved only upon going through the planning commission are not being funded, and the President is not requesting funds for either of those programs, we felt that it would be an act of irresponsibility to cause those commissions to be established.

Mr. FLOOD. You are asking for a lawsuit there, mister.

Dr. MARLAND. I hope you are hearing all I am saying. It is optional.

Mr. FLOOD. That is what your general counsel said.

Dr. MARLAND. Yes, sir. The law is quite clear on that.

Mr. FLOOD. I do not stand in awe of that, believe me. I see general counsels come and go like Greyhound buses around here.

Dr. MARLAND. Sir, you must know, too, then, that we who work in education listen to our counsels, and we do largely what they say as they interpret the statutes of Congress. The commissions are optional at the State level, but they are required——

Mr. FLOOD. I wonder if he would like to go to the Supreme Court as the court of original jurisdiction——

Mr. MILLER. He will refer you to the Justice Department.

Mr. FLOOD. Of course. That is right.

Dr. MARLAND. Let me come to our conclusion where we are now, because it is important to your question. Dr. Ottina is in the process now of drafting a letter to all States and governors that will say: "Since the two programs in question which were required for treatment by these commissions are not at this time being funded, we will not require the establishment of the commissions. You are free to establish them, of course, if you want to, but since they are now optional with you, we are not requiring that the application to the Fund go through them because the law never required that they go."

We prepared regulations on this, Mr. Chairman. We circulated the regulations to some 600 addresses throughout the land. We received 150 responses, in many cases offering very good corrections and suggestions. We spent the last 6 months going through this cycle. Now we have come out at the point where we are saying in spite of all the good work which has been done to establish what might be very desirable commissions, there is enough anxiety in the States about these commissions being overlapping with what is already there, confusing authority, that unless we have programs that they are going to administer, we will be creating a kind of scarecrow without anything to do.

John, would you amplify that?

[Off the record.]

Mrs. GREEN. You do not recommend any money for the commission the chairman questioned you on this morning. You said that you interpreted as optional, and that you are not requesting any funds for title 10.

What will the situation be if the Legislative branch of the Congress, in its wisdom, decides to add some funds for title 10 and the Senate agrees and it becomes the law in the appropriation bill and then there is no commission?

Dr. MARLAND. If that becomes law, we would have to then instruct the States accordingly and they would have to establish their commissions.

Mrs. GREEN. When you sent out the statement to the States that they did not have to, did you take contingencies into account?

Dr. MARLAND. Yes, we did.

Mrs. GREEN. Is it in your letter to the States?

Dr. MARLAND. It implies at least that this could happen at a later date.

Mrs. GREEN. Does it imply that it could happen this year?

Dr. MARLAND. We didn't specify the date.

Mr. FLOOD. If the lady will yield, could we have a copy of that letter for the record at this point?

[The information follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
Washington, D.C., March 7, 1973.

DEAR COLLEAGUE: The purpose of this letter is to bring you up to date on recent developments concerning the State Postsecondary Education Commissions authorized under section 1202 of the Higher Education Act, as amended.

We received almost 500 substantive responses to our invitation of December 4 for interested parties to comment on the preliminary report from the Task Force on State Postsecondary Education Commissions. These comments were analyzed by the task force during the period of December 18–January 12, and a revised report, including preliminary draft regulations, was transmitted from the task force to this office on February 1.

The Education Amendments of 1972 had envisioned major functions and responsibilities for the State Postsecondary Education Commissions in connection with the new authorizations for comprehensive statewide planning (HEA section 1203), community college education (HEA title X, part A), occupational education (HEA title X, part B), and improvement of postsecondary education (GEPA section 404). In addition, the law had authorized the section 1202 State commissions to serve as State administrative/planning commissions for existing programs in community services and continuing education (HEA title I), equipment for undergraduate instruction (HEA title VI), and grants for construction of undergraduate academic facilities (HEA title VII).

However, the Federal budget for fiscal year 1974 provides almost no functions for the section 1202 State commissions to perform. The community service, instructional equipment, and academic facilities grant programs are scheduled to be terminated, and no funding is provided to implement any of the community

college or occupational education authorities. Furthermore, while the budget does provide $15 million to support projects and programs for improvement of postsecondary education, it is our opinion that the implementation of the improvement of postsecondary education authority alone does not warrant the establishment of the commissions at this time.

Under the circumstances, it has been determined that we should indefinitely defer our plans for distribution of the revised report of the task force, and suspend all activity relative to establishment of the section 1202 State commissions.

We want to express our thanks to all of you who have made suggestions and comments concerning the section 1202 State commissions, and to assure you that your thoughts have been taken seriously into account in the revisions to date.

Sincerely,

JOHN OTTINA,
Acting U.S. Commissioner of Education.

STATUS OF FEDERAL SUPPORT FOR SECTION 1202 STATE COMMISSIONS

The revised report of February 1, 1973, referred to in Dr. Ottina's letter of March 7, 1973, was prepared by an HEW task force on State postsecondary education commissions. The work of the task force began last fall prior to decisions on the President's 1974 budget. As such, the task force report explored the broadest possible range of functions and responsibilities for the State commissions and developed draft regulations to carry them out.

The 1974 budget, however, provides few, if any, functions for the section 1202 State commissions to perform. Clearly the revised report was outdated and could provide the wrong signals concerning administration intentions in this area. For this reason we indefinitely deferred our plans for distribution of the revised report of the task force and suspended all activitty relative to establishment of the section 1202 State commissions.

The fiscal year 1974 budget, however, includes $3 million under the higher education appropriation request for the support of State postsecondary education commissions. As a result, the $3 million estimate is being reexamined and both the Congress and the States will be notified as soon as possible concerning our plans in this area.

USE OF COLLEGE DORMS

Mrs. GREEN. Mr. Secretary, one question which is rather irrelevant to what we have been talking about, but it is my understanding that a large number of dorms on college campuses are no longer occupied by students; the Federal Government has a tremendous amount of money invested in those. A few of them, I understand, are closed. Others are used as administrative offices, et cetera.

Has anybody given any thought to remodeling, changing these dormitories, and making them homes for the elderly, especially where a dormitory is on a campus where there is a strong geriatric program?

It seems to me it would be perhaps a happy use of unused space. I think the budget does not reflect the terrible needs of the elderly.

Secretary WEINBERGER. Well, a short answer to your question is, Mrs. Green, that I have not given consideration to this, nor am I competent at this point to speak on the degree of occupancy of some of the federally assisted dormitories. But I would be delighted to look into it and see if there is any possibility of joint usage or usage of this kind.

One difficulty that presents itself, and it does not necessarily arise from a desire to kill the plan or anything of that kind, would be that

the location of the dormitories might not be the most appropriate or congenial for the elderly. But in any event, we can certainly look and see what possibilities are in there.

Mrs. GREEN. I realize many of them would not. But there are some universities that have extensive geriatric programs.

Mr. FLOOD. I might say, Mrs. Green is probably aware of this. Such a proposal has been or is about to be made by a very well known New England university on just this very thing.

Mrs. GREEN. I did not know that.

Mr. FLOOD. Yes. The question of the physical location, as you have quite properly raised and Mrs. Green identifies, the physical location of that particular dorm on that particular campus was affirmatively raised by the petitioner, and apparently it is such a location that it would not be a problem to concern you. But that is about to be or has been presented to somebody for just the very purposes you speak of.

Secretary WEINBERGER. Yes, it could be a very good idea.

Mrs. GREEN. Thank you.

GOVERNMENT DECENTRALIZATION

I would like to go to four concerns of mine now. This may be political heresy. But I do have four concerns and I have had them for a long time. The proliferation, the duplication of programs—and I think you understand the number that we have in the Government—I completely support those who are recommending that we move from categorical to general aid in educational programs and manpower training programs.

I am not enthusiastic about revenue sharing. I wish that you could find another name for that.

Secondly, I have been very much concerned about the decisionmaking in Washington, and I agree with you it seems very arrogant for us to sit here and think we can act as a national school board on the needs of all the country.

So I support the move toward decentralization. I think if we do not have it, the whole Government is going to fall of its own weight—it's not working. I don't think it will work with all decisions made in Washington.

The third concern is on the student assistance programs.

Mr. Obey directed several questions and we have directed several questions to other witnesses. I am not going to repeat those.

But let me turn to the philosophy in your own statement if I may, Mr. Weinberger.

Secretary WEINBERGER. Yes.

Mrs. GREEN. On page 2 you say the primary Federal role in the area of human resources is to provide income support to people in need in a manner which fosters individual independence and initiative.

On page 24, bottom of page 23, and top of page 24, you say these two initiatives are a significant part of our effort to move power and decisionmaking away from the Federal Government in Washington.

Now let's go to the BOG's and the existing programs.

Dr. Marland and Mr. Miller and others have repeated several times to this committee that we are going to increase the economic opportunity grants, the outright grants, fivefold. That under EOG 300,000 students received them; we are going to give BOG's to one and a half million.

But I do not understand, with the administration's philosophy and the philosophy which you have stated, that you cut work-study $20 million and, like Mr. Michel, I worked my entire way through college and did not have a dime of Federal aid; I happen to think the work-study program is one of the best programs we have and maybe it is the Puritan ethic in me, I think that kids appreciate an education if they work more than if money is just given to them. It is the same philosophy opposing a guaranteed income. I would support a guaranteed job program with the Government as the employer of last resort.

You also now are phasing out NDEA. You leave what is in the pipeline as a revolving fund but recommend phasing it out. This is a program where a kid borrows and they ought to be made to better understand that if they borrow, they are to repay.

Now I would think the administration policy would be moving in the opposite direction instead of giving five times as many just outright grants, increasing those fivefold, and cutting back on work opportunities, and cutting back on loans, that kids are going to repay under the subsidized interest payment.

The second concern: The administration wants to move power and decisionmaking away from the Federal Government in Washington. In recommending BOG's, you're supporting a policy of taking decisionmaking away from the local college and imposing a national standard.

Secretary WEINBERGER. The answer I think, Mrs. Green, is that the basic opportunity grants are set in an amount which will not cover the full cost of the education, and for the very reasons you describe, which will require outside income to be applied, either in the form of a privately arranged loan, a guaranteed loan, a loan from a university or private scholarship, or any one of a number of different things, including specifically work by the student.

So we are trying to move toward a situation in which we make a direct grant to the student who could not otherwise afford it for maybe half of his education. It will not be enough to take care of his whole college. So he will have to engage in some work or some fund-raising himself.

I think we are satisfied from what I would conceive to be your very proper concern about this. I agree with you.

I think it is a desirable thing to have a situation in which a student invests some of his own time, energy, and money in acquiring an asset, namely, his education.

Mrs. GREEN. I appreciate what you said, but of course that is exactly the situation at the present time before the BOG's were ever conceived by anybody. Under EOG and work-study and NDEA, everything you described was true.

My question is, Why are you increasing the outright grants fivefold and decreasing the opportunities to work and to borrow money under NDEA?

If I may add this, as I have watched this in the last few years, I have seen student aid programs that have been changed from serving education needs of students into plain welfare programs; the emphasis has been placed almost exclusively on the disadvantaged and, as a result, we encouraged colleges to waive their admission standards; high school graduation today is nothing like high school graduation when I finished. It becomes less meaningful each year. In many instances—we push a kid out of high school, give him a certificate because he is physically too large—he's a discipline problem, et cetera.

Now he can enroll in a university, many universities in the country have open enrollment. Then the day the student enrolls, he or she is entitled to every one of the federally financed student programs. This means, those students of the lowest income are entitled to the largest outright grant and they are entitled to the loans and work-study (if they want to work).

I know that at some of the universities, as a result I think of OE policy, we have encouraged universities to accept students who are in no way able to meet the academic standards. We are actually providing fourth- and fifth-grade reading and arithmetic on a compensatory basis and we call it university work. And those kids are eligible for all of our university student aid programs we are talking about.

The son or daughter of a middle-income family who is highly motivated and has good academic records very often cannot get the financial student assistance, because there is not enough to go around and we give it to the most disadvantaged. This is a philosophy that really is beyond my comprehension. It seems to me "needy" middle-income students should be considered on the same basis as other "needy" students.

Secretary WEINBERGER. Mrs. Green, I do not argue with you on many of the points you have raised. I would say, however, that the basic opportunity grants are geared so they can benefit a great many different income levels of students and that is why we have taken such care in trying to draft the family contribution scale in a way that will reflect that. The work-study program is being maintained at the same level as 1973, at $261 million.

Mrs. GREEN. The what?

Secretary WEINBERGER. The work-study program is being maintained and the insured loans programs is also going up. The only substitution that is coming is the basic opportunity grant instead of the direct Federal loan.

I think that can be justified on the ground that the basic opportunity grant plus these other sources in the community and in the colleges will cover the total educational needs of the student and leave him with a smaller but significant amount to repay or to earn while he goes through the college.

I do not think the basic opportunity grant is a program which is designed entirely to serve just the poor. It is designed to be a flexible program that will take advantage of available family contributions,

but serve a student who should have a college education but is presently denied because he is not able to have any kind of family contribution nor to work enough to pay for the whole thing.

I would say that it is what I would consider to be a nice mixture of available kinds of financing to meet different needs, but I do not think there has been any slighting of middle-income family with deserving students who otherwise would be unable to get into the college. It is certainly not designed to do that anyway.

Mrs. GREEN. It seems to me either by design or default this administration is squeezing out the middle-income family, and I think this view is supported by the majority of people.

Secretary WEINBERGER. The criticism is almost always the other way, that we are doing too much for the silent majority middle-income group, and not nearly enough for people at the other end of the economic scale.

We believe the basic opportunity grant is a program which is flexible and designed to meet actual needs and to reflect differing kinds of needs.

Mrs. GREEN. Mr. Weinberger, when Dr. Marland and his associates were here, he said that there would be no students who would be eligible for basic opportunity grants who would not be eligible for an economic opportunity grant, and admitted there was far more flexibility in the economic opportunity grant program, work-study, and NDEA loan, than there is in the combination which the administration is recommending.

This is my strong view, and I think all of the evidence supports this. But I will not go on with this.

RESEARCH CONTRACTS AND GRANTS

The fourth consideration which I have—and I will save my detailed questions until tomorrow—is the tremendous waste over the years that I have seen in research, in contracts and grants, first in the Office of Economic Opportunity, where we did a detailed study with which you are familiar; and now the study we have done in the last 2 years in the Office of Education.

The Office of Education, in terms of procedures and their monitoring programs and evaluation, is far worse than the Office of Economic Opportunity. Billions have been spent, can be documented. I would say many, many millions of dollars have simply gone down the drain. There have been no results from the studies made or the grants that have been given. There have been cost overruns in many cases that compare favorably—I do not know whether that is quite the word—with the military. Evidence of collusion, of outright corruption in some instances.

We continue to spend and waste. You are asking for $119 million, and then $162 million for NIE.

I have asked and I expect to hear Friday morning why NIE is going to be different from what we have been seeing of O.E. in research and contract and grant procedures.

For the record, I wonder if you might supply the amount that is in the 1973 supplemental and the amount that you are asking for in the 1974 budget for not only NIE, but the research that will still be

done in the Office of Education and in other departments in HEW that might be connected with education. I would like you to take into consideration the amount of Federal funds given to an institution or to a State, and to the subcontractors.

Mr. FLOOD. Do you want that done by a referral to the budget itself by page, article, and section, or would you rather have that right here now for those limited things?

Mrs. GREEN. I would like to have it in the hearing record, if I may. I have not been able to put it together in the whole budget operation. Some of it is hidden.

Mr. FLOOD. You would like that inserted here now for these specific things, instead of a reference to the budget by page and section.

Just put those three or four things in right here.

[The information follows:]

In fiscal year 1973 $415 million was spent in educational research, the amount for fiscal year 1974 is $452 million. This amount is distributed as follows:

[In millions of dollars]

	Outlays	
	1973 estimate	1974 estimate
Educational research:		
Educational development	93	59
Elementary and Secondary Education Act	153	130
Education for the handicapped	30	30
Occupational and adult education	44	39
Emergency school aid	2	2
Library resources	3	2
National Institute of Education	43	118
Office of Child Development	11	19
National Foundation on the Arts and Humanities	13	22
National Science Foundation	23	30
Total	415	452

Mrs. GREEN. I guess I would have to share Mr. Obey's views that this is really one of the great disappointments in terms of the budget recommendations of this administration that we seem to be willing to continue to pour hundreds of millions of dollars down the drain for studies that nobody in God's world reads except the author, maybe.

The budget, in my judgment, in no way reflects what I think is a crisis like this country has never seen before at the elementary and secondary education level. I think every single day we are seeing our schools, especially in our urban centers, deteriorating, and violence is the order of the day, where neither any learning nor any teaching can take place.

I would be so much happier if I saw a tightening up on all of these countless research grants and programs, and some of that money transferred over to actual classroom use.

My school district closed 21 days early last year because there was not enough money to buy chalk or to pay teachers. Then we talk about carrying on a lot more research to help them.

If they had the money, they would keep the doors open and pay the teachers and buy the chalk; they would not be able to buy the new things that may be good or bad that may be recommended from the new research. That is not what our schools need.

I think our schools and teachers and principals and educators know far more now about what should be done, and just don't have the funds with which to do it. If we could transfer some of that terrible waste in esoteric research and some of the other things and put it into the classroom, I think this administration would be performing one of the greatest services to this country.

Secretary WEINBERGER. I would say one thing in response to Mrs. Green, and that is, I share her deep concern about the amount that is going into research, the disposition of those studies, and the sole-source contract problem, which is something we were addressing yesterday at our staff meeting in the Department, apparently for the first time. We are very concerned about that kind of award and the fact that the awards may go to people who are set up in business especially to receive awards.

We have no evidence, but we are certainly examining that whole area very carefully.

We are going to set up and insure that we get a very careful evaluation of the work that is done, because there is certainly no point in asking the Congress for more research funds unless we can demonstrate to the Congress that we have gotten some use out of these funds.

We simply hope that the NIE, which is under the direction of Dr. Glennan, who is Mr. Carlucci's close associate and worked with him in the OEO, will show an improvement and some major results. I certainly hope so. Without it, I would not feel in any sense justified asking Congress to continue research expenditures at that level.

There can be some good come out of it. If we can get some we can see it reflected in long-range policies that will be of great value to everybody, but it can also be thoroughly wasted, and that is something we are keenly aware of and we would be delighted to have any information or suggestion or lead you might have to help us in this.

REGIONAL MEDICAL PROGRAMS

Mr. FLOOD. Mr. Secretary, as you know or have heard, I do not make a practice of writing letters of righteous indignation to you fellows downtown, but I have written two within a week or so, and you happen to be the recipient of both of them.

The one has nothing to do with this question of head-on collision between the executive and the legislative vis-a-vis constitutional prerogatives, and so on. It deals entirely with the question of the operations of this contract business by the Cancer Institute of NIH. We are going to go into that with the Director of the Institute, and so on.

We will be ready for that when they get here. We will examine these people from the Institute.

In the meantime, before they do appear, I wish you would have your people answer that directly for me.

The second letter I handed you the other day is on the RMP's. As I indicated, that is one of our prize pigeons. That being the case, I do not want you to develop it at this point, but I expect you to get an answer to me. I am addressing myself to that part of the letter in which I indicate my opposition to the administration's proposal for eliminating or shutting down the RMP's. That is one thing.

The purpose of my handing you the letter is because of the very serious time problem involved.

The RMP people have been over there for 2 or 3 weeks, 200 or 300 of them, day and night, giving birth to these pages of directions, after the telegram to everybody in the region. This must be done, a fait accompli, by the 15th.

To me, it is transparent and obvious that these are fantastic directions to all these hundreds of people, with 2 or 3 weeks' notice, to produce, sent out to these people in the field, to execute this thing by March 15.

If you know as much about these RMP's as we here know, both the good and the bad, a mandatory terminal date of the 15th of March is utterly fantastic. It would shock you, it is so appalling. Mismanagement could result. So many things have to be done. There are a thousand and one things you know have to be done by March 15 that cannot conceivably be done.

I said in the last part of my letter to you that 90 days to look at this is reasonable. I do not like to say it is ridiculous, because your people are not ridiculous. I think under the pressure of the new unmasking and new philosophy they knocked themselves out to say, "Look at me, how good I am."

Secretary WEINBERGER. Mr. Chairman, I did have a chance to look over the directions. The directions were not requesting action to be taken. They were requesting the development of a plan.

They were also doing what I think is responsible and necessary, and that is, notifying the people concerned that there was a budget request or a nonrequest by the President that would put them out of business.

Mr. FLOOD. No quarrel with that.

Secretary WEINBERGER. And they should get ready.

But there wasn't any direction, as I read it, that they should walk away and leave the installation by March 15. It was just the development of a plan as to how they would proceed.

Mr. FLOOD. Will you get that to me tonight? The reason for my midnight dictation of the letter to my people was that I couldn't believe it myself, but I was not sure. I knew you did not know. I wanted to be sure. I should have something as soon as possible.

Secretary WEINBERGER. As soon as we can. I cannot guarantee tonight.

Mr. FLOOD. They do not know there is an appeal. You scared hell out of them. They are right if that was the intent. If it is not, they should know.

Secretary WEINBERGER. It was to develop a plan, not to execute it.

Mr. FLOOD. Some of them did. Believe me, most of them did not. I do not mean these are fakers. These are bona fide people who really were appalled. I was sure that was the answer, but I did not know.

Mr. MILLER. There is another sentence in that letter which relates to a target of shutting down by June 30 or shortly thereafter.

Mr. FLOOD. But that document of 10 pages, single spaced, was so unlike those people that I do not know what happened to them. I have known these people for years, and they have never acted like this before. I just could not understand.

Secretary WEINBERGER. The document is headed, "Requirement for a June 30 plan to be submitted no later than March 15."

Then it starts out in the usual way, 15 copies of the following are to be sent, and so on.

Mr. FLOOD. The issue deals entirely with the confrontation, but the last part is a practical matter.

REPORTS ON VARIOUS PROGRAMS

Thank you very much, Mr. Secretary.

We will place in the record the usual comprehensive statements regarding the Department's activities in various fields, such as aging, mental retardation, alcoholism, drug abuse control, family planning, and so on.

[The comprehensive statements follow:]

SPECIAL REPORTS

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

House Appropriations Subcommittee Supplementary Data

(Fiscal Year 1974 Congressional Hearings)

MENTAL RETARDATION PROGRAMS

Prepared by: The Office of Mental Retardation Coordination

February 1973

COORDINATION OF MENTAL RETARDATION PROGRAMS

Coordination is the key to fulfilling the Federal commitment in combating mental retardation. Coordination is vitally important in administering the many varied and diverse programs serving the retarded. It is a fact that mental retardation cannot be confined to any single health, education, rehabilitation or welfare program or any one disciplinary group. A coordinated program, therefore, must provide a broad spectrum of activities designed to attack the problem of mental retardation wherever it touches the lives of people.

During Fiscal Year 1973, an estimated $1.3 billion will be obligated by the Department of Health, Education, and Welfare for mental retardation programs. These programs cover most aspects of the retarded person's life. They range in diversity from maternal and infant care to income maintenance for the aged retarded. Many agencies of the Department administer programs which affect the mentally retarded; it is extremely important that these efforts be focused and targeted so as to prevent duplication and gaps in program services.

The 1962 Report of the President's Panel on Mental Retardation recognized the importance of coordination both at the national and local levels. The Report further endorsed the concept of a Departmental committee composed of agency representatives advising the Secretary on activities related to mental retardation. The concern of the Panel resulted in the strengthening of the Secretary's Committee on Mental Retardation in 1963. The Committee had previously been known as the Departmental Committee on Mental Retardation, since its establishment in March of 1955.

Over the next several years the mental retardation program of the Department was expanded and extended. In 1968, in a move designed to make the Secretary's Committee more responsive to prevailing needs, the Secretary reconstituted the membership of the Committee. The membership of the Committee had previously been composed of middle level agency personnel. Through the new action the membership was altered and now included the top level executives of the Department with the Under Secretary serving as Chairman. In addition, Regional Office Staff were also assigned to coordinate mental retardation Regional activities.

The mission of the reconstituted Secretary's Committee on Mental Retardation remained the same; i.e., the responsibility for coordination of the Department's program and activities affecting the mentally retarded.

On January 25, 1972, the Secretary of Health, Education, and Welfare directed the establishment of the Office of Mental Retardation Coordination. This new unit replaced the Secretary's Committee on Mental Retardation and is responsible for the duties formerly assumed by that Office. Specifically, the Office of Mental Retardation Coordination is responsible for the following activities:

- Serves as a means of coordination and evaluation of the Department's mental retardation activities.

- Serves as a focal point for consideration of Department-wide policies, programs, procedures, activities and related matters relevant to mental retardation.

- Serves in an advisory capacity to the Secretary in regard to issues related to the administration of the Department's mental retardation programs.

- Serves as liaison for the Department with the President's Committee on Mental Retardation.

There are two coordinating committees under the Office of Mental Retardation Coordination: Steering Committee: Consists of representatives of the Office of the Assistant Secretary for Health and Scientific Affairs, Social and Rehabilitation Services, Health Services and Mental Health Administration, National Institutes of Health, and Office of Education. This group will be responsible for advice and consultation in the implementation of the Office functions. Mental Retardation Interagency Committee: Consists of representatives of all mental retardation operating programs. Its functions will be to provide a means of communication, information exchange and program development for agency staff concerned with Federal mental retardation activities.

The Secretary has also directed that an interagency coordinating committee be established in each of the Department's Regional Offices. At the present time, the Regional Offices are served by a mental retardation coordinator, located in the Office of the Regional Director. The new committee is the responsibility of that staff member.

The Office of Mental Retardation Coordination places special emphasis on coordination and implementation of the President's proposals to reduce mental retardation, and to minister more effectively to those affected by this problem. To carry out this mandate the Regional Committee evaluates the impact that the Department's mental retardation programs have on the mentally retarded in local communities. The Committee determines the extent of coordination and obtains recommendations for necessary improvements in coordination. The development of volunteer programs for the mentally retarded and of programs for the deaf-blind-retarded is given special emphasis.

The Office of Mental Retardation Coordination maintains a distribution list of over 10,000 names of persons and organizations which receive publications distributed by this Office and agency publications in the area of mental retardation. The Office of Mental Retardation Coordination has also represented the Department at national meetings of the American Association on Mental Deficiency, the National Association for Retarded Children, and the Council on Exceptional Children. Publications and information were provided by Office staff to delegates during these meetings.

SUMMARY OF MENTAL RETARDATION ACTIVITIES

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

Most States have enacted laws related to phenylketonuria (PKU) and make screening for this disorder mandatory. Throughout the country approximately 90 percent of the total registered live births are being screened.

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 and crippled children's agencies use funds administered by the Maternal and Child Health Services for programs designed to: increase the health and welfare services available to the retarded, enlarge existing mental retardation clinics by adding clinic staff, increase the number of clinics, extend screening programs, provide treatment services for physically handicapped retarded youngsters, increase inservice training opportunities, and prqvide 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.

The Health Services and Mental Health Administration, in conjunction with the Division of Developmental Disabilities, Rehabilitation Services Administration, Social and Rehabilitation Service, supports projects for the retarded which have service components of well-integrated comprehensive health and mental health programs.

The Division of Developmental Disabilities 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.

The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) was amended October 30, 1970, by the Developmental Disabilities Services and Facilities Construction Act of 1970 (P.L. 91-517). The new Act was designed to provide the states with broad responsibility for planning and implementing a comprehensive program of services and to offer local communities a strong voice in determining needs, establishing priorities, and developing a system for delivering services. The scope of the present program broadened to include not only the mentally retarded but also persons suffering from other serious developmental disabilities originating in childhood, including cerebral palsy, epilepsy and other neurologically handicapping conditions. On December 28, 1971, the Division of Developmental Disabilities issued proposed regulations for the administration of this Act. They are still in the process of being evaluated in light of comments received prior to final issuance.

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. The amendments of 1969 (P.L. 91-230), signed into law April 13, 1970, consolidated all legislation relating to education of handicapped children in Title VI. The Bureau of Education for the Handicapped in the Office of Education administers Title VI, which is now referred to as "The Education of the Handicapped Act."

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 physical education and recreation for the mentally retarded and other handicapped children.

Research

The National Institute of Child Health and Human Development in the National Institutes of Health will support mental retardation research and research training grants to an estimated amount of over $18 million in fiscal year 1973. The National Institute of Neurological Diseases and Stroke, the National Institute of Arthritis and Metabolic Diseases, among other Institutes of the National Institutes

of Health, also contribute to mental retardation research. These contributions directly or indirectly extend the efforts of the Mental Retardation Branch of the National Institute of Child Health and Human Development.

The Division of Research in the Bureau of Education for the Handicapped of the Office of Education now supports six Research and Development Centers to focus on the more difficult problems of evaluation, communication, instructional procedures, etc. of handicapped children. Through the combined efforts of Research and Development Centers and programmatic research, definite improvement in instructional procedures may well be realized within the next several years. New systems of dissemination are being built upon the foundations already developed by the Instructional Media Centers 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.

The Rehabilitation Research Branch Program of the Division of Research and Demonstrations of the Social and Rehabilitation Service supports 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 to community participation. Current programs of research and demonstration are increasingly concerned with new approaches to retardation in ghetto areas, and especially in model city neighborhoods. Emphasis is placed on the coordination and focusing of all relevant community agencies on the problems of the retarded. The Research and Training Centers Division continues to sponsor three Mental Retardation Research and Training Centers. They are continuing to seek out the cause of retardation, to assess the potential for education and rehabilitation, to develop training and remedial programs, to ascertain their actual learning and socialization difficulties, and to develop methods to more adequately motivate the retarded for work.

Research grants administered by the Maternal and Child Health Service 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. Some examples of support areas include studies of the epidemiology of mental retardation in a rural county, sensory integrative processes and learning disorders, children with congenital rubella, perinatal casualty reports, galactosemia screening, and sensory motor activity in the neurologically handicapped child.

Construction

The university-affiliated facility construction program is administered by the Division of Developmental Disabilities, Rehabilitation Services Administration, Social and Rehabilitation Service.

This construction program is authorized under P.L. 91-517, the Developmental Disabilities Services and Facilities Construction Act of 1970, which supplants in part and expands the old mental retardation law of 1963 to allow for grants to States for planning, construction, administration, and services for the mentally retarded, cerebral palsied, epileptic, and other neurologically disabled individuals. University-affiliated grants are made also to cover the costs of administration and operation of facilities and for the training of physicians and other professional personnel vitally needed to work with the mentally retarded.

Continuing progress is being made in developing projects for the construction of community facilities for the mentally retarded in widely scattered areas throughout the country. Facilities constructed under this legislation are designed to provide diagnosis, treatment, education, training or care for 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 Administration administers a program which contributes to the maintenance of the mentally retarded through the payment of monthly benefits to eligible individuals.

OFFICE OF CHILD DEVELOPMENT

Introduction

In July 1969, the Office of Child Development (OCD) was established in the Office of the Secretary of HEW to serve as a point of coordination for Federal programs for children and youth, and to act as a national advocate of services for children. Although a major concern of the agency is the preschool child, OCD also plans and develops programs for all children and youth and their families.

The Office of Child Development has two chief bureaus: The Children's Bureau and the Bureau of Child Development Services. The Children's Bureau, formed in 1912, was transferred to OCD from the Social and Rehabilitation Service of HEW. Head Start, a comprehensive program for disadvantaged preschool children, was launched by the Office of Economic Opportunity in 1965 and delegated by that agency to OCD in September 1969.

While OCD does not directly operate any programs for the mentally retarded, the agency has an overall advocacy and leadership responsibility for all children, including children with mental retardation. In line with this responsibility, the Office of Child Development may help plan and recommend programs to deal with mental retardation; develop standards and guidelines for such programs; and provide technical assistance to States and public and private agencies in efforts to help mentally retarded children and youth. OCD works cooperatively with the President's Committee on Mental Retardation, the Office of Mental Retardation Coordination, the SRS Division of Developmental Disabilities, and other HEW agencies.

A. Children's Bureau

Project on Classification of Exceptional Children

OCD is serving as lead agency for an HEW study of appropriate and inappropriate classification of children as physically handicapped, mentally retarded, emotionally disturbed, delinquent, or culturally deprived. Funded by OCD, OE, NIMH, NICHD, and SRS, the $369,000 Project on Classification of Exceptional Children grew out of the Secretary's concern for the way children were "labeled" by health, judicial, social, educational, mental health and other agencies for administrative purposes, frequently in a manner detrimental to children and their families.

Dr. Nicholas Hobbs at Vanderbilt University has organized a national advisory committee, with 30 subcommittees throughout the country to assist his staff in examining the sociological, legal, and administrative bases for classification and the effects on children and families. In the fall of 1973, a collection of reports will be issued with policy recommendations for national, state, and local public and private agencies, courts, clinics, etc. Liaison with Federal agencies is maintained through an HEW Interagency Task Force, chaired by Dr. Frederick Green, Associate Chief, Children's Bureau, OCD. Maternal and Child Health Services of HSMHA is represented on this Task Force.

B. OCD Cooperative Affiliations

(1) OCD participates as a member of the Mental Retardation Interagency Committee chaired by Wallace Babington, Director, Office of Mental Retardation Coordination.

(2) OCD is a member of the Board of Advisors for an SRS (Division of Developmental Disabilities) project implemented by the National Association of Private Residential Facilities for the Mentally Retarded, which is gathering comprehensive service data provided by private residential facilities for the mentally retarded.

(3) The Office of the Secretary requested HEW recommendations for improving the care of mentally retarded residents at Willowbrook School in New York. The Office of Child Development is cooperating with NIMH, OMRC, SRS, OE, and other HEW agencies in planning for implementation of the HEW recommendations for Willowbrook, especially in evaluating the contribution made by parents and citizens in improving conditions at the institution.

(4) OCD provides consultation to SRS-Medical Services Administration in its development of Standards for Payment for Intermediate Care Facility Services in Institutions for the Mentally Retarded, under provisions of Title XIX of the Social Security Act.

(5) OCD provides consultation to SRS, Developmental Disabilities Division in development of forward plans for deinstitutionalization of care for mentally retarded children, and upgrading care for those children who still need residential care.

(6) OCD brought together various HEW agencies on the subject of childhood autism, the need for clarification of programmatic responsibilities, and the need for collaboration.

C. Head Start

Head Start, under the mandate of the 1972 amendments to the Economic Opportunity Act, will help to improve the quality of the program for all children, and especially handicapped or retarded children whose special needs must be recognized and individually met.

The Office of Child Development is now actively developing a collaborative program with the Bureau of Education for the Handicapped to integrate the resources of BEH's Handicapped Children's Early Education Program projects into a number of local Head Start programs. In order to provide appropriate services for a Head Start child who may be emotionally disturbed, OCD is collaborating with the National Institute of Mental Health to integrate the resources of NIMH's Community Mental Health Centers into local Head Start programs in the CMHC catchment areas.

Some examples of on-going coordination of services may be found in the Anchorage, Alaska Head Start, in which the Bureau of Education for the Handicapped provides a special education program to deaf and hard-of-hearing Head Start children. In Huntington, West Virginia the Community Mental Health Center provides Psychological Services to Huntington's Head Start program. This type of collaboration will be continued in FY 1974.

OFFICE OF EDUCATION

Report on Mental Retardation
(FY 1974)

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 and training of and research on 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 overarching goal for Federal efforts in the area of education for the handicapped is to equalize educational opportunities for handicapped children. Less than 40 percent of the nation's more than six million school-aged handicapped children receive needed special education services. Federal funds for the education of the handicapped currently average less than $30 per child.

The main issues surrounding the Federal role in education for the handicapped are:

1. How can the limited available Federal resources be used in a catalytic and stimulative manner to bring quality educational services to the greatest proportion possible of the unserved 60 percent of the target group?

2. What is the best use of Federal resources in preventing identifiable handicaps from becoming serious disabilities in school and adult life?

3. What educational techniques and methods can be developed, introduced and adopted to insure handicapped children job skills to enter adulthood with a high probability of participating in society in a meaningful manner?

Five objectives have been adopted for the Federal programs for education of the handicapped:

I. National Commitment

To assure that every handicapped child is receiving an appropriately designed education by 1980 (75% by 1977).

II. Increased Services

To assist the States in providing the appropriate educational services to 75% of the handicapped by 1977.

III. Career Education

To assure that by the year 1977, every handicapped child who leaves school has had career educational training that is relevant to the job market, meaningful to his career aspirations, and capable of bringing him up to his fullest potential.

IV. Manpower Development

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To assure that all handicapped children served in the schools (75% by 1977) have a trained teacher competent in the skills required to aid the child in reaching his full potential.

V. Early Childhood Education

To secure the enrollment of 750,000 (75%) preschool aged handicapped children in Federal, State, and local educational and day care programs.

In order to efficiently implement the program and carry out the Federal mandate, the Bureau is administratively organized into three major divisions under the Office of the Associate Commissioner. Each of the major Divisions -- Training, Educational Services, and Research -- functions as an integral element in the total Bureau program for handicapped children. The following pages describe the functioning of each division as it relates specifically to mentally retarded children.

I. Division of Training Programs

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 supervisory, consultative, 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 Learning Disorders 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. According to data received from the State Plans submitted by State education agencies under Part B, Education of the Handicapped Act, for fiscal year 1972 approximately 484,000 teachers and other personnel were needed to provide educational services to all handicapped children. Approximately 115,000 or 24 percent of the preceding personnel were needed in the area of mental retardation. Still, only 73,400 or 64 percent of the latter number needed for the education of the mentally retarded were employed in 1972 and many of these persons lacked full certification. If general turnover rates applicable to the education profession are applied, approximately 8 percent of the special education teachers will leave the field each year. At current rates of preparing professional personnel in mental retardation more than twenty years will be needed to close the gap between supply and demand, if all other variables remain constant.

Partially as a result of the teacher shortage, approximately two-thirds of the more than six million handicapped children of school age and one million handicapped children of preschool age are not receiving the 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 education program inappropriate to their needs. Similarly, college and university personnel so essential to the preparation of teachers are also in short supply.

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 traineeships 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 traineeship recipients indicated that approximately 75 percent of all programs in mental retardation at colleges and universities are directed or coordinated by these individuals.

A study conducted in February of 1964, of 245 former P.L. 85-926 traineeship 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 trainees indicated that they were currently employed by a college or university, 80 were employed in an administrative or supervisory capacity (19 of these were employed by State educational agencies), and 54 returned to the classroom as teachers of the mentally retarded.

On 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.

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. On April 13, 1970, Public Law 91-230 was signed into law, effective June 30, 1970. Title VI of this law consolidates all of the prior legislation relating to the handicapped children which the Bureau of Education for the Handicapped administers. Title VI of Public Law 91-230 is referred to as "The Education of the Handicapped Act."

These appropriated funds have been used as stipends for students as well as to support colleges, universities, and State education agencies. Since P.L. 85-926 was passed in 1958, approximately 31,000 traineeships have been awarded to individuals preparing to work with mentally handicapped children. This includes both short-term and full academic year awards. Table I gives a summary of the awards made in mental retardation since the passage of P.L. 85-926. This table does not include approximately $700,000 awarded to State education agencies for short term workshops and special study institutes for teachers of mentally retarded.

Table I - Awards made in the area of mental retardation since the passage of P.L. 85-926 (Fiscal Years 1960 through 1972)

Fiscal Year	Number of Traineeships	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	6,366	193	53	9,382,084
1970	6,171	200	55	10,391,341
1971**	4,909	207	55	8,955,355
1972**	5,100	210	56	8,955,355

**Although it appears that the number of trainees and amount of money expended has been reduced, the decrease in actuality reflects the changing focus of our award program. Approximately $4 million was granted to 16 universities for fiscal year 1971 as program support grants rather than the traditional traineeship grants. Undoubtedly, a high percentage of that money, and a large number of personnel trained were in the area of mental retardation. For fiscal year 1972, the Training Division moved completely to Program Assistance Grants. While our expectations are that the number of trainees benefitting from grants and graduating from programs will be substantially increased, it will become impossible to describe our program in terms of the number of trainees directly supported, or to delineate all trainees according to distinct areas of the handicapped. In addition, the area of interrelated handicapping conditions has received significant support. Interrelated handicapping conditions generally cover marginal handicaps (mentally retarded, emotionally disturbed, and learning disabled children).

It is readily apparent that the "old" P.L. 85-926 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 250 institutions requesting funds in the area of mental retardation indicates that more than 170 of them have on their faculties former trainees who received their education under Public Law 85-926.

Under current conditions, it will be 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. It is expected that Public Law 91-230 will enable the continuation of these efforts.

D. Related Program Activities

1. Training of Physical Educators and Recreation Personnel

With the passage of P.L. 91-230 the legislation established by P.L. 90-170, Title V entitled "Training of Physical Educators and Recreation Personnel for

Mentally Retarded and Other Handicapped Children," was incorporated in the "Edu- 14
cation of the Handicapped Act." The present program, Section 634, Part D of this bill is now entitled "Training of Physical Educators and Recreation Personnel for Handicapped Children."

In fiscal year 1972, the Bureau of Education for the Handicapped through the Division of Training Programs awarded a total of $700,000 to twenty-six universities and colleges to assist in providing professional training in physical education and recreation for the handicapped. Funds were provided for planning and student support for graduate students in these institutions.

In addition to the above awards, five regional institutes were sponsored by funded colleges to involve State personnel in Physical Education, Recreation, and Special Education in further planning and development of all levels of training in Physical Education and Recreation for handicapped children in the States. Also, one institute was supported for training relating to camping, outdoor recreation and outdoor education for handicapped children.

Appropriations for fiscal year 1973 are expected to be approximately $700,000. Applications for fiscal year 1973 funds requesting assistance in planning, program development, prototype and short courses have been received. Awards had not been made prior to the completion of this report.

E. Cooperative 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:

University Affiliated Facility Program

The Division of Training Programs in cooperation with the Division of Mental Retardation of the Social and Rehabilitation Service provided support monies to special education components in university affiliated facility programs for fiscal year 1972. The extent of the Division's support ranged from approximately $20,000 to $30,000 with a total expenditure of $465,000.

The Division supports a special educator on the university affiliated facility core faculty. The special educator is responsible for instructing medical students, psychologists, social workers, and other related medical personnel as well as students majoring in special education. He serves to effectively integrate special education concepts into the overall interdisciplinary training program of the university affiliated facility.

The institutions receiving support through this program for fiscal year 1972 were: Georgetown University; University of California at Los Angeles; Johns Hopkins University; University of Indiana; Miami University (Florida); Ohio State University; University of Cincinnati; University of Tennessee (Memphis); Children's Hospital (Harvard); University of Oregon; University of North Carolina; University of Alabama (Birmingham); Utah State University; University of Wisconsin; Georgia Retardation Center (Georgia Department of Public Health); University of Kansas; and the University of Michigan.

F. 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. Effective training programs must be flexible and provide for 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 a means for developing new models the Division of Training Programs administers a Special Projects Grant Award Program. The purpose of this program is to plan; to test new models of training; and to evaluate the effectiveness and efficiency of these new models 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. Planning grants will be utilized to provide funds for the support of personnel, travel, and other costs necessary for developing a detailed plan for the 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 and disseminated to other training agencies throughout the United States for replication. During fiscal year 1972, approximately $5.5 million was awarded for almost 80 projects in colleges and universities, State and local educational agencies, and private non-profit organizations. Grants ranged from $12,666 to $257,575. Approximately $515,100 was expended for programs relating to mental retardation.

G. Future Goals

The goals of the Division of Training Programs are to:

1. Increase the number and quality of personnel for education of the handicapped with special attention to early childhood education, vocational education and the urban and rural poor.

2. Increase the amount and quality of technical assistance to agencies and institutions training professional personnel.

3. With State departments of education, effect comprehensive planning for the training of personnel in special education.

4. Develop a systematic data collection program upon which to monitor current efforts and to base future efforts.

5. Systematically evaluate current programs preparing special education personnel.

6. Effectuate qualitative evaluation of all current programs preparing personnel in mental retardation.

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. 89-715 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. The most recent amendment, P.L. 91-61, passed August 20, 1969 authorized the establishment of a National Center on Educational Media and Materials for the Handicapped. The Center is developing a comprehensive program of activities to facilitate the use of new educational technology with the handicapped. The Media Services and Captioned Films program is, as of January 1972, managed from this Division in conjunction with the 13 Special Education Instructional Materials Centers that were founded as a demonstration project within the Division of Research.

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-operated and 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 and day classes have raised their levels of expectations for such children. While this program has had a relatively limited funding, significant results have been realized, especially in terms of planning for comprehensive services. Monies allotted under P.L. 89-313 for handicapped children were $15.9 million for fiscal year 1966, $15.1 for fiscal year 1967, $24.7 for fiscal year 1968, $29.7 for fiscal year 1969, $37.5 for fiscal year 1970, $46.1 for fiscal year 1971 and for fiscal year 1972, $56. In fiscal year 1969, 63,605 mentally retarded children were assisted under this program at an expenditure of $14, 379,663; in fiscal years 1972 and 1973, over 77,000 mentally retarded children have benefitted under this program at an expenditure of almost $33,000,000.

During 1970, Public Law 91-230 incorporated the former Title VI-A of the Elementary and Secondary Education Act, into Part B of the Education of the Handicapped Act. This program is a State plan program which provides support to local education agencies through their State Departments of Education. While the law authorized $200 million for both FY 1970 and FY 1971, only $29.2 million was appropriated for FY 1970, $34 million for 1971, $37.5 million for FY 1972, and estimated $37.5 million for 1973. About $18 million are expended under Part B for mentally retarded children. More than 150,000 mentally retarded children are served in Part B projects.

Of the approximately 75 million children in this country, more than seven million, including about one million preschoolers, are handicapped. This means that more than one child in ten is either mentally retarded, hard of hearing or deaf, visually impaired or blind, emotionally disturbed, crippled or in some way health impaired. At present, it is estimated that less than 40 precent of these children are in educational programs designed to provide for their unique learning characteristics.

As part of a comprehensive effort to demonstrate innovative approaches to solve the needs of handicapped children, Title III of the Elementary and Secondary Education Act as amended in 1968, mandated that 15 percent of its project funds be set aside for special education programs for the handicapped.

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Title III projects should not be designed "to meet the needs of handicapped children" but rather to demonstrate the solutions to critical problems in American education as they relate to the handicapped. It is recognized that the needs of these children will be met when appropriate programs are designed and implemented but this should not be the major thrust of Title III funds for the handicapped.

In many respects the intent of the legislation has been met. In other respects it has not. As more sophisticated procedures for identifying handicapped children are developed, as projects to serve these children are conceived, as the innovativeness and creativeness of the project designs are improved, Title III personnel, working jointly with special education personnel and other local, State and Federal agencies will be in a better position to meet the mandate of the legislation.

The following statistics for Title III have been taken from the FY 1971 Annual Report:

Fiscal Year 1971

Components:	Single	213	Handicapped children receiving direct services:	179,801
	Multiple	97		
	Total	310	Grants	$19,015,474

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 became effective in fiscal year 1970, and will be continued under the newly entitle "Vocational Education Act of 1963." In fiscal year 1971, $4.5 was used to fund 10 regional centers for the Deaf/Blind. In fiscal year 1972, $7.5 million was used to continue services to the nation's 4,000 deaf blind children and their families, through its 10 regional centers. It is anticipated that about 60,000 mentally retarded persons will be served in 1973 at an estimated cost of $11,500,000.

As Vocational Education instructors become more skilled in teaching this group they accept more students. As special education teachers become more aware of Vocational Education possibilities they refer more mentally retarded students to vocational education programs.

The second phase of an adult education special project benefitting mental retardates is being conducted by the Division of Mental Health, State of Missouri, during fiscal year 1972. This phase of the project, funded in 1971, employs a structured educational environment and behavior modification technique in providing basic education and vocational orientation for mentally retarded patients. Of the sixty participants in the program the first year, sixteen were placed in jobs outside the institution. The second year's activity will allow others in the program to be placed in jobs and will permit evaluation of methods, programs and materials. When the project terminates, its services will be continued by the Missouri Division of Mental Health at the Higginsville State School and other institutions. The results of the project will be shared through a workshop and through national dissemination of information.

P. L. 91-230 (formerly P.L. 90-247) provides for the development of regional centers and services for deaf-blind children under Part C, Title VI "Education of the Handicapped Act." The appropriation for 1970 was $2 million and was used to continue support of eight regional centers to provide direct services for deaf-blind children and their parents and to fund two new centers to plan services for deaf-blind children in their region. The law permits use of the funds for deaf-blind children with additional handicaps, including those who are mentally retarded. The appropriation in fiscal year 1971 was $2.5 million, in fiscal year 1972, $5 million. Ten Centers were supported in fiscal year 1972.

The Handicapped Children's Early Education Program (P.L. 91-230, Part C formerly P.L. 90-538) supports the establishment and operation of model preschool and early education projects designed to demonstrate a variety of effective approaches in assisting handicapped children during their early years. These projects will be distributed strategically throughout the country and the long-range objective is to provide visible, accessible models so that public schools and other agencies may replicate their programs. For fiscal year 1970, $3 million was granted to 41 projects. (23 operational projects were funded at approximately the $100,000 level; 4 combined planning-operational projects about the $40,000-60,000 level; and 14 planning projects at about $25,000 each.) Fiscal year 1971, $7,000,000 supported 41 operational and 28 planning projects for a total of 69 projects. In fiscal year 1972, $7,500,000 supported 62 operational and 28 planning projects for a total of 90 projects.

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. Certainly the newly established interest in early education programs for the handicapped will have major impact on mental retardation. This is especially so in the case of those youngsters from culturally disadvantaged areas who greatly need early stimulation. Without such stimulation, it is highly probable that many of those youngsters might become special education candidates.

D. Current Activities

Under the State plan programs, forty percent of the 115,035 children served by this program during fiscal year 1969 are mentally retarded. It is estimated that a similar number of children received direct services during fiscal year 1970. Approximately 37 percent of the $24.5 million expended in projects during fiscal year 1969, was spent for special educational and related services for the mentally retarded.

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 1970. 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, 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.

E. 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 and Regional Media Centers educational management and information systems.

III. 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, and for support of Regional Resource Centers.

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 have been extended through amendments to this basic authorizing legislation in Public Law 89-105, Public Law 90-170, Public Law 90-247 and Public Law 91-230. Table II provides data on the authorizations, appropriations, obligations, and number of projects supported under this program.

Table II - Division of Research -- Historical Data

Year	Authorization	Appropriation	Actual Obligations	Number of 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	13,593,786	160
1970	28,000,000	19,700,000	15,157,670	135
1971	29,500,000	18,850,000	18,815,124	93
1972	45,000,000	14,805,000	14,413,262	86

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 practices obscures the picture. However, some information on the impact of the program is available. As of the end of fiscal year 1971, approximately 350 reports of research monitored by the Division of Research had been 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. Current Activities

The Division currently supports a variety of research and related activities

relating to the education of mentally retarded children. A major applied research program is involved in a number of studies on the effects of teacher behavior on pupils, and on ways of establishing desired teacher behaviors. Another major program is investigating methods of optimally matching learning characteristics of retarded children with various teaching methods and environments. A comprehensive program of curriculum development activities is currently being supported by the Division. The correlated program includes projects on reading, mathematics, social studies, physical education, academic readiness, and science, each designed to produce both curricula and teaching materials for educable mentally retarded children. An additional project is developing social living and prevocational training materials designed for trainable children.

Under the Regional Resource Center program, each center should provide a bank of advice and technical services upon which educators in a region could draw in order to improve the education of handicapped children. The primary task of a Center would be to focus on the special education problems of individual handicapped children referred to it. Each Center should provide testing and educational evaluation of the child, and in the light of this evaluation could develop a program of education to meet the child's particular requirements. Working closely with the handicapped child's parents and teachers, each Center could then assist the school (or other appropriate agency) in providing this program, periodically re-examining and re-evaluating the program, and making any adjustments which are necessary to keep the program responsive to the educational needs of the handicapped child. Four Regional Resource Centers were funded in fiscal year 1969. These centers are located in Eugene, Oregon; Las Cruces, New Mexico; New York, New York; and Des Moines, Iowa. Two additional Regional Resource Centers were funded in fiscal year 1970 and are located in Salt Lake City, Utah and Harrisburg, Pennsylvania.

Additional efforts of a more general nature have important implications for retarded as well as other handicapped children. One of the most critical projects currently being supported is investigating the reintegration of handicapped into regular education programs. A series of 11 demonstration projects are currently involved with study and development of techniques for integrating the wide variety of community services available to retarded and other handicapped children.

E. 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 now supports five Research and Development Centers to focus on the more difficult problems of evaluation, communication, instructional procedures, etc. of handicapped children. Through the combined efforts of Research and Development Centers and programmatic research, definite improvement in instructional procedures may well be realized within the next several years.

At the same time, systems of dissemination are being evolved which will facilitate the acceptance of these new models by local school administrators. The new systems of dissemination are being built upon the foundation already developed by the Instructional Materials Centers and a system of Regional Resource Centers currently being developed.

Through fiscal year 1972, funds under the Library Services and Construction Act, title IV-A are for the purpose of establishing and improving State institutional library services. Residential schools for the handicapped, including the mentally retarded 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.

This program has acted as a stimulus to the States to expand, initiate and

integrate library services as an important component in the educational development of the State institutions for mentally retarded. Library services have been established where none existed and existing services have been expanded and worn collections have been updated to include multi-media materials and equipment carefully selected to meet the needs of the mentally retarded. Libraries have become an integral part of the school program and in addition service to all residents either in the library or in personnel library services in the dormitories has been strengthened.

In fiscal year 1972, 69 State supported institutions for the mentally retarded participated in this program. For example:

Wisconsin:

The residents library at Central Wisconsin Colony at Madison was initiated in fiscal year 1969, under an LSCA, title IV-A grant and refunded each year since then. The library, in common with other Departments at the Colony, aims to help the residents develop to their fullest potential. All residents are considered potential library users, and materials and services are designed with this in mind. In addition to direct, individual service, the Residents' Library functions as a materials center for word programs, the school and other departments.

Vermont:

Under LSCA, title IV-A, the Brandon Training School, at Brandon, a librarian was hired in 1969 to organize a residents' library at Brandon. The library now has an excellent collection of books, tapes, records, film-strips, and periodicals. Storytelling, film and book services are taken to the dorms for those unable to visit the library. Plans for 1972 include expansion of media services.

Beginning in fiscal year 1972, the Library Services and Construction Act provided library services to State institutionalized persons and physically handicapped persons under Title I. Support for these activities will be maintained at approximately the fiscal year 1972 level during fiscal year 1973.

Three projects were supported by the National Center for Educational Research and Development in fiscal year 1972 for research on the mentally retarded.

Wright Institute is evaluating videotape replay when it is used as positive visual reinforcement for behavioral modification with the retarded adult. The hypothesis is that the retardate will be stimulated by the nonverbal cues to improve his behavior after seeing himself interacting with others on the television screen. It can be expected that valuable information should be gained concerning the importance of nonverbal communication on self-evaluation and human social development as well as better understanding of the technique of behavior modification as it relates to the field of mental retardation.

Another project dealing with visual reinforcement is conducted by the University of South Dakota. Visual masking and information processing in normal and retarded children and adults is being studied so that educators and psychologists may understand what conditions are optimal for presentation. Three studies are proposed: Experiment I, applicable to nursery school children as well as adults; Experiment II, applicable to subjects ranging in age from 4 to 40+ years old; and Experiment III, a comparison of retarded and normal subjects. These comparisons will provide data showing whether chronological or mental age is most directly involved in the processing of visual information.

The third study at Morehead State University is designed to discover retardate vs. normal differences in the realm of discrimination learning and memory. This is a developmental study designed to investigate discrimination learning and memory

processes. Thirty-two retardates and thirty-two normal children will be given[22] training and retention trials of two-choice visual discrimination problems. The first experiment is designed to investigate discrimination learning and short-term retention. The second experiment is designed to investigate discrimination learning and long-term retention.

NATIONAL INSTITUTE OF EDUCATION

Summary of Programs Related to Mental Retardation

In fiscal year 1972, the Office of Education transferred three awards providing support on mental retardation to the National Institute of Education. These awards totaled approximately $64,000.

A Southern Connecticut State College project, "A Study of Music as Teaching Media for Improvement of Speech of the Educable Mentally Retarded Children in Inner City Schools", is based on the premise that speech articulation and vocabulary skills are first imitated, then practiced, and finally acquired by the refinement of guided studies. This study does not expect to replace the traditional teaching techniques but to develop adjuncts to them. The educable mentally retarded children were chosen for this project because many studies have shown that speech defects are more common among them than among average students.

At the Bergen Center for Child Development, a series of teaching methods for receptive speech will be prepared for neurologically impaired and retarded children. This research is a first step in that it aims to develop a procedural manual for people working on an aide level with these children and will furnish further support for the idea of receptive language as a set of discriminations.

An educator in the field of the educable mentally retarded proposed for the return of mildly retarded children to the mainstream of regular classes with the necessary diagnostic services provided by the special education teacher. Since that time, a large number of special educators have implemented this proposed plan, but information regarding this innovation has generally been unavailable.

The Far West Laboratory for Educational Research and Development through the auspices of NIE's Dissemination Task Force targeted for special education coordinators and other school personnel intending to provide a knowledge base about this approach and to hasten the process of practice improvement in the schools.

The PREP (Putting Research into Educational Practice) package will supply a general survey of the literature, outline procedures which have been used to implement this innovative approach, and suggest methods of evaluating program success.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

National Institute of Mental Health

The National Institute of Mental Health supports a broad range of research which contributes to the understanding and more humane treatment of the mentally retarded. Although the Institute has no formal program directed toward alleviating problems associated with retardation, a few individual projects focus on the subject, while many others affect the retarded indirectly.

NIMH-sponsored research into mental retardation includes studies of cognition and the learning process, development of educational techniques, evaluation of treatment modalities, and identification of psychosocial and physiological variables in retardation.

One study on learning, which is being carried out at the University of Connecticut, deals with discrimination, remembering and forgetting, attention, learning, perception, and transfer processes in mentally retarded children.

Among the studies that combine the study of retardation with those subjects which are more strictly under the purview of the NIMH is a long-range comprehensive study of the autistic or schizophrenic child in the early years, including the retarded schizophrenic child. This project, which is being conducted at the University of Indiana and Purdue University, includes studies of social behavior and physiological and endocrine processes in hospitalized patients and outpatients. Operant conditioning techniques are being used to modify undesirable social behavior and personal unresponsiveness --problems that are present in both psychotic and retarded children. Two studies are investigating the response of patients with symptoms of mental disorder and retardation to pharmacological agents. One study underway at Rutgers, the State University of New Jersey, is examining drug effects in female dysphoric patients (retarded, anxious, depressed, and/or elated). Cross comparisons are being made with inpatients and outpatients, using imipramine, amitryptaline and thioridazine; the primary concern of this study is to develop means by which to differentially predict response to the drugs and placebo. The other project consists of a series of drug studies into the action of stimulant drugs (dextroamphetamine and methylphenidate) on behavior, cortical processes, and cognitive functioning in children with conduct problems, hyperactive-inattentive behavior, learning disabilities, and/or minimal brain dysfunction, as well as the effects of diphenylhydantoin on behaviorally disturbed children. This project is being done at the Massachusetts General Hospital. Other psychopharmacological studies that are now underway also affect retarded children indirectly.

Another type of research is being done into physiological processes involved in retardation and mental disorder. One that is being conducted at the University of Iowa is using rats to study the relationship between CNS lesions and drug action in the brain-damaged or mentally retarded. The work will elucidate how such drugs as

amphetamine and reserpine exert their effects on behavior. Another study underway at New York University is concerned with the structure, distribution, and metabolism of acid mucopolysaccharides in the nervous tissue of both human and animal subjects. The study has implications for the origins of central nervous system abnormalities in retardation.

Other research on retardation funded by the Institute focuses on behavior and socialization. An investigator at the University of Alabama, for example, is attempting to identify factors that control the rate of repetitious and stereotyped activities engaged in by retarded children (e.g., body rocking). Interaction in the families of boys with severe conduct disorders, some of whom are retarded, is under study at the University of Oregon. Investigators are attempting to develop testable theories about the relationship between family interactions and deviant behavior and to apply design treatment and prevention programs around this theory.

Maternal and Child Health Service

Maternal and Child Health Service programs designed to meet the needs of children with mental retardation or developmental delay have demonstrated continued growth in three major areas: 1. Basic health and supportive services; 2. Preventive services; and 3. Training of personnel to deliver these services.

Through programs supported with earmarked portions of MCH and CC funds, States are demonstrating both the unique and specific contributions which can be made on a State and local level in evolving balanced services for retarded children and those handicapped children who show a developmental lag.

Through the mechanism of basic formula and special project grants, new and better ways of meeting need and delivering care have been demonstrated. Because of the demonstration nature of the programs, they do not provide total services for an area or community.

I. Basic Health and Supportive Services

Maternal and Child Health Services

Section 501, Title V, Social Security Act, authorizes annual formula grants to the States to extend and improve health services for mothers and children, especially in rural areas.

These are basically programs to improve nutrition, prevent ill health and infectious disease, safeguard the period around pregnancy, and minimize health hazards by identifying them as early as possible. State maternal and child health programs included some of the following services for fiscal year 1971:

- Maternity nursing services to 576,309 mothers.
- Family planning services to 763,234 women.
- Prenatal and postpartum care in maternity clinics for 356,326 mothers.
- Nursing services to 2,591,321 children.
- Dental treatment for 970,610 children.
- Vision screening for 9,379,543 children.

. Audiometric testing for 6,080,914 children.

. Well child conferences, serving 1,559,342 children.

Crippled Children's Services

Section 501, Title V, Social Security Act, authorizes annual formula grants to the States to find children who are crippled or who are suffering from conditions leading to crippling, and to provide them with medical, surgical, corrective and other services.

A total of 498,000 children received physician's services under State crippled children's programs in 1971. Nearly 35 percent of the children seen were new patients.

Children between 5-9 years of age comprised the largest users of the program (30 percent), with the next largest groups those between 1-4 years (26 percent) and 10-14 years (23 percent).

Congenital malformations accounted for 21 percent of all conditions noted, and more than 19 percent of the children served were reported to have multiple conditions.

Clinical Services

Clinical services for mentally retarded children operating in all but two States include diagnosis, evaluation of a child's capacity for growth, the development of a treatment and management plan, interpretation of findings and counseling of parents, and follow-up care. Mental retardation clinic services were provided for over 71,000 children, and 316,000 visits made to 156 clinics supported by MCHS funds during FY 1972.

Children are being seen at these special clinics at an earlier age as a result of multiple screening procedures carried out by the State maternal and child health programs. Thirty percent of the children (37 percent of the new patients) seen in these clinical programs were under 5 years of age; 45 percent were 5-9 years old (42 percent of the new patients); 20 percent were aged 10-14 (17 percent of the new patients).

New patients numbered 30,000. These clinical programs fulfill a major function of "unlabeling" children referred as mentally retarded. Among children classified in FY 1972, 9,500 were found not to be retarded.

Multiply-Handicapped Children's Clinics

Ten specialized clinical programs for multiply-handicapped children provide comprehensive services for children with a multiplicity of handicapping conditions including mental retardation. They are models for the type of staffing and services required to meet the total needs of children in a single setting.

Genetics Program

Projects supported with CC funds provided cytogenetic and biochemical laboratory services as extensions of clinical services at hospitals or medical schools. On the basis of these analyses, counseling is given to parents seeking advice on genetic questions.

II. Preventive Services

Maternity and Infant Care Projects

Section 508, Title V, Social Security Act, authorizes grants for projects to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing and to help reduce infant and maternal mortality by providing necessary health care to high-risk mothers and their infants.

Fifty-six Maternity and Infant Care projects, located in 34 States, the District of Columbia and Puerto Rico were operational in fiscal year 1972. While more than 60 percent of the Maternity and Infant Care projects serve cities of 100,000 or more, projects are also located in rural and urban-rural populations in such States as Alabama, Georgia, Florida, Arkansas, Idaho and others. All the projects serve localities which have shown higher infant and maternal mortality rates than the Nation as a whole.

Approximately 900,000 women have been admitted for maternity care and 600,000 for family planning services since the Maternity and Infant Care program was established.

Inborn Errors of Metabolism

Phenylketonuria (PKU), an inborn error of metabolism, has in the past been responsible for 1 percent of the population in the State institutions for the mentally retarded. By detecting families with the condition and by providing young infants with the condition with a special diet, mental retardation usually can be prevented. MCHS works with State health departments in developing the necessary laboratory facilities and assisting States to provide special diets and follow-up services for these families.

During the past few years, approximately 90 percent of the newborns in the 50 States and the District of Columbia were screened. This screening effort by the States turned up approximately one confirmed case for every 16,000 live registered births.

MCHS is continuing to support a study of the clinical application of screening tests to detect galactosemia, maple syrup urine disease and histidinemia. Support is also being given to studies of new approaches to broader screening methods which would make available a battery of automated tests for detecting metabolic diseases.

Lead Poisoning

MCHS Children and Youth projects are continuing to screen their populations for lead poisoning as a part of their health maintenance program. Earlier detection and treatment is being achieved. House-to-house surveys, work with landlords and community groups to remove flaking lead paint has become an important ongoing aspect of these projects.

Rh Factor

State maternal and child health programs reported continued progress during fiscal year 1972 in the prevention of hemolytic disease of the fetus and newborn through the use of anti-Rh immune globulin. An increasing number of States are utilizing MCHS formula funds to provide immune globulin to women needing it. In a number of States over 80 percent of the women estimated to require the anti-Rh immune globulin are now receiving it. At this rate of increased usage, Rh disease could virtually be eliminated in the next 10 to 15 years.

With the liberalization of abortion laws it will become critically important that the utilization of anti-Rh immune globulin be made available also to these patients.

Rubella

Many of the babies born with birth defects resulting from the rubella outbreak of 1964 and 1965 and showing evidence of mental retardation or other handicaps continue to be cared for under special clinical programs for retarded handicapped children. States are encouraged to use MCHS funds to complete the immunization of children against rubella as part of the national campaign spearheaded by the Center for Disease Control. As of April 30, 1972, more than 75 percent of school-aged children and 50 percent of children aged 1-4 years had been immunized against rubella. The incidence of rubella continues to decline as a result.

III. Training

Under Section 511, Title V, Social Security Act, grants are made for the training of personnel in health care and related services for mothers and children, particularly mentally retarded children and children with multiple handicaps.

Training activities are also supported by funds authorized under Sections 503 and 504 of Title V for projects which may contribute to the advancement of maternal and child health and crippled children's services.

University-Affiliated Centers

The program designed to provide comprehensive multidisciplinary training of specialists who will work with the handicapped and retarded is based on a concept of multi-agency funding and multi-departmental university participation. It had its beginning in 1963 under P.L. 88-164, which authorized Federal support in the construction of facilities to house such training efforts. At many of the universities that applied, MCHS was already involved in the funding of clinical services.

In 1965 this role was expanded to include support for faculty and students in the health services component of the training programs.

During 1972 the 20th University-Affiliated Center was funded at the University of Kansas, for core faculty and the development of multidisciplinary training programs under Section 511.

There were 336 long-term trainees on MCHS stipends in University-Affiliated Centers during FY 1972. These included: Psychologists, 65; pediatricians and obstetricians, 51; medical social workers, 86; speech pathologists and audiologists, 47; pedodontists, 20; nurses, 10; occupational therapists, 9; physical therapists, 10; psychiatrists, 6; nutritionists, 4; geneticists, 3; administrators, 2; dental auxiliaries, 6; others, 17.

Center for Disease Control

Rubella Immunization

Soon after a new live rubella vaccine was licensed in 1969, project grants were awarded to State and local health agencies to assist them in planning, developing and conducting immunization programs to control rubella and reduce the occurrence of mental retardation, blindness and other complications associated with congenital rubella syndrome. Since a rubella epidemic had been predicted in 1970-72 by many health experts, it was necessary that the new rubella vaccine be administered to as many susceptibles as rapidly as possible. As of January 30, 1973, approximately 31 million doses of rubella vaccine had been administered in public programs to children between the ages of one and puberty. It is estimated that an additional 7-8 million doses of rubella vaccine have been administered by the private sector. This total of 38-39 million immunizations given since July 1969 represents the highest degree of protection ever obtained by immunization so soon after licensure of a vaccine.

As a result of the large quantities of vaccine given, the predicted rubella epidemic has not materialized. In fact, reported cases of rubella have declined from 54,928 in 1970, to 42,899 in 1971, to 24,684 in 1972. It is estimated that if the predicted rubella epidemic had materialized, as many as 2.5 million cases of rubella and 20,000-25,000 cases of congenital rubella syndrome could have occurred.

Measles Immunization

After the Department of Health, Education, and Welfare authorized a reinitiation of efforts to control measles in late 1971, measles vaccine distribution and usage increased significantly. During calendar year 1972, over 8.2 million doses of measles and/or rubella-measles vaccine were distributed in the United States. The Center for Disease Control distributed more than half or approximately 4.2 million of the total 8.2 million doses.

The increase in measles vaccine distribution in 1971 and 1972 was followed by almost a 100 percent increase in vaccine usage in 1972 over 1971. As a result, the number of reported cases of measles declined from 75,007 in 1971 to 31,009 in 1972, a decrease of 64 percent. In addition, it is expected that data from the U. S. Immunization Survey conducted in September 1972 will show an increase for the second straight year in measles immunization levels.

Even though measles immunization levels are approaching their 1969 highest level, many pockets of unprotected children remain. Immunization of these susceptible children must be given priority.

Bureau of Community Environmental Management

It is estimated that 2,500,000 children between the ages of 1 and 6 years are at risk of becoming lead poisoned because they live in dilapidated housing containing hazardous amounts of lead-based paint. Of these children who are at risk, it is believed that 600,000 have elevated blood-lead levels, as many as 125,000 may actually be lead poisoned, 6,000 children may suffer neurological handicaps (including mental retardation) and approximately 200 deaths occur annually from childhood lead poisoning. This disease is caused principally by repeated ingestion of lead-based paint by children. Control of childhood lead poisoning is based on the identification and medical follow-up of children with elevated blood-lead levels and the reduction or elimination of lead-based paint hazards in their housing environments.

The Bureau of Community Environmental Management has initiated a national preventive program to assist communities in their efforts to determine the nature and extent of the problem, to develop medical and scientific capabilities necessary to carry out effective local programs and to assist communities in the design and management of local control programs. These efforts are complemented by special project grants which enable communities to initiate new control programs or to expand limited existing activities. In Fiscal Year 1972, the $6,500,000 available for grants were used to support 40 community projects in 23 States and the District of Columbia. As part of an ongoing surveillance program, these project grants will help the communities screen approximately 200,000 children or about eight percent of the children at risk. The first six months of community project operations indicate that of the children screened 20 percent show evidence of undue lead absorption.

Indian Health Service

Preventive Services

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, intrepartum, and postnatal periods. The Indian Health Service, through its efforts to provide high quality, comprehensive 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.

The Indian Health Service provides comprehensive medical care during the prenatal, intrepartum, and postnatal periods. This includes both outpatient and inpatient care for the mother and her newborn child. In the 47 Indian Health Service general hospitals which operate obstetrical services, comprehensive prenatal and neonatal care is given

specifically to reduce the incidence of mental retardation. Where genetic counselling is indicated the Indian Health Service attempts to provide it.

Concurrently, 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 studies as well as the promotion of responsible parenthood. Recent studies have indicated the value of child-spacing as a measure to prevent mental retardation. In this broad concept family planning is implemented in the Indian Health Service. Currently twenty-two percent of the Indian women ages 15-44 were provided family planning services in 1972.

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 and rubella immunization programs for Indian and Alaska Native children. These programs help prevent the measles encephalitis which has a high residual of brain damage of which mental retardation can be one of several adverse consequences, and rubella which threatens congenital malfunctions during the first trimester of pregnancy. Another Indian Health Service program - nurse-midwifery - initiated in Alaska and Arizona, is fully utilizing all possible health staff in the prevention of mental retardation through improved care of expectant mothers and newborn infants.

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. Phenylketonuria (PKU) tests are performed on newborn infants with a depressed apgar score. Those who are born prematurely are further evaluated for PKU or other evidence of brain damage.

The Service continues its efforts to identify causal factors of Otitis Media, one of the major health problems among the children in the Indian and Alaska Native population, and to program preventive and corrective measures.

Headquarters coordinates national mental retardation services and individual Indian Health Area Offices cooperate with State and local health departments and regional offices in planning mental retardation programs made possible through Federal grants-in-aids funds.

Prevention of Functionally - Based Mental Retardation

As part of the on-going comprehensive health program to Indian reservations, mental health projects include prevention, detection, treatment, and planning for functional mental retardation. The Indian Health Service is cooperatively working with Head Start programs throughout all of its areas, and providing extensive consultation to BIA boarding schools and personnel. A model dormitory jointly sponsored by IHS and BIA now in operation over one year is indicative of innovative approaches in prevention of functional mental retardation affecting the early school age child. Its evaluation is complete and indicates a high degree of success.

Professional Preparation

Indian Health Training Program

The Indian Health Service conducts university-affiliated physician residency training programs in pediatrics in its hospitals in the Oklahoma Area and in 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. The Indian Health Service continues to develop and use coordinated teaching guides for hospital and public health nursing personnel, designed as aides in teaching good health practices to maternity patients and their families.

Health Care Facilities Service (Hill-Burton Program)

Mental retardation facilities have been eligible for and have received construction assistance from the Hill-Burton program since its inception twenty-six years ago. Up until the passage of the "Mental Retardation Facilities Construction Act" (1963) - P.L. 88-164, Title 1, the Hill-Burton program was the primary source of Federal assistance for retardation construction, and administered the Act after enactment until August 1967. Since the advent of the specific construction program for retardation facilities, the Hill-Burton program has been acting primarily as a backup resource for construction aid. As of June 30, 1972, a total of 106 retardation projects have been assisted with over $55 million in federal funds since the Hill-Burton program began. Hill-Burton personnel in both the regional H.E.W. offices and in the State Hill-Burton agencies have provided expert consultation to the retardation facility programs and to many retardation project sponsors or potential sponsors. Hill-Burton consultation is especially valuable where retardation services are to be provided in a comprehensive health care facility or in any combination with other health services.

NATIONAL INSTITUTES OF HEALTH

Introduction

Over twenty million Americans, representing the immediate families of our nation's six million mentally retarded persons, are directly affected by the problem of mental retardation. They know and bear its full impact--its economic toll, its pain, its threat to social and human values. Moreover, the effects of this problem weigh heavily on our communities, our schools and our health and social institutions. Recognition of the needs and rights of the mentally retarded and the research engendered by this recognition could ultimately result in great reduction in the hundreds of millions of dollars spent in this country annually on welfare and maintenance services.

With a problem of such scope and complexity it is no surprise that the National Institutes of Health, primary center for research and research support in the DHEW, has a large and direct interest in the problem. The National Institute of Child Health and Human Development (NICHD) has as one of its primary goals the finding of causes of mental retardation, and as such, speeding the development of ways to prevent the problem. Whenever prevention is not possible, reducing human suffering and ameliorating the consequences of mental retardation become the next goal. Focal responsibility for mental retardation research and training programming at the National Institutes of Health resides with the NICHD. In recognition of the importance of the problem, the NICHD has organized one of its five extramural program areas to deal exclusively with the problem and to develop and support mental retardation research and research training. In addition, the activities of the other four extramural branches frequently produce research relevant to the mental retardation problem.

The National Institute of Neurological Diseases and Stroke (NINDS) also conducts research on mental retardation in behalf of the NIH. NINDS contribution to the field lies in the area of studies of mental retardation when it exists concomitantly with diseases of the central nervous system. Because many research projects sponsored by the NINDS bear a secondary relationship to mental retardation, results of these studies contribute to knowledge in this field.

The biological causes of mental retardation are many and varied: it may result from hereditary causes such as inborn errors of metabolism (for example, phenylketonuria, or PKU); from chromosome abnormalities (such as Down's Syndrome, or mongolism); from endocrine dysfunction (such as cretinism); from infection or from intoxication (such as lead poisoning).

Conditions of poverty, lack of good perinatal care, chronic and debilitating diseases, malnutrition, poor sanitation, broken or inadequate homes, insufficient or nonexistant medical care, and inadequate educational opportunity are all thought to combine to raise mental retardation in groups living in poverty to a rate 7 to 10 times higher than the estimated average of 3% for the American population as a whole.

National Institute of Child Health and Human Development Research

The National Institute of Child Health and Human Development sponsors a broad attack on the problem of mental retardation ranging from studies in fundamental molecular biology, biochemistry, neurophysiology, and genetics to epidemiology, pathology, obstetrics, and pediatrics and to psychology, sociology and special education. Of primary concern to the Institute are inquiries into the basic causes and means of preventing mental retardation through research into the biological and behavioral processes which contribute to or influence the development of these disorders. The Institute's research attack is based on a program of research grant support, creation and support of special research facilities and resources, dissemination of scientific information through support of scientific conferences, and through contract support of research designed to accomplish specified research goals for which technology has already been developed. Many of the research accomplishments which the NICHD has supported have been achieved in the 12 Mental Retardation Research Centers for which NICHD has programmatic responsibility. These Centers, located throughout the country, are uniquely capable of carrying out research in the complex problems of mental retardation by calling upon the skills of investigators in many disciplines. In addition, the Centers sometimes provide training for future scientists. Some Centers conduct clinical studies and are thus able to make contributions to the community in which they are located.

The problem of lowering the number of mongoloid births in this country is of special interest to the NICHD. Mongolism, or Down's Syndrome, is a form of mental retardation known to be genetic in origin. Scientists also know that the incidence of mongoloid births rises precipitously among offspring of women over forty. The NICHD hopes to promote increased understanding of the risks in pregnancies among women of this age group.

Progress has been reported this year in extending the use of amniocentesis in diagnosing, before birth, inborn errors of metabolism and Down's Syndrome--genetic deficits many of which cause mental retardation. The technique is also an invaluable research tool for studying basic mechanisms causing the inborn errors.

Basic Biological Studies

In studying biochemical aspects of phenylketonuria (PKU), a group of scientists at the Mental Retardation Research Center at the Medical School of the University of California Los Angeles has found a tissue cell culture system which may serve as a good vehicle for studying PKU. The important requirement was that the tissue culture cells have phenylalanine hydroxylase present. This enzyme is believed to be either missing or insufficiently active in the livers of affected patients. The deficiency causes mental retardation and behavior difficulties but by initiating a special diet for afflicted babies within the first weeks of life, doctors can alleviate the problem. In examining 10 strains of rat liver tissue the investigators found the enzyme to be present in only two lines of cells--both cultured from rat liver tumors. Preliminary testing led the scientists to conclude that both would be useful models for studying regulation of the enzyme at the cellular level.

Institute-supported scientists have also made progress in studying chromosomal abnormalities. Working at the Mental Retardation Research Center at Children's Hospital in Boston, Massachusetts, an investigator is using sophisticated methods to study what happens within the cell nucleus when the chromosome doesn't divide at the normal time or when genetic material does not perform its reproductive function normally. These aberrations are being investigated to determine the

effects on production of necessary enzymes. Also, by making artificial hybrids of cells and by manipulating the cells' environment the investigators hope to determine which parts of the chromosome control production of specific enzymes. Conceivably, this work could contribute to the possibility of replacing or repairing defective chromosomes.

Behavior Modification

The activities of the Mental Retardation research centers encompass a wide range of basic, clinical and applied efforts. At the University of Kansas Mental Retardation Research Center, parents and scientific investigators collaborated to bring laboratory techniques for altering or eradicating undesired behavior into the home setting. Behavior modification is a system designed by scientists either to encourage desired behavior by rewards or to eliminate undesired activities by ignoring them or highlighting an alternative. Previously this technique had been used only in well-equipped laboratories on severely retarded children. In a recent Center report, one parent noted that she was able to increase the frequency with which her son would wear his orthodontic device by giving him a reward if the brace was in his mouth at spot-check times. A second parent gave her daughter points and point trade-in items as an incentive to assist with household chores. The parent of a 4-year-old boy managed to significantly reduce the child's whining, crying, and complaining behavior by refusing to respond to it. And, in the fourth case, a mother decreased the amount of time it took her 5-year-old daughter to dress herself in the morning by making television privileges contingent upon promptness. These behavior problems were not severe enough to impel the parents to seek outside advice; they were, however, typical of those found in many homes that are common sources of friction.

Learning Technique

Scientists studying learning techniques of children compared the methods used by normal teenagers to memorize short lists to those used by mildly retarded teenagers. The normal students were observed to use a series of short pauses in the early part of their task with a longer pause towards the end, and to finish with a rapid spurt. The retarded teenagers did not pause. The investigators attribute the better memorization records of the normal children to their using the pauses to rehearse the material. When the investigators built similar pauses into the memorization lists of the retarded their performance equaled that of the normal group. When the pause time was taken from the normal group their performances declined. Observations of this nature lead to hope that mildly retarded persons may be trained to utilize the learning strategies used automatically by normal persons, and enable them to learn faster and better.

As part of a large study of the relationship between maternal behavior and children's intellectual development, an Institute-supported scientist at UCLA collected data on child-rearing practices fostering optimal development. The investigator observed the effects of the mother's physical and vocal contacts and how much she ignored or played with the child. He found that the amount of contact between mother and child controlled not only the babies' responses to their mothers but also how much they stimulated themselves. The more the baby responded to its mother the less responsive it was to strangers. Also the more suppressive or critical the mother was observed to be, the less socially responsive the baby was. Studies such as these provide data on child rearing practices which may affect children's development and make some children seem mentally retarded. The studies may also provide a basis for recommending certain practices which are shown to enhance development.

Malnutrition and Learning

The effects of malnutrition on the normal growth and intellectual development are still somewhat undefined, although thought to be widespread. A recent Institute-supported study done in cooperation with the government of Jamaica, West Indies, has shown that children who have experienced severe malnutrition during the first two years of life have lower intelligence levels at school age than their siblings and classmates. Because most brain development is completed before the age of nine months, children experiencing severe malnutrition before that age were compared with those affected later. No significant age-related differences could be observed. The finding that the malnourished children have lower intelligence is in accordance with the observation of other investigators. On the other hand, it is surprising that there is no observable association between intellectual level and age (up to 2 years) at which malnutrition occurred. The investigators point out that development of other nervous system tissue extends into later infancy. Accordingly, the child's intelligence remains vulnerable to malnutrition even after 9 months of age. In light of this, the grantees suggest the need for studies of children who have experienced malnutrition at later ages.

National Institute of Neurological Diseases and Stroke

Neurological disorders caused by biological factors, account for a large percentage of the approximately 6 million Americans who are mentally retarded. The biological factors of mental retardation include all those which cause physical or chemical damage to the brain or nervous system. Such a factor can be a virus, poison, an accident, a hereditary factor such as an error in metabolism or a missing gene, or perhaps an unknown cause for which scientists are seeking the explanation of damage to the brain before, at, or around the time of birth. The National Institute of Neurological Diseases and Stroke (NINDS) studies the biological factors known or suspected to be related to mental retardation.

The NINDS supports a large number of research projects aimed at claryifying metabolic derangements leading to central nervous system damage and at identifying specific lesions in the brain or other parts of the nervous system in diseases that have neurological consequences. The NINDS programs dealing specifically with neurological disorders of early childhood include those on cerebral palsy, birth injuries (both discussed in a separate report), Tay-Sachs disease, kernicterus, phenylketonuria, mongolism, spina bifida and hydrocephalus. These disorders are often accompanied by mental retardation.

Researchers sponsored by the NINDS also seek answers to fundamental biological, biochemical, or molecular processes which are critical to a complete understanding of mental retardation. Such fundamental studies are of far more long-term importance in the solutions (prevention, cure, or treatment) of disease problems than efforts merely to alleviate the symptoms.

One of the Institute's most significant projects relating to mental retardation is the collaborative study of the development of children. The NINDS worked with 14 cooperating institutions to conduct the Collaborative Perinatal Research Project. This study made and recorded observations of some 58,000 women and their pregnancies to investigate the prenatal, perinatal and postnatal factors of child development. Most of the surviving children have been given a series of tests through age eight.

As a result of the study, scientists have learned about such things as the distribution of blood antibody levels, the consequences of high bilirubin levels in nursery age children (which produces jaundice and can cause brain damage), the distribution of physical and intellectual measurements, and the frequency of

certain abnormal conditions. Researchers have found low birth weight to be a very important factor in child death at birth, neurologic abnormality, and intellectual development.

Since the Study's beginning in 1959, over 500 papers have been written on the findings. The first major volume to come from the Study, The Women and Their Pregnancies, was published during the past year. A second major volume, Perinatal and Postnatal Factors Associated with IQ at Age Four, will be published in the next few months. This volume examines the effects of socioeconomic factors, conditions of pregnancy, labor and delivery, family characteristics and early infancy characteristics of the IQ of a child. This volume will provide valuable information on the relationship of mental retardation to the factors just mentioned.

The NINDS also supports a large program on developmental neurology at Children's Hospital Medical Center in Boston. This multidisciplinary program combines clinical and experimental research into the abnormalities of the developing nervous system. Mental retardation receives special emphasis as the most devastating consequence of developmental dysfunctions from pregnancy through early childhood.

There are over a thousand genetic disorders that afflict man, and among them are the inborn errors of metabolism which are of special interest to NINDS researchers. Many of the errors cause severe mental retardation and often early death. Of the 200 known, 40 can now be detected before birth by tests of the amniotic fluid from the pregnant mother.

Although only a few of these disorders are treatable, many of them can be prevented through genetic counseling. Standardization and wider use of amniotic fluid tests during the past year have improved prenatal diagnosis and carrier detection.

Standardization and wider use of amniotic fluid tests has also led to improved diagnosis of the nine known lipid storage diseases, which often cause severe retardation. Pioneering biochemical research on metabolic pathways by NINDS-supported scientists has made it possible in recent years to pinpoint the specific enzyme defect in five ganglioside storage diseases, including Tay-Sachs disease. This research has provided the basis for genetic counseling and, in many instances, prenatal diagnosis by amniocentesis.

Scientists are learning more of how these diseases appear in the unborn child, affecting the central nervous system and causing mental retardation. Studies have already provided clues for possible treatment for some of the disorders, improving prenatal diagnosis and carrier detection tests. These, combined with genetic counseling, could lead toward eradication of the errors.

Mental retardation often follows hydrocephalus (an increase in fluid on the brain which causes brain damage) and brain tumors in childhood. Scientists are working to develop appropriate surgery and drug treatment and are using antitumor materials tagged with radioactivity to provide an improved approach to chemotherapy. Tests were conducted last year and will continue this year on the use of a tomoscanner to aid scientists in detection of brain tumors.

In Fiscal 1972, the NINDS supported 189 studies on neurological disorders of early life, a large number of which are accompanied by mental retardation. Intramural and collaborative programs, including the Perinatal Project, numbered 102.

SOCIAL AND REHABILITATION SERVICE

Introduction

On August 15, 1967, the Social and Rehabilitation Service was established by the Secretary, Department of Health, Education, and Welfare, to join under a single leadership income support programs for needy Americans and the social and rehabilitation programs, including services for the mentally retarded.

Five of the eight major components of the Social and Rehabilitation Service have responsibility for providing income maintenance, medical services, social services, and rehabilitation services for the economically, physically, and mentally handicapped. These bureaus and offices administer the legislation concerned with the care and provision of services for retardates and their families in the following order: Assistance Payments Administration, Social Security Acts, Titles I; IV, Part A; X; and XIV. Medical Services Administration, Social Security Act, Title XIX. Community Services Administration, Title IV, Part A and B; Office of Planning, Research, and Training, Title XI, Sections 1110 and 1115 and the Vocational Rehabilitation Act of 1965, as amended; Rehabilitation Services Administration, the Vocational Rehabilitation Act of 1965, as amended; the Developmental Disabilities Services and Facilities Construction Act of 1970, and various other Acts or portions of Acts such as the PHS Act, concerned with the health and welfare of the mentally ill or retarded. Following is a description of the Social and Rehabilitation Service's efforts on behalf of the mentally retarded.

Assistance Payments Administration

The Assistance Payments Administration has primary responsibility for grants to States for public assistance programs under the Social Security Acts, Title I, Old-Age Assistance; Title IV, Part A, Aid to Families with Dependent Children and Emergency Welfare Assistance; Title X, Aid to the Blind; Title XIV, Aid to the Permanently and Totally Disabled. It is in the program of Aid to the Permanently and Totally Disabled that Federal financial participation is available to help needy individuals who also may be mentally retarded through State-administered or supervised public welfare programs.

P.L. 92-603, enacted October 30, 1972, establishes a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled. The national program becomes effective as of January 1, 1974, at which time the Social Security Administration will be responsible for making Federal payments to eligible recipients. Since the Assistance Payments Administration's authority to make payments to recipients of the Aid to the Permanently and Totally Disabled program expires December 31, 1973, Federal expenditures shown in the Table of Obligations are for six months only.

Mentally retarded persons eligible for money payments under the Aid to the Permanently and Totally Disabled program comprise slightly more than 28 percent of total APTD recipients. Based on this statistical calculation, it is estimated that approximately $127,248,000 in Federal funds will be provided to the States from July 1973 through December 1973 for income support of the mentally retarded.

Community Services Administration

The Community Services Administration has responsibility for administering the Social Services program under Title IV, Part A, and Child Welfare Services under Title IV, Part B of the Social Security Act.

The Social Services program provides services to families and children receiving Aid to Families with Dependent Children money payments and to former or potential recipients at the option of the State. Among the services provided under this program are services to children who are mentally or emotionally disturbed. Social Services related to mental retardation may include:

(1) Day Care Services--offering constructive experiences for some retarded children and necessary relief for their parents. This service may be the key factor in determining whether a mentally retarded child can remain with his family.

(2) Foster Care--short-term foster care at intervals or during periods of crisis may enable a retarded child's family to provide adequately for him at home for the most part. For other retarded children, foster family care permits long-term benefits of family life and community living.

(3) Other Services--protective services can reduce the incidence of child abuse, thus helping to alleviate one of the causes of mental retardation. Prenatal services to unmarried and other needy expectant mothers also help to reduce the incidence of mental retardation.

The basic purpose of the Child Welfare Services program is to protect children from abuse, neglect, exploitation, or delinquency and to assure that they have an opportunity for normal development and an adequate home life. Although funds authorized under this program are not specifically earmarked for serving the retarded, mentally retarded children benefit from services provided. Child Welfare Services that are rendered to retardates 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 preadmission and after care services.

During fiscal year 1974, approximately 38,000 mentally retarded children will receive services under the Child Welfare Services program and 495,000 will receive services under the Social Services program.

Medical Services Administration

The Medical Services Administration administers Title XIX of the Social Security Act, as amended. Title XIX, popularly called Medicaid, provides for Federal matching funds to States which have medical assistance programs for the needy. States must include in their Title XIX plans all recipients of cash assistance--AFDC families, and poor aged, blind and disabled individuals. In addition, they may provide Medicaid coverage to similar individuals who would be eligible for cash assistance, except for the level of their income and resources and who have enough money to pay for their maintenance needs but not enough to pay for needed medical care, as well as to all poor children under 21. While there is no special coverage of mentally retarded individuals as a defined group under Medicaid, mentally retarded individuals who are eligible under one of the above categories do receive Medicaid benefits.

All Medicaid services included under the State plan (mandatory services include inpatient hospital care, outpatient care, physicians' services, skilled nursing facility services for individuals 21 years of age and older, early and periodic screening, diagnosis and treatment services for children under 21, lab and x-ray services, and home health services; in addition, States may cover a range of optional services including dental care, drugs, eyeglasses, intermediate care facility services, etc.) are available to eligible mentally retarded individuals.

Effective January 1, 1972, PL 92-223 transferred intermediate care services to title XIX as an optional State service and authorized the provision of intermediate care facility services in public institutions for the mentally retarded if the institution provides health or rehabilitative services and if the eligible individuals are receiving active care and treatment. To assure that the Federal dollars made available for such institutional care would lead to higher quality care and services in an improved environment, and not simply to a replacement of State dollars, the legislation contained a provision requiring the States to maintain their own fiscal effort. To date, 29 States have responded to the new title XIX authority by adding to their State plan coverage of ICF services in public institutions for the mentally retarded. Prior to January 1, 1972, some 17 States claimed Federal matching in the costs of care in institutions which qualified as skilled nursing home services. It should be noted that because services in the past were being provided to the mentally retarded as skilled nursing home services, the adoption of the intermediate care facility program resulted in a redesignation of facilities in some States. The result is that these facilities are able to provide services at a more appropriate level of care in instances where skilled nursing care is not medically necessary. States, however, continue to provide care for the mentally retarded in skilled nursing facilities where medically appropriate.

Total Federal expenditures for services for the institutionalized mentally retarded (including ICF, skilled nursing facilities, and inpatient hospital services) were estimated to be $200 million in FY 1972. Estimates are not available on the number of Medicaid dollars expended on all other Medicaid services provided to the mentally retarded. It should be emphasized that the Medicaid eligible mentally retarded person may receive the full range of Medicaid services, and receive them on the same basis as the rest of the Medicaid eligible population.

Office of Planning, Research and Training

Accurate appraisal of the abilities of retardates is a crucial first step in the rehabilitation process leading to competitive employment, increased earnings and independent community living. As services are extended into ghetto areas to reach more and more of the functionally retarded whose handicaps derive from social and cultural deprivation, of social, educational, and vocational training most likely to help a retardate achieve full participation in the economic and communal life of the country, becomes a more subtle process requiring even more refined techniques. Precise evaluation of individual potentials and of the effectiveness of various rehabilitation approaches is an equally important prerequisite for development of innovative patterns of service to the profoundly retarded.

A comprehensive overview has been completed for types of training programs given the retarded throughout the United States and the environmental and personal characteristics that have contributed to their vocational adjustment. Similarly, a project studied the later social and vocational adjustment of 575 retarded individuals discharged from a training center over a 9-year period (1956-61) to determine those variables that facilitated their ability to get along in society. A satellite workshop program has demonstrated that several workshops in inner city areas were able to provide a variety of prevocational and vocational training experiences which they could not have provided separately.

Future projects will be concerned with improved delivery of services to retardates in model city neighborhoods and one project is presently concerned with deinstitutionalization of the mentally retarded. A new emphasis will be on rehabilitation of the retarded delinquent. Community organization projects will demonstrate in several model cities ways of involving parents of retardates in the rehabilitation process.

Complementing domestic programs, international research in mental disabilities will emphasize projects dealing with non-institutional rehabilitation of the mentally retarded and mentally ill. Rehabilitation research and training centers for the mentally retarded provide for the diagnosis, evaluation, treatment, and training in a variety of occupations in Egypt, India, Pakistan, Poland and Tunisia. Day care programs in India and Poland, supplemented by training of mothers have been successful in complementing other measures to promote the adjustment of mental retardates in the community.

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 study problems relating to the diagnosis, evaluation, treatment and training, vocational counseling and placement of the mentally retarded. Increased attention is being directed toward the developmentally disabled, and the training of personnel involved with providing services to that population.

Rehabilitation Services Administration

The Rehabilitation Services Administration is responsible for a broad range of programs designed to provide rehabilitation services for the developmentally disabled including the mentally retarded. These programs cover support for planning, administration, services and the construction of community facilities through formula grants to States as well as support project grants designed to reduce the resident population in large State institutions for the retarded by making available specialized community services and by increasing the use of generic services. Also included are grants for: Core support of interdisciplinary training programs in university affiliated facilities for manpower needed in care and treatment of the developmentally disabled; improvement of services in State residential facilities for those retarded who are appropriately placed; training of professional, supportive and technical personnel already engaged in occupations involved in the care and rehabilitation of the developmentally disabled; planning and construction of rehabilitation facilities and sheltered workshops; special projects for expansion and innovation of vocational rehabilitation services.

These diverse activities are unified by the common goal of assisting the developmentally disabled, including the mentally retarded 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 opportunities and resources available to the substantially handicapped among the developmentally disabled.

1. Developmental Disabilities

a. Formula Grants to States

The Title I, Part C of the Developmental Disabilities Services and Facilities Construction Act of 1970 (P.L. 91-517) which amended the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) authorizes formula grants to States for comprehensive planning, administration, services and construction for the developmentally disabled. The 1963 Act limited Federal support to facilities and programs for the mentally retarded. The 1970 Act extends support to include not only mental retardation but also cerebral palsy, epilepsy, and other neurological conditions approved by the Secretary. The Developmental Disabilities Act calls for Federal, State and local governments and voluntary agencies to share responsibilities for establishing and maintaining programs that will enable the developmentally disabled to: (1) enhance their physical, intellectual, and social capabilities to the fullest extent possible; (2) gain emotional maturity commensurate with social and intellectual growth; and (3) attain wherever possible skills, habits, and attitudes essential to living a personally satisfying life.

Federal support is available for a wide range of diversified services in terms of life time human needs of the developmentally disabled. The Act provides for the co-mingling of funds under this program with those of other State programs. This facilitates the development of comprehensive services for the developmentally disabled through the combination and integration of the efforts in both specialized and generic services of several State agencies representing diverse areas such as health, welfare, education and rehabilitation, without imposing a set pattern of services on any one State.

Comprehensive planning of needed services and facilities providing for more efficient and effective utilization of existing human and fiscal resources at all levels is required. New or innovative programs will be developed to fill gaps in existing services and to expand the reach of existing services among new groups of individuals. Services and resources of all State, regional, and local agencies assisting the developmentally disabled will be integrated.

Responsibility is placed at State level for developing strategies for the successful implementation of the programs. Use of Federal funds must not result in a decrease in the level of effort at State and local levels in providing services to persons with developmental disabilities. To the extent feasible, this program should stimulate an increase in effort.

To receive Federal funds under the program, States must submit State Plans to the Regional Commissioner, SRS for approval. The State Plan must include a description of how other State-Federal programs provide for the developmentally disabled and how the new program will complement and augment, and not duplicate, these programs. At least 9 programs must be taken into account: vocational rehabilitation; public assistance; social services; crippled children's services; education for the handicapped; medical assistance; maternal and child health; comprehensive health planning; mental health.

Because of a correlation between poverty and developmental disabilities, a higher Federal share is provided for areas of urban or rural poverty. These higher rates of support offer new incentives to alleviate existing inequities.

The Federal share for services in nonpoverty areas was 75 percent in Fiscal Years 1971 and 1972 and is 70 percent for Fiscal Year 1973. In poverty areas Federal support for services is 90 percent for the first 24 months of a project and 80 percent for the next 12 months. For construction projects, the Federal share is up to 66-2/3 percent for nonpoverty areas and up to 90 percent for poverty areas.

In Fiscal Year 1972, $21,715,000 was appropriated for this program. The revised F.Y. 1973 budget request provides $21,715,000, the same as 1972. In 1972, 10 percent of the appropriation was used for projects of national significance and to continue the evaluation program initiated in 1971. Approximately 69 percent of allotted funds for Fiscal Year 1972 have been earmarked for services by States and 12 percent for construction. The remaining allotted funds have been earmarked for planning and administration.

The proportion of funds utilized to provide services in Fiscal Year 1972 was as follows (in terms of primary program emphasis):

Service	Percent
Diagnosis	6.8
Evaluation	1.5
Treatment	5.5
Personal Care	1.5
Day Care	13.0
Domiciliary	2.0
Sp. Living Arrangements	6.0
Training	9.5
Education	4.7
Sheltered Employment	5.8
Recreation	5.3
Counselling	3.5
Protective and Other Soc.	.5
Information & Referral	4.5
Follow-Along	1.5
Transportation	6.0
Comprehensive (combination of services and expansion) not otherwise identified	22.4

Over 45,000 individuals were served.

Typical types of projects included:

Gasoline Service Station Training Program

This project is designed to provide a realistic opportunity for developmentally disabled persons to meet and serve customers, to make money change, and to work in the demanding atmosphere of serving the public. Work experience includes pumping gas, washing cars, changing oil, lubricating cars, and servicing new and used cars for automobile dealers in the area. Six clients were placed in the project. One is currently working as a service station attendant and five are working in other competitive occupations.

Coordinator to Assist Clergy

Funds were awarded to a private non-profit community agency to hire a coordinator to assist local churches and clergy in becoming involved in planning innovative services to the developmentally disabled people and their families.

Hostels for Severely and Profoundly Handicapped

Two developmental hostels for severely and profoundly retarded, multiple physically handicapped children now in State institutions were established. Each hostel will serve 3 children, prepare them in social skills (eating, dressing, toilet training, physical therapy, recreation and education).

Life Enrichment Program for Adults not Eligible for Workshops Placement

In one community within a State, a small segment of the adult cerebral palsied population are so severely involved physically that they do not qualify for existing programs. They are living at home generally with aging parents who find it increasingly difficult to provide a 24 hour a-day care. These individuals are potential residents in State or private residential care facilities within the foreseeable future. The Life Enrichment Program has removed the handicapped persons from the home on a scheduled basis three afternoons a week to an activity center thereby increasing their capability to live within their family environment.

Cooperative Areawide Transportation System

Nine public non-profit agencies have joined together to form the Cooperative Areawide Transportation System for the purpose of providing transportation services and programs to the developmentally disabled in a large metropolitan area. Future plans call for extending this service into an adjoining State. The services include transporting individuals to and from daily routine activities, special necessary services, special functions and occasions, and delivery of goods to sheltered workshops and activity centers.

Coordination with Other Agencies

The State Planning and Advisory Council was able to refer to other agencies four requests which came to it for funds. These projects were rewritten and expanded to provide better services to the developmentally disabled.

Coordinated Protective Service System

One State is in the process of developing a network of protective services including case management and personal advocacy. It represents a joint effort of public and private organizations. Originally projected for a high priorities area, it is now being developed on a Statewide basis.

Special projects of national significance are designed to provide knowledge and information, technical assistance and evaluation which will improve the planning and delivery of services to the developmentally disabled. Ten projects were approved using Fiscal Year 1972 funds. They include:

1-5. Child Advocacy: The Division of Developmental Disabilities, Rehabilitation Services Administration has joined with the Bureau of Education for the Handicapped and the National Institute of Mental Health in comingling funds to support five child advocacy projects: The National Association for Retarded Children project aims at catalyzing the development of a nationwide volunteer child advocacy program. Peabody College seeks to establish four general advocates in four rural counties in Tennessee. The Kentucky Commission on Children will establish State and regional advocacy offices. The National Easter Seal Society for Crippled Children & Youth aims to perfect a model of advocacy for physically handicapped children. And, the United Cerebral Palsy Association seeks to establish three models of advocacy for developmentally disabled children and their families in three areas of the U.S.A.

6. Legal Advocacy: The Division of Developmental Disabilities, Rehabilitation Services Administration has joined with the Bureau of Education for the Handicapped in comingling funds to support a legal advocacy project at Notre Dame University. It will include establishment of a reference system for all national and State legislation on developmental disabilities; a reference system for all national, State, and local legal actions pertinent to the developmentally disabled; an electronic retrieval system for all data in the system; a research arm to study questionable issues pertinent to the legal rights of the developmentally disabled; and eleven other aims related to law.

7. Technical Assistance to State Councils for the Developmentally Disabled: At the University of North Carolina a technical assistance and consultation system is to be established to develop a strategy and organization to deliver technical assistance to State and territorial councils for the developmentally disabled, assisting them in their tasks, especially in planning and evaluation, but also including program management, information, and data collection and dissemination. A needs assessment survey will be conducted prior to the provision of technical assistance in order to determine critical areas for technical assistance.

8. National Information and Individualized Data Base for the Developmentally Disabled: At the Pacific State Hospital (California) in association with UCLA, a national information center and individualized data base is to be established to develop an individualized tracking system, individual developmental assessment of progress through a continuum of services, evaluation of programs providing services to individuals, groups, and families, and derivation of a benefit-cost analysis on services rendered, including living arrangements. The project will attempt to fill the void that exists in terms of information about services and individuals in the national system.

9. National Conference of State Councils for the Developmentally Disabled: The Council for Exceptional Children has conducted a national conference of State Councils with the National Advisory Council on Developmental Disabilities. The conference had as its aim an encouragement of a fuller understanding and effective implementation of the Developmental Disabilities Act, provision of up-to-date technical information relative to the functions of planning and evaluation of services for the developmentally disabled, developmental and extension of communication between the National and State councils, and provision of a forum for discussion of issues related to the Developmental Disabilities Act, and its programs.

10. De-institutionalization or Community Care for the Developmentally Disabled: No States have been selected at the time of this writing to be the recipients of grants to plan, develop, implement, and evaluate new approaches and methods for community care for the developmentally disabled, which will include an effort to prevent individuals from going into institutions, get present residents out of institutions, and keep them out once they have been released. This will include an effort to update standards of care and services for the developmentally disabled remaining in institutions and residing in community living arrangements.

The initial staffing program under P.L. 90-170 will be substantial in the final year of Federal assistance in Fiscal Year 1974. This program supports professional and technical personnel in facilities for the mentally retarded. In 1973 there were 410 projects which served an estimated 91,000 persons. Grants were made on a declining basis for 51 months, the grants did not exceed 75 percent of the cost for the first 15 months, 60 percent for the next year, 45 percent for the third year, and 30 percent for the last 12 months.

b. University-Affiliated Facilities for the Developmentally Disabled

Under Title I, Part B of the Developmental Disabilities Services and Construction Act of 1970, the University-Affiliated Facilities for the Developmentally Disabled Program provides for Federal support for interdisciplinary training in institutions of higher learning as well as for the construction of facilities to house these programs. Grants may be made to cover the costs of administering and operating demonstration facilities and training programs for personnel needed to render specialized services to persons with developmental disabilities. Grants may also be made to assist in planning for construction of facilities to house these programs. In Fiscal Year 1973, $4,250,000 was made available for this program through continuing resolution. Grants were made to the facilities listed below and their satellites to partially fund expenses of administration and operation.

Among the professional disciplines trained 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 program so that each discipline involved in the habilitation and rehabilitation of the developmentally disabled may be fully familiar with the contributions of the other disciplines.

Approved projects for administering and operating demonstration and training programs in university-affiliated facilities for the developmentally disabled are: Children's Hospital Medical Center, Boston, Massachusetts; Walter E. Fernald State School, Waltham, Massachusetts; Newark State College, Union, New Jersey; Albert Einstein College of Medicine, Bronx, New York; New York Medical College, New York, New York; New York Medical College, Valhalla, New York; Georgetown University, Washington, D.C.; Johns Hopkins, Baltimore, Maryland; Temple University, Philadelphia, Pennsylvania; University of Alabama (Birmingham), Birmingham, Alabama; University of Alabama (Tuscaloosa), Tuscaloosa, Alabama; University of Miami, Miami, Florida; Georgia Retardation Center (Atlanta), Atlanta, Georgia; Georgia Retardation Center (Athens), Athens, Georgia; University of North Carolina, Chapel Hill, North Carolina; University of Tennessee, Memphis, Tennessee, University of Kentucky Center for the Handicapped, Lexington, Kentucky; Indiana University, Bloomington, Indiana; Indiana University (Indianapolis), Indianapolis, Indiana; The University of Michigan, Ann Arbor, Michigan; University of Cincinnati, Cincinnati, Ohio; Ohio State University, Columbus, Ohio; University of Wisconsin, Madison, Wisconsin; Louisiana State University, New Orleans, Louisiana; University of Iowa, Iowa City, Iowa; University of Nebraska, Lincoln, Nebraska; Meyer Children's Rehabilitation Inst., Omaha, Nebraska; University of Kansas (Lawrence), Lawrence, Kansas; University of Kansas (Kansas City), Kansas City, Kansas;

University of Kansas (Parsons), Parsons, Kansas; St. Louis University, St. Louis, Missouri; University of Missouri, Columbia, Missouri; University of Colorado, Denver, Colorado; University of South Dakota, Vermillion, South Dakota; Utah State University, Logan, Utah; University of California (Los Angeles), Los Angeles, Claifornia; Children's Hospital of Los Angeles, Los Angeles, California; University of California (Irvine), Irvine, California; University of Oregon (Eugene), Eugene, Oregon; University of Oregon (Portland), Portland, Oregon; and the University of Washington (Seattle), Seattle, Washington.

c. Project Grants for Rehabilitation of the Mentally Retarded

Project grants administered by the Division of Developmental Disabilities under the provisions of Section 4(a)(1) of the Vocational Rehabilitation Act, as amended by the Vocational Rehabilitation Amendments of 1968, pay part of the cost of organized, identifiable activities which are undertaken to contribute to the rehabilitation of mentally retarded individuals generally not eligible for vocational rehabilitation services. Grants provide for expansion or establishment of programs serving the mentally retarded, application of new techniques for rendering services, coordination of resources and information, and for increasing the number and types of specialized personnel working with the retarded.

The activities undertaken should be directed towards the goal enunciated by the President in November 1971 of reducing the population in residential institutions and towards achieving the Department Objective. (Community Care for the Developmentally Disabled.)

Funds for new Rehabilitation Service Projects will be utilized to stimulate community care for the mentally retarded and Institution-Community Services Interaction. The following areas are emphasized:

1. Development and staffing of alternative care settings, and development, improvement or expansion of services which prevent unnecessary periods of institutionalization, such as:

   (a) Services needed by persons on waiting lists for admission to institutions, to prevent or postpone admission;

   (b) Services needed by persons whose discharge from an institution is delayed because of lack of appropriate community resources;

   (c) Supportive services needed by persons discharged from an institution in order to continue to maintain themselves in the community;

   (d) Life-long services which will insure the proper care of a dependent adult outside his parents' or siblings' homes.

2. Development, improvement or expansion of institutional outreach services for "at risk" population, such as:

   (a) Use of institutional staff to provide services in nearby communities;

   (b) Use of resources within institutions to serve non-residents (daycare, special education and training, treatments, respite care, etc.).

In Fiscal Year 1973 approximately 329 new projects will serve approximately 15,640 individuals and provide inservice training to 960 people.

d. Mental Retardation Hospital Improvement and Mental Retardation Hospital Inservice Training

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 services 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). Since all program activities are now being focused toward the Objective of Community Care for the Developmentally Disabled only continuation projects are approved under this program.

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 residents with multiple handicaps; 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 Hospital Inservice Training program provides a means for increasing the effectiveness of employees in State residential institutions for the mentally retarded. It is an integral part of the Hospital Improvement Program. Through this program a rapidly expanding body of knowledge about practices in the care of the mentally retarded into more effective services is being translated into daily practice.

Hospital inservice training has been broadly defined to include: preservice training, job-related training, inservice training, continuing education, special training and technical training needed to introduce new methods, and training of personnel which will result in an improved quality of care for the mentally retarded residing in institutions.

Because personnel such as attendants, houseparents, 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, sub-professional, and technical personnel who have direct responsibilities for resident care and training.

There are four general types of training supported by inservice training grants to institutions for the mentally retarded: (a) 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 content of the training programs includes general instruction in the areas of mental retardation; child growth and development; patient-staff relations; human behavior; intra-staff relations; supervisory skills; communications skills; adjunctive therapy skills; and development of community-living skills.

For Fiscal Year 1973 there are 111 Hospital Improvement and Hospital Inservice Training projects with estimated expenditures of $4,500,000.

The coordination of institutional programs with community services programs and statewide comprehensive planning activities remains an important objective of these programs.

e. Collection and Dissemination of Information

Mental Retardation Abstracts is a specialized mental retardation abstracting and information service published by the Division of Developmental Disabilities, Rehabilitation Services Administration, Social and Rehabilitation Service. Specifically, this service is designed to meet the needs of investigators and other workers in the field of mental retardation for comprehensive information about new developments and research results and to foster maximum utilization of these results.

Mental Retardation Abstracts is published quarterly under contract with Herner and Company, Washington, D.C. which collects all the current world literature on mental retardation, writes informative abstracts, indexes the literature and compiles annotated bibliographies on various topics.

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; (18) Behavior Modification of the Mentally Retarded; (19) Dental Care for the Mentally Retarded; (20) Malnutrition and Mental Retardation; (21) Research and Learning with the Mentally Retarded; (22) Education and Psychological Services for the Mentally Retarded Deaf; (23) Selected Bibliographies and Surveys on Mental Retardation.

Review articles and critiques have been prepared on: (1) Mental Retardation: Definition, Classification, and Prevalence; (2) Research on Linguistic Problems of the Mentally Retarded; (3) Attendant Personnel; Their Selection, Training and Role; (4) Research on Personality Disorders and Characteristics of the Mentally Retarded; (5) Effects of Severely Mentally Retarded Children on Family Relationships; (6) Factor Analysis and Structure of Intellect Applied to Mental Retardation; (7) Counseling Parents of the Mentally Retarded;

(8) Genetic Aspects of Mental Retardation; (9) Instrumental Learning in Mental Retardates; (10) Vocational Rehabilitation of the Mentally Retarded: The Sheltered Workshop; (11) Relationships between Educational Programs for the Mentally Retarded and the Culturally Deprived; (12) A Decade of Research on the Education of the Mentally Retarded; (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 and annotated bibliographies appear in the quarterly journal Mental Retardation Abstracts, and may be obtained through subscription directly from the Superintendent of Documents.

2. 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; personal 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.

Recent years have seen dramatic advances in the provision of vocational rehabilitation services to the mentally retarded. The retarded now comprise about 14% of the people rehabilitated from all categories of disability by the State-Federal program of vocational rehabilitation. In 1973, about 46,700 retardates will be rehabilitated.

Basic to the vocational rehabilitation effort has been the growing reliance on counselors and other vocational rehabilitation staff who work exclusively 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 and facilities for the retarded continue to be developed and expanded, the number of specialized counselors within State vocational rehabilitation agencies is expected 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 make a satisfying transition from school to work. These cooperative 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 separate agreements with individual school districts. Some programs function only to serve the mentally retarded, while 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. 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 a rehabilitation facility may be established by State rehabilitation agencies, or by the State agency in cooperation with 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. In all cases, State or private financial resources must be used to match Federal funds.

The program for Federal employment of the mentally retarded has been an outstanding success, with 7442 placements in 116 different job titles at Federal installations across the country. The retention rate for these retarded employees has been far superior to that of other employees in similar jobs; and the program has become a part of the permanent personnel policy of the U.S. Civil Service Commission. State vocational rehabilitation agencies play a highly important role in this program in that they certify all retarded applicants as job-ready.

Special project grants for the innovation and expansion of vocational rehabilitaton services have been utilized to extend and improve State rehabilitation agency efforts for the mentally retarded. Expansion grants are designed specifically to increase the number of people rehabilitated by the State agency. Within an extensive program of rehabilitation facility improvement, the Rehabilitation Services Administration administers Facility Improvement grants designed to upgrade the services of sheltered workshops and other facilities by supporting such activities as employment of additional staff, technical consultation, staff development, and the purchase of equipment.

During fiscal year 1972, 197 Facility Improvement Grants totaling $4,490,000 were awarded to rehabilitation facilities, many of which were affiliated with local associations for retarded children. Facility 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 to provide workshops and other facilities with special consultation services in such areas as workflow, safety engineering, contract procurement, and vocational evaluation and adjustment; and (2) projects to share in the cost of providing training services for handicapped individuals in public or 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 and the provision of occupational tools and equipment necessary for training purposes and job tryouts. During fiscal year 1972, Training Services Grants totaling $7,810,000 were awarded to 56 rehabilitation facilities serving the mentally retarded as well as other disabled persons.

3. Rehabilitation Training

Rehabilitation training in Mental Retardation has focused on social work and rehabilitation counselor training by supporting field units in which student trainees can concentrate their practicum experience in work with this client population. Such grants also support field instructional faculty.

Federally-funded programs of general student aid are now available to assure that students are not deprived of higher education for lack of funds. These programs include scholarship assistance for needy students at the undergraduate level and guaranteed loans for other undergraduate students and for graduate study. In view of the availability of these more general forms of assistance, specialized programs such as SRS training grants are duplicative and unnecessary. That is, a student who wishes to pursue an education in social work can receive the assistance he needs from the general programs, thus rendering the specialized program unnecessary. Therefore, rehabilitation training will be phased out by the end of fiscal year 1974.

Purpose

The basic purpose of the Social insurance programs (Old-Age, Survivors, Disability and Medicare) is to provide cash benefits to replace, in part, earnings that are lost to individuals and families when earnings stop or are reduced because the worker retires, dies, or becomes disabled, and to provide health insurance protection to persons 65 and over and to the disabled under certain conditions. This part of the program is contributory and self-supporting. Benefits are wage-related and entitlement to benefits is an earned right. Another program, (Supplemental Security Income) recently added to those SSA administers provides payments to the needy aged, blind and disabled, is non-contributory and will be financed entirely out of general Federal revenues.

Historical Development

In 1935, when the original social security law was passed, the program was to have provided only retirement benefits to aged workers. In 1939, benefits for dependents and survivors were added and benefits became payable in 1940. Protection against long-term total disability--not only for disabled workers, but also for adult sons or daughters (who became disabled before age 18) of disabled, retired, or deceased workers--was provided by the 1956 amendments. In 1965, health insurance benefits for the aged were added. The 1967 amendments provided benefits for disabled widows and widowers age 50 and over. Since 1949, there have been eight general benefit increases in recognition of the fact that prices and wages have gone up. In 1972 a section of P.L. 92-336 provided for an automatic benefit increase when the cost-of-living rises by 3 percent or more. Effective January 1974, payments under the Supplemental Security Income Program will be made to qualified disabled persons, including the mentally retarded.

Economic Impact

Mental deficiency is a major factor in more than 65 percent of cases involving dependents or survivors who have been continuously disabled since childhood. It is the primary diagnosis in about half of all childhood disability cases. In fiscal year 1972, an estimated 186,900 mentally retarded adults disabled in childhood and retarded workers received $195 million in benefits.

The regulations contain guides as to the level of severity required in disability cases involving mental retardation. These regulations (published in 1968) have the effect of law and are available to the public and the medical community.

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.

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.

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.

Medicare 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 Medicare program. Recently enacted legislation extends Medicare coverage, beginning July 1, 1973 to social security disability recipients, under 65 years of age, who have been receiving disability benefits for 24 consecutive months.

Activities and Achievements

During 1970, the Social Security Administration launched a new program instituting biennial on-site reviews in State mental hospitals and schools for the retarded. The program focus is an in-depth examination of the way in which these institutions are managing social security benefits on behalf of patients who receive their checks through an institutional official serving as "representative payee."

The observations and conclusions resulting from a State review are, after analysis, communicated to the State Commissioner for his use in the development of improved practices in the State's system. The first report cycle has been completed and issued to States in all 51 jurisdictions (including the District of Columbia). The second cycle will be concluded in June 1974. The findings will also serve as a basis for SSA program and policy evaluation. In this way, it is expected, the on-site approach will strengthen relationships with the States, improve their understanding of their responsibility for optimum use of benefits when serving as representative payee, and open new channels for the discussion of problems and practices affecting the well-being of all beneficiary-patients in State mental institutions.

SSA has participated in the program to employ the mentally retarded since its inception in 1964. It has also tried to generate interest in the program by private employers and other Federal agencies. In SSA retardates are successfully performing in such positions as mail and file clerks, messengers, operators of printing, xerox, card reader machines, and key punch machines. The SSA experiment with the color coding of file cabinets and cartridges of microfilm has proven highly successful in broadening the employment opportunities for retardates to an area of work which requires a very high degree of accuracy. The retardates have performed their duties in an excellent manner.

The Social Security Administration has published a leaflet entitled If You Become Disabled. A number of others are in stages of preparation or revision.

The color film, "Where There is Hope," which tells of the social security benefits available for the adult child, continues to be distributed through district offices for theatrical and general showing. It is also offered to State associations for retarded children. It depicts teenagers and older people at work in a sheltered workshop in Washington, D.C., diagnosis and therapy at the John F. Kennedy Institute in Baltimore, and the trial work period of a beneficiary in Greensboro, North Carolina.

The 1967 Survey of Institutionalized Adults conducted by the Social Security Administration collected basic information on the socio-economic characteristics of mentally retarded and other disabled persons aged 18 and over in institutions such as homes and schools for the mentally and physically handicapped, mental hospitals, chronic disease and other long-term hospitals. Data was obtained from institutional records and from relatives and guardians. The survey focused on types of care, cost of care, sources of payment, economic resources of the patient and his family, and his social relationships with family and friends. The handling of the institutionalized person's economic resources by administrators (including the institution) and payees was also examined. Reports on demographic characteristics, costs of care, financial administrators and economic resources have been published. A monograph summarizing all findings will be available in late 1973.

FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration is concerned with preventing mental retardation that might follow the use or misuse of drugs or hazardous substances. The special age of concern is the reproductive age. The vulnerable periods are those specifically of embryonic, fetal, and infant life. Dosage levels considered safe in older infants may be potential causes of permanent brain damage in the prenatal or newborn age group which possess immature mechanisms of detoxification of these drugs. Infants cannot handle drugs as well as adults because of lack of development of an enzyme system.

Mental retardation can be defined to limit it to the impairment of the learning ability, or extended to include the lack of emotional response. Whether or not mental retardation is defined to include mongoloids, persons suffering from degenerative diseases such as Parkinsonism, institutionalized mental patients, or others, FDA is concerned with the use or abuse of drugs intended to prevent or treat such conditions. Much of the work in this area is so specialized that it is performed by individual investigators rather than by drug companies.

In the Bureau of Drugs, the Office of Scientific Evaluation monitors the investigational use of new drugs in early testing phases. Animal experimentation is required to prove a new drug safe and effective before that drug may be tested on human beings. Observations of adverse effects of new drugs are reported within the surveillance system of the administration.

FDA expects investigators to set up metabolic methodology on new entities, at least to attempt to develop functional toxicology and biochemical toxicology, relating experiences of one species to those of another, eventually to experiences of man.

The Food and Drug Administration also is concerned with the treatment of mental retardation. Special diets and drugs may or may not be effective. Regulatory action is taken against drugs or devices that are represented to be useful in the prevention or treatment of mental retardation but in fact have no such beneficial effects.

Surveillance by the Food and Drug Administration also covers any untoward effect of chemical entities used in foods, drugs, cosmetics, or household chemicals. These data are acquired in close liaison with many hospitals, with the American Medical Association, the World Health Organization, the pharmaceutical industry, and with other health, education, and welfare agencies. This information is catalogued, retrieved, and evaluated by means of an advanced data processing system.

SURPLUS PROPERTY PROGRAM

The Office of Surplus Property Utilization, within the Office of the Assistant Secretary for Administration and Management, carries out the responsibilities of the Department under the Federal Property and Administrative Services Act of 1949, as amended, which makes surplus Federal real and personal properties available for health and educational purposes. The properties which become available under this program are those that have been determined by the General Services Administration as no longer having any further Federal utilization.

Surplus personal properties generating at Federal installations in the United States, Europe and Southeast Asia, are screened to determine those which may be needed and usable by eligible institutions throughout the country in conducting health and educational programs. Properties determined to have such need and usability are allocated by the Department of Health, Education, and Welfare for transfer to State Agencies for Surplus Property which have been established in all States. These State Agencies secure the properties, warehouse them, and make the distribution to eligible donees for health and educational uses within their respective States. The only costs to the eligible donees are the handling and service charges which are assessed by the State Agencies.

In the case of real properties which have been determined to be surplus to Federal needs, notices of their availability are sent to potentially eligible applicants, either by the State Agencies or the Regional Representatives for Surplus Property located in our ten regional offices. Real Properties available for removal from their site for relocation are conveyed by agreement of sale with restrictions as to the use of the facilities which run for a period of 5 years. These properties are conveyed with a 100 percent public benefit allowance applied against the sales price. Land, or land and buildings together with other improvements, are conveyed by deed which contains restrictions as to use for a period of 30 years. These properties are conveyed with public benefit allowances ranging up to 100 percent applied against the sales price. The only other costs to eligible transferees are "out-of pocket" Federal costs, i.e., appraisals, surveys, etc.

Schools for the mentally retarded are eligible to acquire surplus real and personal property. In the case of personal property, such a school must be operated primarily to provide specialized instruction to students of limited mental capacity. It must be tax-supported or non-profit and exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954. It must operate on a full-time basis with a staff of qualified instructors for the equivalent of a minimum school year prescribed for public school instruction of the mentally retarded. It must also demonstrate that the facility meets the health and safety standards of the local governmental body.

An applicant for real property must be a State, or a political subdivision or instrumentality thereof; a tax-supported educational or public health institution; or a nonprofit educational or public health institution that has been held to be exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954. Its proposed program of use must be fundamentally for an educational or public health purpose; i.e., devoted to academic, vocational or professional instruction, or organized and operated to promote and protect the public health. Real property may be put to a joint use, namely, for the training of the mentally retarded as well as the physically handicapped. Conveyances have been made for hospital use where, as a part of the total program, portions of the facility are used for the treatment and training of the mentally retarded.

Available personal property may range anywhere from a nail to an electronic computer. Many items have never been used before. Real properties may consist of all types of buildings which are removable, land with or without structures and other improvements such as utility lines, sewer and water systems, etc.

Pamphlets giving more detailed information as to eligibility of organizations for both surplus real and personal property, as well as additional information in connection with the Surplus Property Utilization Program, along with a directory of the State Agencies for Surplus Property and the ten Regional Offices of the Department, may be obtained from the Office of Surplus Property Utilization, Department of Health, Education, and Welfare, Washington, D. C. 20201.

The following are examples of real properties conveyed under the program for use in aiding the mentally retarded.

The State of Missouri passed legislation authorizing the State Department of Education to establish and operate State schools for mentally retarded in any county or in a district comprised of two or more counties. One of the first of these schools was established on 4.95 acres of land with 9 buildings, we conveyed for this purpose, at the surplus O'Reilly General Hospital, Springfield, Missouri. The facility is a day school with a current enrollment of 113 children, ages 6 - 20.

The Arizona Children's Colony obtained 30 acres of land at the Davis Monthan Air Force Base in July 1967 as a site for the new "Mental Retardation Center at Tucson." Plans were to construct 6 buildings initially, including 3 residential units. These have been completed and provide residential care facilities for approximately 100 residents and day care facilities for 150 people in the Tucson area. In addition, the facilities provide space for a preschool program for children not yet determined to be retarded, vocational training and rehabilitation therapy, consultation services, and, in cooperation with the University of Arizona, training and research. Future plans are to enlarge the Center into a facility which will have approximately 200 beds for residents and space for 300 to 400 day care persons.

The former Sunmount Veterans Hospital Reservation, Tupper Lake, New York, consisting of 111 acres of land improved with 44 buildings and installed equipment, was conveyed to the State Department of Mental Hygiene to provide a complete program of care, treatment, education, and rehabilitation of mentally retarded children and adults. The State first took over the hospital under a permit agreement in 1965, and the majority of the staff remained to operate the new program. Nurses were assigned to the three operating State schools for orientation courses in the care of the mentally retarded. Upon their return to Tupper Lake, the first group of patients was transferred to the new facility. Since that time, this 506-bed hospital has been operated to serve mentally retarded persons of all ages, drawn from the five upstate New York counties.

The State of Florida has undertaken the establishment of a system of Sunland Training Centers throughout the State for the training of its mentally retarded children. Plans call for 10 of these Centers which will have a capacity of approximately 1,000 resident students each. One of these Centers which serves the northwest section of the State, has been established at Marianna on 372.67 acres of land with 65 buildings--formerly the Graham Air Force Station--through our Surplus Property Utilization Program. Most of the personal property for the operation of this facility was conveyed with the real estate.

The State of Georgia obtained the former Veterans Administration Domiciliary in Thomasville, consisting of 207 acres of land and 131 buildings, with a bed capacity of 400 to 800, for the care and rehabilitation of the mentally ill and retarded. Another site of nearly 200 acres at the former U. S. Penitentiary Honor Farm near Atlanta has been conveyed for a Regional Mental Hospital for the rehabilitation and training of the mentally ill and retarded.

In 1966, the State of Ohio received the former Veterans Administration Hospital at Broadview Heights, near Columbus. Now known as the Broadview Center for the Mentally Retarded, inpatient service was begun in 1968. During the year, 580 persons applied for service. Of this number, 115 were admitted to the hospital unit. It is expected that the Center will have a capacity for 250 inpatients, in addition to its large outpatient load, with future expansion to 600.

Other States also have programs for the mentally retarded, using Federal surplus real and personal properties. The Department conveyed 34.39 acres of land and 47 buildings, formerly the Lufkin Air Force Base, Lufkin, Texas to the Texas State Hospital and Special Schools for a resident unit to accommodate between 1,000 and 1,500 retarded children. Louisiana received 537 acres with modest improvements at the Belle Chasse Navy Ammunition Depot, New Orleans, as a site for a State unit serving this area for day treatment or resident training and care of the mentally retarded. The State of Kansas has renovated the Winter Veterans Administration Hospital, comprising 225 acres and 195 buildings, for the treatment and care of some 300 to 400 mentally retarded children. Two acres of this property were retransferred in 1968 to the Topeka Association for Retarded Children, Inc. A building has been constructed to house classrooms, therapy rooms, workshop, and necessary offices. The Association trains and educates the retarded of school age and young adults.

Two outstanding programs for the mentally retarded are operated in Prince Georges County, Maryland. One, operated by the Prince Georges County Association for Retarded Children, is located on approximately 6 acres of land, formerly a part of Andrews AFB, and is known as the Melwood Agricultural Training Center. Two greenhouses have been built, as well as an Administration-Floral Design Shop, and Cement Products Shop. The boys learn to work in greenhouses, to landscape and do field and ground work, and to do the heavy work--such as making cement garden equipment; and the girls concentrate on design and the more asthetic products fashioned from fresh and artificial flowers. The other program is operated by the Prince Georges County Board of Education on 5.7 acres of land at Silver Hill, Maryland--formerly a Weather Bureau test site. A modern comprehensive school has been constructed, which has been designed to meet the individual needs of trainable children. It includes the very latest in equipment, a competent and dedicated staff, and supervised playground. The educational program of this, the Hillcrest Heights Special Education Center, is considered to be an outstanding one in the area of special education. Visitors continue to observe the operation and there is an excellent program of parent education and public relations. Current enrollment is 124 students, with the majority of the students being bused. Bus aides ride the buses in order to help with any problems which might arise during the period of transportation.

Some school districts include classes for the mentally retarded in the same facilities with other educational programs. In August 1968 three quonset buildings, located on 2 acres of land at the Naval Reserve Training Center, Woonsocket, R. I., were conveyed to the City of Woonsocket. These buildings, which were joined together, are divided into 30 classrooms and offices, and house various special educational programs and services, including those for the mentally retarded. One program teaches homemaking to girls, and another provides teenagers an opportunity to become acquainted with the world of work outside the home, and to develop skills and attitudes which enable the child to become occupationally competent.

Smaller areas, such as former Post Office buildings and sites and Nike sites, have been converted into schools and training centers. The former Post Office at Carlisle, Pennsylvania, is now a school, operated by the Cumberland County Association for Retarded Children; Lake County, Ohio has conveyed the former Post Office at Willoughby into a school for the retarded; the former Post Office in Lebanon, Tennessee, has been conveyed to Wilson County for vocational rehabilitation of the retarded; and the Butler, Pennsylvania Post Office was conveyed to the Butler County Association for Retarded Children; and portions of Nike sites

at Needham, Massachusetts and King County, Washington are now used in the care and training of the mentally retarded.

Approximately 1 acre of land and 2 buildings--formerly a part of the Naval Supply Center, Puget Sound, Seattle--were conveyed to the Northwest Center for the Retarded, a nonprofit corporation in Washington. This Center provides education, specialized training and related service to students who are ineligible for any community or public school program. Enrollment is 86, ranging in age from 2 to 47 years. The goal is to develop those skills necessary for students to participate in existing public school classes, workshops, or as contributing members of society. No student is turned away because of his handicap nor because of his family's inability to pay.

The Harrison County Board of Education, Mississippi, received approximately 10 acres of surplus land at the Veterans Administration Hospital Reservation, Biloxi, on which to construct a school for the physically and mentally handicapped. The school, designed to serve approximately 200 students, has been completed and now provides education for the physically and mentally handicapped of school and preschool age children of Harrison County and three nearby counties. While the school does serve educable students, the vast majority are of the trainable classification.

Through June 30, 1971, 5,206.7 acres of land and 805 buildings have been transferred to institutions for use in programs serving the mentally retarded. These properties originally cost the government $46,043,436 and had a fair market value of $17,641,623 at the time of transfer.

Schools for the mentally retarded operated by State and local agencies of government as well as many nonprofit schools operated by Associations for the Mentally Retarded or Cerebral Palsy are major users of surplus personal properties acquired through the State agency distribution center of their State. During FY 1971, surplus personal properties having an original acquisition cost of 332 million dollars were donated to eligible public health, educational and civil defense donees in the States. Representatives of schools for the mentally retarded should establish their school's eligibility with their State agency and make regular visits to their State agency distribution center(s) to inspect available properties and select items needed by their school.

APPENDIX

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Obligations for Mental Retardation Activities

Fiscal Years 1972-1974
(Thousands of Dollars)

ACTIVITY	1972	1973 Revised Budget Estimate	1974 Budget Estimate
OFFICE OF EDUCATION			
Services			
Title I, ESEA, Educationally Deprived Children	$46,400	$46,400	1/
Title III, ESEA, Supplementary Centers	4,900	4,900	1/
Education for the Handicapped Act, Part B	10,160	10,566	1/
Education for the Handicapped Act, Part C, Section 623	950	988	$ 988
Education for the Handicapped Act, Part F	700	3,000	3,000
Vocational Education Act, Part B	11,500	11,500	1/
Total, Services	$74,610	$77,354	$ 3,988
Training			
Education for the Handicapped Act, Part D	10,500	10,920	10,920
Education Professions Development Act	1,400	1,400	---
Total, Training	11,900	12,320	10,920
Research			
Education for the Handicapped Act, Part E	$ 1,600	$ 1,664	$ 1,664
Total, Research	1,600	1,664	1,664
Other			
Library Services and Construction Act	69	69	---
Total, Other	69	69	---
TOTAL, OFFICE OF EDUCATION	$88,179	$91,407	$16,572
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION			
Services			
Maternal and Child Health Services			
Maternal and Child Health Services (Title V, SS Act)	$ 6,988	$ 6,988	$ 6,988
Crippled Children's Services (Title V, SS Act)	6,002	6,002	6,002
Community Environmental Management (P.L. 91-695)	7,546	7,805	7,588
Total, Services	$20,536	$20,795	$20,578
Training			
Maternal and Child Health			
Training for Health and Related Care of Mothers and Children (Section 511, Title V, SS Act)	$13,571	$13,857	$13,857
Maternal and Child Health Services (Title V, SS Act)	2,767	2,767	2,767
Crippled Children's Services (Title V, SS Act)	2,998	2,998	2,998

ACTIVITY	1972	1973 Revised Budget Estimate	1974 Budget Estimate
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (Continued)			
Training (Contd.)			
Mental Health Training (Section 303, PHS Act)	$ 1,527	$ 1,341	$ 1,341
Total, Training	$20,863	$20,963	$20,963
Research			
Maternal and Child Health			
Research Relating to Maternal and Child Health and Crippled Children's Services (Title V, SS Act)	$ 1,600	$ 1,600	$ 1,600
Mental Health Research (Section 301, PHS Act)	605	531	531
Total, Research	$ 2,205	$ 2,131	$ 2,131
Other			
Health Care Facilities (Title VI, PHS Act)	$ ---	$ 1,300	$ ---
Total, Other	$ ---	$ 1,300	$ ---
TOTAL, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION	$43,604	$45,189	$43,672
NATIONAL INSTITUTES OF HEALTH			
Training			
Neurology and Stroke	$ 6,212	$ 5,023	$ 4,550
Child Health	1,897	1,342	1,116
Total, Training	$ 8,109	$ 6,365	$ 5,666
Research			
Neurology and Stroke	$ 6,169	$ 6,010	$ 5,721
Child Health	17,853	18,000	17,528
Total, Research	$24,022	$24,010	$23,249
TOTAL, NATIONAL INSTITUTES OF HEALTH	$32,131	$30,375	$28,915
SOCIAL SECURITY ADMINISTRATION			
Income Maintenance			
Estimated Benefit Payments from Trust Funds	$195,000	$245,700	$281,450
Trust Fund Obligations Incurred to Adjudicate Claims of Beneficiaries	3,205	3,502	3,740
Total, Trust Funds	198,205	249,202	285,190
General Fund Payments for Supplemental Security Income	---	---	104,000
General Fund Obligations Incurred to Adjudicate Claims for Supplemental Security Income	---	---	6,465
Total, General Funds	---	---	110,465
Total, Income Maintenance	198,205	249,202	395,655
TOTAL, SOCIAL SECURITY ADMINISTRATION	$198,205	$249,202	$395,655

ACTIVITY	1972	1973 Revised Budget Estimate	1974 Budget Estimate
SOCIAL AND REHABILITATION SERVICE			
Services			
Rehabilitation Services			
Grants to States, Sec. 2, VR Act	$ 72,670	$ 80,693	$ 82,215
Innovation Grants, Sec. 3, VR Act	---	---	---
Expansion Grants, Sec. 4(a)(2)(A), VR Act	100	100	100
Facility Improvement Grants, Sec. 13, VR Act	3,748	3,150	2,550
Services for the Developmentally Disabled			
Formula Grants for the Developmentally Disabled, (P.L. 91-517, Sec. 131)[2]	$12,571	$19,120	$13,681
Hospital Improvement, PHS Act, Sec. 303	4,624	3,537	3,537
Initial Staffing (P.L. 88-164, Sec. 141)	7,276	5,000	1,500
Project Grants, VR Act, Sec. 4(a)(1)	6,680	5,958	8,275
Social Services, SS Act	102,900	113,900	112,000
Medical Assistance, Title XIX, SS Act	200,000	380,000	420,000
Total, Services	$410,569	$611,458	$643,858
Research			
Research and Demonstrations, Secs. 4 and 7, VR Act	$ 1,230	$ 750	$ 800
Research and Training Centers, Sec. 4(a)(1), VR Act	935	600	600
Social and Rehabilitation Activities Overseas (Special Foreign Currency Program)	347	200	300
Total, Research	$ 2,512	$ 1,550	$ 1,700
Training			
Services for the Developmentally Disabled VR Act, Sec. 4(a)(1) - Project Grants	$ 3,410	$ 3,042	$ 4,225
Hospital Improvement, PHS Act, Sec. 303	1,259	963	963
Rehabilitation Training, VR Act, Sec. 4(a)(1) & 7	750	750	300
Total, Training	$ 5,419	$ 4,755	$ 5,488
Construction			
University-Affiliated Facilities for the Developmentally Disabled	$ ---	$ 31	$ ---
Developmental Disabilities Formula Grant [2]	1,796	2,731	2,172
Total, Construction	$ 1,796	$ 2,762	$ 2,172
Income Maintenance			
Grants to States for Public Assistance - Aid to Permanently & Totally Disabled	$201,286	$236,639	$127,248[3]

ACTIVITY	1972	1973 Revised Budget Estimate	1974 Budget Estimate
SOCIAL AND REHABILITATION SERVICE (Continued)			
Other			
Services to the Developmentally Disabled University-Affiliated Facilities Demonstration Grants (P.L. 91-517, Title II)	$ 3,983	$ 4,518	$ 4,250
Formula Grants for Developmentally Disabled (Planning & Administration, P.L. 91-517, Sec. 131) 2/	4,043	9,355	5,862
Total, Other	$ 8,026	$13,873	$10,112
Total, Grants and Services	428,322	634,398	663,330
Total, Income Maintenance	201,286	236,639	127,248
TOTAL, SOCIAL AND REHABILITATION SERVICE	$629,608	$871,037	$790,578
OFFICE OF THE SECRETARY			
Services			
Office of Child Development - Head Start	$ 4,462	$ 6,000	$ 8,000
Other			
Office of Mental Retardation Coordination	115	179	225
President's Committee on Mental Retardation	625	625	675
TOTAL, OFFICE OF THE SECRETARY	$ 5,202	$ 6,804	$ 8,900
Total, Grants and Services	$597,438	$808,173	$761,389
Total, Income Maintenance	399,491	485,841	522,903
GRAND TOTAL, ALL FUNDS	$996,929	$1,294,014	$1,284,292

1/ These programs are being consolidated in Fiscal Year 1974 into the proposed Special Education Revenue Sharing.

2/ Funds authorized under P.L. 91-517 are obligated for programs in the areas of mental retardation, cerebral palsy, epilepsy and other neurological conditions closely related to mental retardation or requiring treatment similar to that required for mentally retarded persons. The reporting system that provides program data for this authority does not indicate the extent of participation of any one of these conditions. The funds are used for mental retardation as well as other categories that are defined as developmental disabilities. Estimates for mental retardation only are therefore not available; the amounts shown in the accompanying table are the total obligations for developmental disabilities. It is assumed that since the emphasis of the program, according to the definition, is on mental retardation, a substantial portion of the funds are expended in the area of the severely handicapped mentally retarded.

3/ Estimate is for one-half-year payments. P.L. 92-603 governs program as of January 1, 1974.

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 AFFAIRS
OFFICE OF ASSISTANT SECRETARY FOR HEALTH

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This report is the sixth annual report of the Department of Health, Education, and Welfare describing the population and family planning activities of the Department.

Population and 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, sterility, population dynamics and program implementation; and public education--increasing opportunities for sex education, public understanding of human sexuality, and information about family planning and population growth.

Family planning services, as an integral part of adequate medical care, have been routinely and easily available to the majority of the population. In his message to the Congress, President Nixon emphasized that "...no American woman should be denied access to family planning assistance because of her economic condition." There are about five million women among the poor and near-poor whose access to adequate family planning services depends upon subsidization. Under the Social Security Amendments of 1967 (PL 90-248), such services are available through a variety of sources to some of those who want but cannot afford them. The Social Security Amendments of 1972 (PL 92-603) require that family planning services and supplies be made available under Medicaid to all individuals of childbearing age who are eligible under the State plan and who desire such services and supplies. In addition, the enactment of the "Family Planning Services and Population Research Act of 1970" (PL 91-572) assists in a major way in making comprehensive family planning services available to all persons desiring such services.

Highlights of Activities--1967 Through 1972

1. The first Deputy Assistant Secretary of HEW for Population and Family Planning was appointed in August 1967.

2. In September 1967, a Consultants' Report on "Implementing DHEW Policy on Family Planning and Population" was submitted delineating appropriate actions to implement family planning programs in the Department.

3. On January 2, 1968, President Lyndon B. Johnson signed the Social Security Amendments of 1967 (PL 90-248), which included the Child Health Act of 1967. This Act established categorical project grants for family planning services and required that not less than 6 percent of the monies appropriated for Maternal and Child Health under Title V be obligated for family planning services.

4. On July 16, 1968, President Johnson appointed an Advisory Committee on Population and Family Planning under the Co-chairmanship of Secretary Wilbur J. Cohen and John D. Rockefeller, III. The Committee submitted its report, "Population and Family Planning: The Transition from Concern to Action," to the President in November. The Committee made a series of recommendations for Federal action in population research and family planning services, both at home and abroad.

5. In August 1968, the Center for Population Research was established within the National Institute of Child Health and Human Development.

6. On July 18, 1969, President Nixon sent to Congress his message on population growth and the American future. The message called for the establishment of a Commission on Population Growth and the American Future, additional research on birth control methods of all types and the sociology of population growth, and established as a national goal the provision of adequate family planning services within five years to all those who want them but cannot afford them.

7. In October 1969, the Secretary of HEW established the National Center for Family Planning Services within the Health Services and Mental Health Administration.

8. On March 16, 1970, President Nixon signed the Act establishing a Commission on Population Growth and the American Future.

9. On December 7, 1970, the Secretary's Advisory Committee on Population Affairs was formally established.

10. On December 24, 1970, President Nixon signed into law the "Family Planning Services and Population Research Act of 1970" (PL 91-572). The purpose of this Act is:

    (1) to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services;

    (2) to coordinate domestic population and family planning research with the present and future needs of family planning programs;

    (3) to improve administrative and operational supervision of domestic family planning services and of population research programs related to such services;

    (4) to enable public and nonprofit private entities to plan and develop comprehensive programs of family planning services;

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(5) to develop and make readily available information (including educational materials) on family planning and population growth to all persons desiring such information;

(6) to evaluate and improve the effectiveness of family planning service programs and of population research;

(7) to assist in providing trained manpower needed to effectively carry out programs of population research and family planning services; and

(8) to establish an Office of Population Affairs in the Department of Health, Education, and Welfare, to be directed by a Deputy Assistant Secretary for Population Affairs under the direct supervision of the Assistant Secretary for Health and Scientific Affairs. This Office shall serve as a primary focus within the Federal Government on matters pertaining to population research and family planning, through which the Secretary of Health, Education, and Welfare shall carry out the purposes of this Act.

11. On October 12, 1971, the Secretary submitted to the President a Five-Year Plan for Population Research and Family Planning Services, as required by the Family Planning Services and Population Research Act of 1970 (PL 91-572).

12. On January 1, 1972, the National Center for Health Statistics instituted a modified and improved National Reporting System for Family Planning Services to be used by all federally supported family planning programs, clinics and service points, and by other agencies who wish to participate in the reporting system. This system, now fully operational, provides a meaningful body of data essential for the efficient and effective development, operation, and evaluation of family planning programs throughout the Nation.

13. In February 1972, the Secretary submitted the first Progress Report on the Five-Year Plan for Family Planning Services and Population Research to the Congress.

14. On March 27, 1972, the Commission on Population Growth and the American Future submitted its report to the President.

15. On October 30, 1972, President Nixon signed the Social Security Amendments of 1972 (PL 92-603). This Act made the informing of the availability and the provision of family planning services

mandatory to all present, former, or likely recipients of AFDC who are of childbearing age and imposed a penalty of one percent per annum on the Federal share of AFDC funds on States which failed to provide these services in the previous year to eligible persons desiring them. In addition, the Act increased the Federal share of matching for family planning services under Title IV-A -- AFDC -- to 90 percent from 75 percent and increased the Federal share for family planning services under Title XIX -- Medicaid -- to 90 percent from a variable formula.

The increase in Federal, State, and local involvement in family planning services during the last six years is remarkable. Six years ago, there were no Federal funds specifically earmarked for the support of family planning services. In the States, it was necessary to liberalize State laws in order that family planning services might be generally available. Now family planning services are regarded as an integral part of comprehensive health services, have been the primary subject of Federal legislation (PL 91-572, the Family Planning Services and Population Research Act of 1970), and received Presidential emphasis when President Nixon established as a national goal the provision of family planning services to all those who want them but cannot afford them. It has also been recognized that additional research on birth control methods of all types and the sociology of population growth is essential. Congress has provided significant financial support for the expansion of these programs.

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 population and 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, Counselling, and Referral	Hospitals and Clinic Services	HSMHA -- Maternal and Child Health Service -- National Center for Family Planning Services -- Community Health Services -- Indian Health Service -- Federal Health Programs Service -- National Institute of Mental Health SRS -- Medical Services Administration -- Assistance Payments Administration
	Health Departments	HSMHA -- Maternal and Child Health Service -- National Center for Family Planning Services -- Community Health Services SRS -- Medical Services Administration -- Assistance Payments Administration
	Voluntary Health Agencies	HSMHA -- Maternal and Child Health Service -- National Center for Family Planning Services -- Community Health Services 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
Medical Services (either as separately organized services or integrated into larger systems of maternal or comprehensive care), Information, Counselling, and Referral	Private Physicians	SRS -- Medical Services Administration -- Assistance Payments Administration
Information, Counselling, and Referral only	Public Assistance Agencies	SRS -- Community Services Administration -- Medical Services Administration -- Assistance Payments Administration
	Voluntary Social Agencies	SRS -- Community Services Administration -- 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	NIH -- Bureau of Health Manpower Education HSMHA -- Maternal and Child Health Service -- National Center for Family Planning Services -- National Institute of Mental Health -- Center for Disease Control
(b) Social workers and other public assistance personnel	SRS -- Community Services Administration -- 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 -- Community Services Administration -- Medical Services Administration -- Assistance Payments Administration HSMHA -- National Center for Family Planning Services

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
	NIH -- Bureau of Health Manpower Education OE -- Adult and Vocational Education
2. Curriculum Development for Above Programs	NIH -- Bureau of Health Manpower Education SRS -- Community Services Administration NIE OE
Research Training in Population and Family Planning	NIH -- National Institute of Child Health and Human Development HSMHA -- National Center for Family Planning Services -- National Institute of Mental Health -- Center for Disease Control
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	NIH -- Bureau of Health Manpower Education HSMHA -- Maternal and Child Health Services -- National Center for Family Planning Services
(b) Social workers	SRS -- Community Services Administration -- Office of Research and Demonstrations

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
(c) Demographers	NIH -- National Institute of General Medical Sciences
(d) Teachers	OE
3. Curriculum Development for Above Programs	SRS -- Community Services Administration NIH -- Bureau of Health Manpower Education 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 FDA
2. Social Research	SRS -- Community Services Administration -- Office of Research and Demonstrations HSMHA -- Maternal and Child Health Services -- National Center for Family Planning Services -- National Institute of Mental Health -- National Center for Health Statistics NIH -- National Institute of Child Health and Human Development NIE

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. Administrative Research	
(a) Utilization studies	SRS -- Community Services Administration
(b) Demonstrations in innovative service delivery mechanisms	-- Medical Services Administration -- Assistance Payments Administration
(c) Evaluation methods	HSMHA -- Maternal and Child Health Services -- National Center for Family Planning Services -- National Center for Health Statistics -- National Center for Health Services Research and Development -- Community Health Service
4. Facilities	
Construction	NIH -- Bureau of Health Manpower Education
Evaluation	
1. Overall Evaluation and Coordination	Office of the Secretary -- Assistant Secretary for Health and Scientific Affairs Deputy Assistant Secretary for Population Affairs Assistant Secretary for Planning and Evaluation

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. Medical Services Evaluation	HSMHA -- Maternal and Child Health Services -- National Center for Family Planning Services -- National Center for Health Services Research and Development -- National Institute of Mental Health
3. Social Services Evaluation	SRS -- Community Services Administration -- Medical Services Administration -- Assistance Payments Administration HSMHA -- National Institute of Mental Health

II

OFFICE OF THE SECRETARY

Office of the Assistant Secretary for Health

The Office of Population Affairs, under the direction of the Deputy Assistant Secretary for Population Affairs, serves as a focal point for Department policy and program coordination. The Deputy Assistant Secretary has full line authority and responsibility for directing population research and family planning service activities within the health agencies. P.L. 91-572, the "Family Planning Services and Population Research Act of 1970," establishes by statute the Office of Population Affairs and delineates the functions of the Office as follows:

> The Secretary shall utilize the Deputy Assistant Secretary for Population Affairs--
>
> (1) to administer all Federal laws for which the Secretary has administrative responsibility and which provide for or authorize the making of grants or contracts related to population research and family planning programs;
>
> (2) to administer and be responsible for all population and family planning research carried on directly by the Department of Health, Education, and Welfare or supported by the Department through grants to, or contracts with, entities and individuals;
>
> (3) to act as a clearinghouse for information pertaining to domestic and international population research and family planning programs for use by all interested persons and public and private entities;
>
> (4) to provide a liaison with the activities carried on by other agencies and instrumentalities of the Federal Government relating to population research and family planning;
>
> (5) to provide or support training for necessary manpower for domestic programs of population research and family planning programs of service and research; and
>
> (6) to coordinate and be responsible for the evaluation of the other Department of Health, Education, and Welfare programs related to population research and family

planning and to make periodic recommendations to the Secretary.

In addition, the Office of Population Affairs serves a direct staff function within the Office of the Secretary. This function comprises advising the Secretary, through the Assistant Secretary, on policy and new legislation; participation in legislative and budgetary planning; preparation of reports on Departmental and interdepartmental activities for the Secretary and the Congress. The Office also prepares staff documents for the Secretary and any required for the White House.

In addition to direct coordination of programs within DHEW, the Office works in close cooperation with, and gives leadership to, family planning activities of other Federal agencies.

A continuing partnership between the Government and other concerned organizations is essential. The past work of private agencies in fields related to population and family planning has laid a foundation on which the official agencies continue to build. Therefore, the Office of Population Affairs has maintained effective liaison with interested public and private organizations.

Close communication is maintained with the population centers of major universities so that training can be geared to actual needs as they are revealed in ongoing DHEW programs.

In order to stimulate concerned professional and citizen groups, the Office of Population Affairs provides leadership at regional meetings, conferences or other activities which will help develop family planning resources.

The Office of International Health, a staff office to the Assistant Secretary for Health, has primary responsibility for the administration of the Scientific Activities Overseas (Special Foreign Currency Program). The appropriation for this Program enables the three health agencies--NIH, HSMHA, and FDA--to utilize U.S.-owned excess foreign currencies to support health research, research training, and other health-related activities in designated foreign countries. Authority for the Program is provided by Section 104(b)(3) of PL 83-480, the Agricultural Trade Development and Assistance Act of 1954, as amended; and, Section 3 of PL 86-610, the International Health Research Act of 1960.

Population and family planning research studies are an important component of the Scientific Activities Overseas Program. There are currently 22 population and family planning projects representing a total obligated cost of over $4 million equivalent in foreign currencies. Reflecting the research interests of the three agencies, these rojects include studies in reproductive biology important to knowldge of the mechanisms of fertility and infertility and to methods of fertility control; contraceptive development and the evaluation of the safety and efficacy of contraceptives; research in the development of

family planning services and the methods of program evaluation, including manpower and organizational components; demographic and methodological studies of population growth, fertility and abortion rates; the effect of differential use of fertility control by varied socioeconomic and cultural groups; studies on the social, behavioral and economic aspects of population dynamics; family development as affected by population factors; and international health information exchange focused on the population sciences.

A project completed recently in Yugoslavia provides an example of the types of activities supported. It is a study of the effect of extensive application of contraception on the abortion rate. The objective of this study was to determine whether the provision of freely available family planning services could reduce the abortion rate in a group of women who were using abortion as the primary means of controlling family size. Yugoslavia, where abortions are legal, easily obtained, and form the first method of family planning was an ideal location for this research. The study showed that women who have been using abortion are willing to switch to contraception when services are convenient and the advantages and disadvantages are presented to them.

The findings of this study have important implications for the United States. The rapid change in abortion laws as well as the need for providing contraceptive services to the general population makes it necessary to know how these two methods of limiting family size relate to each other and whether the availability of adequate family planning services can modify the utilization rates of legal abortion.

Current plans are for expansion of research activities in Poland, Pakistan, and the Arab Republic of Egypt. Estimated obligations for population and family planning research activities during fiscal years 1973 and 1974 are $909,000 equivalent and $1,145,000 equivalent, respectively. For FY 1974, it is anticipated that funds will be available for new obligations in the Arab Republic of Egypt, Burma, Guinea, India, Pakistan, Poland, and Tunisia.

Obligations for population and family planning activities for fiscal years 1972-1974 are as follows:

Expressed in Dollar Equivalents

1972	1973(est.)	1974(est.)
726,000	909,000	1,145,000

Office of the Assistant Secretary for Community and Field Services

The Office of Community and Field Services coordinates the DHEW response to the Model Cities Program which calls for new approaches to the delivery of health and social services, including family planning. Currently, over 20 Model Cities include family planning

projects in their comprehensive plan. In addition, many other cities have Model Neighborhood-related family planning projects.

The office has also served as the central office for the DHEW Regional Offices. DHEW Regional Directors, through the Operational Planning System, focus Departmental resources in priority programs and special projects. For family planning programs, which are a priority of the Department for 1973, they coordinate the DHEW agencies in Department-wide actions. Their staffs 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 family planning progress in the Regions and periodically participate in special Departmental studies of these programs.

Office of the Assistant Secretary for Planning and Evaluation

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.

The Office of the Deputy Assistant Secretary for Health Planning and Analysis works closely with the Office of Population Affairs in the development of appropriate planning documents, program memoranda, and evaluation studies.

Office of the Assistant Secretary for Administration and Management

The Office of Child Development was established in 1969 to serve as the national advocate of services for children. The Office has two chief bureaus: The Children's Bureau and the Bureau of Child Development Services.

While the Office of Child Development does not directly operate family planning programs, Project Head Start makes social services available to parents, primarily mothers. Social workers aides and health specialists in these programs are in contact with community agencies that conduct planned parenthood education and distribute comprehensive family planning literature. The Office of Child Development does not directly distribute information on family planning, but all publications encourage parents to space their children and to talk to a physician or social worker about planned parenthood.

III

PUBLIC HEALTH SERVICE

Food and Drug Administration

Under the authority of the Food, Drug and Cosmetic Act of 1938, as amended, the Food and Drug Administration (FDA) approves contraceptive drugs for safety and effectiveness before they are marketed and maintains surveillance over the drugs after their approval.

The first oral contraceptive agents were approved by the FDA for general use in 1961 after some years of research, testing, and evaluation. By 1973, there were over 30 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 investigate reported or suggested side effects in human and animal populations.

Although the Food and Drug Administration does not have pre-marketing controls over most contraceptive devices, it maintains surveillance over such devices to ensure their safety and efficacy. There are currently no standards of manufacturing or pre-marketing investigation required by law. However, the FDA has taken steps to set standards for consumer protection.

The FDA established an Advisory Committee on Obstetrics and Gynecology to assist in activities related to family planning. This Committee published its "Second Report on the Oral Contraceptives" in August 1969. The Committee has assisted in revising oral contraceptive labeling, in updating guidelines for clinical investigations of oral contraceptives, in formulating FDA policy on influence of estrogen content of oral contraceptives in their thromboembolic action, and has deliberated the problem of the tumorigenic actions of certain steroidal contraceptives.

FDA consults with representatives of pharmaceutical firms to ensure safety and effectiveness of contraceptive drugs. The agency also maintains close liaison with regulatory agencies in foreign governments, the Agency for International Development, and organized family planning groups.

The activities of the Food and Drug Administration do not include provision of 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, several research projects have been initiated.

The carcinogenic and diabetogenic potential of certain oral contraceptive steroids is under investigation in long-range studies in Rhesus monkeys and beagle dogs at the International Research and

Development Corporation at Mattawan, Michigan. These studies employ three investigational compounds and one estrogen widely used in oral contraceptives. The design of these investigations follows the protocol which was prescribed by FDA to the pharmaceutical manufacturers in 1967, and under which already marketed as well as investigational compounds are currently being investigated. Since initiation of these studies, three investigational products have been found to induce mammary tumors in beagle dogs. Two marketed formulations, containing two of the tumorigenic (in dogs) progestins have been withdrawn by the manufacturers. The long-range design of the investigations prescribing drug administration for seven and ten years to dogs and monkeys respectively should provide some indication of the possible carcinogenic hazard to long-term human users of the contraceptives.

A study of the possible effects of oral contraceptives on renal, bladder, and ureteral function and the incidence of renal tract infection was initiated during May 1969, at the University of Rochester. A comprehensive evaluation of renal function is being performed, and a prospective study for the occurrence of bacteriuria is being performed in a population treated with a standard oral contraceptive preparation. In addition, an evaluation of the immunologic profile of subsamples of the treated population is being obtained. Five-year study of 150 new cases each year was planned.

Supplementary studies concerning the safety of oral contraceptives have been developed utilizing funds from the PL-480 program in Yugoslavia.

One of the studies is being performed at the Institute for Mother and Child Welfare, Zagreb, Yugoslavia. The purpose of this investigation is to assess the effect of selected oral contraceptives on carbohydrates and lipid metabolism. Three hundred women will be studied over a three-year period, with a final report available the end of 1973.

Another study under PL-480 support has been initiated at the University Teaching Hospital for Obstetrics and Gynecology, Lubliana, Yugoslavia. The study has two objectives: to determine whether there is any relationship between the use of oral contraceptive drugs and abnormalities in cervical cytology, and to determine whether there is any relationship between the use of oral contraceptive drugs and fertility after drug discontinuation or the development of congenital abnormalities in the offspring of women using these drugs within three months of conception. Over 30,000 women have been entered in the study of cervical cytology. The outcome of pregnancy study is progressing satisfactorily, and a final report will be available at the end of 1973.

A third study is being conducted at the Institute of Hygiene and Social Medicine in Sarajevo, Yugoslavia. Early studies have suggested that the use of hormonal contraceptive drugs may produce abnormalities in cervical cytology and an increased rate of spontaneous abortions.

A population of 11,000 women and 7,000 newborn infants will be followed to determine the relationship between these drugs and cervical cancer in women and congenital abnormalities among offspring.

A fourth study is being conducted in Belgrade, Yugoslavia and involves a three-year investigation of the effect of oral contraceptive use on coagulation mechanisms. The last women were entered into the study in December 1972.

The FDA recognizes that Prostaglandins may have significant potential in family planning. Therefore, it is monitoring ongoing research and has developed master protocols for pharmacological and clinical investigation of these products in the field of population research. FDA may, in cooperation with other government agencies, initiate some of the projects outlined in the protocols.

On January 12, 1970, the Commissioner of Food and Drugs issued a letter to all practicing physicians in the United States. The letter pointed out that oral contraceptive labeling had been changed in order to fully inform patients of potential adverse effects. The letter also stressed that sequential and high estrogen (0.075 mg. or more) oral contraceptives should not normally be prescribed due to the possible increased risk of thromboembolic disorders associated with these products. In June of 1970, the FDA required that all packages of oral contraceptives contain a statement warning users about the risks of oral contraceptives and referring them to a leaf- available through their doctor or clinic.

In the June 5, 1971, Federal Register, the Commissioner of Food and Drugs published a proposal to make intrauterine implants which incorporate heavy metals, drugs or other added substances, new drugs. Thus, a completed and signed "Notice of Claimed Investigational Exemption for a New Drug" must be submitted to cover clinical investigations to obtain evidence that such contraceptives are safe and effective. An approved New Drug Application is required for marketing such articles.

FDA maintains liaison with appropriate groups within the Department since certain family planning clinics supported by the Department may provide suitable patient populations and investigative staff to perform the studies required by FDA in carrying out its surveillance responsibilities.

The FDA maintains a reporting system which receives information on adverse reactions from various types of contraceptives and serves as a clearinghouse for such information.

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Health Services and Mental Health Administration

Summary of Programs Related to Family Planning

The Health Services and Mental Health Administration (HSMHA) is the major supporter of family planning services in the Federal Government. It administers several organizational components which are responsible for family planning activities. The two largest components are the National Center for Family Planning Services and the Maternal and Child Health Service. In addition, family planning activities are conducted by the Center for Disease Control, Community Health Service, Federal Health Programs Service, Indian Health Service, National Center for Health Statistics, the National Institute of Mental Health, and the Comprehensive Health Planning Service.

The National Center for Family Planning Services (NCFPS) administers programs under the "Family Planning Services and Population Research Act of 1970" (PL 91-572), Title X of the Public Health Service Act and Title V of the Social Security Act as amended by Section 508 of the "Child Health Act of 1967," (PL 90-248). This latter Act specifies that not less than 6 percent of the annual appropriations under Title V of the Social Security Act shall be for family planning services. In addition, Title V authorizes grants to health departments, hospitals and any public or private nonprofit voluntary organization for up to 75 percent of the cost of providing family planning services.

The broad purposes of the NCFPS program, set forth in PL 91-572, include:

1. to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services;

2. to improve administrative and operational supervision of family planning services;

3. to enable public and nonprofit private entities to plan and develop comprehensive programs for family planning services;

4. to develop and make readily available information (including information materials) on family planning to all persons desiring such information;

5. to evaluate and improve the effectiveness of family planning service programs;

6. to assist in providing trained manpower needed to effectively carry out family planning programs.

At least three main NCFPS objectives are necessary to achieve these purposes: (1) to assure the availability of family planning services throughout the United States; (2) to improve the quality (effectiveness) of existing and new family planning services; and (3) to improve the management and organization of family planning services to all administrative levels.

The Maternal and Child Health Service administers family planning programs under Title V of the Social Security Act. It administers programs of formula grants to States, comprehensive maternity and infant care projects and related research grants.

The Center for Disease Control is authorized by the Public Health Service Act to train Epidemic Intelligence Service (EIS) Officers. Some individuals in the program are being trained in an epidemiological approach to evaluating family planning and population programs.

The Community Health Service makes an important contribution in developing family planning services by including these services as a part of comprehensive health programs and programs for services to seasonal and migrant farmworkers and their families. These programs are authorized under the "Comprehensive Health Planning and Public Health Services Amendments of 1966," (PL 89-749), "The Partnership for Health Amendments of 1967," (PL 90-174), and grants for health services for domestic agricultural workers and their families (PL 87-692 and 89-109).

The Federal Health Programs Service is responsible for direct health services to certain Federal beneficiaries. The basic Public Health Service Act, (PL 410, 78th Congress, 58 Stat. 683, 1944), and as amended, particularly Sections 321-346 and the Dependents Medical Care Act and its amendments (PL 84-569) provide beneficiaries with comprehensive inpatient and outpatient medical services. This service also administers the medical assistance program for Cuban refugees under the Migration and Refugee Assistance Act (PL 87-510). Family planning services are included in these programs. Family planning information and counseling is provided to Federal employees through the Federal Employee Health Program authorized by PL 79-658.

The Indian Health Service provides comprehensive health services, including family planning to American Indians and Alaskan natives under PL 83-568.

The National Center for Health Statistics (NCHS) derives its authority in population from the general data collection and research provisions of Sections 305 and 313 of the Public Health Service Act, and the transfer 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.

The Comprehensive Health Planning Service develops, supports, and evaluates State and areawide health planning programs that work to improve the health status of their respective populations. These programs consider the whole range of health concerns including family planning.

Current and Projected Population and Family Planning Activities

The National Center for Family Planning Services project grants program has grown from 80 grants and $12 million of obligations since its inception in fiscal year 1969 to an estimated 350 grants and $98.5 million of obligations in fiscal year 1973. To improve program coordination, many projects have been consolidated into areawide or Statewide grants. Over 150 grants have been consolidated, holding the total number of grants to about 350, rather than the 500 which would exist otherwise. The Center will continue to encourage grant consolidations which improve services and reduce administrative costs.

The estimated services capacity of the 350 projects operating in 973 is 1.65 million individuals. This is an increase of 150,000 people over the 1972 level. The entire increase is due to the transfer of 171 OEO projects which had achieved their demonstration objectives. Capacity for an additional 250,000 women will be added in 1974 to bring the NCFPS total to 1.9 million.

In 1974, priority will be given to the expansion of selected existing projects which have demonstrated a capacity to provide quality services and manage funds effectively. Emphasis will be on combining or coordinating existing grants to achieve full coverage within States or designated areas within States. Continuing efforts will be made to involve all elements of the health services delivery system in the provision of family planning services, and to make family planning a basic component of all comprehensive health programs. The Center will also encourage and assist projects to improve their management and accounting practices in order to improve their ability to obtain third-party reimbursements.

Program objectives of the NCFPS and the activities involved in achieving them are the responsibility of various NCFPS Offices, Divisions, and Branches. The specific functions carried out by these components include the following:

1. Planning and Evaluation

2. Training

3. Services Delivery Research

4. Technical Assistance

5. Information and Education

Planning and Evaluation

In 1971, major planning efforts of the NCFPS centered around the development of a national Five-Year Plan for delivery of family planning services. Subsequently, a Progress Report to the Congress of the United States was submitted in January of 1972.

In 1972, the Center supported two studies in order to update the 1973 Progress Report. One study refined the design, scope, strategies, needs, and resources of the national family planning program. The other study, the 1971 County Study Contract, provided county-by-county data on the national need for family planning services, the level of services being provided, and manpower resources and clinic facilities available. Similar assessments of the national need for subsidized services had been carried out in 1968 and 1969. These studies established baseline data for the family planning program in the United States. They also provided first steps for systematic reporting on the progress of the Federal program. The NCFPS' 1971 County Study Contract will be extended during 1973 in order to carry out additional analyses.

The highest evaluation priority for 1972 was development of a contract methodology for Technical Assistance on the Design and Installation of a Family Planning Evaluation System for all levels of the nationwide family planning program. The aim was to develop a user-oriented evaluation process by which family planning decision makers could better provide and be accountable for services. The twelve-month evaluation contract includes a review of existing evaluation activities, needs of national, Regional and grantee offices, and existing data sources supportive of evaluation efforts. It requires development of evaluation concepts and the designation of performance indicators useful across NCFPS administrative levels. It also requires the design, testing, and refining of the evaluation system and the provision of technical assistance to Regional Offices on the implementation of evaluation procedures.

Systems development activities necessary to carry out continuous NCFPS evaluation processes should be completed by the end of fiscal year 1973. Based on these evaluation processes, fiscal year 1974 activities will emphasize: (a) the systematic conduct of on-site program audits by NCFPS staff; (b) the execution of new contracts for data collection in the field; and (c) the implementation of a program of training in family planning evaluation, provided to all levels of NCFPS by the Family Planning Evaluation Institute.

Training

Training in the area of family planning involves imparting skills and knowledge to insure that staff members will be able to function effectively in provision of services.

The Training Branch, NCFPS, is responsible for developing training programs for personnel at all levels and skills. This charge relates to the three objectives of family planning: provision of services, assurance of service quality, and improvement of program management.

The training of administrative staff at Regional, State, and local levels facilitates expansion of existing services as well as initiation of new programs.

Training of individuals to staff family planning clinics contributes to expansion since more clinic sessions are possible with increased numbers of trained staff available. It also contributes substantially to improvement of services quality.

The Training Branch must assess training needs and develop plans to meet those needs. Both grant and contract funds are used by the Branch to carry out these responsibilities. Grant funds support Regional and areawide training centers while contract funds support special training projects.

Nearly 5,000 personnel were trained in fiscal year 1972 as a result of NCFPS funds. The following table indicates the numbers and categories of personnel:

Family Planning Trainees

	1972
Paraprofessionals	
Clinic Aides	224
Outreach/Follow-up	619
Subtotal Paraprofessionals	843
Professionals	
Health Educators	416
Nurses (all types)	1,012
Physicians	594
Project Administrators	313
Subtotal Professionals	2,335
Unspecified	1,750
Total	4,928

This training is provided through short-term training programs. Seventeen training grants totaling $2,004,497 and seven training contracts totaling $1,005,461 were awarded in fiscal year 1972.

These grants and contracts were for the development of management skills for key family planning personnel, the training of service delivery staff, and the development of training guides, audio-visual aids, self-instruction courses, and related materials.

A fiscal year 1973 priority is the development of new and expansion of existing Regional and State training centers as the primary resource for training local program staff in a given area. These centers will be responsible for development of curricula and training materials and for provision of training. Two large Regional centers have been funded and are currently in operation: a center for Region III located in Baltimore and a center for Region IV, in Atlanta. Each will serve as a Regional resource for development and provision of comprehensive short-term training for the full range of family planning personnel.

In addition to the two major Regional training centers, a number of training centers have been developed at the State level. These State centers are similar to the Regional centers in offering a full range of training courses; however, they are more specifically tailored to the needs of the individual States.

Utilization of Regional and State centers to coordinate training will be given continued priority. Future efforts will be directed toward expanding this mechanism to additional Regions and States.

Contracts have been made for special projects to develop training materials, methodologies, and evaluation mechanisms.

Special emphasis is being placed on the development and utilization of paraprofessionals. To assure proper utilization of these and other workers, a methodology of "train-the-trainers" or "in-project training" is being devised through NCFPS. The contractor will provide training material for a core of local level personnel. The train-the-trainer program will provide local managers with a relatively inexpensive method for developing local training competence. The train-the-trainer program will also allow local supervisory staff to gain greater proficiency by training those who will work under them. This type of program increases the numbers of trained personnel, provides for adaptation to the local situation, and strengthens local self-sufficiency of projects.

As more experience is gained in developing and coordinating training activities and resources, training priorities will be continually reassessed and revised. Limited funds have created a need for alternative resources for support of family planning service training programs. Current projects will be asked to identify other potential sources of support. Reimbursement mechanisms, if feasible, would release NCFPS training funds for development of new programs.

Training Grants and Contracts
(Direct Support)

	FY 1972	FY 1973 (est.)
Training Grants	$2,004,497	$2,000,000
Training Contracts	1,005,461	1,000,000
Total	$3,009,958	$3,000,000

Services Delivery Research

Services delivery research is directed toward the generation of new knowledge relative to the establishment and operation of a national network of family planning services. The techniques of action research, an approach which combines sound scientific principles of investigation with direct field testing and validation, are particularly appropriate for services delivery research. The advantages of this approach are:

1) Immediate feedback on impact of innovations in services delivery models;

2) Complete flexibility to initiate changes;

3) Continuation of services to clients throughout the experimental period;

4) Direct evaluation of benefits from innovations; and

5) Significant reduction in lag-time between testing new modes of operation and implementation of desirable modifications.

The Office of Services Delivery Research, NCFPS, is responsible for developing, implementing, and evaluating the research activity in family planning services. This responsibility relates to all family planning objectives: provision of services, assurance of quality health services, and improvement of management and administration.

a. Objectives

The primary goal of services delivery research is to expand basic understanding of the operational elements which contribute to effective delivery of high-quality comprehensive family planning services to all persons who need and want such services. The basic objectives of services delivery research which support this goal and contribute to the family planning services objectives are:

1) To identify service settings and operational models responsible to the felt needs of the

"hard-to-reach" segments of the primary target population;

2) To prepare tools for operational staff as a resource for continued operation of a high-quality service; and

3) To develop tools for management to assure development of an efficiently managed and effective service.

Objective 1 implies an extra measure of effort to devise ways to serve those who find it difficult to use the available system of services because they are outside the mainstream of social and economic life. We may through this effort also achieve basic expansion of geographic and numerical coverage of family planning programs.

Several categories of the underserved segments of the potential cohort of family planning clients have been singled out for immediate consideration. These are low-income whites, young people from low-income families, and rural residents.

b. Fiscal Year 1972 Activities

Pilot models for delivery of family planning services in occupational settings are being tested for feasibility. It is hypothesized that women employed in low-paying jobs do not have ready access to family planning services because of constraints associated with their employment. A case can be made for benefits to both worker and employer where there is direct access to services at the work site. This model can be both the means for involving the private sector in the national network of family planning services and a resource for private funding. Young people from low-income families generally suffer from the same familial problems or poor health and inadequate access to comprehensive medical care. In addition, they are not sophisticated in the use of special health services specifically designed for their needs. Research is going forward on new ways to serve young people at sites and settings which are meaningful to their special needs.

Rural residents are often handicapped by their relative inaccessibility to established services. A combination of three delivery models (mobile unit, private physician, and store-front setting) are being tested in the southwestern area of the United States. The main focus is to determine both acceptability and effectiveness of these models.

Responsive to Objective 2, preparation of tools for delivery of high-quality services, an operational manual has been prepared for the use of family planning administrative and operational staffs. The validated manual, when distributed to the field in June 1973, will serve as a reliable "how-to" guide for all levels of personnel

concerned with management, operation, and improvement in delivery of family planning services. A recently developed tool responsive to Objective 3, improved management and administration, is the Patient Flow Family Planning Model. This computer simulation model can generate feedback information on proposed modification of facilities, distribution of manpower, expansion of services, and other operational problems so that the impact of such decisions can be determined before they are implemented. This tool is also of benefit to the fulfillment of Objective 2.

c. Fiscal Year 1973 Activities

A continuation of fiscal year 1972 activities with some changes in emphasis is planned for fiscal year 1973. Under Objective 1, research activities will be initiated to investigate the means for integrating family planning services into health care programs for the handicapped. Also in fiscal year 1973, methods of bringing quality family planning services to migrants will be explored.

Technical Assistance

Technical assistance is the provision of aid and guidance to State, local governmental, or private agencies. In some instances, assistance is provided to units of the Federal Government. It is usually short-term (less than 30 days), and task-oriented. Items dealt with include basic matters such as setting up records and extend through more complex issues such as increasing the usefulness of reports or coordinating patient follow-up with patient scheduling. Assistance also includes broader areas such as improving project community relations. Emphasis is on making recipients of technical assistance self-supporting, thereby decreasing their dependence on outside sources.

The Office of Field Operations, National Center for Family Planning Services, provides leadership and guidance for family planning technical assistance activities.

a. Objectives

The NCFPS objective number 1, distribution of family planning services throughout the country, depends upon how well Regional, State, and local project directors perform essential tasks of program development, staff recruitment, and patient services.

The NCFPS objective number 2, improving the quality of family planning services, relates directly to the medical and educational standards established by project managers and others.

Obtaining and utilizing funds from multiple sources is important to NCFPS objective number 3, improving the management of family planning services at all administrative levels. In addition, numerous other technical assistance activities associated with funding, direct operations, and reporting systems are essential to effective program management.

b. Fiscal Year 1972 Activities

During fiscal year 1972 a national technical assistance contract was initiated for provision of aid to Regional Offices, States and grantees. Regional Offices received assistance in planning effectively, in relating to coordinating bodies, other government agencies, and consumer groups, and in improving office procedures. States were assisted in establishing Statewide coordinating bodies representative of all interests in family planning, in managing records and reporting systems, and in obtaining third-party funds. Individual grantees were concerned with project accounting and reporting in compliance with Federal regulations and efficient management principles and with developing mechanisms for involving the consumer in planning, operating, and evaluating the health service delivery system.

c. Fiscal Year 1973 Activities

The increasing necessity for reliance upon third-party reimbursement mechanisms to support ongoing and expanded activities requires technical assistance to grantees in establishing or improving the capabilities of their local accounting system to give adequate information on the cost of services provided. In addition, models of Statewide or areawide agreements for funding services wholly or in part by third-party reimbursements will be developed.

As family planning services become more readily available, it will be necessary to increase the degree of consumer and community participation in the development, review, and evaluation of grant-supported activities. While there are still some areas of the country where subsidized services do not yet exist, the more common situation is that minimal services were initially provided by a single agency. These services will subsequently have been expanded to meet perhaps 25-35 percent of the area's total need. While it is possible for a single provider agency to continue to carry the load by itself, most instances of continued services expansion have involved a multiple agency relationship. This has typically come about through the creation of agencies for coordinating family planning services. The primary purpose of these Coordinating Councils has been to organize providers more efficiently for provision of services.

Since State and local institutions are becoming more involved in decision making with regard to Federal funds, the NCFPS grant program should give even greater emphasis to community and consumer participation in project policy development and implementation.

Information and Education

Family planning information and education encompasses those activities required to insure that individuals have a full and accurate understanding of how to safely and effectively regulate their fertility. Educational services need to be provided to people who

have not yet begun childbearing, to those who need family planning services but have not yet used them, to people who are receiving services and desire to continue, and to those health workers, community leaders, and family members whose understanding of family planning is essential to a successful program.

The Office of Information and Education, NCFPS, provides leadership to national family planning information and education activities, initiates special efforts to improve the quality of materials used in the field, communicates with health and social organizations in the Federal and private sectors to assure their understanding of family planning goals, and evaluates information and education programs throughout the country.

a. Objectives

Information and education supports NCFPS objective number 1, distribution of family planning services throughout the United States, by assisting individuals and communities to understand the benefits of family planning. Expansion of services to additional segments of the population in need is thereby greatly facilitated. The second NCFPS objective, improvement of family planning services quality, also depends on an effective information and education program since services cannot be considered high quality unless individuals are aware of the nature of the services offered, their rights as patients, the full range of choices available, and the advantages and disadvantages of each alternative. Only in this way can the patient make an informed decision about family planning services.

b. Fiscal Year 1972 Activities

During fiscal year 1972 two major activities were conducted in support of objective number 1. The first was a study of State laws to assess legal barriers to the provision of family planning services. Second was the initiation of a Family Planning Digest, a bi-monthly periodical for family planning workers. The Digest increases the technical and program knowledge of family planning workers, provides a means for exchanging information among family planning projects, and increases the visibility of Federal efforts in the area of family planning. Several activities initiated in fiscal year 1972 related to family planning objective number 2. One was an evaluation of information and education services to specific groups of patients, for example, post-partum women. Second, a series of workshops was funded to discuss ways of providing quality family planning services to minorities. These meetings will increase understanding of family planning program goals and of the special needs of minorities in relation to family planning services. A series of State-level conferences relating to problems of early unwanted childbearing was also funded. The conferences will emphasize educational and social services to school-age parents by various service groups.

c. Fiscal Year 1973 Activities

In addition to continuing many fiscal year 1972 activities, several new projects will be initiated during fiscal year 1973. Responsive to objective number 1, a national family planning education campaign will be conducted. Materials outlining the goals and benefits of family planning services will be developed and made available for use at local, State, and national levels. In cooperation with the Office of Field Operations, the NCFPS technical assistance arm, information and education materials for the Spanish-speaking will be developed.

Responsive to objective 2, four Regional workshops will be held to assist grantees in establishing and maintaining high-quality information and education programs. These sessions will stress information exchange among local programs and discussion of innovations in the family planning education area.

The Maternal and Child Health Service carries out family planning services responsibilities under the authority of Title V of the Social Security Act. The 1967 Amendments to Title V, the Child Health Act of 1967, specify that not less than 6 percent of the annual appropriations for Title V purposes shall be used for family planning services under Sections 503 (Maternal and Child Health Services formula grants to States); 508 (Comprehensive Maternity and Infant Care projects and Family Planning projects); and 512 (research grants). The Maternal and Child Health Service administers grants to States, comprehensive maternity and infant care, children and youth projects, and research. The National Center for Family Planning Services administers family planning project grants under Section 508 of the Act.

Under maternal and child health formula grants, States are assisted in extending and improving 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 preventive health services in nature.

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 to all parts of the State by July 1, 1975.

Family Planning Services in Maternal and Child Health Programs

The fiscal year 1972 Maternal and Child Health budget maintained the 1971 increase of $10,000,000, of which $8,250,000 was designated

for family planning services and programs. Additional family planning services were provided by formula funds, at least 6 percent of which are required to be spent for such services.

Funds have been used to employ staff in State health departments, to plan and implement programs to provide broadly based family planning services. Some States will soon have all parts of the State covered by family planning services. A variety of professional and paraprofessional personnel are involved in these efforts. The States are carrying out training in family planning. There is emphasis on getting services to hard-to-reach women. Some States have interagency councils or committees on family planning which have varied functions including developing educational campaigns and promoting further services. In addition, maternity and infant care projects and programs for pregnant teenage girls provide family planning services. Approximately 1,020,000 women were provided family planning services through programs administered by the Maternal and Child Health Service. Of this total, 85 percent received services through Maternal and Child Health formula grants. The Maternity and Infant Care projects served 12 percent of the total, and the Children and Youth projects served 3 percent.

Changing Attitudes

One significant factor in the expansion of family planning services has been a change in public attitudes, policies, and State laws. In March 1972, the U.S. Supreme Court ruled that the Massachusetts law prohibiting the distribution of contraceptives to unmarried persons was unconstitutional and violated the rights of single persons under the Equal Protection Clause of the Fourteenth Amendment. Only one State, Wisconsin, now has a statute which bans the distribution of contraceptives to the unmarried.

According to the journal, Family Planning Perspectives (April 1972), 27 States have changed their health policies and 48 States have changed their welfare policies on family planning since 1967, principally to broaden eligibility for services or to specify administrative responsibility for services.

Family Planning Services by States - Statistical State Programs - Number of Women Receiving Services

Data from States submitting reports show that for fiscal year 1970 the number of women receiving family planning services was 501,795. For fiscal year 1971 this figure was 763,234, and the provisional total for fiscal year 1972 is 866,711.

The following table sets forth the above data on a State-by-State basis.

TABLE 1. Number of Women Provided Family Planning Services Under State Programs Of Maternal and Child Health, FY 1972, 1971, and 1970

State	1972 Provisional	1971	1970	
United States	866,711	763,234	501,795	
Alabama	62,528	50,669	45,571	
Alaska	1/ 733	892	733	
Arizona	25,629	11,804	7,707	
Arkansas	19,114	15,066	7,066	
California	1/ 121,074	93,931	66,522	
Colorado	4,721	1,242	2,215	
Connecticut	-	---	-	
Delaware	7,440	5,676	9,465	
Dist. Columbia	---	---	---	
Florida	98,077	67,704	57,504	
Georgia	88,628	75,799	51,018	
Guam	---	---	---	
Hawaii	390	---	-	
Idaho	1,746	920	383	
Illinois	1/ 6,623	5,997	1,315	
Indiana	10,525	5,127	3,476	
Iowa	---	---	---	
Kansas	1/ 11,870	1/ 8,300	1/ 11,870	
Kentucky	11,215	1/ 17,170	11,255	
Louisiana	-	---	-	
Maine	12,000	3,900	-	
Maryland	---	4,816	---	
Massachusetts	-	---	-	
Michigan	1/ 3,040	1/ 9,654	3,040	
Minnesota	-	1/ 1,300	6,057	
Mississippi	30,156	22,095	15,586	
Missouri	1/ 25,287	25,166	25,287	
Montana	-	1,893	356	
Nebraska	188	---	1/ 7,850	
Nevada	1,469	2,726	---	
New Hampshire	-	---	-	
New Jersey	---	---	---	
New Mexico	-	3,260	4,568	
New York	1/ 5,165	10,034	5,165	
North Carolina	48,644	35,081	28,931	
North Dakota	-	549	---	
Ohio	---	62,944	---	
Oklahoma	---	17,645	---	
Oregon	28,979	6,275	2,696	
Pennsylvania	---	---	---	
Puerto Rico	---	---	---	
Rhode Island	4,254	---	-	
South Carolina	32,554	---	17,165	
South Dakota	1/ 140	---	140	
Tennessee	98,233	72,486	27,023	
Texas	47,095	32,131	28,424	
Utah	1/ 693	963	693	
Vermont	-	---	-	
Virgin Islands	---	---	1,626	
Virginia	1/ 42,000	51,528	42,100	
Washington	5,720	31,680	6,000	
West Virginia	8,443	6,496	2,859	
Wisconsin	1,633	-	---	
Wyoming	265	315	129	

Code:
1/ Estimated
- Zero
--- Data not available.

Highlights of State Programs

A review of State reports received during FY 1972 reveals that some family planning activity took place in almost every State. The following examples illustrate this aspect of State Maternal and Child Health programs:

Arizona

This State now has clinics in all but four southeastern counties.

Arkansas

In fiscal year 1972, family planning services were increased through the efforts of local health departments. Seventy-seven clinics now cover all 75 counties of the State. Fifty-seven of these are under the supervision of the Maternal and Child Health Division. Infant mortality and the birth rate continue to decrease. Emphasis in the clinics is on the total health of the family. Coordination of services with agencies such as OEO, CAP, and VISTA has improved.

California

The California Interagency Council for Family Planning coordinates efforts in expanding family planning services. The State now has some kind of service in all 58 counties and has organized clinics in 44.

Colorado

New family planning projects were started in seven Colorado counties with some support from MCH funds.

Connecticut

In Connecticut, 18 percent of MCH formula grant funds support family planning services in New Haven and Meriden. The State MCH section has developed a licensure unit for free-standing family planning clinics.

Georgia

Adolescent pregnancy has accounted for more than one of every five deliveries in the State since 1960. Annually, approximately 6 percent of livebirths occur as the second or greater livebirth to an adolescent. However, the number of teenage "repeaters" has declined from 6,398 in 1960 to 5,165 in 1970. This may reflect the provision of contraceptive services to adolescents. Nevertheless, teenage pregnancies mean the termination of education for an estimated 12,000 girls each year. The distribution of births by mother's age in Georgia during 1970 is as follows:

Total Births	95,584	Total Unwed	11,029
Total to Teenagers	22,331	15 to 19	5,508
14 and under	541	14 and under	382

23.4% of Total Births . . . . . Teenagers
26.4% of Teenage Births . . . . Unwed Mothers
53.4% of All Unwed Mothers . . Teenagers

The courts are also addressing the problems of teenage pregnancy. A U.S. District Court judge ordered school officials in Decatur, Georgia, to readmit a young unwed mother to classes. The January 1972 action stated that the girl could not be denied enrollment "solely on account of her sex or motherhood." The judge ruled that denying readmission on this basis was a violation of constitutional guarantees of equal protection of the law.

The Atlanta Board of Education adopted a precedent-breaking policy permitting all pregnant students the same rights and privileges held by other students. Thus, as a result of the three-year research and demonstration project funded by a 1968 MCHS grant to the Department of Gynecology and Obstetrics, Emory University School of Medicine, pregnant girls can now remain in school anywhere in the Atlanta School System.

Hawaii

This State has clinics in all counties.

Idaho

MCH funds support family planning clinics in Coeur d'Alene, Lewiston, and Pocatello. Together, these clinics account for approximately 30 percent of the women served in the total Idaho program.

Illinois

A Statewide, not-for-profit corporation, the Illinois Family Planning Council, has been formed to administer all family planning programs in the State which receive Federal funds. This corporation is negotiating a contract with the Department of Public Aid, the Title XIX agency in the State, to provide family planning services for Public Aid recipients.

At the beginning of fiscal year 1972, MCH approved 16 local family planning programs for funding. This represented an increase of two over fiscal year 1971. In cooperation with the Family Planning Council, four other community programs have been developed.

Iowa

The Iowa Division of Maternal and Child Health coordinates a number of family planning programs, and has two HEW grants for family planning services covering Des Moines and the four-county area north

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of Iowa City. The MCH Division is making special efforts to fill gaps in service in rural towns.

Kansas

This State expanded its family planning services to cover 65 counties with 30 clinic sites, most of which doubled their patient attendance during the latest reporting period. These clinics were funded by MCH, NCFPS, and OEO grants.

Maryland

The Chief of the Division of Maternal and Child Health and the Chief of the Maternity and Family Planning Section of this Division gave the following statistical summary as of December 31, 1971:

> "We now have 22,399 active family planning patients. This represents 30% of our Polgar target of 74,000 Maryland women who need but cannot afford help in controlling their fertility. The change in active patients from 20,583 at the end of September to 22,399 at the end of December amounts to 2.46% of the statewide target population added during this quarter. Several counties have made outstanding percentage increases during this time.
>
> There are now 53 family planning clinics listed compared to Maryland's 23 counties not including the federally financed clinics in Baltimore City. The new patients increased this quarter by 1,226 to provide a total of new federal family planning grant patients since July 1 of 2,011. Thirteen of the Maryland counties now have 25% or more of their target population actively enrolled in the State family planning program. As recently as 6 months ago only nine counties had advanced this far."

The University of Maryland Community Pediatric Center in Baltimore is training young women to provide information about family life and contraception and to encourage other teenage females in the community to accept family planning advice when needed. Seven young women who have completed the training program are employed half-time and are supervised by a health educator through the Pediatric and Obstetric Departments.

Massachusetts

In Massachusetts, the State Health Department, in cooperation with the Departments of Welfare, Mental Health, and Community Affairs, as well as State Planned Parenthood League has initiated the Massachusetts Family Planning Consortium, which comprises 22 Statewide groups representing providers and consumers, and is coordinating family planning services in the State.

Michigan

In Michigan, an NCFPS grant has enabled the family planning program to expand to all counties in the State. A breakdown of funds for the program during 1970-71 shows $100,000 from State funds, $431,793 from MCH funds, $905,383 in a direct NCFPS grant, and $226,374 from local funds.

Minnesota

Family planning and family life education responsibilities have been assumed by a Division of Special Services Office of Family Planning and Family Life Education which was established December 1, 1971. The activities of this Office are supported by Maternal and Child Health funds.

The State Department of Health initiated a study to assess services in the State. The survey indicates clinic locations, clinic sessions, eligibility requirements, and number of patients served.

The Minnesota Department of Health established subsidized family planning services in 11 counties in the west-central and southwestern sections of the State during fiscal year 1972. Services are fee-for-service with cooperating local physicians and pharmacies. Follow-up service is also provided. Plans for fiscal year 1973 are to add eight more counties to this program.

The State Department of Health, utilizing a Federal grants-in-aid program, funds local agencies operating family planning projects in the Minneapolis metropolitan area and in out-State areas.

During 1971, the State Legislature approved legislation permitting certain minors to obtain medical, dental and related health services for themselves and their children without parental consent.

Montana

Through MCH and NCFPS funds, this State has expanded its family planning services to include 13 projects.

Nebraska

A Statewide Family Planning Program has been developed and should become operational during fiscal year 1973. Based on a grant from HSMHA and a contract with the Nebraska Family Health Associates, family planning clinics will be set up throughout the State. As these clinics become operational, they will be turned over to the MCH Division for Administration. These clinics are to become general medical clinics as part of a comprehensive health care program.

New Jersey

Standards for family planning services have been developed. Nearly all counties now have family planning programs.

New Mexico

In New Mexico, a Family Planning Council was incorporated in April 1972, to coordinate family planning programs in the State.

New York

In New York, MCH program funds are used to support family planning services in line with the State policy of making such services available to all who wish to have them. Local resources are also used for these services.

North Dakota

This State now has a family planning clinic in Minot, supported with MCH funds.

Ohio

Fiscal Year 1972 has been a year of growth and expansion in the family planning programs with the advent of Maternal and Child Health Services funds making much of this possible. Services were initiated in 13 counties with no previous services and expanded in 12 other counties. Family planning services are now available in 72 of Ohio's 88 counties.

The main thrust of the Maternal and Child Health Division was in providing technical assistance and consultation to the counties. Included were training, program need assessment, development of educational components, and assistance with service delivery mechanisms. The Division developed guidelines for comprehensive family planning services funded by the Division of Maternal and Child Health. Training sessions were conducted for project staff and personnel from local welfare agencies.

Among the family planning priorities established are the following:

To assure the provision of family planning services in every county in Ohio.

To encourage multi-county or regional coordination wherever possible. This will help to extend services, lessen duplication, and encourage a single, high-quality standard.

To encourage the broadening of definition and scope of service of a family planning project and discourage free-standing, single purpose programs.

There is continued emphasis on utilization of nonprofessionals and development of career ladders through program consultation.

Oklahoma

The State now has family planning services in 59 of its 77 counties.

Of the estimated 92,000 women in the State potentially in need of subsidized family planning services, approximately 26,700 received services through health department programs.

Oregon

In Oregon, the Health Division of the Department of Human Resources uses MCH funds to contract with local agencies for family planning services. Twenty-five clinics are in operation in 20 of the State's 36 counties.

Pennsylvania

Pennsylvania is using one of its health regions as a site for interagency planning for a family planning service project. Planning is being coordinated by the State MCH Division, with a view to using it as a model for development of a Statewide program.

South Carolina

The South Carolina Family Planning Program expanded its services in six health districts so that the percent of need met increased from 16.9 percent in 1971, to 23.7 percent in 1972. The percent of need met in the State increased from 15.7 percent in 1971, to 21 percent in 1972.

South Dakota

This State is supporting family planning services to Rapid City and Aberdeen with MCH monies.

Tennessee

The Bureau of Family Health Services, the State agency for Maternal and Child Health, has done preliminary recalculations of the need population for family planning in Tennessee based on 1970 Census data.

Texas

Texas is initiating maternal and child health services including family planning services in areas in 37 counties lacking such services. In six other large Texas counties, a mobile van provides family planning services.

The People's Free Clinic in Austin, Texas, has been in operation since April 7, 1970. During the first year of operation, clinic personnel saw more than 3,000 individual patients for approximately 5,500 patient visits.

Utah

In Utah, two local health departments have family planning clinics supported with MCH funds. In other sparsely populated areas of the State, low-income women can contact the public health nurse, who arranges for services through a private practitioner.

Virginia

In Virginia, family planning services are available in all 96 counties. The State health department employs a full-time consultant nurse in family planning who serves as coordinator between special projects, the Virginia League of Planned Parenthood, and all public health nurses at State and local levels.

Washington

This State now has 18 family planning clinics, most of which were initiated with MCH funds. Several additional clinics are being proposed, and services are being extended by joint funding with NCFPS.

West Virginia

Family planning services were provided to 10,000 women in 55 clinics located in 50 of the States' 55 counties. This expansion of services was made possible by the NCFPS Statewide Family Planning Project.

Wisconsin

In Wisconsin, the Maternal and Child Health Section of the Bureau of Community Health Services has funded or helped to fund 13 family planning projects, as compared with four the previous year.

Maternity and Infant Care Projects (M&I)

Statistical

The number of women provided family planning services through Maternity and Infant Care Projects was 109,742 for fiscal year 1970; 134,685 for fiscal year 1971; and 120,284 (provisional) for fiscal year 1972. The apparent decline from 1971 to 1972 in total M&I patients served is actually a consequence of revised reporting procedures. MCHS no longer reports patients in those M&I projects which are in clinics also receiving funds from the National Center for Family Planning Services (NCFPS). These patients are now included in NCFPS reports. The following table sets forth the above data on a State-by-State basis:

Maternity and Infant Care Projects New Family Planning Admissions, by State, for FY 1970, 1971, and 1972

State	1972 provisional	1971	1970	
United States	120,284	134,685	109,742	
Alabama	4,497	2,998	2,971	
Alaska	-	-	-	
Arizona	-	-	-	
Arkansas	2,233	2,316	1,707	
California	249	252	205	
Colorado	4,858	4,713	3,510	
Connecticut	1,091	1,150	1,022	
Delaware	-	-	-	
Dist. Columbia	7,855	5,615	6,530	
Florida	15,637	12,580	11,287	
Georgia	16,405	14,631	10,560	
Guam	-	-	-	
Hawaii	501	427	421	
Idaho	146	157	97	
Illinois	6,173	18,474	13,410	
Indiana	13	-	-	
Iowa	-	-	-	
Kansas	-	-	-	
Kentucky	558	552	616	
Louisiana	-	-	-	
Maine	6	0	128	
Maryland	2,076	6,939	4,094	
Massachusetts	3,031	3,328	2,164	
Michigan	3,319	2,858	3,333	
Minnesota	827	1,747	1,306	
Mississippi	849	815	637	
Missouri	2,555	2,412	2,064	
Montana	-	-	-	
Nebraska	1,592	1,355	967	
Nevada	0	0	0	
New Hampshire	-	-	-	
New Jersey	449	622	532	
New Mexico	1,048	920	350	
New York	14,019	19,143	18,216	
North Carolina	1,380	1,185	947	
North Dakota	-	-	-	
Ohio	5,148	5,453	2,755	
Oklahoma	-	-	-	
Oregon	462	338	377	
Pennsylvania	4,386	4,218	3,733	
Puerto Rico	1,658	2,192	1,063	
Rhode Island	691	463	107	
South Carolina	2,872	2,483	2,148	
South Dakota	-	-	-	
Tennessee	-	-	-	
Texas	9,531	10,367	8,423	
Utah	-	-	-	
Vermont	-	-	-	
Virgin Islands	-	-	-	Code:
Virginia	1,090	1,245	1,646	- States with
Washington	1,526	1,201	915	no M&I project
West Virginia	1,553	1,536	1,501	
Wisconsin	-	-	-	
Wyoming	-	-	-	

Highlights of Maternity and Infant Care Projects

The comprehensive maternity and infant care program has as one of its primary objectives the reduction of infant mortality. There are indications that this program is contributing significantly to the large reductions in infant mortality that are taking place nationally and in major cities. Only three of the 21 largest cities had significant annual reductions in their infant mortality rates during the period 1960 to 1965. For the Nation as a whole, infant mortality decreased by only 5 percent during the entire decade 1956 to 1965. From this static situation, there was a sudden change in 1966, when the rate dropped to 23.7 per 1,000 live births, a decrease of 4 percent over the previous year. The provisional rate for 1971 is 19.2. Therefore, in the past four years the infant mortality rate has decreased three times as much as in the previous decade.

Trends in the provision of family planning services include: increasing services to sexually active single females; more useful and complete statistics due to computerization of data; increased and improved patient education; increased counseling and assistance for infertility; and utilization of various allied health professionals in providing family planning services, as well as the use of health aides.

Good maternity care and family planning services, which are an integral part of maternity and interconceptional care, are effective in reducing infant mortality. States which have the largest number of Maternity and Infant Care projects and whose projects have the longest duration of operation had the most noteworthy reductions in infant mortality since 1965. Many of these projects show an increase in numbers of patients receiving postpartum care at which time family planning counseling and services are provided.

In the spring of 1964, the first Maternity and Infant Care Projects to provide comprehensive care for poor expectant mothers at high risk and their infants and to reduce maternal and infant mortality were funded. Between this time and the end of FY 1972, 56 projects have become operational. The projects are located in 35 States, the District of Columbia and Puerto Rico. Each was established to serve a locality which in the past showed much higher infant and maternal mortality rates than the Nation as a whole. Approximately 900,000 women have been admitted for maternity care and 600,000 for family planning services since the M&I program was established.

Data reported for the first two quarters of FY 1972 indicate that Maternity and Infant Care Projects will probably care for about the same number of new maternity patients as in FY 1971 (141,521) and about the same number of infants (45,252).

When compared with FY 1971 data, patients served in 1972 by the projects were relatively stable in the following areas: race (59.7 percent black and 40.3 percent white, other, or not stated) and

marital status (44.5 percent out of wedlock and 55.5 percent other). The number of girls ages 15 or under seems to be increasing slightly as a percentage of total project patients--5.6 percent in FY 1971 as compared with 6.6 percent estimated for FY 1972. The percent of new family planning patients who had been enrolled in the project for their last pregnancy is expected to increase slightly from 58.5 percent in FY 1971 to an estimated 60 percent in FY 1972.

The following examples of project activities related to family planning services are taken from narrative reports submitted to program offices:

In the Richmond, Virginia, Maternity and Infant Care Project, 91 percent of the maternity patients who returned for postpartum examinations were provided family planning services....Staff of the two M&I Projects in West Virginia made 486 home visits on family planning services and held 97 clinic sessions for 3,214 patients.... In Philadelphia, the M&I Project, now in its seventh year of operation, reported that new patients registered each quarter for family planning services increased 40 percent over the corresponding period in the prior year and that there has been a 60 percent increase in return visits.

Grady M&I - Atlanta, Georgia

The project obtained a small OEO grant to institute a teenage birth control clinic for one year postpartum follow-up of younger adolescents. The clinic proved to be impractical as younger teenagers would not attend. Many denied the need for contraception since that identified them as sexually active. It was soon obvious that a birth control clinic would not meet many of their needs as young mothers. As a consequence, the project has set up an interconceptional care clinic which provides health services, including birth control and health education. Peer group meetings are held regularly. A case worker aids with problems, and routine contact is maintained with school personnel. Even so, the average number of teenage interconceptional care clinic visits for the year was only 1.44. The average number of visits made by MIC patients for the year, ante- and postpartum, was 9.14. Routine electrophoresis for detection of sickle cell anemia continues to be carried out, and routine rubella screening has been added. Patient booklets have been developed for sickle cell anemia, and the preventive management of possible Rh sensitization is carried out through the use of anti Rh immune globulin.

An excellent postpartum return rate of 90.4 percent is reported. The project director states that over the years the project has not served merely to pay for a pre-existing level of care or available services. On the contrary, it has helped increase facilities, equipment, personnel, and services and enabled Grady Memorial Hospital to provide obstetric care for almost the entire population of indigent and medically indigent patients in the two-county area served.

M&I - Augusta, Georgia

This project, which served Richmond County and a surrounding predominately rural area composed of ten counties, has had a significant impact since its beginning in 1964, as evidenced by a number of vital statistics including infant mortality which is given here:

VITAL STATISTICS - 11 COUNTIES
of the
MATERNAL AND INFANT CARE PROJECT, BY RACE, 1965 - 1970
AUGUSTA, GEORGIA

	1965			1970		
	Total	White	Non-White	Total	White	Non-White
1. Birth Rate	24.0	20.5	28.7	22.9	21.4	25.3
2. Infant Mortality Rate	34.0	22.7	45.1	22.8	16.5	31.1

In Houston, Texas, the M&I Project is linked closely with the Family Planning Project of Houston and the Harris County Health Department. The caseload is increasing at the rate of 750 to 850 new patients monthly. Of those returning for a postpartum examination, 85 percent have requested family planning services.

In the West Palm Beach, Florida M&I Project, admissions to family planning clinics were 16.8 percent higher in calendar year 1971 than in the previous year.

Children and Youth Projects (C&Y)
(Number of Women Receiving Services)

A total of 59 Children and Youth Projects have been funded at the present time. Approximately three-fourths of these projects provide family planning services. During the past year there has been an increase in the number of projects providing these services, as well as an increase in the number of teenage girls served. In 1972, an estimated 31,000 were served compared to 26,000 the previous year.

Increasing interest is being devoted to the needs of adolescents in the C&Y Projects. Health needs of these young people are frequently related to experimentation in sexual activity. Although the C&Y Projects have varying age limits, those projects which are involved with teenagers emphasize providing guidance in such areas as family planning, venereal disease, pregnancy, and delivery.

Family planning is a high priority area with health education in this field provided by group discussion and individual counseling.

Some projects make referrals to family planning clinics, but others have a gynecologist or other staff member who can provide pelvic examinations and prescribe the contraceptive chosen by the patient.

C&Y Project in the Health Department, Topeka, Kansas, describes its services as follows:

> "For the past year, health department family planning services have been offered two evenings a month at the project clinic. Though this service initially got off to a slow start, the number of clients attending this clinic has increased to approximately fifteen patients per session. This time has been found to be convenient for working mothers and the location is readily accessible to those living in the surrounding neighborhood who do not have transportation to the health department across town. Some of the teenagers in the area prefer to come to this family planning clinic for information because the center has general health services rather than more specialized services such as venereal disease, family planning, or drug abuse counseling, found at the health department. They are also acquainted with the staff and find it easier to talk over their concerns about birth control in a familiar place. During the clinic, films are shown about birth control methods, pamphlets are available, counseling with the nurse or physician and a physical examination is done. Aside from these specified clinic times, project nurses are always available to talk with families about birth control methods. A limited stock of birth control supplies is also kept at C&Y for those clients who run out of pills and cannot or would not have to go to the health department for refills."

C&Y Project at Beth Israel Hospital in New York City states:

> "The Gynecologist in Teen Age Service sees young women as needed for diagnosis, therapy, discussion and prescription of contraceptive methods and marriage counseling. When a diagnosis of pregnancy is made, plans are made with the girl and her family, assisted by the social worker, nurse and primary physician."
>
> "A family planning counselor, employed by the Maternity and Infant Care Project of the New York City Health Department, is assigned to Teen Age Service for two sessions a week. She has provided valuable assistance to other staff by her discussions with groups of girls and boys of reproduction and sex, family planning techniques and pregnancy care."

C&Y Project located at the Medical College of Georgia in Augusta, Georgia, emphasizes the prevention of the first pregnancy in these words:

"In an effort to tackle the prevention of the first pregnancy, we reviewed cases and found that many girls in the regular C&Y caseload for the usual pediatric illnesses may have been visiting the C&Y Clinic for years without ever having had a gynecological examination. The director has since made it the policy of the clinic to refer every girl (age 12 and over) visiting the C&Y Clinic to the Gynecology Clinic for annual examinations and contraceptive counselling and methodologies. There are some girls who, as in our present GYN Clinic, will be taught the advantage of responsibility of sexual activity and yet for various not-too-well-understood reasons choose not to use a method and elect pregnancy. For these girls, at the time of pregnancy, we mobilize our skills in trying at the second opportunity to educate and motivate them in the value of the family planning unit and the desirability of marriage and economic and educational maturity for those choosing to become parents."

These reports demonstrate the serious attention being devoted to the prevention of unwanted and ill-timed pregnancy in the C&Y Projects. These young people are often already disadvantaged to such a degree that the additional burden of unwanted pregnancy could handicap them permanently both physically and socially.

Education and Training Programs

(Education and Training Programs in Nurse-midwifery, Nursing, and Medical Social Work, and some Highlights of Activities in these Fields)

Maternal and Child Health Service supports long- and short-term training programs for a variety of health professionals. This support is in the form of grants and technical consultation. A number of these programs include family planning as a component.

Nurse-Midwifery

New funds made it possible to provide additional faculty and student support to upgrade the skills of nurse-midwives in family planning. The nurse-midwifery programs integrated family planning into both their classroom work and their clinical practice for a larger number of students. The following table identifies these programs:

School	Program Length	Number of Students Supported by MCHS	Degree
University of Mississippi	12 months	13	Certificaie
Columbia University	11 months	15	M.S.
Emory University (Grady Hospital)	12-24 weeks (refresher)	16	None
Johns Hopkins University	24 months	5	M.S.
University of Utah	24 months	14	M.S.
State University of New York	20 weeks (refresher)	8	None
University of Illinois	24 months	6	M.S.

The following are examples of what these programs have been able to do. In addition to several hours of theoretical content, the students at Columbia University have clinical experience in the maternity programs of four hospitals. Family planning principles are appropriately integrated for patients in the antepartum, intrapartum, postpartum and intraconceptual periods. Midwifery students have considerable experience in inserting IUCDs, fitting diaphragms, dispensing oral contraceptives, and in providing individual and group counseling. This group of nurse-midwifery students have had an additional opportunity to initiate family planning with young people since they manage a maternity clinic for adolescents.

At the University of Utah, nurse-midwifery students frequently counsel older women who are still in the childbearing period. This group of patients appear to have difficulty in seeking family planning services without supportive counseling and referral assistance.

In the Johns Hopkins University nurse-midwifery program, experience includes counseling and conducting annual physical examinations of women using prescribed contraceptive methods. Students may elect to have additional clinical training in doing pelvic examinations, fitting diaphragms, and inserting IUCDs.

The University of Mississippi nurse-midwifery program has a modular curriculum, allowing each student four to six weeks to master the family planning concepts. They are taught to deal with normal family planning concerns as well as such issues as infertility, unwanted pregnancies, and requests for sterilization. They also do individual and group counseling.

Refresher programs for nurse-midwives at the Grady Hospital and the State University of New York are important because many midwifery students were graduated prior to the development of some of the current knowledge regarding family planning.

Nursing

Maternal and Child Health and Community Health Nurses are expanding their family planning efforts. The following are examples. During the past year, the nurses at the Rhode Island Maternity Hospital in Providence, Rhode Island, chose to focus their inservice training program on family planning in order to better prepare themselves to counsel hospital patients.

In Concord, New Hampshire, one nurse has a joint position with the Children and Youth Project, Community Mental Health Center and Family Planning Project. She is responsible for integration of the nursing efforts in the family planning programs of these organizations.

In Connecticut, State Department of Health nurses were instrumental in developing and field testing the protocol for licensure of family planning clinics in the State.

Boston University has gradually increased student involvement with family planning. Beyond the classroom experience, the students receive clinical experience in family planning clinics as well as in other settings where they are engaged in individual or group counseling for unwed adolescents and married couples. Some students seek additional assignments in family planning. For example, one nursing student works with a geneticist who is performing amniocentesis, a procedure for prenatal genetic evaluation. The nursing student, with interdisciplinary supervision, counsels the women prior to and following the procedure.

Walter E. Fernald State School for the mentally retarded provides another example of nursing's involvement in family planning. A nurse from the Eunice Kennedy Schriver Center conducts group sessions with the young adults at this school. The focus is on human sexuality, associated responsibilities, and resources available for these young people in preparing them for minimally supervised living in the community. The attendants at Fernald are also being prepared to counsel the residents.

In Virginia, the consultant nurse in family planning has helped to train outreach aides who are working in migrant camps. She has also been accepted as a family planning coordinator by the special projects, the Virginia League of Planned Parenthood, and all public health nurses at State and local levels. As in several other States, couples applying for marriage licenses are given family planning literature.

Through its antepartum clinic, Temple University in Philadelphia is conducting an active family planning program. Community aides are being prepared for outreach work and nurse-midwives are being trained to counsel clients and to determine the presence of IUCDs by examination.

At the University of Maryland, Baltimore, undergraduate nursing students are introduced to family planning concepts, including the methods available for contraception and child-spacing and the problems associated with infertility. These students have clinical experience in both the women's clinic and the vasectomy counseling clinic.

At Emory University, Atlanta, Georgia, efforts have been made to broaden the family planning aspects of the nursing program. Working for three consecutive quarters with a given population of families, students provide family planning counseling and follow-through. In addition, some students work with adolescent residents in the Florence Crittenton Home.

The Department of Gynecology at the University of Oklahoma Health Science Center offers a six-weeks' training program for family planning nurse practitioners. One of the two nurses trained has been employed by the University of Oklahoma School of Medicine as Coordinator of Family Planning Services at the Medical Center. The second nurse, a Public Health Nurse, is working in the Comanche County Health Department Family Planning Program.

The Nursing Division of the Arkansas Department of Health, the University of Arkansas Medical Center Department of Obstetrics and Gynecology, the Arkansas Maternal and Infant Care Project and the University of Arkansas School of Nursing are meeting jointly to plan a continuing education program for nurses concerned with maternity care and family planning. Their skills and responsibilities would include family planning counseling, pelvic examinations, and IUCD string check.

Medical Social Work

In locations where there is a Maternity and Infant Care Project and a family planning project funded by the National Center for Family Planning Services, social workers in both projects coordinate services. Notable of such cooperation is the Houston Maternity and Infant Care Project where social workers work interchangeably to render continuous assistance to patients. As a result, more women use some method of family planning and more return for follow-up care.

In other Maternity and Infant Care Projects and Children and Youth Projects, social workers train and supervise outreach workers who work in family planning.

In the Los Angeles County Health Department, social workers provide premarital counseling, including family planning counseling, to teenagers applying for marriage licenses. These young people gladly accept referrals to Health Department family planning clinics.

In the State crippled children's programs of Hawaii, Minnesota, and Wyoming, family planning and genetic counseling is being

provided by medical social workers. This service is particularly helpful to families of children born with birth defects.

Research

Research supported by Maternal and Child Health Service relative to family planning and population includes the five grant projects described below. The grants totaled $463,546 in fiscal year 1972.

The Atlanta Adolescent Pregnancy Program is implemented under a grant to the Atlanta Public Schools amounting to $46,355 in FY 1972. This project is an attempt to evaluate the effects of the school system's new policy permitting students to attend regular school during pregnancy and after giving birth. The study seeks to determine whether the presence of pregnant and postpartum pupils in the regular schools is accompanied by a decrease in the number of pregnancies that occur each year. Other aims are to determine (1) how teachers and other students feel about regular school attendance by the pregnant girl, (2) what behavior they feel is appropriate for pregnant students, (3) the extent to which punitive attitudes toward pregnant students are held, (4) what change results in attitudes toward sexual behavior as a result of school attendance of pregnant girls, and (5) rates of school retention, performance, high school graduation, and dropout for pregnant students. The project is planned for completion in July 1973.

As grantee, the Johns Hopkins University, Baltimore, investigates "Therapeutic Abortions: Special Reference to Teenagers," with funding of $22,532 in FY 1972. The goal of this project is to develop data on the demographic characteristics of Baltimore City residents who obtain therapeutic abortions in hospitals of the city compared with the resident population who deliver live babies in the city during an 18-month period beginning July 1, 1970. Data on the incidence of therapeutic abortions are being collected for specific groups of women classified by age, parity, economic status, geographical area of the city, and marital status. The data will be examined with respect to specific birth rates, prematurity rates, and illegitimacy rates to assess the possible association of therapeutic abortions with changes in vital statistics. Another goal of the study is to present data which can be used for determining the usefulness of a therapeutic abortion reporting system similar to that used for birth certificates. Reports of findings of the study will be available late in 1972.

Wake Forest University of Winston-Salem received a grant of $104,484 in FY 1972 for its project entitled "Family Planning Approaches Among High Risk Females." This project is designed to evaluate various programs for increasing and maintaining the proportion of females who become effective and consistent in practicing family planning over a period of three to five years as a primary prevention of various illnesses and physical impairments among mothers and children in a target population of 6,500 high risk,

poverty level Negro families of childbearing ages. Analysis of data from a one-in-five sample from this population is being done to determine which educational methods and clinic procedures are most effective in overcoming resistance to family planning and in converting availability and accessibility of health services into life styles and time patterns of the high risk population. The data were obtained from 500 males and 1,000 females. Sub-studies include a longitudinal study of 3,100 13-15 year olds, and evaluation of an action-education approach among the population of 6,500 females using "excess births" and numerator analysis techniques and comparative data from a quota sample of 1,600 Costa Ricans. This study is to be completed in June 1974.

"Pregnancy Spacing and Birth Outcome - Family Planning" is the title of a research project at the University of North Carolina, Chapel Hill, for which $231,735 was awarded in FY 1972.

This project is an evaluation study of family planning service projects funded in whole or in part by the National Center for Family Planning Services. The design is a multiple block action experiment using program and control cities including 18 cities in all. Data collection includes operating service statistics from the projects, household sample surveys, hospital interviews of newly delivered mothers, special vital statistics tabulations, and observation of interaction and facilities in family planning clinics. The project has an anticipated completion date of July 1973.

A project entitled "The Consequence of Adolescent Illegitimacy," at the University of Pennsylvania, Philadelphia, was funded in FY 1972 in the amount of $58,440. This project began as a study of unplanned pregnancy and parenthood among teenagers and is being continued to examine the long-term effects of unplanned parenthood on both parents and offspring. The initial research examined a population of girls who became pregnant in 1965-67; they were interviewed prior to delivery, a year after delivery, and again three years after delivery. The sample was then compared to a matched sample of classmates who did not become pregnant during this period. Finally the fathers were interviewed to determine the consequences of early and unexpected parenthood on males and the factors that lead couples to marry or separate. The mothers in the original sample are being interviewed a fourth time and the fathers a second time; the offspring are interviewed as they are approaching school age; and a matched sample of classmates are being interviewed. This phase of the study is expected to update findings on the career of the adolescents, to reveal problems and to define needs of parents, and to aid in the study of behavioral problems among the offspring. The project ends in June 1974.

1973 - 1974 Program

The 1973 budget for maternal and child health activities under Title V of the Social Security Act anticipates obligations of $16.4 million for family planning services. This amount includes $11.7

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million in the Maternal and Child Health Service formula grant program to assist States in making progress toward achieving the legislative requirement to make family services available Statewide by 1975. The funding level for 1974 continues the program at approximately the 1973 level.

Title V legislation currently in effect provides that no grant may be made for Section 508, Special Project Grants for Maternity and Infant Care (M&I), and Section 509, Special Project Grants for Health of School and Preschool Children (C&Y) for any period after June 30, 1973. The statute provides a program of projects be carried out which offers reasonable assurance of satisfactorily helping to reduce the incidence of mental retardation and other complications associated with childbearing, and to help reduce infant and maternal mortality.

The Center for Disease Control (CDC) through its Epidemic Intelligence Service (EIS) officers provides assistance to State and local health agencies in the evaluation of family planning programs. EIS officers have been assigned to Georgia, Maryland, and Tennessee to develop and maintain data processing systems for family planning service statistics, to analyze contraceptive use and effectiveness, and to conduct special studies based on these analyses. In addition to these continuing assignments, EIS officers have provided short-term assistance for improving program management, designing service statistics systems, and evaluating family planning program performance. An assessment of State family planning programs conducted by the Maternal and Child Health Service places the family planning programs of the States to which CDC assigns EIS officers (Georgia, Maryland, and Tennessee) in the top five States of the Nation.

As State abortion laws became less restrictive beginning in 1967, data concerning abortion mortality and the practice of legal abortion became increasingly important. CDC maintains surveillance of abortion practice and abortion deaths through a nationwide reporting system. In 1969, approximately 22,000 legal induced abortions were reported to CDC on a voluntary basis by State and local health departments. The following year, more than 180,000 abortions were reported; and in 1971, that number increased to over 480,000. During 1972, New York City, Philadelphia, Buffalo, Chicago, and the States of Arkansas and Kansas were assisted in assessing abortion-related health problems and in determining the measures necessary to prevent them. From the mid-1950's to the mid-1960's, abortion mortality did not decline even though other causes of maternal death decreased substantially. Provisional statistics indicate that abortion mortality is now decreasing. In 1969, 132 abortion-related deaths were reported. In 1970, there were 140 such deaths; and in 1971, 120 occurred. Provisional data reported to CDC suggests that the number for 1972 may not reach 100. As more women seek legal abortions in places other than their home State, Federal and State cooperation must be improved if the favorable trend in abortion mortality is to continue.

The Comprehensive Health Planning Service finds that State and areawide comprehensive health planning agencies are devoting increasing attention to family planning services. A 1970 review of areawide agencies found half of the agencies concerned in some way with family planning. CHP activities have ranged from designing a Family Planning Information Center to participating in the development of programs to provide direct family planning services to those who want them.

The Community Health Service encourages the integration of family planning services into programs of neighborhood health centers supported through Public Health Service Act, Section 314(e) project grants for health services development. There are currently 67 centers located in 28 States and D.C. These centers are located in areas with a high concentration of urban and rural poor and provide access to a broad range of comprehensive health services to an estimated one million people.

The Family Health Center Program, initiated in 1972 under Section 314(e), offers another means for improving access to care in medically underserved areas. The Family Health Center will provide a basic package of prepaid health services to an enrolled population.

In addition, CHS supports approximately 115 migrant health projects. These are designed to provide health care services to migrant agricultural laborers and seasonal farmworkers and their families. Several of these projects include family planning services.

Under the Formula Grants to States authorized by Section 314(d), States receive funds for meeting the special health needs of people or for launching new programs which result from their own planning. Many States utilize the flexibility of this funding mechanism to expand their services into areas such as family planning.

The Federal Health Programs Service provides comprehensive family planning services to eligible beneficiaries through its system of hospitals and outpatient clinics. Family planning services may include the prescription and provision of pharmaceutical preparations including oral contraceptives and mechanical devices, surgical sterilization, and counseling.

All postpartum patients are offered family planning information and services as part of the follow-up medical care at the Public Health Service Hospitals which have obstetrical services (Staten Island and New Orleans). All USPHS hospitals and clinics provide family planning services upon request. There were an estimated 15,000 family planning services visits in fiscal year 1970, 15,500 visits in fiscal year 1971, and 18,400 visits in fiscal year 1972. 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 St. Elizabeth's Hospital.

The Division of Federal Employee Health, through the health unit operations, provides the following family planning education and counseling services upon request:

1. Family planning literature.

2. Access to a physician and/or nurse to discuss family planning.

3. Referral 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, 1972, family planning services have been provided to 48,600 women. In fiscal year 1972, there were 37,200 medical visits by 20,300 Indian and Alaskan native women for family planning services. In FY 1972, the number of Indian women 15-44 years of age was estimated at 94,100.

The National Center for Health Statistics (NCHS) collects and publishes natality, marriage and divorce, 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 conducts annual vital records surveys. NCHS is currently developing an interview questionnaire and final operational plans for a continuing survey of family growth in the United States. This survey is designed to collect data on factors affecting the birth rate, family planning, and infant and maternal health. This survey will be conducted through the use of the field operations of a private survey organization with periodic interviewing of a representative sample of ever-married women in childbearing ages. NCHS and the Research Triangle Institute in North Carolina have collaborated in the development of a computer model intended to simulate the dynamics of population growth. A manual is being prepared to enable others, within this country and abroad, to apply the model to their own population structure and problems.

NCHS is responsible for operating a uniform national family planning services reporting system. This reporting system has been developed in two steps. NCHS worked with the National Center for Family Planning Services, Maternal and Child Health Service, the Office of Economic Opportunity, and Planned Parenthood-World Population, and other governmental and private family planning groups to initiate a provisional family planning reporting system. This provisional system provided data on the utilization of family planning services which were financed at least in part by Federal funds, and for which there was an immediate program need for data.

Based on the experience gained from the operation of this provisional system, NCHS developed the National Reporting System for Family Planning Services (NRSFPS) for use by all federally supported

family planning programs, clinics, and service points, and by other agencies wishing to participate in the reporting system. This system provides monthly, quarterly, and annual reports essential for the efficient and effective development, operation, and evaluation of family planning programs throughout the Nation.

The National Institute of Mental Health (NIMH) recognizes the special contribution that can be made by mental health personnel in the area of family planning. The Institute is involved in this area of concern through its research, training, and service programs.

The Institute views family structure as it relates to the larger social structure and to such social structure variables as occupation, social class, economic status, and life style. Since the Institute recognizes that programs of family planning must be modified to fit the facts of a diverse society, it seeks to determine these facts as they relate to mental health issues.

The Institute is interested in the implications of family size for the physical and mental health of family members. It is also interested in child spacing and its effect on family functioning and on the personality development of children. It seeks to determine the strengths and weaknesses of differing family forms and sizes; the effects of abortion and sterilization; the role of adoption; and the implications of working mothers, increased family incomes, and day-care centers on the family planning process.

Thus, the Institute seeks to determine the kinds of mental health services needed by families of differing sizes and forms, the adequacy of one-parent homes in providing crisis support to individual members, and the correlations between family size and the emotional characteristics of family members. Biometric data, for example, indicate that the heads of families with one child - both parents present - have lower admission rates to psychiatric facilities than the heads of those families which contain several children; yet, the children of one-child families - both parents present - have higher rates of hospitalization than children in families where siblings are present. Data of this nature have important implications for the Institute's contribution to family planning services.

The Institute encourages and supports family planning services provided through community mental health facilities. In its training and educational support programs, NIMH stimulates family planning programs in the training of public health nurses, teachers, social workers, and others involved in sex and health education. Through the Center for Studies of Child and Family Mental Health, the Institute encourages research in mental health and the behavioral aspects of family life. Examples of NIMH-supported research grant projects which deal directly with family planning are:

1) Examining the effects of siblings - number, relative ages and sexes - on a child's intellectual ability, social behavior, and personality characteristics.

2) Studying the motives and conflicts which influence childbearing and family planning; relating these factors to the course and outcome of pregnancies and postpartum family relationships.

3) Exploring the philosophies of family formation held by "trans-racial adoptive families;" the social and emotional characteristics of these adoptive parents.

4) Developing scales for appraising sexual attitudes and use of the scales in assessing in-service sex education programs for teachers.

5) Investigating the role resolutions of young mothers to determine the factors involved in assumption of an adult status vs. returning to the world of youth.

6) Evaluating a program of intensive aftercare with discharged psychotic mothers of young children and conducting a survey of family planning knowledge, attitudes, and practices of the women.

7) Studying a variety of social policy issues, including family planning, for which marital and family variables are important.

In addition, a large group of research grant projects bear indirectly on family planning: communication and decision-making within families; patterns of family life; motivation; sex education; and population characteristics. The Center for Studies of Child and Family Mental Health investigates the structure of the American family; i.e., what factors contribute to breakdown in the family structure in the affluent suburban household; problems of role identification as a father for the third generation AFDC recipients. The NIMH Division of Intramural Research carries out projects on family formation, child spacing, and animal studies of population density.

National Institutes of Health

Summary of Programs Related to Population Research and Family Planning

The research programs of the Department in the population sciences are directed by the National Institute of Child Health and Human Development. Section 444 of the Public Health Service Act authorizes the Institute to conduct and support research and training relating to maternal health, child health, and human development, including research and research training in the special health problems and requirements of mothers and children and in the basic sciences relating to the processes of human growth and development, including prenatal development.

In addition, Section 1004 of Public Law 91-572, "The Family Planning Services and Population Research Act of 1970," authorizes the Secretary of Health, Education, and Welfare to make grants and to enter into contracts"...to promote research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population...." Expenditures by the Institute in fiscal year 1972 for population research were $40.0 million. They are projected to be $39.8 million for fiscal year 1973.

Other components of the National Institutes of Health provided $5.0 million in fiscal year 1972 to support a variety of extramural activities with important implications for population research. Reproductive endocrinology research supported by the National Institute of Arthritis and Metabolic Diseases required approximately $2.0 million in fiscal year 1972. These studies provide information for the development of new methods for controlling reproductive processes. The National Cancer Institute's interests in reproductive endocrinology and other physiological functions are relevant to understanding normal function and fertility control. In fiscal year 1972, $0.7 million was spent to support these studies. The National Heart and Lung Institute, in investigations of the broader aspects of blood clotting mechanisms and circulation physiology, has included studies of the effects of estrogens, progestogens, and steroid contraceptives. Several studies in reproductive neuroendocrinology are supported by the National Institute of Neurological Diseases and Stroke. Support by these two Institutes totals about $0.5 million. The Division of Research Resources administers approximately $1.7 million in general research support relevant to the population field particularly in primate research centers. The National Institute of General Medical Sciences awarded support of about $0.1 million in reproduction research.

The Bureau of Health Manpower Education promotes and supports the education, training, utilization and practice of professional and allied personnel in all areas of health. While Bureau activities are generally noncategorical, they encourage the incorporation of specific content, based on new or continuing public health problems, into educational programs, projects, and demonstrations. The Bureau provides grants for the training of health personnel in family planning, population, demographic studies, and maternal and infant care. The Bureau supports a small number of projects to develop training programs for personnel in obstetrics and family planning.

Current and Projected Population and Family Planning Activities

National Institute of Child Health and Human Development

Within the Department of Health, Education, and Welfare, the Center for Population Research (CPR) of the National Institute of Child Health and Human Development

(NICHD) has primary responsibility for research efforts to improve contraceptive technology and to increase understanding of the biological and behavioral aspects of population growth and change.

This report describes research relating to new contraceptive agents, evaluation of current contraceptive methods, and analysis of social factors in population problems. The report also describes the Institute's fundamental research in reproductive biology and the social sciences which facilitates its achievement of targeted research goals. Finally, the report describes the NICHD programs of institutional support, research manpower development, and information.

The Institute's program follows four major divisions: Biological Research, Behavioral Sciences Research, Institutional Development, and Scientific Information.

A. Biological Research

1. Contraceptive Development

The goal of research supported in this area of contraceptive technology is to develop a variety of methods of fertility regulation which are effective, safe, and acceptable to various population groups. The research strategy requires: (a) drug development and testing, (b) development of new or improved contraceptive devices and systems, and (c) directed biomedical research in targeted areas. The relative level of effort devoted to each of these three elements is a result of several factors: the possibility of fairly rapid advance in certain areas such as device development but not in others such as drug development, the size and areas of specilization of the NICHD staff, and the types of research being undertaken by other nonprofit and industrial agencies.

(a) Drug Development

The drug development program--the synthesis and testing of antifertility agents--has been in operation since June 1971 and in part involves the synthesis of new compounds which are expected to show antifertility activity with a minimum of side effects. By June of 1972, twelve contracts were awarded, dealing with unusual prostaglandin analogs, unique steroidal compounds, and the preparation and testing of hypothalamic releasing factors and their analogs.

The introduction of silicon into certain steroids used for contraception markedly affects their biological activity by separating their antifertility activity from their other hormonal (estrogenic) activity. Since the hormonal activity of steroids frequently causes side effects, a separation of these two activities is desirable. This kind of activity manipulation may, in addition, eventually permit development of a postcoital or antiovulatory agent of greater potency than currently available.

NICHD also supports the synthesis of prostaglandin-like compounds. Such drugs might act as luteolytic agents and thus become once-a-month pills. The naturally occurring most widely evaluated prostaglandins ($PGF_{2\alpha}$ and PGE_2) have a number of side effects which limit their widespread utility in fertility regulation.

The NICHD has also emphasized developing methods for male fertility regulation. Subcutaneous implantation of the male sex hormone testosterone completely inhibits sperm production in rabbits without affecting potency or sex drive. Inhibition of spermatogenesis (sperm formation) can be achieved with combinations of

drugs possessing progestational (female) and androgenic (male) activities. The progestational component inhibits sperm formation while the androgenic drug maintains the male sex drive. Clinical trials of combined drugs as male contraceptives have been reported, and the Institute plans to sponsor similar work.

To uncover new leads in drug development, the NICHD established a testing facility for chemical compounds being synthesized with government, drug industry, and other funds. This work has begun at the Mason Research Institute in Worcester, Massachusetts, through the largest single contract in contraceptive development yet negotiated by the NICHD. Out of an annual review of some 5,000 compounds of varying chemical structure, the staff of the Center will select approximately 300 to be evaluated during the first year.

(b) Device Development

The development of devices for reversible blockage of the sperm carrying channel (vas deferens) has progressed to the point of testing various devices in guinea pigs and dogs. Implantation of the devices in the closed position blocks sperm passage. In the open position, the devices allow free sperm passage. A major problem to be resolved concerns the occasional failure of the device to adhere to the vas lining. When this happens, sperm granulomas (inflamed tissue) may form, leading to a variety of complications.

Significant strides have been made in the development of devices to block the oviducts in women, although implementation of the human program must await further animal experimentation. For example, placement of plugs in the oviducts requires adequate visualization of the tube openings. For this purpose, an instrument has been built which permits seeing the interior of the uterus and the junctions between the uterus and oviducts. The instrument can be steered, allowing investigators to examine the uterine cavity in detail and, theoretically, to place tubal plugs. Placement of plugs in female baboons is planned during FY 1973.

The eventual development of new contraceptives will depend in large measure on NICHD support. However, the biological and regulatory complexity of bringing new contraceptive drugs to the point of extensive human trials justifies classifying this as a long-term enterprise. The device and drug delivery projects are closer to the human experimentation stage than are the drug development studies so that we can anticipate possible selective human testing in these areas within calendar year 1973.

(c) Directed Biomedical Research

Product development is shaped by directed fundamental research to the extent that the latter exploits likely leads. The directed portion of our program provides the NICHD and the scientific community with information explaining factors regulating normal reproductive processes, and suggesting new avenues for controlling them. Examples of work in each category are described below.

The Oviduct. The effect of the oviduct's movements on the passage of ova is being studied through direct observation of the isolated oviduct and through a variety of bioengineering approaches. The aim of this research is to determine what types of oviductal contractions occur during normal cycles and how these contractions are modified by various drugs. This research will also help to explain how postcoitally-administered estrogens exert their contraceptive effect since current studies are documenting the drugs' influence on oviductal contractions.

Another promising area is the fabrication of specialized instruments for detect-

ing the passage of the ovum through the oviduct. Since the ovum enters the oviduct shortly after ovulation, this method could be employed to pinpoint the exact time of ovulation and, therefore, be helpful in producing simplified tests for the detection of human ovulation.

Prostaglandins. Clinical trials using prostaglandins (PGs) for the induction of labor or termination of pregnancy have shown that PGs induce side effects such as nausea, vomiting, and temperature elevation. These reactions currently limit but do not preclude PGs acceptability as drugs for fertility regulation. Basic research into the interaction of prostaglandins with the reproductive system is continuing in order to understand their action and potential usefulness.

Spermatozoa and Fertilization. After developing for a time within the testis, spermatozoa (sperm) are stored in the epididymis, where they acquire fertilizing capacity. In the epididymis, fluids and hormones from the testis are absorbed, and the male sex hormone, testosterone, is converted to another hormone called dihydrotestosterone. The importance of this transformation is not fully understood; however, dihydrotestosterone may be required for the maturation of sperm so that prevention of the transformation could control fertility.

As a last example, sperm possess several enzymes needed for penetration and thus fertilization of the ovum. Inhibition of these enzymes leads to infertility in mice and rabbits. If enzyme antibodies capable of neutralizing sperm enzymes could be developed, they might prove useful as contraceptives.

2. Fundamental Biomedical Research

Most of the fundamental research in reproductive biology conducted in this country is supported at least in part by the NICHD. The increased knowledge of reproductive processes resulting from the work is essential for achievement of the Institute's program goals. The following examples of efforts within this broad program illustrate the progress that has been achieved.

Despite decades of study by endocrinologists and reproductive physiologists, little was known until recently about the mechanism of hormone action. Significant breakthroughs have increased our understanding through new developments in qualitative and quantitative studies of sex hormone receptors in hormone sensitive tissues.

Such hormone receptors are specific proteins which bind hormones and which are found both in the cell cytoplasm and the nucleus. Drugs that interfere with hormone binding are called hormone antagonists. Since the use of progesterone antagonists, for instance, should produce infertility, NICHD is actively searching for drugs with this activity.

A laboratory technique has been devised using radioactive material which specifically discriminates between the pituitary hormone LH and the pregnancy hormone HCG. These assays are so sensitive that scientists can now detect HCG as early as 5 days after fertilization, making pregnancy detectable 5 weeks earlier than previously possible. The demonstration that HCG is present this soon after fertilization challenges traditional concepts and suggests either that implantation occurs earlier than previously believed (7-8 days after conception) or that HCG is produced by the blastocyst before implantation occurs.

3. Contraceptive Evaluation

Although this program is responsible for monitoring the medical effects of

all contraceptives currently in use, oral contraceptives (OCs) have received major emphasis. Secondary efforts have been started on IUDs and vasectomy.

(a) Oral Contraceptives

More than 12 years have elapsed since the general clinical introduction of oral contraceptive drugs. They were marketed with excellent proof of efficacy and without suspicion of serious adverse effects. Except for the possibility of carcinogenesis (cancer-causation), there was little expectation of long-range risk.

These drugs, while unsurpassed in clinical efficacy, have medical effects which are not limited to the reproductive system. Virtually every physical characteristic that can be tested is found to be influenced to some degree by use of oral contraceptive drugs. Even more important are rare adverse effects. Although projected morbidity and mortality rates are low, the widespread use of these drugs means that the absolute number of women affected to some extent will be large.

Much concern has been related to thromboembolism with most initial information derived from individual case reports submitted to industry and the Food and Drug Administration (FDA). Studies to evaluate the risk were initiated in 1965 by NIH and the FDA. As a result, the FDA called for a major revision of product labeling in 1968. Subsequent studies have suggested that thromboembolism risks are dose-dependent, adding further refinement to risk estimates.

NICHD monitors oral contraceptives through seven major approaches:

1) The general surveillance program involves a large Contraceptive Drug Study at the Kaiser Foundation Hospital in Walnut Creek, California. This study of 17,000 women of reproductive age was initiated to assess the changes produced by the oral contraceptives in a generally healthy population.

2) The possibility that oral contraceptive drugs might be carcinogenic, particularly to the cervix and breast, has been a concern since introduction of these drugs because of the carcinogenic effect of estrogens in experimental animals. Since the types of epidemiological studies performed so far could have detected only major risks, other more discriminating and sensitive studies have been initiated.

3) The possible genetic effects of oral contraceptives have been of concern since the drugs suppress ovulation. As a result, ova are suspended, in a sense aged, and possibly compromised, as long as medication is taken. Direct hormonal effects may also be produced in women taking the drugs before or shortly after conception.

4) Since oral contraceptive drugs were marketed before the FDA required drug metabolism studies, fundamental pharmacological knowledge for evaluation of adverse effects of these drugs is lacking. Original dosage schedules were based largely on empiric observations, and only recently have attempts been made to determine the lowest possible effective dosage.

5) As noted, adverse cardiovascular effects of OCs received earliest attention. The risk of thromboembolism has now been well established. Furthermore, the increased blood pressure and changes in carbohydrate and lipid

metabolism accompanying OC use might contribute to risk.

Epidemiological studies to define elements of this risk should be completed in early FY 74. A study of stroke in women of reproductive age suggests the same increased risk demonstrated for other types of thromboembolic disease in OC users. Detailed analyses of contributing risk factors are underway.

6) Comparative pharmacology has become important in this program. Toxicology studies in animals are important in the pre-clinical evaluation of drugs, and the FDA now requires long-term trials on OCs in the beagle and monkey. These studies show that certain progestogens stimulate breast tumors in the beagle, but not in the monkey.

Although the suspect drugs were removed from clinical use, there is uncertainty about the design of the studies and the interpretation of the findings in terms of cancer risk. Because these studies are important to the further development of contraceptive drugs as well as to the status of current drugs, programs to evaluate these animal models and enhance the scientific base of the studies have been designed.

7) Among the effects of OCs on biological processes are those on nutritional biochemical systems. A wide variety of effects on the metabolism of fat and water-soluble vitamins and on trace elements normally present in the body has been demonstrated.

While there is little association between human disease and these changes in populations within the United States, these metabolic effects might be more significant in populations in the developing countries. In recognition of this problem, an American pharmaceutical firm has marketed a multivitamin preparation for use by women taking oral contraceptives.

(b) Intrauterine Devices

Recent study results support the hypothesis that the IUD alters the uterine environment in such a manner that blastocysts are destroyed or are not able to stay in the uterus until an estrogen surge permits implantation. If the IUD is removed before day 4 of pregnancy, there is an improved likelihood of survival of the fertilized ovum.

The addition of copper to the IUD enhances its effectiveness and stimulates leukocyte (white cell) accumulation. Copper devices currently available are less often spontaneously expelled from the uterus, produce fewer cases of irregular bleeding, and cause less pain that conventional devices. Reasons for the copper devices effectiveness are being investigated.

(c) Vasectomy

The acceptance of sterilization by males has been increasing rapidly. Although this contraceptive method is effective, isolated reports suggest the possibility of changes in the immunologic system. Similar effects on antibody production have been demonstrated in limited animal studies. These changes may affect the endocrinologic system or produce a variety of diseases which may be caused or exacerbated by autoimmune phenomena. Although there is no firm evidence to support these concerns, the NICHD regards the suggestions as too serious to be ignored. A program to detect possible complications from male sterilization and to identify

the mechanisms by which such complications might occur was initiated during late FY 72.

B. Behavioral Sciences Research

The goals of the NICHD behavioral sciences program in population research are: (1) to ascertain the social, psychological and economic determinants of fertility; and (2) to expand our understanding of the consequences of population growth and change so that public policy may be guided by adequate information.

This program has been underway only four years but has already made significant contributions, the most notable being the National Fertility Study (NFS). Data from this survey became an integral part of the Report of the Commission on Population Growth and the American Future.

Since fertility is the most significant component of population change it has received the highest priority. Particular emphasis is given to the causes of changes in fertility patterns. Current studies concern the psychological, social and economic factors which affect fertility and the differences in fertility patterns among population groups in the United States.

Studies in this report are those initiated or having reported findings since the beginning of 1972. They will be discussed under the following headings: (1) fertility in the United States, (2) trends in fertility and correlates of fertility decline, and (3) consequences of population growth.

1. Fertility in the United States. With industrialization and urbanization, fertility in the United States declined. Following World War II, however, the birth rate rose until 1958, and then began to decline. A series of studies since 1955 has attempted to document changing family-size preferences of American women and other factors affecting their fertility.

Data from the most recent of these, the 1970 National Fertility Study, reveal an increased use of the most effective methods of fertility control. In addition, there was a drop in the rate of unwanted fertility between the early and latter 1960's, to about 35 percent for white and 56 percent for blacks. This finding proved particularly important in the Population Commission report.

The decline in unwanted births was chiefly due to the increase in use of the pill, IUD, and sterilization from 37 percent in 1965 to 58 percent in 1970. By 1970, nearly 6 million, or one in five, married women of reproductive age were using OCs. (Pharmaceutical firms estimate total users at 9 million.) Increased reliance on surgical procedures (about 2.75 million or 1 in 6 couples by 1970) suggested that many couples who had completed their families preferred sterilization to temporary contraception.

While the National Fertility Study covers only married women, Johns Hopkins University is conducting a study of the sexual behavior, contraceptive practices, fertility and nuptiality of females at ages 15-19. Their sample includes 4,611 young women, 1,479 black and 3,132 white. Several findings to date are: (1) slightly less than one-half (46 percent) of all unmarried females in the U. S. experience sexual intercourse by age 19; (2) by age 15, 13.8 percent of the unmarried girls in the U. S. have experienced intercourse; (3) more than one-half of the sexually active teenage girls in the U. S. do not use contraceptives; (4) 82 percent of the blacks and 46 percent of the white incorrectly answered multiple

choice questions relating to the time of the menstrual cycle when greatest pregnancy risk occurs; and (5) the risk of pregnancy is four times greater among black unmarried females than white who have experienced intercourse.

As part of the NICHD plan to study attitudes toward specific contraceptives, four hundred women and men from three communities have been selected for a study of the psychological effects of vasectomy. The study will measure public opinion toward vasectomy and ascertain the frequency of its use in selected communities. This investigation should help in evaluating the present and potential role of vasectomy as a means of birth control.

Attitudes toward abortion are also under study. In March, 1970, Hawaii became one of the first States in the nation to allow abortion essentially at the request of the woman. A study there compares women having had babies with those having had abortions. This investigation should increase understanding of the effects of liberalization and provide insight into the motives and decisions of pregnant women undergoing either abortion or delivery.

2. Trends in Fertility and Factors Contributing to Fertility Decline.

Fertility declined in western Europe and elsewhere in response to social changes associated with industrialization and urbanization. However, declines in fertility have occurred in dissimilar circumstances in different countries. Part of the behavioral sciences research, therefore, has been directed toward studies of fertility decline with emphasis upon the socioeconomic conditions under which it occurred.

3. Consequences of Population Growth.

Behavioral research on the consequences of population growth and change, for example, the consequences of increasing numbers of individuals, higher density, and changing age distributions, has been accorded high priority since it is significant for formulation of population policy.

Migration is one of the chief means by which populations adjust to social and economic change. Thus, migration, as well as fertility and mortality, is a major component of population change. To identify the conditions which bring about migration and to define its consequences, several studies have been undertaken. They will increase our understanding of problems of depopulation as well as overpopulation.

During FY 1973, the behavioral sciences program will expand research directed toward its major program goals: the development of new knowledge about the social, economic, and psychological determinants of fertility and about the consequences of population change. Several components of these areas will be stressed: (1) the consequences of childbearing and child spacing patterns for the individual and for the family; (2) the economic and environmental consequences of population change; (3) psychological factors influencing success in using various methods of fertility control; (4) the social and economic causes of the rise and fall of fertility in the U. S. in the period 1940-1970; and (5) the causes of low fertility among women of childbearing age in the 1920s and 1930s.

C. Institutional Development.

1. Population Research Centers and Program Projects

These two types of large grants are designed to increase institutional

support of population research. A Center Award represents a long-term NICHD commitment to an institution to provide shared facilities and foster population research program development. A Program Project Award supports actual research, usually on an interdisciplinary basis, often within a Center. Although the Center program is only three years old, six awards have already been given. These six Centers together with the nine Program Projects currently in force clearly constitute the initiation of a major national program.

The Population Centers' program supports the expansion of existing Centers and the development of new Centers. Research at the Centers includes basic, directed, biomedical, and behavioral and concentrates on areas related to problems of population growth, structure and distribution. NICHD expects eventually to make 15 Center Awards with the following six awards made to date:

1. The Center at Vanderbilt University;

2. The Population Research Center at the University of Texas;

3. The Population Council in New York;

4. The Center for Demography and Human Ecology at the University of Wisconsin;

5. At the University of Chicago, the Biomedical Center for Population Research;

6. The Laboratory of Human Reproduction and Reproductive Biology at Harvard University.

Program Projects in reproductive biology are presently being supported at the following nine major institutions in the United States: Columbia University, the University of Hawaii, Johns Hopkins University, the University of Michigan, Northwestern University, Ohio State University, the Oregon Primate Research Center, the University of Pennsylvania, and the University of Texas at Austin.

2. Manpower Development

Although NICHD population research funding has increased in the last five years, research training has shown little growth, with about 280 scientists in training at any one time and about 80 graduated each year.

During FY 1972, three new training grants were awarded and five were terminated. The overall training grant program went from 25 to 23 grants in the last year.

D. Scientific Information

1. Research Inventory.

The Interagency Committee on Population Research (ICPR), for which the NICHD has staff responsibility, has been extended for two years by the Secretary. This Committee has issued its third annual Inventory of Population Research Support by Federal Agencies--Fiscal Year 1971.

This Inventory includes approximately 700 projects totaling more

than $100 million in funds. Of this total, the Department of Commerce reported the largest expenditure ($47 million) in connection with compiling census data. The Department of Health, Education, and Welfare ranked second in dollar support ($36 million) with more than two-thirds of this amount provided by the NICHD. Of the 700 projects, DHEW supported 80%, and NICHD's Center for Population Research funded 60%.

2. Research Analysis.

The Analysis of Population Research Supported by Federal Agencies--Fiscal Year 1971 was also prepared by the ICPR. This three-part report utilizes the Federal Inventory as a data base. Part one reviews previous actions of the Committee and summarizes current population research funded by the Federal Government. Part two analyzes and evaluates ongoing biological and social science research. The third section contains the recommendations. The Population Council and representatives of the Ford and Rockfeller Foundations are presently considering including a supplement to identify research projects funded by the three major private organizations.

3. Publications.

Communication of population information is being improved through the NICHD publication of Population Sciences: Index of Biomedical Research. NICHD plans to publish the Index monthly after several additional experimental issues. This bibliographic journal is produced in cooperation with the National Library of Medicine (NLM) using information from the Library's computer-based Medical Literature Analysis and Retrieval System (MEDLARS). For several years NICHD has helped support Princeton University's Population Index, a bibliographic journal devoted to population research in the social sciences. Population Sciences will provide a parallel service in the biomedical field.

To provide comprehensive coverage of biomedical literature, the NICHD has contracted with the Karolinska Institute in Stockholm, to produce a Reproduction Thesaurus. The CPR is also initiating monographs in population research to review and evaluate progress in specialized areas of biomedical or social science population research. This communication of information will help to indicate future directions for research.

4. Bureau of Health Manpower Education

The Bureau supports training 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 trainees' stipends and tuition costs; (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.

In fiscal year 1972, two Project Grants under Section 309 provided $164,504 for institutional support of family planning programs. The level of support is estimated at $150,000 for fiscal year 1973 and $78,000 for fiscal year 1974.

In fiscal year 1972, seven Special Purpose Traineeship Grants were awarded for the support of 32 trainees in family planning. In the area of genetic counseling, Allied Health awarded 2 grants totaling $134,483.

The Division of Nursing (under the Nurse Training Act) supports projects to improve nursing curricula in family planning and related subjects. In FY 1972, two grants and three contracts funded programs specifically mentioning units on family planning and/or population dynamics both in theory and clinical practice.

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IV

SOCIAL AND REHABILITATION SERVICE

Summary of Programs Related to Family Planning

The Social and Rehabilitation Service (SRS), through the Office of Planning, Research and Training, Community Services Administration, and the Medical Services Administration supports family planning services as a regular part of services for the handicapped and underprivileged. Particular target groups are those receiving "Aid to Families with Dependent Children" (AFDC) payments, and those eligible for medical assistance. These services promote health, reduce out-of-wedlock pregnancies, and enable State welfare agencies to carry out their responsibilities in work-training and employment programs for AFDC recipients. Included in these services are targeted programs of research and demonstration projects in family planning.

The Social Security Amendments of 1967 (P.L. 90-248) and 1972 (P.L. 92-603) include the authority to provide family planning services to those individuals desiring such services, including medical contraceptive services (diagnosis, treatment, supplies, and follow-up), social services and educational services. Such services must be available without regard to martial status, age, or parenthood. Individuals must be assured choice of method, and there must be arrangements with varied medical resources. Acceptance of any service must be voluntary and may not be a prerequisite or impediment to eligibility for the receipt of any other service or financial aid. Medical services must be provided in accordance with the standards of other State programs providing medical services for family planning, such as maternal and child health services.

States are required to report the results of implementing the family planning provisions of the Social Security Acts, as amended, to the Secretary. The Secretary is required to make similar annual reports to the Congress.

Prior to the passage of the Social Security Amendments of 1972 (PL 92-603), the provision of family planning services was a State option. However, PL 92-603 makes the informing of the availability and the provision of family planning services mandatory to all present, former, or likely recipients of AFDC who are of childbearing age. The Act imposes a penalty of one percent per annum on the Federal share of AFDC funds on States which failed to provide these services in the previous year to eligible persons desiring them. In addition, the Act increases the Federal share of matching for family planning services under Title IV-A -- AFDC -- to 90 percent from 75 percent and increases the Federal share for family planning services under Title XIX -- Medicaid -- to 90 percent from a variable formula.

The 1968 Amendments to the Vocational Rehabilitation Act (PL 90-391) provide for services to family members when this will contribute to the rehabilitation of the handicapped individual. Therefore, the Rehabilitation Services Administration may arrange for family planning services for handicapped individuals and their families as a part of the client's overall rehabilitation plan when such services can "substantially" improve the successful rehabilitation of the client.

Current and Projected Family Planning Activities in the Social and Rehabilitation Service

Office of Planning, Research and Training

Emphasis will be placed on family planning programs to demonstrate comprehensive services to families and individuals in model cities, neighborhood health centers, the center cities and rural poverty areas. Through in-service programs providing knowledge and skills needed by public welfare employees, a project has been developed to enable them to provide more effective family planning services to families and individuals.

A project in family life education in a neighborhood service center in St. Louis, Missouri has been completed. Results of the contract are being evaluated.

Past efforts have been directed toward reducing recidivism in illegitimate births among girls of school age. The Cuyahoga County Welfare Department, Cleveland, Ohio, currently has a project which demonstrates the effectiveness of a multidisciplinary interagency approach to meeting the needs of pregnant teenage girls through vocational guidance, medical care, and individual and group counseling.

Based on a program for unmarried, pregnant school-age girls conducted at the Webster School by the D.C. public schools, surveys were made at schools elsewhere in the nation. Findings indicated that little national attention was being given to an uninterrupted school experience for these girls. A utilization conference was held, and as recently as 1968, 35 school districts in the country had programs modeled on the Webster School research. Findings of this program were incorporated into provisions of the Elementary and Secondary Education Act.

A survey of family planning publications for low-income families with limited reading ability indicated that most of the material was unsuitable for the reading level or culture of the people. Much of the information did not provide the best scientific knowledge related to birth control or family planning. Based on these findings, a contract was developed to assess neighborhood service centers offering family planning services. Data will be analyzed to determine ways to disseminate family planning information to the needy. This contract will be funded in fiscal year 1973.

Community Services Administration

The Community Services Administration assists States in developing plans and administering programs for family planning services. All States and jurisdictions, with one exception, have fulfilled the Title IV-A requirements of the 1967 Amendments to the Social Security Act to provide for the offering of family planning services in all appropriate cases and to assure that acceptance of family planning services is voluntary.

Family planning services include the provision of information, personal counseling, medical services, payment for medical services, referral for medical care, 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.

The 1972 Amendments to the Social Security Act, PL 92-603, make the informing of the availability and the provision of family planning services mandatory to all present, former, or likely recipients of AFDC who are of childbearing age and impose a penalty of one percent per annum on the Federal share of AFDC funds on States which failed to provide these services in the previous year to eligible persons desiring them. In addition, the Act increases the Federal share of matching for family planning services under Title IV-A -- AFDC -- to 90 percent from 75 percent. The Act expands the universe of persons to whom family planning services are offered since it includes applicants for, as well as recipients of, public assistance and adds a statement on sexually active minors.

A program directed to sexually active minors will reach young males as well as females. Counseling and information about family planning and family planning methods will be available to assist adolescents in making decisions which will enable them to continue their development without the burden of very early parenthood.

The subject of medical services to minors will receive continuing attention from the Community Services Administration. Due to State laws, medical standards prevailing in a State and its localities, and the attitudes of individual medical practitioners, medical services may not be available to minors without the consent of their parents. A few States permit medical care without parental permission when referrals for family planning medical resources are made by persons specifically designated in State legislation. Other States are contemplating such changes in their laws.

The provision of medically supervised family planning services to minors has strong proponents for and against the provision of such services. The Community Services Administration will follow the developments in this area to determine how minors may secure family planning assistance consistent with attitudes of the public regarding parental involvement.

State and local agencies have been working to develop cooperative relationships with public and private providers of medical services. The emphasis in the 1972 Amendments to the Social Security Act on the immediate provision of family planning services to those desiring them should assure continuation of efforts to develop additional medical resources.

The estimated numbers of families provided family planning services in the AFDC social services program and adult social service programs served in Fiscal Year 1972 and anticipated to be served in Fiscal Year 1973 are as follows:*

	FY 1972	FY 1973
AFDC Families	1,290,800	1,352,500
Adult Individuals	51,600	67,200

The estimated Federal expenditures for family planning services in the AFDC social services program and adult social service programs in Fiscal Year 1972 and the estimated Federal expenditures anticipated for Fiscal Year 1973 are as follows:

	FY 1972	FY 1973
AFDC programs and the adult programs	$17,900,000	$18,300,000

*(These generally represent social rather than medical services.)

Medical Services Administration

The Social Security Act of 1965 (PL 89-97--approved July 5, 1965) added Title XIX, "Grants to States for Medical Assistance" to the Social Security Act. Under the Federal-State medical assistance program which it established, known as Medicaid, States participating in the program were required to provide medical assistance to all recipients of cash assistance. At State option, they could also finance medical care for the medically needy, i.e., those persons who would otherwise be eligible for cash assistance except that the level of their income is sufficient to sustain themselves, but too low to provide necessary medical care. In addition, States could opt to provide coverage to low-income children under 21.

Under the original legislation, inclusion of family planning services was a State option. However, PL 92-603, passed in October 1972, made coverage of family planning services for cash assistance recipients under Title XIX mandatory on the States. In addition, the rate of Federal financial participation for family planning services for both the categorically and medically needy was increased to 90 percent on the date of enactment of the Bill. The Law also provides a penalty of a one percent reduction in the Federal share of AFDC

funds if a State fails to (1) inform AFDC adults of the availability of family planning services or (2) fails to provide such services when requested. This provision becomes effective July 1, 1973.

Medical assistance for family planning includes payments for appropriate medical examinations, diagnosis, medical counseling and treatment, laboratory services, surgical procedures, drugs, supplies and devices. These services may be provided in doctor's offices, clinics, hospitals (on both an inpatient and outpatient basis), family planning center, or any other suitable setting.

Because of the increased responsibility placed on the State agencies to assure that family planning services are offered to all eligible persons who wish to utilize them, and because of the increased Federal matching to support State Title XIX expenditures for family planning, a sizeable increase occurred in Title XIX expenditures for family planning in FY 1973. Federal expenditures are estimated to be $25.5 million during FY 1973, an increase of $15 million over the Federal Title XIX FY 1973 expenditures of $10.6 million projected before the passage of PL 92-603. Title XIX expenditures for family planning during FY 1972 totaled $8.7 million. The number of women receiving family planning services under Title XIX was estimated to be 150,000 during FY 1972 and 425,000 during FY 1973.

Rehabilitation Services Administration

The Rehabilitation Services Administration does not have a family planning program, per se. 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 clients. Services to family members may also include homemaker services, day care services, foster family care services, and group counseling. Services to family members, however, are optional with the State rehabilitation agencies and are not mandatory under the current Vocational Rehabilitation Act and Federal regulations.

Under the current Developmental Disabilities Act, counseling services may include specialized family planning services where needed to DD clients and their families.

V

EDUCATION DIVISION

National Institute of Education

Summary of Programs Related to Family Life, Sex Education and Population Growth

The National Institute of Education is currently monitoring projects transferred from the Office of Education dealing with family life, sex and population growth education. The Institute does not specifically include these components in its programs; but because it does support a field initiated research program, projects pertaining to family life, sex education and population growth may be funded.

Education on family life, sex and population growth have gained increased emphasis in the Nation. Examples of the types of research conducted by the Institute include:

Population Education, Inc., an affiliate of the National Commission on Population Growth and the American Future, is developing and publishing supplementary curriculum materials for use by junior high, senior high and college level audiences.

The Children's Center of Brookline, Massachusetts child day care center is conducting research on sex roles. Traditional stereotypes limit the range of possibilities for both boys and girls. Its main objective is to see that no child is denied the opportunity to develop to his or her fullest extent.

An Oklahoma State University study is based on the premise that behavior, rooted in attitudes and beliefs, will change as a result of communication and involvement between parents and teachers. Low-income scale mothers will serve as Communication Specialists and trainers of teachers in the skills of family-school communication and involvement. They hope to achieve a more satisfying and productive school experience for children.

Scientific evidence appears to indicate that later school disadvantage is markedly linked to poverty-related omissions in the early family life of low-income children. Indications also show that though low-income children are born with intellectual capacities equal to their middle-income peers, socioeconomic status group differences appear by the age of three which are predictive of low-income children's handicapped school performance. The Family Service Association of New York has adopted the Mother-Child Home Program to assure that children from educationally disadvantaged populations will arrive at the first grade equipped for adequate academic achievement. This is to be accomplished through a Demonstration Center showing audio-visual material about the program, talks with school administrators and other community groups, and through distribution of reports on the program.

Office of Education

Summary of Programs Related to Family Life, Sex Education, and Population Growth

The Office of Education, through its varied grant programs made possible under general legislation, has enabled educational institutions at all levels to include family life, sex education, and population growth education in their programs and has supported innovative demonstration projects. However, it does not prescribe State and local school curricula.

Family life, sex education, and population growth education are receiving increasing emphasis in the Nation's schools, with course content and methodology determined by local school authorities.

Legislation beginning with the National Defense Education Act of 1958, Title V (PL 85-864), enabled the Office of Education to support training and curriculum development in family life and sex education. PL 90-35, the Education Professions Development Act, modifies the professional training aspects of some of the authorizations. Training of professional education personnel in family life and sex education personnel in family life and sex education is supported through the following:

Title 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 educational media specialists, were subsumed in 1968 under Title V of the Higher Education Act, the Education Professions Development Act.

Title V-B and Title XI of the National Defense Education Act were absorbed in the Education Professions Development Act of 1967 (PL 90-35). Preparation programs formerly funded under these titles are now included under the new provisions of PL 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 (PL 89-10) and its amendments provide several titles under which family life and sex education activities are eligible for support. Title I assists in expanding and improving education programs which contribute particularly to meeting the special educational needs of educationally deprived children 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, pre-schoolers, and teenage unwed mothers, or other approaches to remedying educational deprivation.

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.

Originally, the Commissioner made grants directly to local education agencies. Beginning in fiscal year 1971, 85 percent of Title III funds were administered by State educational agencies, with 15 percent to be used at the Commissioner's discretion within the State.

The Elementary and Secondary Education Amendments of 1967, (PL 90-247), contained a new section 807 in Title VIII: "Dropout Prevention Projects" which may have far-reaching effect on the continuing education of teenage pregnant girls.

Title VIII, Section 807, the dropout prevention program of the Elementary and Secondary Education Act has no family planning program as such. However, projects in Miami, Florida and St. Louis, Missouri, have components of "Continuing Education." These programs are designed for young pregnant girls. Their training is in pre- and postnatal care, personal grooming, child care, and personal counseling. These are areas that are related to family planning programs. Emphasis is on keeping the girls up in their school work so that they can go back to regular school or develop a skill so that they are employable.

Under this section, appropriations not to exceed $31.5 million for fiscal year 1972 and $33 million for fiscal year 1973 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. (Fiscal year 1972 appropriations, $10 million.)

Since pregnancy and/or early marriage constitute the largest cause of dropout by teenage girls, the need for inclusion of family life and sex education in a comprehensive school program is apparent.

Title I of the Higher Education Act of 1965 (PL 89-329) provides financial support to colleges and universities to assist in the solution of community problems through specially designed continuing education and community service programs. A State desiring to receive its allotment of Federal funds under this Title must designate or create a State agency which is required to submit an annually amended State plan to the U.S. Commissioner of Education for approval. The plan must set forth administrative policies and procedures and identify community problems it wishes colleges and universities to attack. The State Agency reviews proposals from institutions of higher education, and awards funds to approved projects on a 66 2/3 percent Federal and 33 1/3 percent non-Federal matching basis. During the current fiscal year, all States plus Guam, the Virgin Islands, Puerto Rico and the District of Columbia are participating in the program. The request for 1973 is $5,700,000, compared with a 1972 appropriation of $9,500,000.

A major program first included in the Economic Opportunity Act of 1965, (PL 88-452), renewed by the Adult Education Act of 1966, and continued in the current Adult Education Act (PL 91-230, Title III), is the adult education program administered by the Office of Education. It encourages and expands programs of adult public education that will enable adults 16 and older to continue their education to the completion of high school. Major emphasis is on programs to help educationally disadvantaged adults to overcome English language limitations and improve their basic education in preparation for occupational training and more profitable employment. These programs frequently include education for family living.

The Environmental Education Act of 1970

Public Law 91-516 authorizes population education activities. The environmental problems related to population, pollution and depletion of natural resources are inseparable from each other. Thus, any discussion of sex and family planning must be seen in the larger environmental context. The purposes of the Environmental Education Act are to educate citizens on the problems of environmental quality and ecological balance. This is accomplished through a program of grants to institutions of higher education, State and local educational agencies, regional educational-research organizations; and other public and private nonprofit agencies, organizations, and institutions for:

1. Community education projects
2. Environmental education centers
3. Training projects for noneducational personnel
4. Curriculum supplementary materials development

5. Curriculum development--new curricula

6. Workshops for government personnel

7. Educational personnel training

8. Pilot elementary and secondary education programs

9. Evaluation projects

10. Dissemination projects

Current and Projected Activities in Family Life, Sex Education, and Population Growth Education

Approximately 10 percent of the effort in adult basic education under the State grant program is related to family life and sex education.

Three special projects which impact on family life were funded in fiscal year 1972. In Akron, Ohio, a parent education program on urban family living uses mini-courses to enable parents to assist in the learning process of their children. An instructional component is included that involves both adults and children in mutual educational improvement. Counseling services are provided to help adults benefit from various community social agencies.

The Southern Mutual Help Association, Inc. in Abbeville, Louisiana, is carrying out a project to determine the effectiveness of a home-based adult basic education program on eight plantation housing settlements. At least ten home sites are being used to provide relevant instruction and social and health services. Volunteers and paid paraprofessionals are employed in this self-help, family-centered project dealing with literacy, health, consumer education, and counseling services.

The Bexar County Schools, San Antonio, Texas, is conducting a project entitled "PORFIN: Program Organizing Related Family Instruction in the Neighborhood." This project is a continuation and expansion of a Model Cities area adult basic education project to develop better recruiting and retention methods and materials for Mexican-American adults. Homesite classes as well as more formal classroom instruction are used. Parents of school children participate in discussion groups designed to identify and communicate family needs. It is expected that participating parents will be motivated to continue in ongoing ABE classes with emphasis on family relatedness. Curriculum development, field testing of materials, the use of volunteer teachers and aides, and continued working relations with other agencies are planned for the project.

Under the Consumer and Homemaking Programs of Vocational Education, about 10 percent of instructional time relates to subject

matter dealing with family life. Within this 10 percent, some portion would be concerned with family planning, but this activity cannot be identified more discretely.

Family planning may be included as a part of the study of family relationships and preparation for marriage offered in vocational home economics courses for 11th and 12th grade postsecondary students. Whether a study of family planning is included depends upon the approval of the local community, although there has been increasing acceptance of instruction in this area by the schools. Advisory groups composed of community leaders such as clergymen, school administrators, counselors, and parents decide whether or not the study of family planning is included.

Following is an example of the content included in a family living course offered to 12th graders in one school which is representative of those offered in schools nationwide and excerpt from one representative State curriculum guide of suggestions for teaching family planning:

- A semester course in Family Living, Auburn (Washington) High School: Family planning, if considered in the broadest aspects, refers to the total responsibility for teaching in all areas of home economics. Family planning as a segment of the home economics curriculum continues to be reflected specifically in the family relationships, child development area.

  A semester course taught in relation to the total home economics curriculum is now a required course for all junior boys and girls. During the second semester these students take a course in family health.

  Units taught during the first semester focus upon:

  Understanding how physical, mental, and emotional maturity affect the family.

  Understanding factors involved in mate selection.

  Laws pertaining to marriage and their influence on the family life.

  Adjustments required in marriage (includes family planning).

  Managing family income.

  Children as a part of the family.

  Child development.

- Excerpt from the curriculum guide on "Human Development and Family" published by the Oklahoma State Department of Education for use by vocational home economics teachers:

> Unit on Responsibilities of Parenthood: Objective--to assess the pros and cons regarding the freedom to plan or choose the size of one's family.
>
> Suggested learning experiences:
>
> Discuss what forces in society have caused changes in social thinking about planned parenthood.
>
> View and discuss the film, "Fair Chance," (shows how Planned Parenthood helps families have only those children they want).
>
> Local member of the medical profession or family planning agency speak and answer questions on planned parenthood, birth control, abortions. Invite parents.
>
> Discuss how can family planning be related to the idea that inadequate education perpetuates the cycle of poverty, deprivation, and family instability.
>
> Discuss readings on--in which countries planned parenthood is encouraged and why. Discuss the relationship between the increasing world population and food supply.
>
> Examine the points in favor of and against the use of contraceptives in our present social order and the laws concerning contraception.
>
> Discuss what factors should be considered in determining birth control practices.

Under Title I of the Higher Education Act, there are currently 22 projects in 14 States for university and college programs and workshops emphasizing various aspects of family life. Family planning is frequently one aspect of these broad programs. In addition, there are a number of youth opportunity and personnel development programs that relate indirectly to the goals of family stability and adolescent responsibility.

Under the Environmental Education Act of 1970, five of 162 projects funded in FY 1972 deal with population education. For example, the Alexis DuPont School in Greenville, Delaware operates a curriculum development workshop for 20 individuals to prepare population environmental studies material for the school district's multidisciplinary K-12 curriculum. The Indiana University Foundation is developing and evaluating a 12th grade instructional unit on population-environmental affairs. The material is designed for use by

schools throughout the country. The University of North Carolina is developing two experimental in-service teacher training courses in population education. The Fargo-Moorehead Chapter of Zero Population Growth in North Dakota will conduct a pilot project designed to disseminate information on the effect of man's activities and life style on the environment to the rural population in North Dakota and northwestern Minnesota by establishing environmental booths and exhibits at State and county fairs. The University of Cincinnati will develop and implement a one-quarter in-service training course on population education for 35 junior-senior level teachers. In addition to these five projects, ten projects funded under the Environmental Education Act include population education components.

One project funded under the Cooperative Research Act involves the development of educational materials in the field of population education.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
POPULATION RESEARCH AND FAMILY PLANNING ACTIVITIES

Obligations, FY 1970 -- FY 1974

Agency and Program	Fiscal Year 1970	1971	1972	1973	1974
Total, Department of Health, Education and Welfare	71,902,000	107,267,000	191,807,000	219,055,000	243,161,000
PUBLIC HEALTH SERVICE					
Health Services and Mental Health Administration					
National Institute of Mental Health	644,000	284,000	100,000	100,000	100,000
Maternal and Child Health					
Formula grants to States	3,500,000	11,700,000	11,700,000	11,700,000	16,200,000
Project grants for maternity and infant care	3,600,000	4,500,000	4,500,000	4,500,000	---
Research	500,000	500,000	200,000	100,000	100,000
National Center for Family Planning Services	22,800,000	33,275,000	96,656,000	107,413,000	123,013,000
Center for Disease Control	15,000	15,000	55,000	55,000	55,000
Patient care and special health services	255,000	309,000	386,000	414,000	455,000
National Center for Health Statistics	246,000	396,000	842,000	700,000	700,000
Indian Health Service	353,000	500,000	754,000	999,000	1,238,000
Subtotal, Health Services and Mental Health Administration	31,913,000	51,479,000	115,193,000	125,981,000	141,861,000
National Institutes of Health					
National Institute of Child Health and Human Development	15,541,000	28,357,000	39,973,000	39,844,000	39,200,000
Health Manpower, Training	356,000	332,000	428,000	---	---
Subtotal, National Institutes of Health	15,897,000	28,689,000	40,401,000	39,844,000	39,200,000
Subtotal, Public Health Service	47,810,000	80,168,000	155,594,000	165,825,000	181,061,000

Agency and Program	Fiscal Year 1970	1971	1972	1973	1974
SOCIAL AND REHABILITATION SERVICE					
Social Services	10,300,000	12,300,000	17,900,000	18,300,000	18,700,000
Medical Assistance	6,100,000	6,459,000	8,700,000	25,500,000	43,400,000
Research	300,000	---	---	---	---
Subtotal, Social and Rehabilitation Service	16,700,000	18,759,000	26,600,000	43,800,000	62,100,000
EDUCATION DIVISION					
National Institute of Education					
Programs Related to Family Life, Sex Education and Population Growth	---	---	176,000	---	---
Office of Education					
Elementary and Secondary Education:					
Supplementary Education Centers and Services	900,000	800,000	600,000	500,000	--- 1/
Dropout Prevention Programs	---	40,000	40,000	40,000	---
Higher Education:					
Grants to States for Community Service and Continuing Education	400,000	400,000	356,000	213,000	---
Prospective Elementary and Secondary Teacher Fellowships	200,000	150,000	150,000	200,000	---
EPDA Institute Programs	162,000	---	---	---	---
Adult Education:					
Adult Basic Education Programs	4,230,000	4,819,600	5,578,000	5,613,000	--- 1/
Grants to States for Vocational Education	1,500,000	2,125,000	2,563,000	2,563,000	--- 1/
Environmental Education	---	6,000	150,000	300,000	---
Total, Education Division	7,392,000	8,340,000	9,613,000	9,430,000	---

1/ Funds for the activities shown in previous years are now consolidated under Special Revenue Sharing

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Agency and Program	Fiscal Year 1970	1971	1972	1973	1974
Scientific Activities Overseas 2/ (Special Foreign Currency Programs, P.L. 480)	601,000	1,673,000	726,000	909,000	1,145,000

2/ Not included in the DHEW total

HEARING AND SPEECH

Obligations Fiscal Year 1970 to Fiscal Year 1974

Agency and Program	1970	1971	1972	1973	1974
SOCIAL AND REHABILITATION SERVICE:					
Rehabilitation Services Administration:					
Basic State grants	$27,904,000	$31,700,000	$31,304,000	$33,573,000	$34,104,000
Innovation grants	209,188	159,000	---	---	---
Service Projects	224,342	160,000	310,000	280,000	225,000
Rehabilitation Training	3,443,790	4,863,995	832,540	1,995,600	1,100,000
Subtotal, Rehabilitation Services	31,781,320	36,882,995	32,446,540	35,848,600	35,429,000
Office of Planning, Research and Training:					
Rehabilitation Research and Demonstrations	2,260,000	1,850,000	1,678,000	1,000,000	500,000
Research and Training centers	475,000	250,000	354,000	500,000	400,000
Special foreign currency program	400,000	---	513,725	400,000	200,000
Subtotal, Office of Planning, Research and Training	3,135,000	2,100,000	2,545,725	1,900,000	1,100,000
Subtotal, Social and Rehabilitation Service	34,916,320	38,982,995	34,992,265	37,748,600	36,529,000

HEARING AND SPEECH

Obligations Fiscal Year 1970 to Fiscal Year 1974

Agency and Program	1970	1971	1972	1973	1974
OFFICE OF EDUCATION:					
Elementary and secondary	$12,600,000	$13,400,000	$14,000,000	$14,000,000	1/
Education for the handicapped	31,000,000	36,412,000	34,645,000	37,700,000	26,700,000 2/
Vocational and adult education	3,800,000	4,463,624	4,729,500	4,729,500	1/
Libraries and educational communication	40,000	40,000	40,000	40,000	---
Research and Training	49,166	88,800	68,143	---	---
Subtotal, Office of Education	47,489,166	54,404,424	53,482,643	56,469,500	26,700,000
HEALTH SERVICES AND MENTIAL HEALTH ADMINISTRATION:					
Maternal and Child Health Service	2,851,140	2,801,464	3,155,000	3,032,000	3,032,000
NATIONAL INSTITUTES OF HEALTH:					
National Institute of Neurological Diseases and Stroke	7,267,000	9,160,000	11,446,000	9,997,000	9,884,000
National Institute of Child Health and Human Development	6,504,000	8,394,000	10,810,000	10,200,000	9,825,000
National Institute of Dental Research	1,496,477	1,685,210	1,461,102	1,444,000	1,463,000
National Institute of Environmental Health Sciences	---	---	---	212,000	245,000
Subtotal, National Institutes of Health	15,267,477	19,239,210	23,717,102	21,853,000	21,417,000
SPECIAL INSTITUTIONS:					
National Technical Institute for the Deaf	2,985,000	4,200,000	30,826,000	7,256,000	7,226,000
National Advisory Committee on Education of the Deaf	100,000	100,000	100,000	100,000	50,000
Model Secondary School for the Deaf	567,000	3,132,000	2,582,000	4,625,000	4,002,000
Subtotal, Office of the Secretary	3,652,000	7,432,000	33,508,000	11,981,000	11,278,000
TOTAL, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE	104,176,103	122,860,093	148,855,010	131,084,100	98,956,000

HEARING AND SPEECH

Obligations Fiscal Year 1970 to Fiscal Year 1974

1/ The programs in these activities which supplied funds for hearing and speech are being consolidated, in fiscal year 1974, into the proposed Special Education Revenue Sharing.

2/ The State grant program, which will provide approximately $11,000,000 for hearing and speech in fiscal year 1973, is being consolidated into the proposed Special Education Revenue Sharing.

PROGRAMS IN HEARING, SPEECH, AND LANGUAGE

PREFACE

A report on the prevalence of handicapping communicative disorders made in 1969 by the Subcommittee on Human Communication and its Disorders, National Institute on Neurological Diseases and Stroke, disclosed that over 20,000,000 Americans are afflicted. It is estimated that 10,000,000 persons have handicapping speech disorders such as stuttering, laryngectomy and cleft palate, 8,500,000 have hearing impairments and 2,100,000 have a central communicative disorder such as aphasia and mental retardation.

Offsetting this distressing situation is the fact that more and more speech, hearing and language handicapped persons are being aided in becoming self-sustaining and contributive members of society. Research in the fields of medicine, rehabilitation and education has been a vital force in exploring, devising and demonstrating techniques and devices that are helping more people with communicative disorders to overcome their handicaps completely or in part. A growing supply of trained manpower is combining with innovative rehabilitation techniques, new medical and surgical processes, improved prostheses, refinements in language and speech therapy and other communication aids in affecting full or partial restoration of hearing and speech power in significant numbers of persons.

Challenging opportunities in mounting effective programs to meet the needs of persons with communicative disorders have been made possible through legislative authorization and appropriations for the handicapped. Some of the more outstanding activities being undertaken by the Social and Rehabilitation Service, the Health Services and Mental Health Administration, and the Office of Education are mentioned here.

The Social and Rehabilitation Service through its program of training and research in speech pathology and audiology and rehabilitation of deaf persons continues its investment in people with communicative disorders who need assistance. Rehabilitation Services Administration training programs have supplied approximately 2000 speech pathologists and audiologists to rehabilitation settings which provide services to adults with communicative disorders. A major manpower study has made available guidelines on effective use of paraprofessionals in many rehabilitation activities affecting deaf, hearing, speech and language handicapped persons. The rehabilitation of adult aphasics has become much more widely understood through short-term training courses. A national census for the deaf to be completed in 1973 will yield critical data for rehabilitation and education program planning. Demonstration vocational-technical programs for deaf people at junior colleges are opening new and better employment opportunities and stimulating the development of similar programs at other schools. Greater involvement of parents in the habilitation and rehabilitation of their deaf children is the promising outcome of short-term training courses. The dissemination of current information on research and training to the growing body of professionals in the field of deafness is being implemented through an annual monograph. Research has provided needed models in community service to deaf people including coordination, diagnosis, evaluation, counseling and supportive services. Professional interpreting is constantly being improved to provide deaf people with this critically needed authorized vocational rehabilitation case service. Development and implementation of a model State-wide plan of vocational rehabilitation services by State vocational rehabilitation coordinators of services to deaf and severely hearing impaired people, who organized in 1972, will enhance this program specialty. An important start has been made in investigating discrimination in employment of deaf people. The development of guidelines for State vocational rehabilitation agencies on services to deaf, hearing, speech and language handicapped public assistance clients will be a consuming short-term project task.

The Office of Education expanded significantly its activities related to improving and enlarging educational opportunities for hearing, speech and language handicapped children during the past year. Over 50,000 deaf and hard of hearing pupils are receiving specialized help from schools and classes appropriately equipped to serve them with an additional 14 percent not being served due to a continuing shortage of teachers and other obstacles. A downward extension of educational services to very young preschoolers is increasing the total number. In fiscal 1973, the State grant program will provide approximately $11,000,000 for hearing and speech. For academic year 1972-73, $3,957,231 was obligated for awards to colleges and universities to help increase the number of professionals trained to work with communicatively handicapped children, for the development of graduate programs in the area of speech pathology and audiology and for research and demonstration projects related to the instruction of children with communication disorders.

Educational research relating to speech and hearing during fiscal 1973 will continue to focus on two major problems: 1) communication problems of the deaf, and (2) effective use of speech therapists. A program of research investigating the comprehension and production of syntactic structures by deaf children is currently being supported. By the end of 1973, it is expected that a solution of how speech therapists can best allocate their resources and time will have been found. In fiscal year 1972 Media Services and Captioned Films reached more than 3,300 groups of hearing impaired persons of which 1,200 were schools or classes for the deaf. Four Regional Media Centers for the Deaf continue conducting intensive summer institutes and workshops in schools during the academic year on educational technology. More than 500 captioned educational films are available on loan to schools which also receive extended loan of other educational media including filmstrips, transparencies, slides, overhead and filmstrips projectors, projection tables, screens and miscellaneous instructional materials. In fiscal year 1971, 20 State institutions for the deaf and/or State supported institutions for the deaf and blind benefited through the Libraries and Educational Communication program. Estimated enrollment of communicatively handicapped children in Vocational Education programs in fiscal year 1973 include 1000 deaf, 5000 hard of hearing and 15,000 speech impaired.

The Maternal and Child Health Service continued its activities related to the development, improvement and extension of programs in State health departments and crippled children's agencies for children with hearing and speech disorders. Health and speech services are an integral part of Maternal and Child Health Service project grants for comprehensive health services for children and youth who live in poverty areas. About 100 hearing and speech specialists are employed as staff in these projects where they provide screening, diagnostic, preventive, corrective and follow-up services. Special projects related to the hearing and speech field include grants to (1) the Colorado State Department of Health for demonstrations related to hearing conservation; (2) the Iowa Crippled Children's Service to explore developments in providing hearing and speech services to mentally retarded children; (3) the Alaska Department of Health to develop a a joint program in audiology with the Indian Health Service. In the area of training, a grant to Vanderbilt University includes an agreement for a cooperative training program with Tennessee State University, a historically black institution, as an attempt to develop new patterns of education to prepare speech pathologists and audiologists to serve children from cultural and linguistic backgrounds which differ from that of the speech and hearing specialist. An objective of the Maternal and Child Health Service Speech and Hearing Unit has been to aid the profession of speech pathology and audiology in preparing to make its services

accessible and available in whatever delivery system eventually evolves as a result of the changes which have been proposed for improved national health services.

The National Institute of Neurological Diseases and Stroke continues to provide insight on the basic psysiologic processes involved in both normal and deviant patterns of speech, hearing and language through its comprehensive program of research and training. The Institute is currently supporting 331 research projects including four out-patient clinical research centers; seven contracts; 62 training grants to universities and medical centers; and five multi-disciplinary centers. The centers and the individual grants support research on hereditary deafness and hearing loss, and hearing problems caused by noise, old age, drugs, infection, tumors of the hearing nerve, middle ear infections and Meniere's disease. They also support research on speech and language disorders including the severely traumatic speech and language problems which can result from stroke and removal of a traumatized larynx. The Institute is also in the process of analyzing data on thousands of pregnancies whose offspring have been studied for eight years to determine prenatal and early childhood influences on communication disorders.

The National Institute of Child Health and Human Development continues to support research leading to a better understanding of the acquisition and development of the processes associated with normal human communication and the problems of communication associated with mental retardation. The Institute is currently supporting 127 research and training grants concerned with human communication in the context of physiological, social, and intellectual development from a biomedical,psychological, and sociological point of view. In addition, there are 12 Mental Retardation Centers where a wide range of investigations encompassing the biological, behavioral, and social sciences are conducted.

The National Institute of Dental Research continues to support concentrated research on cleft palate, a major handicapping speech disorder in children and adults. In 1972, the Institute awarded 14 research grants and six training grants for study of this anomaly which occurs once in approximately every 600 births.

The National Institute of Environmental Health Sciences has begun a program on the effects of noise on hearing with one intramural research study and one contract.

The Office of the Secretary continues to administer programs that promote the development and education of deaf and other communicatively handicapped persons. Within the Office of Child Development, established in 1969, the Bureau of Child Development Services administers Project Head Start which has a 10 percent national enrollment reserved for severely handicapped children including the hearing, speech and language impaired. The National Technical Institute for the Deaf with a current enrollment of 473 students continues its activities related to the provision of post-secondary vocational education, and technical training to deaf persons, training to assist in developing professional manpower to serve the deaf nationally, and to research on education of the deaf in general. The National Advisory Committee on Education of the Deaf continues to carry out its functions related to the development of a system for gathering information, identification of emerging needs and suggesting promising areas of inquiry in improving the education of deaf persons. The Model Secondary School for the Deaf an open laboratory school which has a current enrollment of 110 students and a staff of 94, continues the development of its innovative program that is expected to stimulate the development of similarly excellent programs throughout the nation.

SOCIAL AND REHABILITATION SERVICE 7

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 1971, 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 20,000,000 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 combination 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 20,000,000 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 450,000 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 message 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 fact of their inadequate verbal communication. This is the handicapping base of their disability. It is primarily psychosocial. It manifests itself in many ways: underinvolvement in the main stream of community life; limited sharing with fellowmen; lack of acceptance among neighbors, employers, and fellow employees; severe underemployment. It seldom yields at all to medical intervention such as drugs, surgery or prosthesis. It does yield in approximate ratio to their

availability in quality and depth, to training and adjustment services that 8
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 underemployment: (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, instruction in manual communication and interpreting, (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 other, 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; (4) by extending assistance in the establishment of post secondary programs for deaf people; (5) by encouraging and assisting universities in opening new professional fields to deaf people through special programs and placement techniques.

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 psychosocial 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. 9

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 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 find 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 program 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 handicap. 10

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 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 1971 and the numbers estimated to be rehabilitated in fiscal 1972 through 1974 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 1971-74

	Estimated and actual number of rehabilitatants in fiscal year 1/			
	1971	1972	1973	1974
All rehabilitants	291,272	326,138	340,000	350,000
Number of rehabilitants with major disability of speech or hearing.....	16,012	18,300	19,100	18,900
Deaf.....	5,566	6,000	6,100	6,100
Hard of Hearing...	8,169	9,800	10,400	10,500
Speech.....	2,277	2,500	2,600	2,300

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-four States 2/ now have or are actively recruiting staff who may be classified as expert vocational rehabilitation workers for the deaf since they are trained as professional counselors and are also able to communicate by sign language with deaf clients. Several of the States are searching for 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

1/ Data are actual for fiscal year 1971 and total of all rehabilitants for 1972. Estimates appearing in the President's budget are used for other data for 1972-1974 and will be updated at a later date.

2/ Alabama, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Guam, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

agency is now able to work more effectively with them. The Rehabilitation Services Administration urges that each State have at least two highly skilled vocational rehabilitation counselors for the deaf and preferably that there be one in each metropolitan area. 12

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 1969 alone, ten 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 used in the creation of 25 projects at a total cost of over 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-seven 1/ States, an increase of one over the previous year. 13

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 simple 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 has been an utter vacuum of opportunity aside from an occasional local situation, such as on-the-job training or a receptive vocational school for normally hearing people, which may rise and fall in accordance with attending circumstances. Moreover, apprenticeships are seldom available to deaf people for age or other reasons. None of these latter provides the rich depth in training experience by which a permanent institution with its highly skilled staff reaches and motivates the deaf person to be somebody.

1/ Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Louisiana, Maine, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Vermont, and Wisconsin.

The tragedy of these failures of our society to meet its responsibility is that a large portion of deaf people can benefit very much from more training. 14
However, until very recently, when formal schooling terminates, there had been no place for them to go for more at the time or when they are motivated to want more training.

Of long concern to the Rehabilitation Services Administration has been the void in vocational training for 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 poorly served or not at all by overcrowded vocational schools. This has intensified 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. Fortunately, the situation is changing for the better as programs are being developed to meet the various service needs of the deaf adult population.

Accomplishments

The establishment of the National Technical Institute for the Deaf authorized by Public Law 89-36 is another 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. An exploratory conference and a training institute in early 1970 identified service qualifications that will help to upgrade program work with this population.

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 institutional life to discharge to independent living of those who have been patients because of improper diagnosis. It was developed as an innovation project for adoption in other States. It has unusual economic significance in view of the large ratio of deaf persons in institutions for the mentally retarded. It is important that this project be replicated in all States.

At long last regional vocational schools for deaf people are a reality. The Delgado College in New Orleans was the site of the first. Two others began operations in 1969 at Seattle Community College and at St. Paul Technical-Vocational Institute. The three programs are now operating at full capacity with two hundred deaf men and women enrolled and there is a long waiting list. New and better employment opportunities are opening to these deaf people as they complete their training. Each region should have at least one such program.

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) becomes available.

Rehabilitation Services Administration Training Grants in Speech and Hearing (Speech Pathology and Audiology and Rehabilitation of the Deaf)

Rehabilitation Training

		1972 (Actual)	1973 (Est.)	1974 (Est.)
SPA and Deaf	Total	$832,540	$1,995,600	$1,100,000

Accomplishments

In common with other professional disciplines, speech pathology and audiology is affected by shortages of trained personnel resulting from maldistribution of rehabilitation workers particularly in rural and central city settings. The current available manpower is providing services to a significant number of the communicatively handicapped individuals in this country. Significant progress is being made, however, to alleviate these shortages. Since support of rehabilitation training was initiated in 1958, the number of training institutions has grown gradually, and commitment of these institutions to train professionals in this specialty has been significant. For example, in FY 1958, 75 percent of RSA training funds in this field were committed to direct support of program development; 25 percent to student support. In FY 1971, direct support programs decreased to approximately 25 percent, while student support increased to 75 percent. Estimates for FY 1973 are not available but projections indicate an even stronger commitment on the part of training institutions to absorb direct costs of training programs.

Attrition rate among professionals in the speech, hearing, and language rehabilitation areas has been estimated liberally at about 5 percent. This is significant in light of the fact that certified professionals in this field constitute one of the large categories of workers in rehabilitation settings contributing to the national rehabilitation effort. The number of speech pathologists and audiologists trained under the VR Act since FY 1958 is approximately 2,500. The majority of these workers are presently delivering services in accredited service settings which contribute to the national rehabilitation effort.

The Future

Although this Federally supported program is being phased out in FY 1973 and FY 1974 in favor of Federally funded programs of general student aid, the Administration is sensitive to the special personnel needs of the deaf population and is studying ways to be responsive.

OFFICE OF PLANNING, RESEARCH, AND TRAINING

HEARING AND SPEECH

	1970	1971	1972	1973	1974
Rehabilitation research and demonstrations	$2,260,000	$1,850,000	$1,678,000	$1,000,000	$500,000
Research and Training Centers	475,000	250,000	354,000	500,000	400,000
Special Foreign Currency Program	400,000	---	513,725	400,000	200,000

Research and Demonstrations

Hearing, Speech, and Language Disorders

Recent review and analysis of available data indicate that the actual prevalence of speech, hearing, and language disorders in the United States is double previous estimates. Approximately 20,000 persons have communicative handicaps, with at least one-third of these suffering either substantial or severe social, education, and economic disadvantage. This relatively large portion of the handicapped population presents a continued challenge to rehabilitation. Most communicative handicaps have their origin in childhood from varied causes, such as birth defect or injury, cultural deprivation, untreated disease, etc., but persist into adulthood. However, other causes occur in later life, such as problems of Aphasia related stroke, accidents, or brain injury, and problems of traumatic hearing loss due to excessive exposure to noise. Continued emphasis must be placed on the development of test instruments to assess the communicative behavior problems in order to facilitate rehabilitative and therapeutic goals.

A major manpower study is in the final stage of completion. Information indicates that a significant number of rehabilitative activities with this handicapped group may be carried out by trained aides. Plans are being developed to prepare such subprofessionals to work under supervision and to use such positions as employment opportunities for inner city residents. Computer assisted instruction and programmed materials are being developed for clinical rehabilitation use of speech and hearing handicapped persons. The breakdown of communication barriers will allow for increased work potential and thus increased earnings for such individuals. Improved diagnostic techniques have been developed for the Aphasic patient, stutterers, and language handicapped persons. Studies of the older population and hearing aid use have been initiated. A longitudinal exploration has been made of perceptual abilities of culturally disadvantaged children by means of a perceptual language test battery.

There must be continued development of clinical procedures to assist Aphasic patients, laryngectomees, and stutterers in social adjustment as the individual returns to his family and to the work community. Projects concerned with the rehabilitation of the hard-of-hearing, especially in culturally deprived populations and with the older American, will be encouraged. Greater emphasis must be placed on developing the full vocational potential of persons with varying degrees of speech, hearing, and language disorders.

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.

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 have 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 goal 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 for a theatre of the deaf through the Eugene O'Neill Theater Foundation. 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 on demonstrating the use of counselor aids in providing service to deaf welfare recipients. Improved services to severely disadvantaged deaf adults through facility demonstration including a free-standing residential facility, training techniques and media is being thoroughly explored.

Rehabilitation Research and Training Centers
Hearing and Speech Activities

1970	1971	1972	1973	1974
$475,000	$250,000	$354,000	$500,000	$400,000

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; conducts research and training 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 specialities.

In the area of training, the Research and Training Centers provided approximately 41 short-term courses in speech and hearing to approximately 2,550 professionals and subprofessionals in the rehabiliation-related disciplines. Examples of such training include a course in speech patho-physiology 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 all, 51 speech and hearing-related research projects were conducted by Centers in such areas as technological sensory aids for the deaf, evaluation of speech intelligibility of stroke patients, and the assessment of treatment process for aphasic children.

Special Foreign Currency Program

	1970	1971	1972	1973	1974
Special Foreign Currency Program	$400,000	---	$513,725	$400,000	$200,000

Collaborative research projects are planned between researchers in the United States, Yugoslavia, Tunisia and Egypt to determine the efficacy of various new rehabilitation techniques developed under the SRS International Research Program. Specifically, the verbal tonal system rehabilitating hard of hearing individuals will be thoroughly evaluated for its relevancy to the U.S. cultural setting.

HEARING AND SPEECH

Obligations Fiscal Year 1970 to Fiscal Year 1974

Agency and Program	1970	1971	1972	1973	1974
OFFICE OF EDUCATION:					
Elementary and secondary education.	$12,600,000	$13,400,000	$14,000,000	$14,000,000	1/
Education for the handicapped.....	31,000,000	36,412,000	34,645,000	37,700,000	26,700,000 2/
Occupational, vocational, and adult education.....	3,800,000	4,463,624	4,729,500	4,729,500	1/
Libraries and educational communication.....	40,000	40,000	40,000	40,000	---
Research and Training.....	49,166	88,800	68,143	---	---
Subtotal, Office of Education.....	$47,489,166	$54,404,424	$53,482,643	$56,469,500	$26,700,000

1/ The programs in these activities which supplied funds for hearing and speech are being consolidated, in fiscal year 1974, into the proposed Special Education Revenue Sharing.

2/ The State grant program, which will provide approximately $11,000,000 for hearing and speech in fiscal year 1973, is being consolidated into the proposed Special Education Revenue Sharing.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Education

Report on Speech and Hearing

Education for the Handicapped

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 20 million handicapped individuals. Of this number approximately 3.1 million possess learning difficulties severe enough to interfere with communication and the development of normal speech and language. 450,000 of these are considered totally deaf, and thereby incapable of understanding 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, articulation and voice disorders, and developmental language disorders. These problems may be related to other handicaps such as cerebral palsy, mental retardation, learning disabilities, laryngectomy, and emotional disturbance.

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.

For academic year 1972-73, $3,957,231 was obligated for awards for speech and hearing. The Training Division has moved completely to Program Assistance Grants. While our expectations are that the number of trainees directly supported will rise slightly, we do not delineate all trainees according to distinct areas of handicaps.

In addition, the State Educational agencies expended approximately $500,000, mainly through special study institutes and summer session traineeships in order to upgrade and update the skills and knowledge of inservice speech and hearing personnel.

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 50,000 deaf pupils in the United States. Due to a shortage of teachers and other obstacles, an 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 1,000 new teachers of the deaf plus 1,000 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 were 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 1972-73, $2,100,000 was awarded for preparation of persons in education of the deaf.

Research

The research and demonstration program for handicapped children administered under Public Law 91-230 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 was tested with more than 25,000 school children in order to establish the prevalence of a variety of speech and hearing problems. A longitudinal survey is being conducted to ascertain demographic and educational data on 35,000 schoolage deaf children.

Table I - Research and Demonstration Projects in the area of Speech and Hearing supported by the Bureau of Education for the Handicapped: 1964-72

	New Grants S&H & HI	Funds for S&H &HI	R&D Funds	Percent
1964.....	9	$ 184,691	$ 999,739	18
1965.....	9	239,980	2,000,000	11
1966.....	21	598,041	5,994,231	9
1967.....	24	841,560	8,049,041	10
1968.....	14	495,845	10,794,113	4
1969.....	16	904,943	12,800,000	7
1970.....	5	788,723	13,048,284	6
1971.....	4	1,782,503	15,832,059	11
1972.....	7	1,429,269	15,043,262	10
Total.....	109	$7,265,555	$84,560,729	9

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. 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 have been initiated during 1972 which complement these previously funded.

Educational research relating to speech and hearing during fiscal year 1972 continued 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. A program of research investigating the comprehension and production of syntactic structures by deaf children is currently being supported. Further, a major effort is being supported to develop cost-effective CAI language arts and mathematics programs for deaf children. Additional research and development activities will be sought in this area. It is

expected that significant steps will be taken during fiscal year 1973 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 1973, 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 1972 Media Services and Captioned Films reached more than 3,300 groups of hearing impaired persons. Of these, 1,200 were schools or classes for the deaf. The total audience for recreational films numbered over one and a half million with a monthly average of 2,700 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 500 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 in-service 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, and Tennessee and New Mexico State University.

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 and other handicapped. 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 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 six 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.

The most recent amendment to the program was the passage of P.L. 91-61 (now sections 653 and 654 of part F of P.L. 91-230) providing for the establishment of a National Center on Educational Media and Materials for the Handicapped. The Center is located in an institution of higher education, as required by law, and

was procured by competitive contract award process. It provides a setting wherein the fields of special education and educational materials and technology meet to facilitate the development of, training in, information about, and delivery of instructional media and materials for handicapped children. The Center is the nationwide agent and advocate for those regional materials centers and other agencies who develop materials to meet the instructional needs of handicapped children in the process of getting materials to the intended beneficiary. Construction is authorized.

EHA, Part B, State Plan Program

The 1966 amendment to the Elementary and Secondary Education Act provided under former Title VI-A, now Part B, EHA, P.L. 91-230, a program of support to local education agencies through a State plan program. During fiscal year 1973 $37.5 million was requested. It is anticipated that approximately $11 million of this amount will be expended on behalf of speech and hearing handicapped children. In fiscal year 1974, this State grant program will be consolidated into the Special Education Revenue Sharing proposal.

Early Education Assistance

This Act, Part C, EHA, P.L. 91-230, 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 are distributed on a broad geographical basis throughout the Nation. Projects also are 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. During 1972-73, the entire early education program, which serves all types of young handicapped children, included 71 local activities and was funded at 7 million dollars.

Libraries and Educational Communication

Through fiscal year 1971, funds under Title IV-A of the Library Services and Construction Act were 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 1971, 20 State institutions for the deaf and/or State supported institutions for the deaf and blind benefitted through the efforts of this program.

Activities included:

Florida:

Since 1968, the Florida school for the deaf has received an annual grant under LSCA, Title IV-A for the purpose of bringing the library up to minimum standards.

Each year books, filmstrips, periodicals, and other materials are purchased. The project aims at improved programming for the use of these materials. In line with this, in 1971, a workshop was held in the library for the librarian media specialist, teachers and a teacher's aide for the purpose of correlating library materials with the curriculum.

Indiana:

The library at the school for the Deaf at Indianapolis has participated in the LSCA IV-A program since 1968. Benefits have included grants for materials and equipment, cataloguing processing and interlibrary loan service from the State library. In addition workshops and onsite training opportunities for the staff were provided.

In December 1971, a landmark in the development of library services was reached with the opening of a modern, attractive up-to-date library in the former gymnasium. The new facilities provides space in the 13,000 volume book collection, periodicals, films, filmstrips, slides, maps, charts, and pictures. In addition study areas and display areas and work space are provided.

Beginning in fiscal year 1972, the Library Services and Construction Act, as amended, provided library services to State institutionalized persons and physically handicapped persons under Title I. Projects involving these activities will be maintained at the 1971 level during fiscal years 1972 and 1973.

In fiscal year 1974, the Library Resources program is being terminated.

Vocational Education

At least ten percent of the basic grant funds under the Vocational Education Amendments of 1968 are mandated to be spent on the handicapped. This category includes those who are hard of hearing, deaf, or speech impaired. From the descriptive reports of the States which are submitted annually, there are a number of programs in which these particular handicapped students are being served.

Illustrations of the kinds of programs carried on in some States are: pre-employment vocational experience programs; vocational printing; office occupation programs for the deaf; pre- and post-testing of occupational aptitudes; utilization of teacher and instructional aides to provide individualized instructions; work adjustment.

Vocational Education reporting system does not collect data for each category of the handicapped.

Estimated enrollments for fiscal year 1973 include 1,000 deaf persons, 5,000 hard of hearing and 15,000 speech impaired.

Adult Education

Adults with speech or hearing impairments who have not attained the equivalent of a high school education are eligible to attend adult education programs. It is estimated that approximately 2% of the total effort in State grant funds are used for educational programs designed specifically for under-educated adults with such impairments.

In 1974, the State grant programs under Vocational Education and Adult Education are being consolidated under Special Education Revenue Sharing.

Research and Training

In fiscal year 1971, the National Center for Educational Research and Development continued the study at Indiana University Foundation for a Doctoral Research Training Program to Train Experimental Investigation for Multiple-Section Speech Courses.

As part of a $2,477,000 project at the Central Midwestern Regional Educational Laboratory in Missouri, one of the major programs was an Instructional systems program to develop learning environments appropriate to the needs of Inner-City low income children, and nonverbal autistic children.

In fiscal year 1971, San Fernando Valley State College, California, was awarded a grant to conduct an institute for 40 participants from 38 of the States and Territories to work in or toward better programs for deaf adults. The institute is designed to (1) train hearing-impaired teachers to develop adult basic education programs for other hearing-impaired adults; (2) aid deaf persons in motivating and helping the deaf adult to take full advantage of these programs; (3) train deaf persons to take paraprofessional roles in adult basic education programs for deaf citizens; (4) acquaint deaf personnel with the wide range of ABE programs in most major cities; (5) prepare qualified deaf persons to teach ABE classes for the deaf; and (6) develop techniques for organizing community action and recruiting for ABE classes.

Elementary and Secondary Education

Benefits under Title I of the Elementary and Secondary Education Act were extended to handicapped children in State-operated and State-supported programs under the provisions of the P.L. 89-313 amendment passed by Congress in November of 1965. In fiscal year 1971 more than $7.7 million were awarded State agencies to expand and improve services to more than 20,242 deaf and hard of hearing children in State-operated or State-supported programs. In fiscal year 1972 almost $9.0 million were awarded State agencies on behalf of approximately 21,439 deaf and hard of hearing children under this Federal program. For fiscal year 1973 approximately 22,723 deaf and hard of hearing children received expanded or improved State service with Federal support of $8.8 million.

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 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. At least fifteen percent (15%) of the grant funds are to be devoted to programs for education of handicapped children.

In fiscal year 1974 the Title I and Title III programs are being consolidated under Special Education Revenue Sharing.

Special Education Revenue Sharing

Under the proposed Special Education Revenue Sharing, in 1974, there are five broad categories of support (disadvantaged, handicapped, vocational education, impact aid, and support services). Within each earmarked category, State and local officials will have wide discretion in addressing the needs of the area for which they are responsible.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
MATERNAL AND CHILD HEALTH SERVICE

Hearing and Speech

	Actual Obligations[1/]			Estimated Obligations	
	1970	1971	1972	1973	1974
Special Projects	916,424	916,424	930,000	940,000	940,000
Children and Youth Projects	1,032,000	745,517	745,000	760,000	760,000
University-Affiliated MR Centers ..	623,100	823,832	1,070,000	1,000,000	1,000,000
Subtotal	2,571,524	2,485,773	2,745,000	2,700,000	2,700,000
Research	160,326	232,778	320,000	235,000	235,000
Special Foreign Currency Program ..	119,290	82,913	90,000	97,000	97,000
Total	2,851,140	2,801,464	3,155,000	3,032,000	3,032,000

[1/] Excludes formula grant funds expended by States for hearing and speech activities, for which no estimate is available.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
MATERNAL AND CHILD HEALTH SERVICE

Hearing and Speech Program

The Maternal and Child Health Service, Health Services and Mental Health Administration, administers funds appropriated under Title V of the Social Security Act for Maternal and Child Health and Crippled Children's Services. These funds are available as formula grants to State Maternal and Child Health and Crippled Children's agencies, and also as project grants for the comprehensive health care of children and youth, for maternity and infant care, for dental health care, for training of professional personnel and for research related to the health of mothers and children.

The data in the table accompanying this report represent the obligations and expenditures for speech and hearing services which are included in the different categories of project grants. The amounts expended by the States for speech and hearing services under Title V formula grants have not been uniformly reported by all states and thus the total national cost of the program for speech and hearing is not identifiable.

The Maternal and Child Health Service assists state and community health agencies in planning, developing and evaluating programs of services for children with communicative disorders of speech, hearing and language. These efforts consist of (1) providing technical assistance by staff which is consonant with the national goals and objectives of the HSMHA and MCHS; (2) initiating, conducting and supporting conferences and seminars to improve speech and hearing services and to make the delivery system compatible with comprehensive health planning; (3) issuing program guidelines and other material relevant to the needs of professionals and parents; (4) reviewing the performance of programs and initiating studies which focus on improving the quality of services; and (5) developing projects which have as their purposes the improvement or extension of services, the training of personnel, or the study of the development and disorders of speech, hearing and language.

GOALS

The MCHS program for speech and hearing services is guided by the following goals:

1. To assist State and community health agencies to develop additional programs and to extend present programs, especially to infant and early childhood, for the prevention, identification, diagnosis and treatment of communicative disorders of hearing, speech and language.

2. To develop and improve, with technical and financial assistance, the training of personnel to serve children with hearing, speech and language disorders.

3. To identify problems related to providing or improving specialized services and to develop and support studies pertaining to these problems in serving children with communicative handicaps.

STATE PROGRAM SERVICE

The services provided in a hearing and speech program in a State Maternal and Child Health or Crippled Children's Service program include medical and surgical treatment, hospitalization and aftercare, audiology and speech pathology services, nursing, social work and psychology services and other health services as required, including the provision of hearing aids. While services for hearing and speech impairments are provided in each of the States, the nature and scope of these services vary among the States and among communities within the States.

Some of the activities related to a hearing and speech program are basically activities related to overall preventive health services and general health care provided to children. For example, the program for immunization is significant in the prevention of disease leading to sensorineural hearing impairments. Similarly, medical treatment of upper respiratory infections, and acute otitis media is a significant part of preventing conductive hearing impairments. Just as the provision of early and necessary health care is an essential part of a hearing and speech program, so hearing and speech services are an essential part of a health delivery system. The health services required for an effective hearing and speech program include a wide range of disciplines involved in case-finding, assessment, medical and non-medical treatment and therapy, counselling and habilitation.

In most states, either the Maternal and Child Health agency or the Crippled Children's Service agency, or both, employ professionally qualified speech pathologists or audiologists to be responsible for the development and implementation of a program for hearing and speech services.

The State departments of health have reported a consistent and gradual increase each year in the number of children whose hearing is tested. For fiscal 1971, the hearing of more than six million children was tested. The number of children who are found by these hearing tests to need medical and other help is, on a national average, approximately 2% to 3% of the total. This national average, however, fails to emphasize the fact that in some geographic areas the prevalence of significant hearing impairment is 15% and in Alaska, for instance, it is about 30%. The number of persons who are profoundly deaf from birth is approximately two per thousand in the general population. Speech and hearing programs in State Maternal and Child Health and Crippled Children's Services Agencies provide services both directly and indirectly in a variety of different delivery systems.

Most provide casefinding, preventive and diagnostic services directly by utilizing State personnel at both the professional and supportive personnel level.

Treatment services for both hearing and speech impairments may be provided by state employed staff, or are purchased, from existing hearing and speech facilities and from professional personnel in hospitals, rehabilitation centers and other facilities. Speech services are provided as an integral part of the services for children with cerebral palsy and cleft lip and cleft palate. In fiscal 1971, the total number of children with cerebral palsy served by the Crippled Children's Service was 40,406; with cleft lip and palate, 22,324. The Crippled Children's Service reported providing services to approximately 56,425 children with hearing impairments; of these, 23,141 were serviced for the first time in fiscal 1971.

MATERNAL AND CHILD HEALTH SERVICE CONTINUING ACTIVITIES

Hearing and speech services are an integral part of Maternal and Child Health Service project grants for comprehensive health services for children and youth who live in poverty areas. The projects provide screening, diagnostic, preventive, corrective and follow-up services for children of families who live in low income areas. About 100 hearing and speech specialists are employed as staff in these projects to provide speech pathology and audiology services.

Special projects specific to the hearing and speech field include grants to (1) the Colorado State Department of Health for demonstrations related to hearing conservation; (2) the Iowa Crippled Children's Service to explore developments in providing hearing and speech services to mentally retarded children; (3) the Alaska Department of Health to develop a joint program in audiology with the Indian Health Service.

Grants for training in speech pathology and audiology have been continued at the Johns Hopkins University, University of Iowa, University of Oklahoma Medical School, University of Kansas Medical School, the New York University Medical School, and Vanderbilt University Medical School. The grant to Vanderbilt University includes an agreement for a cooperative training program with Tennessee State University. This agreement with Tennessee State University, as a historically black institution of higher education, is an attempt to develop new patterns of education to prepare speech pathologists and audiologists to serve children from cultural and linguistic backgrounds which differ from that of the speech and hearing specialist.

Training for speech pathology and audiology is one of the more than fifteen health professions which receive support for training in the twenty university—affiliated training centers from the Maternal and Child Health Service.

Grant support has been continued for several research studies. A study of computerized audiometry, utilizing the responses evoked by electroencephalography is being supported at the Albert Einstein College of Medicine for the purpose of developing more effective diagnostic tests. A study at the University of Hartford is concerned with developing automated procedures for evaluation of the language functions in infants and young children with severe auditory impairments. The Langley Porter Neuropsychiatric Institute is conducting a study to describe the development of parent-child communication in families with a child who is deaf. A study of the auditory and visual perceptual deficits related to neonatal jaundice is being carried out at the Pennsylvania Hospital in Philadelphia.

Continuing activities in research under the International program include studies of the methods for the early detection of hearing loss. Such studies are supported with special currency funds in Israel, Poland, and Yugoslavia. Projects pending approval have been developed in Egypt and India for the purpose of studying innovative methods of delivering speech and hearing services.

MATERNAL AND CHILD HEALTH SERVICE INNOVATIVE ACTIVITIES

The changes in the payment systems for improved national health services which have been proposed can be expected to result in changes in the program systems for services, including speech and hearing services. An objective of the Maternal and Child Health Service Speech and Hearing Unit has been to aid the profession of speech pathology and audiology in preparing to make its services accessible and available in whatever delivery system eventually evolves. Activities to implement this objective included (1) A pilot program for training speech pathologists and audiologists in the methods of comprehensive planning. The initial seminar, held at the University of Denver, included as participants representatives of state agencies and of state professional associations for speech and hearing in DHEW Region VIII; (2) A seminar conference for directors of training in speech pathology and audiology in the DHEW Regions I and II. This seminar was conducted by the School of Public Health at Columbia University; (3) Planning efforts to achieve this objective which were followed by conferences in the succeeding fiscal year. One of these was a national conference on "Speech and Hearing in the Emerging Health Delivery Systems" held at the Johns Hopkins University in October 1972. The planning conference held at Children's Hospital, Philadelphia, was concerned with future speech and hearing services in Children's Hospitals throughout the nation. This planning conference will result in a national conference to be held in January 1973.

To achieve an objective to aid the States and communities in their efforts to establish standards and improve their systems for quality control, guidelines were developed jointly with an advisory committee and distributed widely. This publication, "Guidelines for the Purchase of Services and the Procurement of Hearing Aids for Children with Communicative Disorders," attempted to take into account the possible variations in future health delivery systems.

To achieve an objective to assess the effectiveness and efficiency of speech and hearing services, guidelines were developed jointly with the Minnesota Systems Research, Inc. These guidelines establish original definitions and a coding system for data on speech and hearing services, especially in those projects receiving support from the Maternal and Child Health Service. This coding system is now in the process of pilot-testing and is expected to have a widespread significance.

To achieve an objective to improve the training for speech and hearing specialists in the University Affiliated Centers, an evaluation project was initiated with the University of North Carolina. The project will attempt to develop a valid and discriminating method of evaluating the effectiveness of interdisciplinary training for speech pathologists and audiologists.

To achieve an objective to improve the speech and hearing services available for minorities, a conference on the needs of the Hispanic population in New York City was planned and funded jointly with local resources. The conference was held in November 1972. The Maternal and Child Health Service Speech and Hearing Unit participated actively in conferences held by the American Speech and Hearing Association on recruiting black students into the profession of speech pathology and audiology.

NATIONAL INSITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke
National Institute of Child Health and Human Development
National Institute of Dental Research
National Institute of Environmental Health Sciences

HEARING, SPEECH, AND LANGUAGE

More than 20 million Americans have difficulty communicating because they have a speech, language or hearing problem. This figure represents more than 10 percent of the entire population. It includes a vast number of children and aged persons for whom the attending problems of confusion, anxiety, withdrawal, and isolation can be devastating. National Institutes of Health is vitally concerned with understanding, through research, human communication and its disorders and in preventing these problems. Sharing this concern are the National Institute of Neurological Diseases and Stroke (NINDS), the National Institute of Child Health and Human Development (NICHS), the National Institute of Dental Research (NIDR), and the National Institute of Environmental Health Sciences (NIEHS).

NIH Research Support for Hearing, Speech, and Language

Agency and Program	1970	1971	1972	1973 (estimate)	1974 (estimate)
NINDS	$7,267,000	$9,160,000	$11,446,000	$9,997,000	$9,884,000
NICHD	6,504,000	8,394,000	10,810,000	10,200,000	9,825,000
NIDR	1,496,477	1,685,210	1,461,102	1,444,000	1,463,000
NIEHS	---	---	---	212,000	245,000
Subtotal NIH	15,267,477	19,239,210	23,717,102	21,853,000	21,417,000

The National Institute of Neurological Diseases and Stroke (NINDS) 34

This Institute is currently supporting 331 research projects--including four out-patient clinical research centers; seven contracts; 62 training grants to universities and medical centers; and five multi-disciplinary centers. These centers, and the individual grants support research on hereditary deafness and hearing loss, and hearing problems caused by noise, old age, drugs, infection, tumors of the VIIIth (hearing) nerve, middle ear infections and Meniere's disease, which causes dizziness and loss of balance in addition to hearing loss. They also support research on speech and language disorders, many of which are caused by congenital defects or brain damage resulting from accidents and childhood infections. In later life, many severe and traumatic speech and language problems can result from stroke and removal of a diseased or traumatized larynx.

In addition to the grant program, the NINDS this year initiated a concentrated collaborative and field program for directed research, which is expected to be expanded to include laboratory studies at NIH as well. This program is designed to lead to improvements in diagnosis, treatment, and prevention of communication disorders.

Initially, under this new program, scientists will develop and evaluate tests for detecting hearing loss in infants. This is a crucial need, since hearing loss can best be treated when discovered early. In addition, the feasibility of using a sensory aid for deaf infants will be determined. This aid would translate patterns of sound energy into tactile patterns which could be felt and interpreted by the infant as language. The development of a wearable clinical research hearing aid is another facet of this program. This aid would be used to determine possible improvements in tailoring hearing aids to the specific needs of its wearer.

The NINDS is also in the process of analyzing data on thousands of pregnancies whose offspring have been studied for eight years to determine prenatal and early childhood influences on communication disorders. This information should provide important insight into the myriad of factors which can cause communication problems.

The National Institute of Child Health and Human Development (NICHD)

Through research in the biological, behavioral, and clinical sciences this Institute promotes a better understanding of normal and abnormal developmental processes in human beings of all ages. As an integral part of the Institute's mission the NICHD supports research leading to a better understanding of the acquisition and development of the processes associated with normal human communication and the problems of communication associated with mental retardation. Specific research is sponsored in the area of speech and language acquisition, and the maintenance of the complex mechanisms whereby humans receive information from their environment and express themselves by means of actions coordinated through multiorgan systems. While the NICHD focuses on specific aspects of hearing, speech, and language it also studies human communication in the larger context of physiological, social, and intellectual development from a biomedical, psychological, and sociological point of view. The NICHD currently supports 127 research and training grants in this area.

In addition to this form of research support there are 12 Mental Retardation Research Centers created by PL 88-164 which represent for the NICHD and for the country as a whole the major research thrust in the field of mental retardation. These Centers conduct a wide range of investigations encompassing the biological, behavioral, and social sciences. Prominent among the behavioral studies undertaken are those concerned with and focused on language acquisition, development and training in the mentally retarded child. Among the various handicaps shared by the mentally retarded, language deficiencies are probably

the most common and prevalent. In keeping with the NICHD view that language is central to developmental processes, the Institute has encouraged a wide-range of research activities dealing with this aspect of human development. 35

The National Institute of Dental Research (NIDR)

This Institute is supporting concentrated research on cleft palate (an incomplete closure of the roof of the mouth) and other oral-facial defects. In 1972, NIDR awarded 14 research grants, including several to research treatment teams, and six training grants for study of this anomaly which occurs once in approximately every 600 births. Since 90 percent of these babies, some with severe associated malformations, survive the first year of life, cleft palate children and adults constitute one of the largest groups of handicapped people.

The National Institute of Environmental Health Sciences

This Institute has begun a program on the effects of noise on hearing. This new program includes one intramural research study and one contract.

HEARING

An estimated fourteen and one-half million persons have handicapping hearing impairments; 450,000 of these are totally deaf; approximately 100,000 were born with a hearing loss. The number with severe hearing disorders has risen tremendously in the last decade as a result of the 1963-64 rubella epidemic. In addition, a nationwide survey has indicated that the incidence of ear disease, which could lead to hearing loss if left untreated, is far more prevalent than was previously thought.

The past few decades have seen significant developments in treating hearing loss. Otosclerosis, the growth of spongy bone in the middle ear which immobilizes small middle ear bones that normally vibrate and conduct sound to the inner ear (one of the most common types of hearing loss in adults) can now almost always be surgically treated. Certain tumors which can lead to deafness and even death can now be surgically removed if discovered early, and new techniques now permit early diagnosis. Although there is as yet no cure for sensori-neural hearing loss (a defect in the inner ear's ability to convert incoming messages into ones which can be interpreted by the brain) intensive research on possible causes and cures continues. Other scientists are seeking to improve hearing aids for sensori-neural loss.

Although sensori-neural loss cannot as yet be prevented, hearing loss, can in some instances, be prevented by avoiding harmful antibiotics (particularly streptomycin and its derivatives); avoiding or protecting against harmful levels of loud noise; by frequent examination for otitis media, a treatable middle ear infection; and by early screening and testing for hearing loss. It is now the consensus of scientists, based on results of the massive NINDS perinatal research program, that screening all newborns for hearing loss is not effective because hearing loss cannot, as yet, be accurately tested in infants. Instead, clinicians favor maintaining a high risk register for identifying and following closely those infants with high probability for hearing loss based on genetic or environmental factors. These children as well as "normally" hearing children, would then be tested periodically during their school years for any hearing problems. In 1972, 24 states reported they have some type of statutory requirement of hearing screening of school children.

Hearing and Communication

Although it is well known that the congenitally deaf have great difficulty acquiring normal verbal skills, many of the underlying relationships among normal

and partial hearing and communications remain unanswered. The NICHD supports 36
research projects concerning the child's ability to respond to acoustic stimuli both for pure tone and for language related complex sound. One investigator at the Research Unit of St. Joseph's Hospital in Lancaster, Pennsylvania, has recently demonstrated that neonates, both normal and abnormal, respond consistently to acoustic stimuli--both of a single and complex nature. This investigator in another aspect of the study is now developing two scales of children's performance: (1) communicative abilities from retarded to normal, and (2) activity patterns from lethargic to hyperactive.

Even slight hearing impairment may be a major problem in child development because of the essential role hearing plays in normal speech and language development. It is, therefore, critical that auditory abilities be defined early in life. Investigators at the University of Kansas Mental Retardation Center have used an operant approach to make significant improvements in our assessment of hearing ability in neonates and young children as well as in the difficult-to-test severely retarded individuals. One investigator, working at the University of Kansas Medical Center portion of the Kansas Mental Retardation Center, has been conducting research with three basic objectives: (1) to refine procedures to evaluate auditory sensitivity of neonates, (2) determine whether sensory feedback is reinforcing to neonates, and (3) relate responsiveness of neonates to sensory feedback to subsequent intellectual development. Other research, at the Parson State Hospital setting of the Kansas Mental Retardation Center, has developed reliable and valid procedures for obtaining auditory sensitivity information from severely retarded children. This work has been extended in two directions. The first was to apply this improved technology to obtain pure tone audiograms on infants as young as seven months of age. The second extension has been in the direction of modifying the procedure for more advanced audiologic assessment procedures.

Because of the importance of better defining the relationship between auditory abilities and language development, the NICHD has recently developed a major contract in this area.

Noise

Noise constitutes one of the leading threats to hearing. More than 16 million Americans may be exposed to dangerous noise levels on the job. Another 10 million urban dwellers are often exposed to harmfully loud noise levels generated in their home environment.

The Walsh-Healy Act was recently amended to set limits for noise in a work situation, based in part on NINDS research. For instance, recent studies by a Minnesota grantee indicated that 16 hours, noise-free, are required to restore initial sensitivity after exposure to noise loud enough to cause temporary damage. In an industrial situation, therefore, chronic hearing fatigue could lead to permanent and irreversible damage. This research scientist also reported that damage can occur from a single explosion or severe head blow. According to another researcher, by age 50, 19 percent of all males exposed to routine everyday noise will have a hearing loss level exceeding that at which industrial compensation begins.

Noise can be particularly damaging to the aging. An NINDS-supported study at the University of Michigan School of Medicine is determining the combined effect of aging and noise, and has found that both can decrease blood circulation and therefore oxygen to the inner ear. Noise constricts capillaries through which blood flows to the inner ear structures and aging thickens capillary walls.

Scientists also are seeking to determine whether the combined effects of noise and some drugs can be particularly damaging to hearing. Several tests, including those made by NINDS-supported scientists at the Kresge Hearing

Research Institute and the University of Michigan, indicate that salicylates (aspirin) and certain ototoxic antibiotics (streptomycin and its derivatives and kanamycin) can cause hearing loss through nerve and sensory cell destruction, just as noise can. Further research is needed to determine whether the combined assault by both hastens this destruction. 37

The possibility for determining this has been enhanced by a recent animal model developed by University of Oregon scientists supported by NINDS. The scientists found that the guinea pig heart rate can be conditioned to respond to sound differentially, and therefore the effect of both noise and drugs can be tested in the animals.

Genetic Hearing Loss

An estimated 16 percent of the population carries one or more of the many different recessive genes for profound deafness. These carriers may themselves have normal hearing, but may pass the gene and possible hearing loss on to their children. There are currently about 100,000 persons in the U.S. born with a hearing loss. It is believed that heredity accounted for 50 percent of these.

To better understand the genetic mechanisms responsible, NINDS is supporting research on different types of hereditary hearing loss and their characteristics. A researcher at The Johns Hopkins University has classified more than 60 types of hearing loss, resulting from four or five different genes. In 80 percent of the cases, hearing loss is only a part of a genetic syndrome involving many problems. These other problems identify the particular hereditary syndrome. In the remaining 20 percent of the cases, hearing loss is the only problem and its cause is identified by the age of onset, severity, and genetic mode of transmission. Genetic counseling now can be tremendously important in preventing hereditary deafness, and may be one of the most significant factors in reducing the incidence of deafness.

Middle Ear Infection

Middle ear infection or otitis media is one of the most common childhood afflictions according to a recent Minnesota Academy of General Practice survey. In otitis media fluid accumulates in the middle ear. This is caused by a blockage in the eustachian tube which extends from the nose to the ear and under normal circumstances allows the fluid to drain from the ear. If untreated it causes gradual hearing loss. With early diagnosis, treatment is easy and temporary hearing loss is now almost always medically or surgically reversible.

Otitis media is particularly prevalent in children with cleft palate. In fact, about 50 percent of cleft palate children have hearing loss which is usually due to middle ear problems. NIDR-supported researchers at the University of Pittsburgh Cleft Palate Center have studied the influence of early ear management on the speech and language development of children with cleft palates. Of 34 children who had ear care during the early months of life, a definite relationship was found between the amount of early care and the present condition of the child's ears in all 34 participants. In addition, while the children's pronunciation was still immature, each had a mean IQ well above the standard mean of 100. This indicated mental functioning was not decreased as had previously been reported for cleft palate children.

Acoustic Neuroma

Acoustic neuromas or tumors of the hearing nerve can also be treated effectively if diagnosed and treated early. Early diagnosis is crucial, however, because acoustic neuroma can lead not only to hearing loss, but to death, if not removed early. Striking advances have recently been made in the diagnosis and surgical removal of these tumors.

Acoustic neuroma is a benign tumor (not a cancer) which begins in the bony channel between the inner ear and the brain. The only known treatment is surgery for complete removal as early as possible. When totally removed, the acoustic neuroma can no longer grow and threaten life by pressure on the brain. The one-sided hearing loss, and other symptoms such as dizziness, facial numbness and a feeling of fullness in the ears also may be relieved by early surgery. Diagnostic tests have recently been developed which differentiate acoustic neuroma from a non-fatal disorder producing similar symptoms, known as Meniere's disease. This differentiation can be life-saving for the patient with acoustic tumor.

Some acoustic tumors are hereditary, and these usually produce hearing loss in both ears, as opposed to loss in only one ear with those arising from other causes. Scientists in the NINDS collaborative program are currently investigating possible means of identifying those persons who carry the genetic trait for acoustic neuroma.

Hearing Aids

At present, prevention is of course, the best deterrent to hearing loss. In persons with a hearing loss, however, one of the main assists is the hearing aid. Tremendous advances in microelectronics and materials within the last few years have opened a new and exciting field of development of biocompatible, implantable devices for direct control of neural deficits. Such devices may not necessarily provide hearing to profoundly deaf persons, but they can greatly enhance current hearing aid function by reducing distortion, improving speech discrimination, eliminating ringing feedback, and increasing the efficiency of transmission.

Two approaches to new hearing devices are currently being investigated. One type commonly referred to as an "implantable hearing aid" is a very small electro-mechanical transducer which causes a mechanical vibration of the inner ear. This device would be most helpful for persons with conductive hearing loss (which occurs when sound waves are not transmitted adequately to the inner ear). But they could also reduce distortion in some persons with sensori-neural loss (which occurs when sound waves are not properly converted into messages to be passed on to the brain). The aid has shown successful results in guinea pigs and in one human ear, where it was found to greatly aid speech discrimination and pure-tone identification. Although initial mechanical problems of such an aid have been solved, the important problem of tissue rejection still remains, requiring further research.

In addition to an implantable type aid, other NINDS-supported scientists are currently investigating the possibility of using an auditory prosthesis which would directly stimulate the auditory nerve, also called the VIIIth nerve or main nerve of hearing. Patients participating in early prosthesis trials were able to discriminate pitch and amplitude, but were not able to perceive complex tones and speech. One obstacle to artificial stimulation of the auditory nerve has been lack of data on the way in which auditory information is encoded in the fibers of the auditory nerve. Therefore, other NINDS-supported researchers are studying the response of single nerve fibers to simple acoustic and electric stimuli and finally to speech signals. For several years a number of scientists have been experimenting with electrical stimulation of the auditory nerve in cases in which the sensory cells in the inner ear are destroyed but the auditory nerve is intact. One of these receives grant support from NINDS.

Still a third approach is direct stimulation of the auditory portions of the brain. Two years experience in the Institute's collaborative program to determine the feasibility of a visual prosthesis has provided scientists with valuable information that would appear to be directly applicable to

development of other types of prostheses, including an auditory prosthesis. 39
The Institute is therefore expanding its program to include possible development of several types of neuroprostheses. In support of this approach, there is evidence that different parts of the brain respond to different tones. By developing methods of placing electrode arrays in presently inaccessible brain tissue, pitch discrimination and speech recognition may become possible. In addition, the person may then be able to utilize "normal" functions for recognizing auditory patterns which may not be possible with other approaches.

Some scientists are also exploring the possibility of using tactile (through the skin) stimulation--either vibratory or electrical--for conveying auditory information. Such a system could provide valuable information on how auditory signals are processed, leading to improvements in all types of auditory prostheses.

SPEECH

About 10 million people in this country have a speech disorder which significantly interferes with communication; half of these are children, and a sizeable proportion appears in the older age groups.

Normal Speech Development

There is strong evidence that a child's speech is acquired through a set of evolved, genetically based abilities. In fact, it would appear that the normal infant is born with a built-in capacity for speech. Unlike all other animals, most human infants acquire the speech patterns of their immediate environment more effectively than could be expected if "learning" were the only explanation.

In the late 1950's two basic concepts advanced by a Massachusetts Institute of Technology psycholinguist, currently supported by the NICHD, revolutionized studies on speech and language. He found that children acquire the rules of language grammar; and that they also acquire rules for transforming the underlying meaning (deep structures) of the language to the spoken word (surface structure). This work has led other NICHD-supported investigators at Harvard to design and test new methods of assessing and developing linguistic knowledge and communication skills in later childhood.

Another NICHD-supported researcher at Brown University revealed startling evidence that a five-day-old infant can discriminate between speech sounds (phonemes) such as "b" and "p." This research was made possible by two technological advances which were also supported in part by the NICHD. The first is a technique for determining an infant's response to environmental change by recording variations in his non-nutrient suckling motions. These motions, recorded on paper, have been used in a wide variety of infant behavior studies. The second is the recording of precisely controlled synthetic speech sounds through a highly sophisticated computerized system. This system has also been used to study brain localization for speech and non-speech perception.

As a result of this type of NICHD-supported study, speech and language scientists are now able to conclude that from an evolutionary view, speech perception, and other aspects of human language are genetically based and specific to the human species, but that there is much individual variation within the species. Today, the salient questions are not whether speech and language acquisition are species-specific and genetically based, but how many abilities are involved and how variation is determined.

Speech Disorders

The term articulation, as applied to human speech, refers to the movements of such structures as the lips, jaw, and tongue and also to the acoustic impression of the utterance. Articulatory problems account for the largest number of

speech disorders requiring therapy. NICHD grantees are studying the acquisition and development of normal articulatory behavior to provide the necessary base from which diagnosis and treatment of articulatory problems may be accomplished. One NICHD investigator at the University of Missouri is applying concepts developed in the field of verbal learning and retention to the development and retention of articulatory responses. This research is considered particularly significant because the concepts involved, which have provided a framework for research in their field of origin, may prove useful within the field of speech where there has not been a systematic theory of articulatory development.

Nearly 70 percent of the mentally retarded exhibit some degree of articulation disorder. Since most retarded children also manifest other language problems, the intelligibility of their communication depends even more on articulation. NICHD-supported investigators at Parsons State Hospital and Training Center and the University of Kansas have developed improved methods for improving the articulation of retarded children. One of their major advances applies to the carry-over of more intelligible speech from therapy to everyday use. This is done by allowing stimuli which occur in the child's natural environment to reinforce correct responses acquired in the therapy session.

The person, usually an adult, who loses his larynx because of injury or disease can manipulate his lips and tongue to correctly form sounds, but he has no voice to make these sounds heard. An NINDS-grantee estimated that in one year alone, over 6,000 new cases of cancer of the larynx would be diagnosed, with subsequent removal of the diseased organ in most cases. Attempts to provide the "laryngectomee" with a new voice have in the past included mechanical vibrating devices and a very difficult to master technique of speaking on "burped" air. Neither approach could provide a natural sounding voice. A concentrated effort therefore in several NINDS-supported projects is currently being made to perfect a technique for transplanting or reconstructing a larynx to replace the one removed.

A University of Cincinnati surgeon succeeded in reconstructing a functioning larynx in dogs from their own throat tissues. With NINDS support he is attempting to repeat this with baboons, whose upright stance is similar to man's. To date the primary construction of the new larynx has been completed. Scientists are now attempting to open the larynx and construct vocal cords. When this has been completed successfully in the baboon, the procedure may be available to humans.

Some surgery for cancer of the larynx is so radical that there may not be enough throat tissue to reconstruct a new larynx. In such cases a true "transplant" from a donor or an implant made from synthetic materials may be called for. To date synthetic materials have been used with no success because of complications with infections and rejection of the prosthesis. This failure results because a foreign body cannot be partially submerged in tissue and partially exposed to oral secretions and bacterial contaminants without becoming infected. Use of allotransplants, natural tissue from an unrelated donor, has to date only been successful when combined with immunosuppressive drugs originally developed for treatment of cancer. Since these drugs pose a definite danger to the patient, NINDS-supported scientists at the Washington University School of Medicine are developing various techniques necessary for allotransplantation of the larynx which would not require use of these drugs. They have produced a serum and are testing it for immunosuppressive abilities in animals.

The scientists also have determined that in certain cases partial removal of the larynx may have a satisfactory cure rate. Conservation surgery is paramount to obtaining best results for functional restoration of the larynx. Since a partial laryngectomy causes great difficulty swallowing for a period of time, the Washington University group has developed a surgical technique

for immediately restoring ease of swallowing. By studying the reinnervated larynx, which is similar in function to the transplanted larynx, they have determined which nerves are important for voice production. 41

LANGUAGE

Language is a means of communicating, usually accomplished through an organized set of signals, such as written or spoken words. Everyone must learn it or be at a disadvantage socially and educationally. Currently it is estimated that more than three and one-half million children between the ages of four and seventeen have some degree of language disability. This figure does not include the five million children who are physically or socially handicapped.

Normal Language Development

As a direct outgrowth of its 1965 conference on Language Development in Children and resultant text, The Genesis of Language, the NICHD has supported a wide variety of projects dealing with the acquisition of language. Because children everywhere learn spoken language as a matter of course, the complexity of the acquisition process and of language itself is frequently overlooked. Since the conference, the Institute has, however, encouraged scientists from many different disciplines to define the major unsolved problems and has stimulated research in appropriate areas. With the growing research interest in how children develop language, it recently became apparent that many competent child development specialists needed specialized research materials to conduct essential studies. The NICHD, therefore, developed a research contract with the Haskins Laboratories of New Haven which has provided over fifty different scientists with natural and synthetic speech-like stimuli recorded in a precise manner suitable for a variety of experiments. As a direct result of this work, advances have already been made in the area of speech and language perception which may lead to improved language and reading instruction and better hearing aids for the hard-of-hearing.

Mental Retardation

Illustrative of the NICHD concern for language disorders is the research at several of the Mental Retardation Research Centers where there are large-scale comprehensive programs concerned with communicative disorders among the mentally retarded. Within one of these programs, individual studies are being conducted on the basic mechanisms of language acquisition, the cognitive processes employed by the mentally retarded, the structure and use of language, and intervention strategies for enhancing the capabilities of retarded children to acquire language. In collaboration with this program project, others at the Kansas Center are developing non-speech systems for teaching language to hearing-impaired retarded children and to severely retarded children with normal hearing. Another investigator at the Fernald State School Center has utilized cross modality (more than one sense) discrimination and behavior modification strategies as a primary tool for developing reading and verbal skills in children with Down's syndrome. Another project at the Center at Peabody College in Nashville is based on the assumption that positive intervention of nearly any sort at the earliest possible age is likely to yield more beneficial results for the developing child. Efforts to train toddlers in language skills have thus far demonstrated considerable success.

Aphasia

One of the most severe and devastating types of language disorder is aphasia, which can produce anxiety, confusion and anguish in its victims. This little understood disorder results in an inability either to assign meaning to words, repeat them, or organize words into thoughts. Children born with these inabilities and termed aphasic, may never learn language. Adults who

become aphasic from stroke, head injury or trauma, can sometimes regain language function, but only after constant, agonizing and rigorous therapy and practice which can itself become demoralizing and exhausting. Past studies have indicated that language function is handled by the left side of the brain. A classical neurological model of aphasia often is used to explain the role of damage to or interruption between signals from various language centers in the brain. What baffles many researchers is that children under eight years of age who suffer serious injury to the left side of the brain can develop adequate language function emanating from the right side of the brain. This has led clinicians to believe that aphasic children either may have damage to both sides of the brain, have a damaged brain stem which would impede the relay of information between brain hemispheres; or have genetically determined organizational brain defects.

NINDS is supporting a special educational approach to training aphasic children, stressing constant reinforcement for correct responses, and fending off situations which could produce emotional frustrations from not understanding speech. In addition, the Institute supported a study by University of Iowa researchers which resulted in a test battery for determining the extent of aphasia and for predicting levels of rehabilitative success. A third Institute program, at the Boston Veterans Hospital, is developing improved techniques for measuring and diagnosing aphasia and studying the basic properties underlying word-finding problems. Scientists there are using geometric configurations of cards to represent linguistic units, and have adopted a "normal" language acquisition model as the basis of their research. Patients observe this "language" used in meaningful situations. NINDS-supported researchers at Clark University are specifically looking for brain functions which underlie language and related higher perceptual motor functions. These studies should provide some help to therapists in determining the best individualized methods of treatment. However, a great amount of research is needed on all aspects of aphasia and its treatment as well as on all aspects of less severe language disorders. According to some clinical and research experts in the field, progress in remediation of children's language disorders is hampered by several factors. Among them are: failure to distinguish between rehabilitative needs of those who have had language and lost it and those who have failed to develop language normally; lack of a common definition of language disorders; and inadequate tools for testing language.

Spreading the Word

The dissemination of research findings and their application are considered by NIH to be one of its major functions in promoting relevant and appropriate research.

Each of the Institutes involved in communication research has recently held several conferences and published proceedings. The latest of a series of conferences supported by NICHD on "Communicating by Language" has resulted in a publication entitled Language by Ear and by Eye. This book concerns the relationships between speech and learning to read. Other publications in the NICHD series include The Speech Process, The Genesis of Language, and The Reading Process.

In co-sponsorship with its Mental Retardation Centers, the NICHD has also initiated a series of seminars which will result in a parallel series of state-of-the-art documents on aspects of mental retardation. Recognizing that language ability is a vital element in the development and performance of the mentally retarded, and that language deficiencies are the most commonly shared handicaps of mental retardation, the first seminar in this series dealt with language and the mentally retarded. This conference has resulted in a recent publication entitled Language of the Mentally Retarded.

NIDR has supported almost twenty workshops since 1967, sponsored by the Developmental Biology and Oral-Facial Anomalies Program. Several held during the past year dealt with the various problems of cleft palate. Proceedings will be published under these titles: Clinical Research in Cleft Palate; Anatomy and Physiology of Cleft Lip and Cleft Palate; and Craniofacial Anomalies. Another publication will result from a symposium jointly sponsored by the NIDR Oral Pharyngeal Development Section and the NIH Fogarty International Center on "Oral Sensation and Perception: Development in the Fetus and Infant."

NINDS supports an Information Center for Hearing, Speech, and Disorders of Human Communication as part of the NINDS Information Center Network. Located at The Johns Hopkins University, the Center serves as a national focal point for scientists, educators, clinicians, and students to obtain comprehensive lists of literature, state-of-the-art analyses, and critical reviews of literature on specialized topics. In the last three years the Center has answered more than 27,000 requests for information.

The Center supports a number of workshops each year which bring top scientists and clinicians from a variety of specialties together to discuss various problems of communication. The proceedings of these workshops, some of which have already been published, include Vascular Disorders and Hearing Defects, Sensory Input in Hearing Impaired Children, and both Neuroanatomy and Physiology of the Auditory System. A future workshop is planned in cooperation with the Clinical Neurology Information Center at the University of Nebraska (also NINDS supported) on acquired aphasia. Two conferences on noise will be held next year. Funding for the conferences on noise will be provided by the Deafness Research Foundation, The American Council of Otolaryngology, and the American Academy of Ophthalmology and Otolaryngology. As a special project, the Center published an Index-handbook on Ototoxic Agents, a reference manual on the drug literature appearing in the past five years. The Center also published a comprehensive directory of organizations, centers, and laboratories concerned with speech, hearing, and language.

OFFICE OF THE SECRETARY

Office of Child Development

Hearing and Speech

The Office of Child Development, established in 1969, has advocacy and leadership responsibility for all children, including the handicapped. In line with this responsibility, OCD develops standards and guidelines for health programs; and provides technical assistance to State, public and private agencies in an effort to help handicapped children and youth. Within the Office of Child Development, the Bureau of Child Development Services administers Project Head Start. Head Start was designed as a massive social experiment to break the cycle of poverty. One of the key components of every Head Start Program is health - health education, health screening, and treatment of identified illness or condition.

The goal of the health component of Head Start and all its demonstration programs is to identify and coordinate existing health services to insure provision of health care to preschool children and their families over a long period of time. These programs are making the first attempts to compile a listing of health services for low-income groups at the local level. All programs also focus on nutrition, general health education and the early identification of health problems.

A child who is in poor health will function at a level considerably lower than that of a well child. Head Start centers provide a complete medical examination, including visual acuity and hearing tests. For many children, this is the first time they have seen a doctor or nurse.

Head Start has always had a policy of encouraging enrollment of handicapped children, but in the future, greater emphasis will be placed on their needs. OCD is in the process of working out the details of plans to serve more handicapped children within regular Head Start programs.

In FY 1973, five projects to demonstrate and integrate handicapped children into Head Start classrooms will be announced by OCD and OE's Bureau of the Education for the Handicapped. Effective techniques developed in the experimental projects will be utilized by all Head Start centers as they implement a new policy on enrollment of severely handicapped children. The policy directs increased efforts to identify, recruit and enroll the handicapped. It is consistent with a broad 3-year Head Start improvement plan to stress services tailored to individual needs and will also serve to meet the requirements of a recent legislative provision directing that 10% of Head Start's national enrollment be reserved for severely handicapped children. The mandate was contained in the Economic Opportunity Amendments of 1972.

The new policy on the handicapped will be carried out in three phases: first, local programs will be required to give immediate priority to the handicapped in filling vacancies created by normal turnover; second, summer Head Start programs must make provision for services to the handicapped; and finally, all full-year Head Start programs funded after July 1, 1973 must include plans for service to the handicapped.

Data related to numbers of children served and cost of hearing and speech tests for each child for fiscal years 1972-1974 will not be available until after July 1, 1973.

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. NTID, when construction is completed, will be a residential facility offering post-secondary vocational education and technical training to deaf persons in order to prepare them for successful employment, a training and practicuum center to assist in developing professional manpower to serve the deaf nationally, and a research and demonstration center to influence education of the deaf in general.

The new NTID facilities now under construction include an academic complex, a residence hall and a dining hall commons and are scheduled for completion in January 1974. The fifth interim class, using existing RIT facilities, entered in September 1972. The total current enrollment is 473 students. Current staff which includes instructional, supportive, clerical, administrative, research and training personnel totals 165.

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. NTID also has research and inservice training components.

The obligations for fiscal years 1970-74 are as follows:

	1970 Actual	1971 Actual	1972 Actual	1973 Estimate	1974 Estimate
Salaries and expenses	$2,985,000	$3,980,000	$ 4,636,000	$5,341,000	$5,826,000
Construction	---	220,000	26,190,000	1,915,000	1,400,000
Total	$2,985,000	$4,200,000	$30,826,000	7,256,000	$7,226,000

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 Advisory Committee is required by law to carry out the following functions: (1) make recommendations to the Secretary for the development of a system for gathering information on a periodic basis in order to facilitate the assessment of progress and identification of problems in the education of the deaf; (2) identify emerging needs respecting the education of the deaf, and suggest innovations which give promise of meeting such needs and of otherwise improving the educational prospects of deaf individuals; and (3) suggest promising areas of inquiry to give direction to the research efforts of the Federal Government in improving the education of the deaf.

The obligations for fiscal years 1970-1974 are as follows:

1970 Actual	1971 Actual	1972 Actual	1973 Estimate	1974 Estimate
$100,000	$100,000	$100,000	$100,000	$ 50,000

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, other advanced training or employment. The Public Law authorizes the Secretary, after consultation with the National Advisory Committee on Education of the Deaf, to enter into construction, of such a school. The agreement was signed in May 1969. The school will serve residents of the District of Columbia and nearby states of Virginia, West Virginia, Maryland, Pennsylvania, and Delaware.

The Model Secondary School for the Deaf (MSSD), an experimental school program, will be built on the campus of Gallaudet College. One of the boldest experiments in the history of American education, the third fully operational year of the MSSD, students and staff have come together in a school with no classes in classrooms with no walls, to seek new ways in which today's young deaf students may be educated toward more productive and meaningful lives. In 1973, the MSSD has an enrollment of 110 students and a staff of 94. An open laboratory school which employs computer-assisted education, educational television, and individualized instruction, the MSSD is, hopefully, a promise of things to come for schools for the deaf throughout the country. It is expected that the MSSD will provide an exemplary secondary school program to stimulate the development of similarly excellent programs throughout the nation.

The FY 1970-74 obligations are as follows:

	1970 Actual	1971 Actual	1972 Actual	1973 Estimate	1974 Estimate
Salaries and expenses	$430,000	$2,189,000	$ 2,533,000	$3,625,000	$3,962,000
Construction	137,000	943,000	49,000	1,000,000	40,000
Total	$567,000	$3,132,000	$ 2,582,000	$4,625,000	$4,002,000

ALCOHOLISM

Obligations for Programs in Alcoholism

(In thousands of dollars)

	1970	1971	1972	1973 estimate	1974 estimate
Health Services and Mental Health Administration:					
National Institute of Mental Health	10,151	17,306	86,735	90,444	86,421
Bureau of Community Environmental Management	386	135	41	---	---
Indian Health Service	1/	1/	1/	1/	1/
Subtotal, Health Services and Mental Health Administration	10,537	17,441	86,776	90,444	86,421
National Institutes of Health:					
National Institute of Arthritis, Metabolism, and Digestive Diseases	1/	1/	1/	1/	1/
Social and Rehabilitation Service:					
Rehabilitation Services:					
Basic State grants	18,226	24,647	25,714	27,683	30,450
Innovative grants	324	300	---	---	---
Rehabilitation services projects	783	764	410	403	323
Rehabilitation training	52	15	20	40	---
Rehabilitation research and demonstrations	75	348	---	300	300
Special foreign currency program	100	150	---	100	200
Subtotal, Social and Rehabilitation Service	19,560	26,224	26,144	28,526	31,273
Total	30,097	43,665	112,920	118,970	117,694

1/ Obligations not identifiable

THE SCOPE OF THE PROBLEM

Alcoholism or problem drinking today afflicts an estimated 9 million Americans. Alcohol-related problems are the cause of more than 85,000 deaths in the United States each year. An estimated 2 1/2 million arrests every year are related to alcohol. Alcoholism shortens life expectancy 10 to 12 years. Approximately 35,000 accidental deaths at home, work, or recreation involve abuse of alcohol. One-third of all deaths reported as suicide and one-half of all homicides are alcohol-related. To these statistics must be added immeasurable human costs and suffering -- broken homes, deserted families, and psychological problems -- resulting from alcohol abuse and alcoholism. Alcoholism affects the lives of some 36 million persons in the United States.

In the past, alcoholism was considered mainly a moral or judicial problem. In recent years, however, alcoholism has become recognized as an illness, and alcoholism and alcohol abuse as major public health problems in our society. Because of the tremendous overlap among complicated social, psychological, physical, and cultural factors associated with the nature and development of these problems, a long-term program is necessary for a better understanding of alcohol, its abuse, and alcoholism in our culture and society, and to integrate help for these problems into routine provision of health and social services.

Alcohol abuse and alcoholism drain the United States economy of at least $15 billion a year. Of this total, $10 billion is attributable to lost work time in business, industry, Government, and the military. Another $2 billion is spent for health and welfare services provided to alcoholic persons and their families. Property damage, medical expenses, and other costs account for another $3 to $3.5 billion annually.

About 5 percent of the nation's work force are alcoholic individuals, while almost another 5 percent are serious alcohol abusers. Although the most visible victims of alcoholism are inhabitants of skid rows across the nation, they represent only 3 to 5 percent of the alcoholic population. Public intoxication, however, usually involving skid row inhabitants, accounts for 50 percent or over one million of all arrests reported annually, including arrests for traffic violations.

Among American Indians, alcoholism is at an epidemic level. The rate is at least 10 percent, or twice as high as the national average. On some American Indian reservations the rate runs from 25 to 50 percent.

Alcohol abuse and alcoholism are recognized as major health problems in most developed and many developing nations, but despite the virtual universality of the problems, there has been very little multinational collaboration in developing more effective methods to combat them.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

National Institute of Mental Health

National Institute of Alcohol Abuse and Alcoholism

Among the many interesting developments in the field of alcoholism during the past 2 years, perhaps the most significant event has been the wide-ranging commitment of the Federal government to the problems of alcohol abuse and alcoholism. This commitment signals a change in basic attitudes of the American population, a shift from prior inattention to and neglect of alcohol problems to active interest and concern.

The National Institute on Alcohol Abuse and Alcoholism, created by an Act of the United States Congress (Public Law 91-616), was formally established in May 1971. Fiscal Year 1972 was the Institute's first full year of operations, a year of dynamic growth and challenge. Throughout the country, along with the expansion of programs initiated in FY 1971, there are new programs for alcoholic people such as those for public inebriates and the alcoholism poverty program.

In FY 1972, a great deal of publicity was given to the Secretary's First Special Report to the U. S. Congress on Alcohol & Health and its principal finding that alcohol is the most abused drug in the United States. Model State legislation which is designed to treat alcoholism as an illness instead of a crime is in the process of being adopted by a growing number of States. A nationwide public educational program to reach large numbers of people through the mass media has begun; and a growing amount of research concerning ethyl alcohol and its effects on the human body is underway. In accordance with President Nixon's Health Message delivered to the Congress in February 1971, special efforts are being made to develop new techniques for improving the effectiveness of the health care provided to alcoholic people.

The Institute has two broad goals for its program efforts to reduce the toll taken by alcohol abuse and alcoholism. The immediate goal is to assist in making effective alcoholism treatment and rehabilitation services available at the community level throughout the Nation. The longer range objective is to foster the concept and practice of responsible drinking, to encourage respect and acceptance of an individual's choice not to drink, and to develop other effective methods of preventing problem drinking and alcoholism.

The Institute develops and supports programs to (1) improve treatment services for alcoholic persons in States and communities, (2) treat and rehabilitate employees with drinking problems in Government and private industry, (3) modify public attitudes toward alcoholism and alcohol-related problems by developing a program of education and public information (4) train professional and non-professional personnel, and (5) determine through research the causes and prevention of alcoholism and alcohol abuse. This new Institute is rapidly developing a coordinated national alcoholism program. As

a step toward the accomplishment of this goal, the National Institute on Alcohol Abuse and Alcoholism is providing funds for the development of adequate treatment services for alcoholic persons, based, whenever possible, on existing services.

The Federal resources administered by the NIAAA reach States, communities, and individuals through the activities of four operating Divisions: State and Community Assistance Programs, Special Treatment and Rehabilitation Programs, Prevention, and Research.

DIVISION OF STATE AND COMMUNITY ASSISTANCE PROGRAMS

The Division of State and Community Assistance Programs provides policy guidelines, technical and financial aid, coordination, and evaluation help to State and community organizations and facilities to provide improved alcoholism treatment and rehabilitation services.

State Assistance Programs

The State alcoholism formula grant program was activated in FY 1972 through an appropriation of $30,000,000. Authorized by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 91-616) the formula grant program provides funds to States to assist them in planning, establishing, maintaining, coordinating, and evaluating projects for the development of more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism. Funds were allotted to the States according to a formula which is based upon relative population, financial need, and the demonstrated need for more effective programs. According to the Act, no State shall receive less than $200,000 (with the exception of Guam, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands).

All 50 States, the District of Columbia, Puerto Rico, the Trust Territory of the Pacific Islands, Guam, Samoa, and the Virgin Islands are now participating in the formula grant program.

This new program has been greeted with great enthusiasm, and it is expected that it will have considerable impact on reducing the problems of alcohol abuse and alcoholism.

FY 1972 was a year of laying foundations both within the Institute and within the States. As with the initiation of any new program, work within the Institute centered around the development of regulations and guidelines, training for Regional Office and State agency staff, consultation with Regional Office and State agency staff, and review of State plans. State efforts were devoted to the designation of single State agencies for administering the program, establishment of State advisory councils, surveying existing resources and needs, and developing the essential State plans.

Each State plan is based upon that State's existing resources, needs, and unique characteristics. The quality of the plans and the scope of the proposed activities vary considerably from State to State, reflecting the level of alcoholism program development within each State and the experience and expertise of the designated State agencies. Those States that already have an operating alcoholism treatment and rehabilitation network will utilize a major portion of their formula grant funds for direct services at the community level. The States which are in the beginning stages of alcoholism program development are devoting funds to a deeper survey of need, coordination, community organization, and program planning.

With few exceptions, the State plans still require greater in-depth development. Staff of NIAAA will provide the necessary consultation and assistance. During FY 1974, the Institute will continue to work with the States to improve and update their State plans.

Community Assistance Programs

Community Assistance funds are made available to support community efforts to develop and conduct comprehensive health, training, and planning programs for the treatment of problem drinking and alcoholism. Such support helps cover initial salary costs of professional and technical personnel providing comprehensive alcoholism services and initiation and development of new service programs or other specialized programs and activities.

In FY 1972, a total of 40 new Community Assistance grants were approved and funded:

Comprehensive program staffing grants	14
Initiation and development	11
Direct service	10
Training	5

Total allotments for the 40 approved and funded grants amounted to $8,855,000 for the first year. Thirty-one additional grants were approved but not funded.

Twenty-seven of the 32 comprehensive programs which had been funded in FY 1971 were funded again in FY 1972 for $7,493,540, including supplemental awards. The five remaining FY 1971 programs became operational in FY 1972 under their original funding.

Comprehensive Treatment Programs

When all 46 comprehensive staffing programs in FY 1973 are fully operational, they will provide treatment and rehabilitation services in areas where nearly 400,000 alcoholic people reside. Each of the comprehensive programs provides a range of services including inpatient, outpatient, intermediate, and emergency care, as well as consultation

and education services. The programs are in a variety of community and population situations and include alternative approaches to the treatment and care of alcoholic people. Twenty-three of the comprehensive programs serve designated poverty areas and, therefore, receive preferential poverty funding.

Evaluation is an essential component of these comprehensive treatment programs. The evaluation and monitoring activities tested in eleven (11) treatment centers in FY 1972 were expanded to 41 of the 46 alcoholism treatment centers in October 1972. These activities will enable the Institute not only to take action necessary in FY 1973 to remedy the deficiencies in its centers but also to make appropriate changes in operating policies in the distribution of resources to increase total effectiveness.

The preliminary results of the evaluation system for alcoholism treatment centers, developed in cooperation with the Stanford Research Institute, indicate that some of the centers have had difficulties in providing an effective course of treatment because of patient dropouts and lack of followup. Although this information is now limited and tentative, the Institute has already initiated changes in policies and procedures which should help eliminate many of those initial problems.

Other Community Service Grants

Eleven initiation and development grants were awarded in FY 1972 which will enable 11 communities to survey their needs for alcohol treatment and prevention activities and to develop plans on how best to meet their community situations. The six training grants awarded in FY 1972 provide for in-service training of professional and paraprofessional treatment staff in community facilities. The 10 direct service grants demonstrate to a particular community various programs or methods that can be used to initiate, extend, or improve a delivery system.

DIVISION OF SPECIAL TREATMENT AND REHABILITATION PROGRAMS

Special Projects

The National Institute on Alcohol Abuse and Alcoholism has collaborated with various Federal, State, and local agencies in developing programs to reduce and prevent alcohol-related problems in special population groups. For example, some collaborative programs provide treatment services specifically designed for drinking drivers, American Indians, chronic drunkenness offenders, and low income persons.

The Drinking Driver Program

Among these special treatment and rehabilitation programs is a 10-point interagency collaborative program with the National Highway Traffic Safety Administration (NHTSA) of the Department of Transportation and HEW aimed at reducing the number of deaths and injuries caused by drinking drivers. Under this agreement, NIAAA provides consultation and assistance in the development of the DOT community-oriented Alcohol Safety Action Projects (ASAP) and support for treatment and rehabilitation of problem drinking drivers identified in ASAP operations. In other areas of cooperation, NIAAA's information and education program on the use and misuse of alcohol is coordinated with DOT's information campaign on drinking and driving, and shares research findings.

At present, 35 cities have been approved by the Department of Transportation as sites for their ASAP program and 29 are operational. During FY 1972, the NIAAA supported 10 comprehensive staffing grants for $4,076,497 and 15 demonstration projects for $2,451,000 in these sites. One additional demonstration project for $204,945 is located in a "mini-ASAP" site. "Mini-ASAP" sites are established by the use of DOT State formula funds for communities located outside ASAP sites which have substantial drinking-driving problems.

The NIAAA special demonstration grants within the Drinking Driver program focus both on meeting the needs of problem drinkers and on the future development of comprehensive treatment and rehabilitation services for all alcoholic persons in the community. There are a number of special concerns and directions resulting from the development of the Drinking Driver program. For example, an effort is being made to utilize the highway safety efforts of the Department of Transportation to identify candidates for treatment early in the course of their problems with alcohol abuse. The program also seeks to change the attitudes of police, judges, and probation officers toward accepting the concept of alcoholism as an illness and taking responsibility for directing the drinking driver to treatment.

The development of a cooperative working relationship between NHTSA and NIAAA and the enforcement and the health care systems within each of the ASAP community sites is an example of the way in which States may implement the Uniform Alcoholism and Intoxication Treatment Act. The emphasis becomes one of reeducation, treatment, and rehabilitation rather than the traditional one of imposing fines, jail sentences, or other punishments.

The American Indian Program

The Alcohol and Health Report stated that alcoholism among American Indians is at epidemic level. Support for the planning and delivery of appropriate prevention, treatment, and rehabilitation services for this large population has a high priority within the Institute. The goal of the American Indian program is to assist in

making excellent alcoholism treatment and rehabilitation services available in the Indians' community -- in reservations, rural areas, and large cities. Programs are being developed and supported for the education and training of Indian people and for the development of innovative community services, with emphasis on the importance of giving Indian people the authority and resources to identify and solve the alcohol abuse and alcoholism problems of their own people.

The NIAAA American Indian program began in FY 1971 with the award of 11 contracts and one grant for the development and implementation of alcoholism programs. In FY 1972, 45 Indian programs, including the previously approved programs, were funded for $3,341,726. An additional nine programs were approved but not funded. During FY 1972, negotiations were carried out for the transfer of Indian programs from the Office of Economic Opportunity to NIAAA. The transfer, effective June 30, 1972, included 37 programs from the OEO Indian branch and 10 other Indian alcohol programs. As a result, at the close of FY 1972, the Indian programs to be funded by NIAAA included 45 initiated by NIAAA and 47 transferred from OEO, for a total of 92.

In order to be fully responsive to needs associated with the American Indian alcohol problems, NIAAA also has been cooperating with DHEW Indian Health Service and other Federal agencies that are directly servicing the Indian population.

The Community Alcoholism Services Poverty Program

The Community Alcoholism Services Poverty Program was initiated as an official program of NIAAA in FY 1972. The purpose of this NIAAA program is to demonstrate how a variety of services provided by different service agencies can be coordinated and made available to the low income alcoholic person and his family. It is intended to ensure that alcoholic persons in need will receive appropriate medical, psychotherapeutic, social, educational, and other public and voluntary services.

During FY 1972 much of NIAAA staff effort was devoted to the development of a Program Guide which would provide direction for grantees and yet be flexible enough to allow individual communities to adopt techniques that would effectively meet their needs.

During FY 1972, the Department of Health, Education and Welfare and the Office of Economic Opportunity conducted negotiations to transfer the administrative responsibility for 207 Alcoholism Recovery Projects from OEO to the NIAAA. Under the transfer agreement, signed on May 7, 1972, NIAAA made available to OEO $5,521,000 for use in the Alcohol Poverty Program prior to transfer of the program on July 1, 1972. The NIAAA also agreed to fund, up to 3 years, those programs requiring renewal after July 1, subject to NIAAA staff review and availability of funds. As part of the transfer, a contract with the National Council on Alcoholism, a private, nonprofit organization,

allows six full-time field representatives to continue to provide technical assistance to the transferred programs. In addition, six training sites were transferred.

Since the official transfer of the 207 projects, four regional meetings have been held to open lines of communication and exchange information, and to bring together grantees, State alcoholism authorities, and both NIMH and OEO Regional Office representatives.

Four new poverty program applications, which were not part of the OEO Alcoholism Recovery Projects, were submitted to NIAAA for review in June 1972. Three of these projects, costing $211,826, were recommended for approval.

The Public Inebriate Program

In FY 1972, the Institute initiated a grant program to demonstrate a comprehensive approach to the needs of the public inebriate. Six public inebriate grants were funded for a total of $2,539,844. Two additional grants have been approved but not yet funded. The general objective of the Public Inebriate Program is to develop comprehensive and integrated services for individuals with chronic drunkenness problems, particularly those living in the subculture of skid row. The program will focus upon the common needs of the public inebriate, namely: food, clothing, shelter, medical care, alcoholism treatment services, public welfare services, and vocational assistance. Each project in this program will develop a range of services adapted to the individual's health, employment, and social situation.

In addition to reducing the number of public inebriates and improving the health of those remaining, the program should demonstrate that service for alcoholic people is better through the health care system than the criminal justice system. Likewise, it is anticipated that the health care system will prove to be less costly in the care of the public inebriate than the criminal justice system. Also, it is expected that an intensive inpatient rehabilitation program will be effective when provided for the troubled drinker who has not yet reached skid row. Another objective is to show that the transitional residence can be therapeutically advantageous to those clients who wish, at least initially, to adhere to the values of the skid row subculture.

Other Special Population Groups

NIAAA is concerned with special population groups for whom specially arranged or developed services can have significant impact on the problem of alcohol abuse and alcoholism. Spanish-speaking Americans, as well as offenders within the correctional system, women, and young adults are among the population groups for whom categorical programs do not yet exist within the NIAAA. However, applications for these and other groups are currently being processed

upon receipt within the Special Projects Branch. In FY 1972, a total of 11 applications were received from these groups, six of which were approved and funded for a total of $640,835. Three grants were awarded to provide services to Spanish-speaking people, two for services to offenders within the correctional system, and one for services to women.

OCCUPATIONAL ALCOHOLISM PROGRAMS

During FY 1972, NIAAA Occupational Alcoholism activities were largely devoted to modifying attitudes and concepts in the occupational alcoholism field regarding the identification and treatment of alcoholic people. Through a variety of educational and low-key promotional efforts, the Institute has been promulgating conceptual models for occupational alcoholism programs, and stimulating their implementation and evaluation. The NIAAA has been active in the provision of consultation to the Federal Civil Service Employees Alcoholism Program, the development of training programs for State selected personnel, and the stimulation of research to determine answers related to occupational program activity.

Federal Employees Alcoholism Program

At the end of FY 1972, most Federal agencies had issued instructions for implementing P.L. 91-616 and designated a headquarters-level program administrator to accomplish the program tasks within each agency. Through the cooperative efforts of NIAAA and the Civil Service Commission, these program administrators have participated in monthly training sessions. With NIAAA funds made available to CSC, 30 administrators received scholarships for a 3 week intensive training program, with special emphasis on program implementation in the Federal setting.

Thirty part-time consultants were selected and trained during FY 1972. They are now assisting in both public and private sectors throughout the country giving priority to the implementation of the Federal Employees Program. This consultative field force services military as well as civilian requests from Federal agencies under the guidance of the Regional Occupational Health Representatives of the Civil Service Commission.

Military Services

The Department of the Army has been preparing guidelines, with consultation from the Institute, for implementing troubled employee programs for all commands. Further, with consultation from the NIAAA, the First Army has developed a training seminar for selected installation personnel which demonstrates how NIAAA and CSC resources can be used to implement programs following the Civil Service guidelines. In addition, a demonstration effort funded by the NIAAA is underway in the

Third Army area to coordinate the military identification program with both military and civilian treatment resources. The NIAAA has continued to make its regional consultants available to Army posts and installations upon request.

The Department of the Navy has also received frequent consultative support from the Institute on the development of its program. Specific evaluation support has been supplied upon request.

State Occupational Staffing Program

During FY 1972, grants totaling $2,569,589 were awarded to 48 States and two territories to initiate an occupational alcoholism program within each State to consist of two staff members, one to focus on State and local governments and the other to focus on the private sector. These consultants willprovide uniform guidance in their consultative efforts throughout the country. The average award to each State is approximately $50,000.

Training Effort For State Occupational Staffs

The lack of trained manpower for providing consultation to the States through the program described above necessitated a National training effort for State personnel. The training effort is an ongoing 18-month program using occupational Regional Consultants as problem solvers and trouble shooters. At the conclusion of training, it is expected that 115 top occupational consultants with high level expertise will be prepared to help improve the quality of each State program.

Demonstration Projects

The exact nature of effective, industrially oriented treatment resources is still open to question. In FY 1972 ten grants totaling $1,773,963 were awarded to stimulate a variety of sponsors to establish such a resource. A variety of behavioral, caregiving facilities to meet industrial needs have been set up across the country analogous to those physical health resources already available to most industrial organizations. A research evaluation contract with Stanford Research Institute provides for the overall evaluation and comparative analysis of these programs.

Research Efforts

During FY 1972, the NIAAA stimulated a series of research efforts designed to answer specific questions related to industrial alcoholism programs and to provide more effective application of program concepts and directions. These include analyses of: (1) the roles of middle management in the development of social action programs within private industry and the Federal Government; (2) the role and impact on State alcoholism programs of the occupational alcoholism program

consultants; (3) the linkage between identification of alcoholic persons and their subsequent treatment in a variety of industrial program settings to determine those factors that tend to inhibit the smoothness of such linkage; and (4) the dynamics of Alcoholics Anonymous to allow translation of these dynamics into terms that are understandable to the professional.

DIVISION OF PREVENTION

The Division of Prevention was officially activated in September 1972 and is comprised of two branches -- Community Education and Youth Education. Although the Division is new, a number of programs in prevention have been in a developmental stage since the creation of NIAAA. An inventory is being made of prevention projects currently designated to other programs throughout NIAAA, and, where appropriate, these will be placed under the responsibility of the new Division.

Community Prevention

A major effort has been undertaken to involve a broader cross-section of American citizens in voluntary efforts to overcome the growing problem of alcohol abuse and alcoholism. The NIAAA and the United States Junior Chamber of Commerce, with its 500,000 Jaycees, have, for example, joined in a nationwide campaign to provide information on the preventive aspects of alcohol abuse. A grant of $250,000 has been provided. In addition to the community endeavor, the Jaycees are providing educational information to school districts and other youth organizations.

The National Congress of Parents and Teachers is currently working with NIAAA to provide parents of school-age children with educational information on alcohol abuse and alcoholism. Another program currently underway is a special project developed with the Chemawa Indian School Advisory Board. Consultation is being provided by the Bureau of Indian Affairs, Department of Interior, and the DHEW Indian Health Service. Four additional prevention programs are being reviewed for possible funding during FY 1973.

The Institute has established a close working relationship with the National Clearinghouse for Alcohol Information (discussed later in the Report) for the purpose of monitoring and indexing prevention information which can be made available to States, regions and other interested agencies. The Institute has also joined the National Smoking and Health Clearinghouse in the utilization of a community laboratory project for the purpose of developing educational techniques which are applicable to the prevention of both smoking and alcohol abuse.

Youth Education

The NIAAA is working with the DHEW Office of Education in the development of visual aids and print material on alcohol education

that will meet the needs of students, Grades K through 12, across the Nation. The Institute is also working with the Office of Alcohol Countermeasures in Department of Transportation to develop a curriculum guide for alcohol education as it relates to traffic safety for public school usage.

The NIAAA and the Seattle Public Schools, Seattle, Washington, have entered into a collaborative project for students, Grades 4 to 7. In addition to intensive teacher training in alcohol abuse and alcoholism, the curriculum for students has been developed by the School District. There is also wide participation among parents of the children.

Fifteen requests for assistance in youth education are currently being reviewed and evaluated to determine whether funding is feasible and what other assistance might be provided by the NIAAA. Consideration is being given to awarding two contracts on a competitive basis, one to a major inner-city school district, and one to an urban school district. These contracts would cover the development of curriculum materials and training strategies for teachers and administrators in alcohol abuse and alcoholism with the intent that the products could become prototypes to be used nationwide.

In FY 1972, an instrument was developed for surveying teenage drinking attitudes and behavior. The national survey, which is to be carried out in FY 1973, should be a major contribution toward designing more effective programs of education and prevention for young people.

Several research studies, funded through the Extramural Research Branch, are being conducted in the area of youth and prevention. One study attempts to clarify the relative contribution of heredity and environment to the development of alcoholism by studying adopted children whose biological parents were alcoholic. Another study has the potential for adding much needed information regarding the relative effectiveness of various ways to carry out educational preventive programs with adolescents.

Manpower Development

Progress against alcoholism problems to date has been hampered by the small number of expert and knowledgeable people working in this health area. The major objective of the training program of the National Institute on Alcohol Abuse and Alcoholism is to increase the source of manpower to treat and eventually prevent problems of alcohol misuse. A high priority has been given to funding programs to introduce and include information about alcoholism in the curricula of schools of medicine, social work, nursing, public health, psychiatry, and psychology. Other training program objectives are the development of alcohol specialists to take leadership roles in

training, research, public education, and administration; alcoholism training for hospital staff and private practitioners; and training of alcoholism counselors to function in both clinical and coordinating roles.

Some of the types of training programs supported by the Institute are as follows: Initiation of multidisciplinary workshops for professionals in the field; exploration of methods by which para-professionals and lay workers may be trained to work with minimal supervision; development of programs to prepare technicians for work in alcoholism; expansion of fellowship opportunities for special graduate study in social work, the behavioral sciences, chemistry, and biology; and provision of specialized training in prevention for qualified medical residents. During FY 1972, 48 training grants and seven fellowships totaling $4,074,000 were supported by the National Institute on Alcohol Abuse and Alcoholism.

The Institute is currently emphasizing the development of programs which concentrate on individuals who will work with alcoholic employees, drinking drivers, American Indians, and public inebriates, as well as the general public. Effort is being made to develop a group of well-trained individuals who in turn can develop alcoholism training programs, thereby increasing the number of persons receiving training.

The Direct Operations subactivity under Manpower Development provides the staff and resources for administration and direction of the alcoholism training program.

During FY 1974, the Institute will continue to support projects started in prior years. Priority will be given to new projects focusing on training personnel to work in prevention and treatment activities on the community level, in particular the development of a NIAAA National Training Center to serve as an innovative and forward-looking provider of models of excellence in alcoholism training programs.

National Training Center

The establishment of a NIAAA National Training Center in the Greater Washington Area will assist in the development of State and community-based leadership in alcoholism program developments. The Center will also strengthen the working relationships between alcoholism leaders in the public and private sectors at the national, State, and local levels. In addition, the NIAAA National Training Center proposes to assist in the identification and provision of teaching programs and in the training of practitioners in job skills which would aid in the development of leadership in these areas throughout the alcoholism treatment community.

The National Training Center will include five components: Leadership Training for policy makers and State and regional leaders; an Experimental Training Laboratory; a Resident Scholar and Fellow Program; a Curriculum Development component; and, a survey of all

private and public sector training activities at the local, State, and national levels in progress in the area of alcoholism problems.

DIVISION OF RESEARCH

Extramural Research

The primary goal of the Institute's Extramural Research is to foster the development of effective methods of preventing and treating alcoholism and alcohol abuse. To achieve this objective, the Institute supports a broad program of research on etiology, diagnosis, treatment, and prevention of alcoholism.

Since alcoholism is the product of a comple nteraction of biological, psychological, and social factors, hope for developing a better understanding of its causes, natural history, and treatment lies in a wide range of research in all relevant disciplines. The NIAAA encourages and supports basic and applied investigations in universities, medical schools, and other institutions. Projects are supported to develop and evaluate new techniques, approaches, and methods for the treatment and prevention of alcoholism and the rehabilitation of alcoholic persons and problem drinkers.

During FY 1972, the Institute approved 91 research projects covering a wide range of problems associated with the use and abuse of alcohol. Of these, 76 were funded in FY 1972, while 15 were deferred for funding until FY 1973. Among the approved applications were 15 requests specifically programed as new health initiative projects in the NIAAA priority areas of research on treatment and on special target populations.

The NIAAA's extramural research grants program included 151 new and continuing grants totaling $10,234,767. This includes 31 health initiative grants funded for a total of $2,739,767. These health initiative grants have been awarded for research on the psychological and the medical treatment of alcoholic patients; the assessment of drinking problems and practices of urban American Indians; cross-cultural studies of problem drinking of Irish-Americans; the identification of the employed alcoholic person and his supervisor's attitude towards his drinking problems; and the drinking driver problem. Because these projects are in priority areas of the Institute, they will be closely followed in order to bring forward research results as soon as they become available.

The remaining 120 projects were funded under the regular NIAAA grant program for a total of $7,495,000. Grants were awarded for basic and applied studies on the behavioral and biomedical aspects of the effects of alcohol abuse, treatment and rehabilitation, prevention, and the etiology of alcoholism.

The following provides more detailed and descriptive information regarding some of the grants awarded in the various areas of the grant program.

During FY 1974, the Institute will continue to support projects started in prior years. Increased emphasis for new projects will be placed on the redirection of research activity toward determining and developing improved prevention and treatment techniques.

Extramural Research also conducts collaborative studies with non-Institute researchers. Four projects have been or are now being completed. One study involved a project on devising a personality inventory scale for differentiating alcoholic from psychiatric patients. Another study of personality showed that there may be a significant difference between alcoholic patients and heroin addict patients in psychiatric facilities. A third study suggested that a national driver register of convicted drunken drivers may serve as a useful means of case finding of alcoholic persons. A study now in progress will evaluate data collected on fatal vehicular accidents.

Grants For University-Based Centers

During FY 1972, funding was continued for three grants awarded to university medical schools for the support of multidisciplinary research centers. The program was established for the purpose of conducting research from a variety of perspectives, including psychiatry, psychology, biochemistry, and physiology. In addition to recruiting scientists into alcoholism research, each center maintains an active program for research training. The training program has attracted highly qualified young scientists to work on alcohol problems, and it is gratifying to note that one of these trainees received the Hofheimer Prize for Research from the American Psychiatric Association for his research on half-siblings which was also supported by funds from this grant. The results of this research suggest that genetic factors seem to be more relevant than environmental factors, even in instances where a half-sibling was raised by nonalcoholic substitute parents from early infancy. Though these findings are based on well-designed research, further work is required to reach more definitive conclusions.

Biomedical Studies

The largest number of grants and funds were awarded for basic and applied research into the biological aspects of alcohol effects. There is a continuing interest in mechanisms concerned with the metabolism of alcohol, the etiology of liver cirrhosis, and other alcohol-related diseases, and the study of the withdrawal syndrome and its treatment. In one study, a number of chemical substances are being investigated regarding their capacity to activate the enzyme mainly responsible for the metabolism of alcohol. The development of such a substance would enhance the efficiency of the enzyme and thereby accelerate the degradation of alcohol in the body. Recent findings in this study indicate that several compounds were found which increase twentyfold the activity of the enzyme.

Another line of research relates to the formation of neurochemical substances which may be associated with alcoholic addiction. Earlier research suggested that addiction to alcohol and to morphine may have a common basis; subsequent studies, however, have not corroborated these findings and have challenged the earlier conclusions. Several research projects are addressed to this crucial problem which, if fully elucidated, would be invaluable in developing a medical approach to the treatment and prevention of alcoholism.

One clinical study incorporating an extensive medical screening of alcoholic patients uncovered a significant incidence of abnormalities of the mechanisms regulating carbohydrate metabolism. The research will continue in order to establish the clinical utility of these findings in the therapeutic and prophylactic management of abstinent alcoholic subjects.

Treatment Studies

In FY 1972, the research grant program increased its emphasis on studies of psychological and social treatment methods for alcoholism, projects designed to develop and assess the efficacy of new treatment modalities. Three projects in this area focus on the alcoholic person in the context of his family. One project will attempt to describe how family systems use and abuse alcohol and to evaluate changes in families participating in a novel family-oriented treatment program. Another project will investigate verbal and nonverbal communication patterns between the alcoholic person and members of his family. In families with an alcoholic member, alcohol serves a function different from that in the majority of families without an alcoholic member. By employing new techniques for recording and analyzing social interaction, it is hoped that these projects will yield insight into the role alcohol plays in the family unit. A third project will study the methods families use in coping with alcoholism and utilization of community resources such as Alcoholics Anonymous and church organizations.

Recently concluded projects or those soon to be completed may have far-reaching implications for health-care and treatment procedures. A complex study of the therapeutic effectiveness of several treatment methods will be concluded next year. A preliminary examination of the limited data on readmission rates suggests that some alcoholic patients receiving detoxification services are returning to the hospital at a greater frequency than patients in other experimental groups. The research team developed the impression that implosive therapy may be less successful with some patients than other forms of individual treatment and that for some patients, intensive aftercare is not more effective than standard aftercare. Readmission is a crude indicator of treatment outcome and the suggested findings remain to be confirmed by more differentiating data based on such variables as social, financial, legal, employment, and drinking outcome measures.

A monograph will be published reporting the results of a project evaluating the impact of an alcoholism information and referral service in a large city, noting that a more effective system of referral to

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bring alcoholic persons into treatment may be developed. The data indicate that providing more services of an individualized nature, such as establishing appointments for treatment with a followup, results in more persons being reached for treatment. On the other hand, persons with few problems, or problems of minor dimension, tend not to follow through after referral. Clearly, these findings demonstrate that those persons who may be helped the most because they may have fewer alcohol-related problems are not recruited into the treatment process and, if the referral service were to pay more attention to these clients, the longer range benefits to the patient and his family are obvious.

Studies concerning differentiation among subtypes of alcoholic persons continue to be funded by the Institute. Since these projects are still in the data collection stage, no results can be reported as yet. It is expected that, as subtypes are identified and specific treatments are devised which are maximally effective for each group, a higher treatment success ratio can be achieved.

Highway Safety

During the past fiscal year, five new projects related to the problem of alcohol and driving have been added to the two previously funded. This is an area of urgent need for study because of the seriousness of the consequences of driving while under the influence of alcohol. The projects are concerned with the effects of alcohol on driving skills and performance; the assessment of tests for alcohol-produced behavioral impairment; and the relationship between social-psychological attributes and driving behavior of youthful drivers. One study of special interest is a 2-year evaluation of the impact of recently passed legislation in one State which automatically will impose a jail sentence of 48 hours and driver's license revocation of up to 6 months for a first offender convicted of drunken driving. The results from this study will clarify the effectiveness of such legislative sanctions.

Laboratory of Alcohol Research

Structure and Objectives

The Laboratory of Alcohol Research at the St. Elizabeths Hospital, Washington, D. C., is the intramural research component of the Institute. The primary focus of the Laboratory is an interdisciplinary analysis of the biological and behavioral parallels of alcoholism in man and animals and the development of new approaches to these fundamental questions. In the area of clinical and applied research, the recommended examination of factors which influence the reinitiation and persistence of drinking and the study of concomitant metabolic changes during intoxication and withdrawal have long been a primary focus of the Laboratory's concern. Moreover, during the past 4 years,

studies from the Laboratory of Alcohol Research on the effects of alcohol on adrenal function in alcoholic persons have laid the basis for the application of pharmacological blocking agents (i.e., the Beta adrenergic blockers) which may be significant in the treatment of alcoholism. The clinical program of the Laboratory is now preparing a major reorientation of its research. It is planning to study alcohol problems in the context of married couples and to develop methods suitable for treating families with an alcohol problem.

A second major concern of the NIAAA has been enhancement of interdisciplinary training of biomedical scientists for work in the field of alcoholism. Since its inception, the Laboratory has maintained a Visiting Scientist Program and has attracted investigators both from the U.S.A. and other countries for 1 to 3 year periods of research training and collaboration with senior investigators on the Laboratory of Alcohol Research staff.

Publications and Activities

During FY 1972, NIAAA has published 25 papers in scientific journals. These research papers cover a variety of topics ranging from the effects of alcohol on emotions, memory, sleep, and social interactions to the study of alcohol effects on blood methanol accumulation, adrenal and liver function, as well as alcohol addiction.

Intra-Governmental and University Collaboration

During FY 1972, the Laboratory has developed collaborative research projects with the NIMH Laboratory of Preclinical Pharmacology and the Laboratory of Clinical Science. In addition, the Laboratory of Alcohol Research is continuing its collaboration with the NIH National Institute of Arthritis, Metabolism, and Digestive Diseases; the Department of Psychiatry, Harvard Medical School; and the Texas Research Institute of Sciences in Houston.

If the problems of alcohol abuse and alcoholism are to be reduced, the Nation must be made aware of the facts and problems of alcohol use and misuse. The National Institute on Alcohol Abuse and Alcoholism is committed to the development and activation of a national education and information program to communicate facts about the effects of alcohol and its dangers in an endeavor to change the public attitudes and behavioral practices which lead to alcohol abuse and alcoholism.

As a complement to its treatment, rehabilitation, and prevention programs, the Institute is working to create greater awareness and concern for this major national health problem through public and professional information programs and national education projects.

NIAAA's information and education programs in the alcoholism area started in 1971 and expanded in 1972. Initial efforts were devoted to building a foundation of awareness of the nature and scope of alcohol-

related problems in the United States. This has been carried out through such means as public service advertising, surveys of existing printed materials and films on alcohol, development of general and scientific publications, and production of a film for junior high and high school use. The Institute has developed a nationwide advertising campaign to build a public awareness of the nature and scope of alcohol-related problems.

National Clearinghouse on Alcohol Information (NCALI)

The Clearinghouse, which was established in 1972, serves as the national focal point for the collection and dissemination of technical and public information on alcohol abuse and alcoholism. Support services will be provided by General Electric which was awarded a $993,000 1-year contract by NIAAA. It will disseminate a wide range of information prepared for medical and scientific personnel and for the public at large. Among the many activities of the Clearinghouse are the acquisition and processing of various materials on alcohol and related topics; establishment of a materials repository and library; compilation and indexing of a source availability list; production of a guide to selected technical documents; utilization of automated data processing systems; replying to public inquiries and requests; distribution of documents; publishing a NCALI bulletin and a quarterly newsletter; and preparation of directories of Federally-supported alcoholism programs. In addition, standard and nonstandard responses, as appropriate, will be mailed to the millions of Americans who request information as a result of the advertising campaign.

During FY 1974, the Institute will continue those activities initiated in FY 1972 and FY 1973. The activities of the National Clearinghouse on Alcohol Information will be closely evaluated, realigned, and refined in order to improve and enhance the distribution of alcohol information. With the expanding nature of the Federal alcoholism effort and recognition of alcoholism as America's largest "hidden" health problem, the Clearinghouse will play an important role in helping to fulfill the goals and objectives of the NIAAA.

Health Initiative Program

The President's Health Initiative Message of February 1971 directed the Department of Health, Education, and Welfare to focus research in the field of health care services on new techniques of improving the productivity of our medical system, and in so doing, to establish pilot experimental and demonstration projects, disseminate the results, and encourage the health industry and medical professions to bring the techniques into full and effective use.

In FY 1972, $7 million was allocated to NIAAA to accomplish this goal.

A total of 51 grants and contracts were awarded out of these funds in FY 1972.

The following is the breakdown, by area, of the number of projects initiated:

(a) Eleven surveys which are aimed at assessing existing resources and additional needs;

(b) Fifteen projects to develop and evaluate innovative, preventive, and treatment modalities, some of which may later be applied on a broad scale;

(c) Twelve demonstration projects employing innovative techniques of service delivery for alcoholic people, incorporating adequate evaluation measures; and

(d) Thirteen projects to study concepts related to the development of innovative treatment modalities.

Program Support

The Program Support function of the National Institute on Alcohol Abuse and Alcoholism provides staff, planning, direction, and evaluation for the various programs within NIAAA.

Since its inception, the Institute has developed and implemented a rigorous evaluation program for all the treatment and rehabilitation activities it supports in conjunction with the start-up of program operations. The primary purpose of this emphasis on early evaluation is to provide information for improved program management, rational decisionmaking, and to add to the collective knowledge at both local and national levels regarding effectiveness of alcoholism treatment and rehabilitation modalities. Several contracts have been awarded for evaluations in such areas as: grant programs in support of the American Indian; activities of NIAAA's community assistance Alcoholism Treatment Centers; the program aimed at the largest group of individuals suffering from alcoholism -- the employed population; and, the effectiveness of the Public Education Campaign being conducted by the Institute. In addition, the Institute is sponsoring a project to measure the effectiveness and efficiency of the OEO alcohol programs transferred to NIAAA in order to determine how well they are meeting their objectives and to develop an ongoing system for monitoring program progress. This concept of factually documenting all alcoholism program activities in order to monitor their effectiveness and to provide inputs for improved management will be continued as a primary policy of the Institute.

PROGRAM COORDINATION

In addition to the specific program coordination activities described in other sections of this Report, action to achieve more comprehensive program linkage was begun during FY 1972. The focus was on a better framework for the integration of related programs and coordination of all programatic activities. Emphasis has been placed on facilitating program planning and support of program evaluation.

Collaboration With Other Agencies

Realistic integration was demonstrated in gaining the cooperation and involvement of other agencies whose resources are needed by alcoholic people. Agreements were developed for the utilization of each agency's resources in collaboration with NIAAA.

The Institute devoted $2,138,892 in FY 1972 towards developing a number of such projects with other agencies of the Department of Health, Education, and Welfare and with other Federal Departments.

NIAAA is working with the Office of Education, for example, on a collaborative project for the development and testing of teaching materials and techniques for developing a lifestyle of responsible behavior for young people, particularly with respect to the nonuse or responsible use of alcoholic beverages.

Coordinated efforts are being made by NIAAA and the Rehabilitation Services Administration in the major area of vocational rehabilitation. Counseling in this area is a significant element of a comprehensive rehabilitation program, and the network of vocational rehabilitation resources spread throughout the country should be used to provide services adapted to alcoholic people.

The Institute and the Clearinghouse for Smoking and Health are providing collaborative funding to include alcoholism education programs, utilizing special techniques developed by the Clearinghouse.

The Institute has worked closely with the Civil Service Commission and other agency and Department administrators, including the military services, in activating the Federal Employees Alcoholism Program.

A 10-point interagency collaborative program was worked out in FY 1971 between the Secretary of Health, Education, and Welfare and the Secretary of Transportation. This agreement had facilitated coordination of NIAAA and NHTSA efforts in establishing the DOT community-oriented Alcohol Safety Action Projects. It has also served to coordinate the public education programs of the two agencies.

The Institute has initiated several international research projects ranging from the epidemiology of alcoholism to the evaluation of effectiveness of various treatment methods. The Institute also

initiated several international research projects ranging from the epidemiology of alcoholism to the evaluation of effectiveness of various treatment methods. The Institute also initiated proposals for multinational research projects under auspices of the World Health Organization which may result in a major research agreement with WHO in 1973. As a result of discussions with the Director of the Pan American Health Organization, a pioneering study project is now underway in Latin America. The project has four objectives; to gain knowledge of the current attitudes and prevalence of problem drinking, to determine the role played by alcohol in accidents and violence, to promote the establishment of centers for study of alcoholism, and to disseminate information concerning research, prevention and treatment services, and training programs.

Indian Health Service

Special Approach for the Indian Population

In 1969 an Indian Health Service Task Force on Alcoholism stated that "the majority of suicides, murders, accidental deaths, and injuries are associated with excessive drinking, as are many cases of infections, cirrhosis, and malnutrition. By far, the majority of arrests, fines, and imprisonments are the result of drinking (76 percent)." As a part of the President's message to the American Indians in July 1970, additional dollars were committed to begin development of needed special programs. Among these monies, $1,200,000 was pledged from OEO, and $750,000 was pledged from the National Institute of Mental Health. A combined total of 32 alcoholism projects were funded by both agencies under the leadership of the Indian Health Service, in F.Y. 1971.

With the development of the National Institute on Alcohol Abuse and Alcoholism in F.Y. 1972, the OEO funded projects totalling $1.2 million were transferred to NIAAA.

In addition, NIAAA funded Indian alcoholism programs totalling $2,700,000 in fiscal year 1972.

The problem of alcohol abuse and alcoholism among Indian people requires excellent technical assistance in developing Indian alcoholism programs, training for Indian people, research into psycho-social variables of alcohol abuse and alcoholism among Indian people and sufficient funding, in order to deal effectively with this major health problem. The Indian Health Service and the NIAAA are in agreement on this approach together with the Indian community whose input helps clarify what the objectives should be, and who will assist in setting national policy with respect to the delivery of more effective alcoholism services to the American Indian and Alaskan Native communities.

NATIONAL INSTITUTES OF HEALTH

National Institute of Arthritis, Metabolism, and Digestive Diseases

The National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD) supports substantial research in alcoholism, but is concerned largely with ethanol (alcohol) metabolism and the effects of ethanol upon various organs, particularly the liver. In recent months, several significant findings have emerged from this line of research.

At the University of North Carolina a 5-year NIAMDD grant-supported study of alcoholic hepatitis by Dr. Harold J. Fallon has shown that treatment with the steroid drug prednisolone may substantially improve the prognosis of severely ill alcoholic subjects with hepatic encephalopathy. All such patients who did not receive the steroid drug died within the first 1-12 weeks of the study; however, all but one of the prednisolone-treated subjects were still alive during the 1-4 year follow-up period.

Prednisolone apparently had little or no direct effect on liver function, or on the appearance of the liver tissues. A significant increase in mean daily caloric intake, however, was noted, in patients given the drug. This was observed in both severely and moderately ill subjects, suggesting that prednisolone's effect is indirect and is related to improved caloric intake.

Dr. Fallon concluded that survival in severely ill alcoholic patients with hepatic encephalopathy (toxic brain syndrome from liver degeneration) is poor, and that it is improved markedly by prednisolone therapy, at least for the type of patients entered in this particular study.

At the Mount Sinai School of Medicine, New York, Dr. Charles S. Lieber, also supported by a NIAMDD grant, has shown that chronic ethanol ingestion produces abnormalities in the very fine structures of tissues in the small intestine strikingly similar to those seen in the liver.

The investigator had previously reported that chronic alcohol ingestion, even in the absence of nutritional deficiency, is associated with subcellular abnormalities in the liver (eventually followed by cirrhosis). He now has described similar ultrastructural changes in the small intestine, which could account for the intestinal dysfunction and diarrhea frequently associated with chronic alcoholism.

As revealed by electron microscopy, chronic ethanol administration led to striking ultrastructural changes in the small intestine. The observed alterations are remarkably similar to those produced by ethanol in the liver and suggest that ethanol is injurious to the small intestine even in the absence of nutritional deficiency. The effects of alcohol on the liver are known to be more pronounced in man than in the rat, and the present results indicate that this species difference appears to hold true for the intestine as well.

Since ethanol is well absorbed in the stomach and upper intestine, it is improbable that the observed abnormalities were caused by contact with ethanol during its absorption. Their persistence during the post-ethanol period suggests that they may be related to the slow recovery of absorption in some alcoholic patients, which may take months.

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

Rehabilitation Services Administration--A steadily increasing number of alcoholics are being provided services by State rehabilitation agencies, and restored to gainful employment. In Fiscal Year 1972, an estimated 15,000 alcoholics were rehabilitated, a figure expected to rise to 16,000 in 1973 and 17,500 in 1974. Alcoholics now constitute about 5% of clients rehabilitated from all categories of disability by the State agencies.

The Rehabilitation Services Administration has utilized special grant resources to encourage the development of programs for the alcoholic. For example, an Expansion grant was made to the Wisconsin Division of Vocational Rehabilitation for the establishment of a comprehensive program for rehabilitation for alcoholics in Northwestern Wisconsin involving nearly 500,000 people. Another Expansion grant has been made to the District of Columbia, Department of Rehabilitation, for a project designed to establish an aftercase facility with team services for alcoholic clients during their readjustment period. The Gila River Indian Community received an Expansion grant through the Arizona Division of Vocational Rehabilitation providing vocational rehabilitation services to an alcoholic program on the Reservation.

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 has provided multiple new resources to combat alcoholism. The Rehabilitation Services Administration has completed a cooperative agreement with the National Institute of Alcohol Abuse and Alcoholism to develop close linkages between the two agencies. This has led to: (1) collaboration in a series of planned action steps aimed at developing a network of integrated treatment-vocational rehabilitation services for the alcoholic; and (2) the initiation of 8 jointly-monitored Expansion projects in rehabilitation of the alcoholic located in Alabama, Alaska, Connecticut, Florida, New Jersey, Texas, Washington and Wisconsin.

Short-term training in alcoholism for State agency personnel has been supported by the Rehabilitation Services Administration. A national conference of State alcoholism and vocational rehabilitation agency directors is also planned for FY 73 to encourage cooperative programming by these agencies.

Office of Planning, Research, and Training

Office of Planning, Research, and Training--As in the case 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 longterm 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.

Especially necessary for future study is development of methods of reaching the alcoholics in ghetto areas and providing innovative services to minority groups with special need; for example, American Indians.

During 1973 a longitudinal study of the durability of rehabilitation of alcoholics provided services by State vocational rehabilitation agencies will be undertaken as well as evaluation of eight expansion projects supported by transfer funds from the National Institute of Alcoholic Abuse and Alcoholism.

Also administered by this Office is the Special Foreign Currency Program. Evaluation and reports on progressive action programs 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. There is a greater recognition by programmers in this field, that these men and women need social and psychological rehabilitation services. New projects emphasize an interdisciplinary approach to ascertain the most efficient methods of bringing about vocational rehabilitation in a community setting for alcoholics and problem drinkers.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ACTIVITIES SERVING OLDER AMERICANS

1972

(Report compiled by the Administration on Aging)

The Nation's elderly have a variety of needs in differing combinations. To meet this variety of needs, a wide range of programs was administered during 1972 by several agencies throughout the Department of Health, Education, and Welfare. This report describes, in the following order, the activities of agencies which administer the major programs serving Americans aged 65 and over.

I. Social and Rehabilitation Service

- A. Administration on Aging
- B. Assistance Payments Administration
- C. Medical Services Administration
- D. Rehabilitation Services Administration
- E. Office of Planning, Research, and Training
- F. Community Services Administration

II. Public Health Service

- A. National Institute of Child Health and Human Development of the National Institutes of Health
- B. Health Services and Mental Health Administration

III. Social Security Administration

IV. Office of Education

I. SOCIAL AND REHABILITATION SERVICE

Among the services and benefits for older Americans rendered by the Social and Rehabilitation Service are rehabilitation services, cash benefits, social services, and medical assistance for the needy aged; rehabilitation services for the handicapped aged; and a variety of programs and services to help the elderly solve their problems and take advantage of their opportunities.

Within the Social and Rehabilitation Service, the Administration on Aging, the Assistance Payments Administration, the Medical Services Administration, the Rehabilitation Services Administration, the Community Services Administration, and the Office of Planning, Research, and Training all have responsibility for programs serving older persons. The Administration on Aging, while maintaining overall responsibility for the aging, joins with and works together with the other components of the Social and Rehabilitation Service in meeting social and rehabilitation service needs of the aged.

In the field, the activities of the Social and Rehabilitation Service are supervised by a Regional Commissioner, located in each of the ten HEW regions. Through these regional offices technical assistance is provided to State and other Federal agencies. SRS is thus 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 1972 by the components of SRS are described separately in the reports which follow.

There are approximately 21,000,000 Americans over 65. In 1971, about 4,300,000 were below the poverty line. An estimated 1,000,000 are institutionalized with a sizeable number of these people institutionalized unnecessarily. Furthermore, it is estimated that 5,000,000 older Americans live alone, very often in virtual isolation. Additional contributing factors to the problems of the elderly are wholly inadequate nutrition, chronic health problems, and the lack of adequate transportation and other services. All of these problems combine to aggravate the mental and physical deterioration of the elderly.

The Administration on Aging was created by the Older Americans Act of 1965 to provide assistance in the development of new or improvised programs to help older Americans, and to serve as the focal point for the Federal Government's concern for the needs and problems of the aging. 1972 was the post-White House Conference on Aging year. Initial actions were taken in the transition to the restructured and expanded Title III and the new Nutrition Program. The following is a summary of the major activities undertaken by the Administration on Aging during the past year.

State Agency Activities

The primary mission of State agencies is to: (1) be the focal point in the State on all matters related to the aged and aging; (2) be the primary point of contact for the Administration on Aging on all matters concerning the aged relating to State and local governments; and (3) be the primary force in State government for mobilizing all available resources and programs for meeting the identified priority needs of the elderly in the State.

These funds are used to carry out the following State agency responsibilities:

- Development of the annual operating plan.
- Administration of the State plan.
- Evaluation of activities under the plan.
- Collection of data and research related to the need for social and nutritional services.
- Dissemination of such information.
- Provision of technical assistance to public or non-profit private agencies related to the problems of older persons.
- Carrying out program coordination and development with other State agencies concerned with problems of the elderly.
- Carrying out demonstration projects relating to the initiation, expansion or improvement of social or nutritional services.
- Training of staff.

In 1972 the State agency staffs were significantly strenghthened and will be roughly doubled prior to the end of FY 73. This increase was and is being accepted in order to raise staffs to a manpower level capable of providing effective State planning, coordination, and evaluation on behalf of the elderly population of the State. This included planning for and implementing new initiatives and greater thrusts in comprehensive State and local planning, nutrition, advocacy for all Federal programs for the elderly within the State, mobilization of public and private resources to meet the problems of the State elderly, and increased em-

phasis on evaluation at all program levels to include a more systematic, thorough and measurable collection and analysis of program data to effectively evaluate program results.

A comprehensive training and technical assistance strategy was designed and development was begun on a training package for Area Agency on Aging Staffs on area planning, community organization and evaluation. A separate training package is being developed for the staff of nutrition projects. In late 1972, program regulations were published for the Title VII Nutrition program. Program guidelines and a comprehensive handbook for project directors were also issued. These documents are important tools provided to State agency and local personnel for effective program implementation.

Technical assistance contracts were awarded in each region to provide necessary assistance to State and local agencies in their implementation of the new Title VII Nutrition program with a primary focus on development of strong local projects.

During the past year, State agencies on aging completed the initial phase of their statewide planning responsibilities which included the following:

1. The completion of a study of the Status and Needs of the Elderly in the State; and

2. The completion of a report on Achievements of State Programs for the Aging.

These planning activities and achievements will enable the State agency to expand its leadership capacity and planning and programming activities for the aging. Subsequent phases of statewide planning activities will build upon this data foundation.

Area Planning and Social Service Programs

The purpose of this activity is: to provide a focal point and leadership at the sub-State level for advocacy, planning, coordination, evaluation, administration and program monitoring of activities in aging; and to develop comprehensive and coordinated community based service systems for older people within a defined geographic area. The thrust of this activity is: to secure and maintain maximum independence and dignity in a home environment for older persons capable of self-care with appropriate supportive services; and to remove individual and social barriers to economic and personal independence for older persons.

1972 was a period of considerable expansion from the $12,000,000 originally appropriated to a total of $30,000,000 for FY 1972 and to the anticipated expansion in FY 1973 to $68,000,000. This represents both an expansion in the level of program funds and a redirection of program thrust. The FY 72 supplemental of $18,000,000 provided an opportunity for selected additional program growth and an opportunity to provide the means for front-end planning and an early start up of the new Title VII Nutrition Program and the revised and redirected Title III programs.

1600 projects were funded from FY 72 funds and it is anticipated that 1923 projects will be funded during FY 73. Services which are being or will be supported by FY 1973 funds are quite broad in scope. These various services include: health services; transportation; homemaker; nutrition; information and referral; counseling; continuing education; and recreation and leisure.

Of the 194 planning grants which were initiated in FY 72, the best 125 of these are being continued in FY 1973 and will form the nucleus of the area planning agencies which will be established in designated priority planning and

service areas. Numerous activities have been carried out to effect a smooth and efficient transition from the Community Programs Activity to the new strategy of Area Planning Agencies, providing comprehensive and coordinated service delivery systems of high priority services to high priority planning and service areas.

A comprehensive training and technical assistance strategy will have been designed and implemented by AoA during FY 73. Technical assistance contracts were awarded in each region to provide necessary assistance to local agencies and project directors in their implementation of the new Title VII Nutrition program with a primary focus on the development of strong local projects.

Nutrition Programs

The purpose of this program is to provide older Americans, particularly those with low incomes, with low cost, nutritionally sound hot meals served in strategically located centers where they can obtain other social and rehabilitative services. This program also provides meals served on a home delivery basis to immobilized elderly persons. Emphasis will be placed on serving low income and minority individuals. This program will make a direct contribution to the achievement of the SRS priority of maintaining the elderly in community settings.

Although the initiation of the Title VII Nutrition Program will be delayed until the latter part of fiscal year 1973, current nutrition projects under Title III and IV of the Older Americans Act, OEO, and other agencies are currently providing nutrition services to older persons. There are 459 such projects, serving approximately 31,000 meals daily. Slightly over 50 percent of these projects will conform to the requirements of the Title VII Nutrition Program and will be phased into the Title VII program after it has been implemented.

A full $99,600,000 program level will be reached within a period of one year after funds become available for implementation. It is anticipated that funds will be available prior to the fourth quarter of FY 73 and that more than 20,000 meals per day will be served to older persons prior to June 30, 1973.

Measures have been taken in anticipation of funds becoming available. First, regulations and guidelines have been published and issued to the State Agencies. Some State Agencies are currently in the process of developing their State Operating Plans. Furthermore, some State Agencies have taken the initial steps in identifying prospective grantees for nutrition projects in their local areas. Secondly, a portion of FY 1972/1973 supplemental appropriation funds for Title III State Planning and Operations and Community Programs have been utilized in planning for the implementation of the Nutrition Program so that projects will be operational and delivering meals as soon as possible after funds become available. Third, States have been encouraged to initiate Nutrition Programs by use of Title III or State and local funds pending the appropriation of funds for the Nutrition Program. Fourth, a short-term training curriculum for nutrition project directors, as well as for State and Regional personnel, has been developed. This curriculum has been pilot tested. An amended and improved curriculum is being reissued and will provide training for relevant nutrition program personnel during FY 1973. Fifth, a management information system is in the process of development to provide for improved project management. Finally, technical assistance contracts have been awarded in nine of the ten regions. Through these contracts, project manuals for guidance in project administration and management are being developed.

Model Projects

The purpose of this activity is to develop and test innovative approaches to change those conditions which prevent or limit opportunities for older persons to live independently and participate meaningfully in community life. Needed projects are targeted specifically to attack the most urgent and pressing problems facing groups of older persons within priority geographic areas of each State.

Of the $9,700,000 appropriated in FY 1972, $8,900,000 was used for direct support and approximately $800,000 was used for evaluation of Older Americans Act programs and administration and management of the new 1973 initiatives. Funds used for direct support provided $2,000,000 to meet the continuation costs of 9 projects initiated in FY 1971, $3,100,000 to initiate 12 new projects and $3,800,000 to fund 90 area planning grants in 44 States.

The 21 functioning Model Projects are testing a variety of combinations of service programs designed to meet the unique needs of elderly persons in specified geographic areas. Alternatives to long term care and the reduction of isolation are the primary foci of these projects. The ninety planning projects were funded near the end of FY 1972 to initiate comprehensive planning within the States and had a double focus of planning for implementation of Title VII Nutrition Programs and planning for potential area agencies on aging.

Training Activities

AoA's Training Division planned to distribute the $8 million allocated in FY 73 in much the same way as the same amount was distributed in FY 72. This would mean: $4 million for ongoing and new gerontology career training programs (including gerontology centers); $1.1 million for consolidated social work career training programs; $900,000 for curriculum and materials development, planning and evaluation; and $2.0 million for short-term training in keeping with AoA objectives.

In an effort to respond to the demonstrated needs of agencies and organizations serving the older population, AoA has fostered the development of facilities or consortia for offering career education and training, short-term training, and technical assistance for conducting research in aging. Support of such multifaceted programs has been contingent upon the willingness of the educational institutions to assume responsibility for the core developmental functions and upon the satisfaction of additional criteria identified below.

There is now one such facility or consortium in 9 of the 10 HEW regions:

Region I. Brandeis University-New England Center for Continuing Education

Region II. Syracuse University

Region IV. University of South Florida

Region V. The University of Michigan - Wayne State University

Region VI. North Texas State University

Region VII. University of Nebraska, Omaha and Lincoln

Region VIII. University of Utah - Utah State University - Brigham Young University - Weber State College

Region IX. University of Southern California

Region X. University of Oregon-Portland State University - Oregon State University

Region III. Is without a multidisciplinary facility receiving AoA training support

Criteria

Criteria employed in providing support for multifunctional programs have been --

- Capability of faculty for offering career education and training and for conducting research within two or more basic disciplines or professional fields
- Expressed interest in performing these functions and in providing short-term training and technical assistance
- Willingness of the parent institution to establish a multidisciplinary unit, independent of any single department or professional school, to serve as a focal point for activities in gerontology and to provide core support
- Demonstrated history of effective working relationships with outside agencies and organizations in the field of aging
- Appropriate geographic location

Developmental History and Competition

Support for programs in aging at the educational institutions listed above has evolved over the 7-year history of AoA's activities. Availability of funds for support of training in gerontology was announced widely following passage of the Older Americans Act in 1965. Broad encouragement has been given to educational institutions to develop training programs, research, and other activities compatible with AoA's objectives and priorities. All proposals have been reviewed in Regional Offices and by technical review or advisory committees when AoA was permitted to have such committees. Awards were made to institutions whose proposals showed the greatest capability and promise for future development.

Initially, most of the support was directed toward career training and research. Some support was given for short-term training. Demands for short-term training and various forms of technical assistance increased, and some training institutions responded. Additional support was provided--when funds permitted--to institutions which expanded their training programs and met requests for other services.

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Administration on Aging Supportive Services

Besides conducting actual program work, the Administration on Aging has had a number of Divisions carrying out a variety of supportive services, as well. These include: evaluation activities; legislative liaison work; public information activities; data analysis activities; and administrative support activities. A summary of this work follows.

Evaluation Activities

The Administration on Aging has continued to place increased emphasis on the assessment and evaluation of its programs.

During FY '71-72 all States conducted studies of the status and needs of the elderly. AoA is conducting an evaluation of these studies and their uses. The result will be an increased understanding of the results of these studies and their uses.

In collecting these data, some 30 States used a social indicators questionnaire developed for AoA. Evaluations of this questionnaire and its related social indicators weighting system are in process, to be completed by the end of 1973.

The evaluation of the community projects programs (under Title III of the Older Americans Act) is completed. The contractor is preparing an executive summary of the final report.

An evaluation of the Title V Career Training Program in Aging is in process. This study will attempt to measure the effectiveness of the Title V program in attracting students into the field of Aging and determine the number of graduates of the program that are actually employed in the field of aging. This study will be completed in April of 1973.

A detailed FY '73-74 evaluation plan was developed and is currently undergoing Departmental review. Included in this plan is a comprehensive evaluation of the 21 areawide model projects funded under Title III in 1971 and 1972.

AoA began implementation of a long range planning process with the development of a FY '74-78 plan. This plan, for the first time, provided an ordered projection of AoA program activities for a five year period. Greater attention and emphasis will be given to the long range aspects of planning during 1973.

Legislative Liaison Activities

The Administration on Aging, through its Legislative Liaison office, makes an effort to keep in close touch with legislative proposals and other developments in Congress. It is apparently necessary for AoA to do so if it is to comply with section 202 of the Act, which makes it "the duty and function of the Administration to --

"(1) serve as a clearinghouse for information related to problems of the aged and aging;

"(2) assist the Secretary in all matters pertaining to problems of the aged and aging;

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"(4) develop plans...in the field of aging;

"(5) provide technical assistance and consultation to States and political subdivisions thereof with respect to programs for the aged and aging;

* * * * * * * * * * * * * * * *

"(8) stimulate more effective use of existing resources and available services for the aged and aging..."

The principal activity of AoA's Legislative Liaison during 1972 was its work on proposals to amend the Older Americans Act and to extend the authorizations of its grant and contract programs. Until the Administration's proposal in this area was transmitted to Congress during March, AoA's Legislative Liaison office represented Commissioner Martin and the agency in working out the details of the Administration bill, which was introduced as S. 3391 by Senator J. Glenn Beall, Jr. (R.-Md.), and as H. R. 13925 by Congressman Ogden R. Reid (D.-N.Y.). Thereafter, the Liaison office was heavily involved in consideration of this and other related proposals by House and Senate committees and the conference committee. Late in the year, after the President withheld his approval from the measure passed by Congress, the Liaison office began work on a measure to be introduced in 1973.

For its own information, as well as to inform members of Congress and the public, the Liaison office prepared and published a "Summary of Selected Legislative Proposals Affecting Older Americans," covering measures introduced in Congress between January 22, 1971 and April 1, 1972.

The Liaison office received and processed numerous requests from Congressional offices for advice and assistance on legislation affecting the elderly, and served those offices as an initial information and referral point for all of AoA.

Public Information Activities

Calendar year 1972, following the White House Conference on Aging in late 1971, was designated the year of action for older Americans. As the year began, expectations and interest were at fever pitch and an increasing number of inquiries and requests for materials were received by the Information Division. A summary of the Division's activities follows.

1. Continuing Conference Activities

The Division took over public information chores for the White House Conference on Aging during January 1972. In March and April, it planned, scheduled, announced, and manned a series of 7 press conferences for Dr. Arthur S. Flemming, Chairman of the Conference, at which he released recommendations of individual Sections and Special Concerns Sessions of the Conference.

The Division edited, designed, and prepared for the printer 23 interim reports on these recommendations, prepering draft versions for the press conferences, and formal printed copies for general distribution. Each contained not only the recommendations of the particular Section or Session but all related recommendations as well. A total of 10,000 were ordered for free distribution by AoA, with additional thousands sold by the Government Printing Office. A special set of the 23 interim reports was prepared for the President. The Division also designed, edited, and prepared for the printer the official two-volume final report of the Conference.

2. Senior Citizens Month

Senior Citizens Month, May 1972, featured a followup theme for the Conference --Action Now. A poster based on this theme, a Presidential Proclamation, radio and TV spots, and a special media feature story-calendar were developed for distribution. The latter reported on activities throughout the Nation which were taking place every day of the month of May and was widely used. A visual calendar showing high spots of the story was also prepared and distributed to media.

Aging featured the poster and theme and carried special stories on the President's Message on Older Americans, the new Nutrition Program for the Elderly, and the Advisory Committee on Older Americans. The Advertising Council supported the Division's special program, featuring it in its Public Affairs Media Bulletin. In addition three of the five films produced from the White House Conference multimedia presentation were distributed to State and regional offices on aging before the Month began and two more followed later.

3. Other Major Publications

Throughout the year, the magazine Aging carried "The Post-Conference Action Year" banner on its masthead. Only 8 issues were published during 1972, four of them covering 2 month periods. In part this was necessary because of the small Information Division staff.

In the spring the Federal Editors Association awarded its first place for a popular publication in two or three colors to Invitation to Design A World: Second Reader, 1971 White House Conference on Aging. The Second Reader, had been the Senior Citizens Month preprinted supplement to Aging in May 1971.

To meet the greatly increased requests for publications on nutrition following the enactment of the Nutrition Program for the Elderly (P.L. 92-258) as Title VII of the Older Americans Act, 14 additional final reports of AoA nutrition projects were published in the Administrative Papers series. A Home Delivered Meals Program for the Elderly, the report of the only AoA nutrition project with its primary focus on this method of providing nutrition to the elderly, was published as a separate major publication.

A series of manuals on information and referral, developed under an AoA research project, was published for the use of the national information and referral demonstration project located in the State of Wisconsin, and also was made available to others requesting this type of information.

The Division also published A Summary of Selected Proposals Affecting Older Americans, prepared by the Legislative Liaison Division, and the Manual of Policies and Procedures for the Nutrition Program for the Aging, in addition to a number of revised and reprinted publications.

4. Other Information Activities

Interest in aging, greatly stimulated by the 1971 Conference, provided the Division with expanding opportunities (and demands) for media cooperation. Some high points of the year were:

- Special articles prepared for Food Management for the Secretary's and Commissioner's bylines.
- Article on "Aging in Russia" for the Commissioner's byline for ACTION Newsletter.
- Information provided for articles in Ladies Home Journal, Changing Times, New York Times, Wall Street Journal, Milwaukee Journal, Washington Star, Washington Post, Phoenix Gazette, Christian Science Monitor, Philadelphia Inquirer, National Observer, National Restaurant News, CNI Weekly Report, and Washington Report on Long-Term Care.
- Time and information were contributed to NBC for various Today shows, Baltimore Sun, UPI and AP special stories, follow through with specialty press first contacted for the WHCOA segment reports.

The Division planned, arranged, scripted and rehearsed a 30 minute segment of the NBC series, "There's No Place Like Home," which featured Administrator Twiname, Commissioner Martin, and the directors of two AoA nutrition programs; worked with SRS staff to prepare a TV spot entitled "To Find the Way," symbolizing the difficulties older people have finding services; working with SRS staff, edited and re-scored two radio spots on aging; prepared outline script in detail for Secretary Richardson, Commissioner Martin, and WHCOA Vice-Chairman, Bertha Adkins, for a TV taped report by the Secretary to the HEW Regional offices.

The Division also prepared several slide presentations, including one on "Let's End Isolation" with a 5 to 10 minute narrative script, and participated in major discussions with the Public Broadcasting System and the Corporation for Public Bradcasting in preparation for a continuing series for older people.

Press releases during the year included two on the regulations for the Nutrition Program for the Elderly, several on research and demonstration grant awards of particular interest, and one each on new appointments to the Advisory Committee on Older Americans and the establishment of the Technical Advisory Committee on Aging Research.

Data Analysis Activities

The Division of Data Analysis participated in AoA's assistance to the Domestis Council's Committee on Aging project of collecting estimates from selected Federal agencies of their anticipated commitments of funds for programs of benefit to older persons. This was done to help implement that portion of the President's March 23, 1972, message on aging dealing with "Coordinating Federal Efforts."

Also, cooperative arrangements with the Census Bureau were continued and reinforced. These centered on exploitation and distribution of data concerning older people from the 1970 census enumeration and the monthly Current Population Surveys. In this connection, flow of data resources to the State agencies on aging was maintained.

The Division responded to hundreds of requests for data, for technical assistance, and for consultation in related areas of research, analysis, planning, studies, resources for training and institute activities, and special analyses or presentations. Requests originated from within public agencies at the Federal, State, and local level, and from private profit-oriented and nonprofit entities. A most significant source of requests during 1972 were the Congressional committees and individual members of the Congress who were involved in the development of legislation in aging, including the amendments to the Older Americans Act and the proposed National Institute on Aging. Speeches and signed articles were prepared for delivery at national conferences and publication in journals and magazines.

During the year, an informal statistical memorandum series was developed to supplement the more formal "Facts and Figures on Older Americans" series since the latter requires more expenditure of manhours and funds.

Administrative Support Activities

This Division has continued to advise on management policies and to give AoA all necessary administrative services. Primary areas of responsibility are: budget; personnel; management analysis; and operational planning. During the past year major emphasis has been placed on management by objectives and the operational planning system. Major workloads have been managed and tracked through the DHEW Operational Planning System with very significant results. The Division has also placed emphasis on work planning as a tool to assure good management.

I. SOCIAL AND REHABILITATION SERVICE (Continued)

B. ASSISTANCE PAYMENTS ADMINISTRATION

Under the maintenance assistance programs, cash payments are made to needy persons for the cost of food, shelter, clothing and other necessary items of daily living.

The maintenance assistance program supporting aged persons is old age assistance. Additionally there are some persons over age 65 who are recipients under the aid to the blind and aid to the permanently and totally disabled programs, plus those persons in the aid to families with dependent children cases who are aged.

P.L. 92-603, enacted October 30, 1972, establishes a national program to provide supplemental security income to individuals who have attained aged 65 or are blind or disabled. The national program becomes effective as of January 1, 1974 at which time the Social Security Administration will be responsible for making Federal payments to eligible recipients.

The number of aged persons and the total Federal share of cash payments for maintenance assistance programs affecting the aged are shown in Table 1 below for fiscal years 1970 through 1974.

Table 1.--Number of aged and Federal share of payments

Fiscal Year	Number of Recipients	($ in thousands) Federal Payments	Administrative Costs	Average Annual Total Payment
70 Actual	2,110,464	$1,361,085	$ 93,831	$644.92
71 Actual	2,128,846	1,486,788	105,991	698.40
72 Actual	2,098,967	1,217,401	80,118	580.00
73 Estimate	2,089,677	1,224,444	92,339	585.95
74 Estimate 1/	2,107,537	582,196	50,294	276.24

1/ Estimate includes one half-year payments and costs for programs affected by P.L. 92-603.

C. MEDICAL SERVICES ADMINISTRATION

Title XIX, known as Medicaid, provides Federal matching payments for State expenditures for health care for the poor. In FY 1972, fifty-two States and jurisdictions were participating in Medicaid (Alaska entered the program early in FY73, leaving Arizona as the only non-participating State). All States participating in the program must provide medical assistance to recipients of cash assistance--poor persons aged 65 and over, low-income blind and disabled individuals, and AFDC families; in addition, States may extend their programs to cover the medically needy--those persons who would be eligible for cash assistance except that the level of their income and resources is sufficient for their maintenance needs but not to pay for necessary medical care (some 27 States have opted to extend such coverage to the medically needy).

States are required to provide in their title XIX program: inpatient hospital care, out-patient care, skilled nursing home care for individuals 21 and over, early and periodic screening, diagnosis and treatment services for children under 21, physicians services, lab and X-ray services and home health services, as well as, by regulation, transportation to medical care where needed. Use of skilled nursing home services, particularly, is primarily by the aged. In addition, States may cover optional services, many of which are of particular concern to the elderly; for example, 48 offer prescribed drugs, 35 cover eyeglasses, 33 finance physical therapy, and 37 pay for prosthetic devices. Additionally, title XIX in FY 1973 contained several provisions directed solely to those over 65: payment of Medicare premium, copayment and deductible amounts (for cash assistance recipients), and coverage of inpatient hospital services in institutions for mental diseases.

The aged account for a significant portion of Medicaid expenditures. Some 40 percent of the $7.9 billion Federal, State and local program dollars was spent on care for the aged in FY72, and 3.8 million people over age 65 received Medicaid services. For most of these persons, Medicaid was providing services which supplemented and complemented those provided by Medicare.

In January 1972, a new benefit of prime importance to the aged was transferred to the title XIX program by P.L. 92-223--intermediate care facility services. The transfer from the cash titles allowed States to provide ICF services not only to cash assistance recipients but also to medically needy persons. In addition it provided the Federal government with broad authority to establish standards for quality of care and for safety and sanitation in participating homes.

During 1972 MSA gave increased attention to upgrading the care offered in nursing homes certified to participate as Medicaid providers. A major recertification effort was conducted under the guidance of MSA Central Office and SRS/MS Regional Staff. All States having a title XIX program were required to resurvey all nursing homes participating in title XIX. This effort was completed on July 1, 1972. The recertification effort resulted in approximately 500 homes being either decertified or voluntarily withdrawing from Medicaid participation. Twenty-eight thousand patients were relocated to other skilled nursing homes or intermediate care facilities based on a review of their needs.

The Medical Services Administration also intensified its activities in FY 1972 to develop alternative modes to institutional long term care. A grant awarded in June 1971 to the Development Education and Training Research Institute (DETRI) of American University produced a project on "Long Term Institutional Care and Alternative Solutions." The American University project developed and catalogued data on long term care needs and resources, and identified 37 outlines of potential demonstrative concepts and components to be used in testing the feasibility of a wide variety of non-institutional approaches to care. In April 1972, as part of the study, a multi-disciplinary group of selected experts in the long term care field was drawn together to develop the best strategies for reducing reliance on institutions for care of the aged and chronically ill. Building on the components developed by the research group, this group developed about 23 models of service delivery systems designed to improve health care and to avoid or delay institutionalization.

Upon the recommendation of MSA, SRS selected two of these demonstration models for funding in fiscal year 1972, and invited proposals. The models selected were "Day Hospital," and "Day Care Center." There is little experience in this country with these alternatives to institutional care, yet there is evidence in other countries, especially Great Britian, that the Day Care approach is promising and effective for the elderly. Subsequently, four projects were funded--one "Day Hospital" and three "Day Care Centers."

D. REHABILITATION SERVICES ADMINISTRATION

The major goal of the Rehabilitation Services Administration's program for the Aging is to rehabilitate as many older handicapped individuals as possible into gainful employment through activities of the State-Federal rehabilitation program administered by the agency.

The Rehabilitation Services Administration 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 to ascertain capacity for work; counseling to help in developing a good vocational plan; medical care to reduce or remove the disability; vocational training and placement into employment; and follow-up to ensure satisfactory placement.

Progress in Rehabilitation of the Aging--It is estimated that there are over 4 million people 45 years of age and older eligible for, and in need of, rehabilitation services, of whom nearly 1 million are aged 65 and beyond.

In an effort to alleviate this, State rehabilitation agencies have been intensifying their efforts to serve the aged handicapped and a steady increase in the number of these individuals has resulted. For example in FY 1959, a total of 80,739 disabled persons were rehabilitated into employment, of whom 24,275 were aged 45 and over and 1,432 were aged 65 and over. In FY 1972, a total of 326,138 disabled persons were rehabilitated into employment 80,100 of whom were aged 45 and beyond and 4,800 were aged 65 and beyond.

Training--Short-term Training courses serve to focus on problems faced by older handicapped persons and stimulate interest on the part of professional rehabilitation staff, and staff from health, welfare, and other agencies who may attend, in developing methods and techniques to cope with these problems. A recent course sponsored by the Rehabilitation Services Administration and San Diego State College focused on vocational rehabilitation and the older handicapped worker. Staff from States in Region IX attended this meeting together with staff from appropriate public and private agencies in the San Diego area.

In 1971, a Short-term Training course was conducted to prepare recommendations to be presented to the 1971 White House Conference on Aging.

Two Short-term Training courses are being developed and will be conducted in the near future. These will be Regional Short-term courses and will focus on implementation of recommendations on rehabilitation voted upon by delegates to the 1971 White House Conference on Aging.

Special Activities in the State Agencies-State rehabilitation agencies have utilized expansion grants and Basic Support resources to expand their services to the aging disabled. For example, the Iowa rehabilitation agency has worked cooperatively with the Easter Seal Society in that State on a project for the home bound which serves a large number of older disabled people. Also, the Ohio rehabilitation agency has participated in a public housing project designed for the handicapped and senior citizens.

Currently, three expansion grants are in operation focused on rehabilitation of the aged disabled on, or near, the poverty level into employment. Public Welfare recipients are also included in this grouping. These projects are located in New York, Illinois and Massachusetts.

Social Security Disability Applicants-The Rehabilitation Services Administration coordinates with 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.

The 1967 Amendments to the Social Security Act provided reduced disability benefit payments to a new group of persons age 50 and over, namely to totally disabled widows, widowers, and surviving divorced wives. In Calendar year 1972, an estimated 49,000 for such benefits were processed and it is estimated that another 51,000 applications for reduced disability benefits will be processed in 1973.

Future Plans--The Rehabilitation Services Administration cooperates with the Administration on Aging in various activities such as Senior Citizens Month and other special projects and will continue to do so.

State Rehabilitation Agencies: Rehabilitated persons 45 years of age and over and 65 years of age and over at acceptance - Fiscal years 1970-1974.

Fiscal Year	All Rehabilitants	45 years of age and over	65 years of age and over
1970	266,695	67,738	4,245
1971	291,272	69,244	4,489
1972	326,138	80,100 1/	4,800 1/
1973 1/	340,000	82,400	4,800
1974 1/	350,000	83,500	4,700

1/ Estimated

E. OFFICE OF PLANNING, RESEARCH & TRAINING

The demonstration projects program in public assistance under Section 1115 of the Social Security Act provided grants for at least 18 different projects during the calendar year 1972 which were totally or partially concerned with providing a variety of services to elderly recipients in public welfare. These projects were carried out under the auspices of State public welfare agencies.

A project in three Florida counties is demonstrating a program aimed at integrating nutrition, health, social and rehabilitation services to persons 60 years of age and older. This project is stressing the volunteer and paraprofessional participation of the elderly in program planning and operation. The project focuses on specific problems of the elderly including transportation, housing, nutrition, employment, income and social isolation. In addition, the project includes the recommendations of the 1971 White House Conference on Aging in program planning and problem identification. This effort is also being supported by a grant under Title IV of the Older Americans Act.

Two projects are providing housing assistance to the aged. The Kentucky Department of Economic Security together with the programs of the Department of Labor, Department of Agriculture, Department of Housing and Urban Development, and the Office of Economic Opportunity is carrying out a project in four counties in eastern Kentucky. The homes of 1,000 aged, blind, and disabled and 1,000 AFDC families are being repaired to make them safe and suitable for occupancy, thus enabling the recipient to remain in his own home rather than being placed in a nursing home or institution. A Model Cities project in Georgia is demonstrating the coordination of various types of housing, aids and resources made available to local communities through HEW and HUD programs to improve the housing of aged recipients.

Two projects in consumer affairs are currently in operation. A project in Georgia is providing educational materials and help to the elderly as well as other low income families and individuals. A project in Michigan is operating a Consumer Information Center which provides consumer education, training information and referral services for the elderly and low income residents in a Model City area.

Two projects are demonstrating the coordinated and comprehensive delivery of social services to the aged, blind, disabled and AFDC recipients. In Florida one-stop information and referral centers are coordinating existing community services and developing new services while a project in New Jersey is operating a decentralized community organization in a suburban rural area to improve the delivery of such services as protective services, home management, housing, consumer education, etc.

Three neighborhood service center projects serving elderly recipients are conducting experiments to determine which services are most wanted and needed at the neighborhood level.

A project in Washington is operating a Home Management Service Center to provide such services as money management, housekeeping skills, and family management for the aged and other public assistance recipients. Other States, Virginia, Montana, Texas, Utah, Florida and Tennessee demonstrating the value of providing homemaker services are enthusiastic about the results which include helping the elderly remain in their homes or return to their homes following hospitalization. In all instances, the States experimenting with the provision of homemaker services have adopted the project activity into their on-going program upon termination of the demonstration.

A project in Michigan is working to integrate public health general hospital community outreach and social services in a practical manner in cooperation with the Inkster Comprehensive Service Project for the Elderly.

Other projects involve aged welfare recipients in pre-paid health insurance plans, health maintenance organizations, and integrated services delivery centers also involve aged welfare recipients.

Vocational Rehabilitation Research and Demonstration Projects

A pilot project has completed a viable plan for a massive attack on the problems of aging through a system of industrial placement facilities for the aging in several locations of wide geographic distribution, with emphasis on poverty locations.

A study is being conducted to demonstrate and evaluate the effectiveness of a new concept in public transportation to substantially improve the mobility of the disabled and aged.

A demonstration center has been set up to show that the needs and talents of older workers can be matched with specific job requirements and the needs of the general economy, and the program given high visibility through mass media. Local businessmen are cooperating with social scientists to provide and evaluate temporary placements in a work center leading to jobs which have been identified as those in which demand exceeds supply and job characteristics are ideally suited to characteristics of older workers. One new study is examining the characteristics of public housing for the disabled and elderly with respect to services and architecture that may have a significant impact on new construction of housing for the elderly. One other project jointly funded with Division of Aging is examining the role of Statewide planning for the elderly, to provide detailed empirical knowledge of the ways in which various State planning tools, structures, and functions combine effectively.

Special Foreign Currency Program

International research deals with special aspects of programs for the elderly-in such fields as income maintenance, health functioning, social welfare, work and leisure activities--where different forms of local action are possible and necessary to implement provisions originating at the national level, and to improve their efficiency through measures for active community participation. One program which has generated interest in participating countries is a "Foster Grandparents" program designed simultaneously to meet the needs of older people for more material security and the desirability of providing institutionalized mentally retarded children with care and greater closeness of grown-up persons.

Aging Research

Fifty-six different research and demonstration projects were supported during calendar year 1972 under Title IV of the Older Americans Act, and carried out under a variety of auspices including universities, local and state governments, councils on aging, and private non-profit research organizations.

Five projects are testing Day Care, Day Hospital & In Home Care as alternatives to institutionalization of older persons. Four projects are funded jointly with other agencies in the U. S. Department of Health, Education & Welfare.

Several of the projects will investigate changes needed in Federal, State, or local laws, policies, and practices that serve as barriers to continued independence of the elderly. For example, public payment can be arranged with relative ease for care in institutions but it is difficult to obtain payment for equivalent service on a continuing basis to persons outside of an institution.

Six projects were studying relationships between the older person and his environment, and developing knowledge to contribute to the formulation of housing policy for the elderly. The Home for Jewish Aged in Philadelphia is surveying 100 low-cost public housing and 100 limited-income housing projects for the elderly to

determine the features associated with successful housing environments. The Philadelphia Geriatric Center is studying the effect of different types of living arrangements on the elderly person's health and socialization. The Institute for Community Studies in Kansas City is exploring new possibilities of group living arrangements for older persons. Policy criteria for housing for elderly people are being formulated by the Gerontological Society.

The mobility problems of elderly people were addressed by five projects seeking improved solutions to the need for transportation. The New York City Office for Aging began feasibility study and demonstration of the use of shared taxicabs. The North Carolina State University at Raleigh has developed a pool of 100 elderly volunteer drivers as part of a test of another way to provide transportation opportunities. Fisk University in Nashville, Tennessee, is studying life styles and mobility patterns of elderly inner city residents to better anticipate the impact of constraints on their mobility, and Northwestern University, Evanston, Illinois, developed a methodology for more accurately assessing the impact of reduced fare programs on transit company revenues. The utility of escorts to assist elderly people in using public transportation is being determined by the National Council of Jewish Women in Essex County, New Jersey.

A major project during 1971 was the continuing development of models for a complete information, referral and planning program to be demonstrated in a pilot state-wide system in Wisconsin. The American Rehabilitation Foundation in Minneapolis is designing the system.

The study of state planning methods for special services and welfare programs and the development of more effective methods is the objective of a pioneering project at Brandeis University. Work was continued in Minnesota on the development of social indicators as a tool of planning and program assessment.

The results of 21 earlier demonstrations of meal service programs for elderly people pointed the direction for two nutrition and coordinated services demonstrations launched in three counties in Florida and in Chicago and jointly supported with the Office of Economic Opportunity. The goal is to develop efficient operating systems for a comprehensive social service and meals and nutrition program for elderly people.

Duke University in Durham, North Carolina, began a major cost benefit evaluation of protective community services. Several methodological improvements are expected to result as well as significant data on alternatives to institutionalization for elderly people.

One of the first studies of the incidence of alcholism among the elderly population has been undertaken by Rutgers University.

F. COMMUNITY SERVICES ADMINISTRATION

Service Program for the Aged: Title I and OAA of Title XVI of the Social Security Act

The Community Services Administration, Division of Human Service Systems Development, Services to the Aged and Handicapped Branch, has responsibility for implementing Federal legislation relating to these titles by developing appropriate regulations and guides. The purpose of CSA, in cooperation with its regional counterparts, is to stimulate State welfare agencies to develop and provide a full range of social services at the community level to needy aged. Technical assistance in interpreting Federal requirements and strengthening State practice is an ongoing CSA activity.

Under the previous Federal adult service regulations which included OAA, certain social services were mandated. States were obliged to provide these in order to qualify for 75 percent Federal matching funds. The same matching was available for provision of approved additional optional services. The mandated list consisted of information and referral, protective services, services to enable persons to remain in or return to their own homes or communities, and services to meet health needs.

The social service program regulations proposed in February 1973 which were applicable to services provided to the aged had the effect of defining 14 social services and gave the States the option to include them in their State Plans rather than making inclusion mandatory. These 14 services include all of those previously mandated (except Information and Referral) and most of those which were previously optional. Thus Federal financial participation will be available to those States wishing to provide a comprehensive array of basic social services to the needy aged.

The last expenditures made and estimates for 1972-4 are as follows:

Funds for Programs on Aging
(dollars in thousands)

	1970	1971	1972 Estimate	1973 1/ Estimate	1974 1/ Estimate
Social and Rehabilitation Service:					
Social Services.....	53,417	83,794	198,000	224,000	207,000

1/ Estimates reflect impact of closed-end appropriation and pending regulation changes.

II. PUBLIC HEALTH SERVICE

A. NATIONAL INSTITUTES OF HEALTH
National Institute of Child Health and Human Development

INTRAMURAL AGING RESEARCH--THE GERONTOLOGY RESEARCH CENTER

The Gerontology Research Center (GRC) of the National Institute of Child Health and Human Development in Baltimore, Maryland, provides the base from which Government scientists study the biological, physiological, and behavioral changes that take place with aging in humans. In addition to its own staff of investigators, the Center provides laboratory facilities for guest workers and foreign fellows and also serves as a national facility for the study of aging. The Center's facilities and staff are frequently used resources for scientists in the community and at universities, medical schools, and other biomedical institutions throughout the country.

The primary requirement for aging studies is access to animals of known age, parentage, and exposure to infectious agents. In past years, aging research has often been hampered by difficulty in obtaining these experimental animals. In response to this need, the GRC has now developed a large colony of aging rats which are made available to qualified investigators in other laboratories.

During 1972, 12 collaborative research projects, involving some 50 guest scientists and supporting personnel, operated at the Baltimore Center. In addition to modern scientific equipment and senescent animals, the Center's resources include an extensive gerontology library, temperature control rooms useful for studying the effects of environment on aging, tissue culture facilities, up-to-date electronic data processing equipment, an animal surgery suite, regular research seminars, and special conferences on aging.

Investigators from many disciplines study what happens to people and animals as they age, how older organisms adjust to aging, and what might be done to slow or prevent some of the harmful effects of aging.

Studies which compare measurements made on a group of young subjects with those made on a different group of old subjects may lead to erroneous conclusions about aging because the old subjects could represent survivors who were superior individuals in their youth. Studies using statistics based on data averaged from subjects of different ages do not necessarily show the progression of age-caused changes. In order to determine the interrelation between aging in different organ systems it is necessary to obtain serial measurements on the same individual. These measurements are essential if gerontologists are to find out whether there is a general aging factor, or whether aging is simply the result of random deficits that develop in different patterns in different people. A principal activity of the GRC is the conduct of the Baltimore Longitudinal Study. This study is an effort to obtain a detailed understanding of aging in humans by making repeated observations on the same individual as he ages. A sample of some 600 men, leading successful and active lives, has been recruited for this study. Primarily from the Baltimore-Washington area, all subjects are volunteers ranging in age from 20-96 years. Each subject in this study spends two and one-half days at the Gerontology Research Center every 18 months. At each visit these volunteers are given extensive clinical, biochemical, physiological, and psychological tests to measure age changes.

Investigators interested in nutritional aspects of aging are participating in the Study. Recently, these scientists, working in collaboration with nutritionists at Philadelphia General Hospital and the Hoffman-LaRoche Company, have collected data on the vitamin status of the 600 volunteers.

Early results from this study show that with advancing age even well-nourished men are deficient. Of the 200 men studied to date, 30 percent take a vitamin supplement to their diet on their own initiative. As measured by the amount

excreted in urine, one-fifth of the subjects not taking vitamins show evidence of abnormally low levels of thiamine (B_1) and riboflavin (B_2). At least half of these older men show a deficiency of pyridoxine (B_6) in blood plasma. Not only do the men have low vitamin levels, but also there is evidence of abnormal enzyme levels in the plasma and in the red blood cells of those not taking vitamin supplements.

These early results are surprising because the group under study is made up of highly educated, successful, community-living subjects who have access to adequate diets. On the positive side, chemical evidence of vitamin B deficiency is rare in the middle-aged and in those elderly subjects who, without direction, include a vitamin supplement in their diets.

In a different GRC laboratory, a guest investigator is studying still another vitamin which sometimes is found to be deficient in older people. This vitamin, folic acid, is essential for the formation of new cells in the body.

Early results indicate that there is a significant difference in rates of folic acid absorption in the small intestine of young rats (6-weeks old) compared to old rats (2-years old). A 2-year-old rat is roughly comparable to a 70-year-old man.

If the age-related difference in absorption rates observed in these early experiments continue to be observed as more animals are studied, then scientists may pursue similar human studies. It is possible to theorize that some of the vitamin deficiencies seen in older humans might result from age related defects in vitamin absorbing capability of the intestine.

Learning Ability Among the Aged

Still other GRC investigators have been studying the verbal learning ability of participants. Recent analyses of data show that when material to be learned is presented visually at a fairly fast rate, the subjects make increasingly more errors as they grow older.

These results are consistent with the finding based on cross-sectional analyses that there is an age dependent decrement in verbal learning performance. In a cross-sectional study, people of various ages are tested once and only age differences between individuals can be measured. In the longitudinal study, each person is tested initially and then retested approximately six years later, thus providing a measure of change in performance with age. The verbal learning procedures used at the Center require the acquisition and recall of new information, whereas intelligence tests tap old information. In contrast to verbal learning performance, intelligence tests have demonstrated no age-related changes in mental ability. In view of the disparity of results between the two measures of intelligence, further studies of the relation between mental ability and age are required.

It is important to note that the magnitude of the age-related decline in verbal learning performance varies with the rate at which material to be learned is presented. Under conditions where material to be learned is presented at a slower speed, the decline with age is much less marked and tends to show up much later in life.

Biological Aspects of Aging

Age-related deterioration of the body's immune response to invasion by foreign proteins is thought by many to be responsible for the increased susceptibility to infections and to cancer in the elderly. Researchers have observed a marked loss of immunological responsiveness in aging humans. Studies have shown that the defect in immunological competence is located in the immunological cells of the aged animal. The immunological system is made, at least in part, of cells formed in the thymus gland (T cells) and in the bone marrow (B cells) that are capable of producing the active disease fighters. These T and B cells concentrate themselves in the spleen and lymph nodes or travel through the body with white blood cells.

When an infectious organism (an antigen) enters the body, a team of these cells work to destroy the invaders. In early infancy this immune system receives assistance briefly from maternal antibodies transferred during pregnancy. The activity of this system reaches its peak during adolescent years then decreases as the animal ages.

It has been suggested by some experts that cells become different genetically with time. When this happens they can become antigenic and stimulate a response by the body against its own cells. This results in an autoimmune disease harmful or deadly to normal cells. The aging and cell death that follows represents the end result of an autoimmune process and an active immune system gone awry.

Immunologic techniques perfected over the past few years now make it possible to initiate new research efforts to identify changes in the immune system with aging. In recognition of this fact, NICHD in the fall of 1972 established a special Section on Immunology within the Gerontology Research Center's Laboratory of Cellular and Comparative Physiology.

Seven outstanding immunologists have been recruited as the nucleus of the new section. These investigators are initiating studies on the mechanisms of the age-related decrease in immune responses in both animals and humans. In addition, they are conducting studies to determine the role of the autoimmune response in aging and to find out how cells distinguish between cells of their own kind and foreign invading bodies. The extramural Adult Development and Aging Branch is also supporting studies of the immunological aspects of aging.

Cellular and Molecular Aging

Old animals take more time than do young ones to produce certain enzymes, although they eventually do produce appropriate amounts. This means that while the older animal can perform a particular metabolic task it takes him much longer.

Recent studies by scientists in the GRC Laboratory of Molecular Aging have shown that impairments in the body's cell control mechanisms lessen the ability of old animals to produce certain proteins, essential to the maintenance of life. This means that aged cells can produce enough essential proteins if they are properly stimulated and if the materials needed for the protein production can be delivered to the cells.

Research in this area is aimed at experimental introduction of new materials into cells to repair or counteract the effects of age. An investigator in the GRC Laboratory of Molecular Aging has synthesized new compounds (polymers) that can penetrate cell membranes without destroying the cell wall and disrupting the whole cell. (Previously scientists depended on living organisms, usually special viruses, to get into the cells.) Under normal circumstances it is extremely difficult to introduce substances such as hormones, enzymes, or genetic material

(nucleoproteins) into the cells. Now, with the synthesis of the polymers it may be possible to introduce these large molecules into the cells by attaching them to the polymers.

The polymers used at the GRC have been designed, produced, and evaluated for their ability to stimulate protection against viruses. A Center investigator has also found that the antiviral defense mechanisms of human cells grown in tissue culture change with age. The viral protection induced with chemicals is most effective in the middle of the *in vitro* (cell culture) life span, then decreases sharply but is still functional up to the last 10 percent of the cultured cell's life span.

EXTRAMURAL RESEARCH AND TRAINING PROGRAMS

The history of medical practice has shown a movement from intervention during medical crises toward the prevention of crises. The earliest results of this shift in strategy were studies in the prevention of diseases due to infectious agents and nutritional deficiency.

Today the philosophy of prevention can be seen even in basic studies designed to isolate and characterize risk or predisposing factors--the modification of which can prevent the development of overt disease. An important tool for this type of research is the longitudinal study. NICHD longitudinal studies in Baltimore, Durham, N. C., Boston, and Berkeley are being applied to analysis of the various types of deterioration that occur in the aging human. The Durham study has resulted in increased appreciation of the role hypertension plays in deterioration with age and particularly in the decline that may occur in mental function. This decline is a problem which is not only devastating to the elderly, but also to their families and to society. Longitudinal studies have also contributed greatly to our knowledge of metabolic changes that occur with increasing age. We have learned that energy requirements decrease; the ability to convert carbohydrates to energy declines, and the ability of the body to regulate levels of blood lipoproteins (fat carrying proteins) is disturbed. All these changes have significant implications for health and functional ability.

A series of studies of former college students by NICHD grantees has identified four characteristics that when present at college age predispose the men in later years to fatal strokes, hypertension, and fatal and nonfatal coronary heart disease. These factors--higher than normal levels of blood pressure, overweight, short height, and cigarette smoking--were also recently identified by the grantees as risk factors for nonfatal stroke.

Certain characteristics of aging men were also found to be associated with an increase in stroke. These were: high blood pressure (which had also been a predictor at college age), coronary heart disease, diabetes, and a history of parental high blood pressure. High blood pressure in later life had the greatest effect on the incidence of stroke, and, along with a family history of high blood pressure, was a better predictor of nonfatal stroke than high blood pressure at college age. A comparison of these findings with those of fatal stroke showed that the predisposing factors were the same.

Many of the deteriorative processes that occur with age cannot yet be treated effectively. The menopause--a condition occurring in middle-aged women--is an outstanding exception to this. It is due to a decrease in the secretion of hormones by the ovaries. Some degenerative processes that occur in women after the middle years are definitely known to be due to this hormonal decline. It is clear that hormonal replacement reverses the unfortunate changes, but much remains to be learned about what constitutes optimal therapy, what effect it has on many aspects of health, and what side effects it may have. NICHD-

supported studies are designed to determine what is occurring in menopausal and postmenopausal women and what the good and bad effects of hormonal replacement therapy are.

Studies of humans as they age and studies of preventive and therapeutic intervention are invaluable, but progress can be slow. Scientists are hampered because certain experimental procedures are inappropriate on humans and because the human life span is too long to permit rapid results. As a result, scientists look to experimental studies in animals for the relatively rapid acquisition of knowledge about aging that can then be tested in appropriate ways in humans. For some time now, scientists have considered rodents to be the most appropriate experimental animals, although breakthroughs resulting from studies with other animals may occur. The advantages of rodents are that they can be raised relatively cheaply, have short life spans, and are similar to humans in several ways.

NICHD maintains colonies of special research rats and mice both in its intramural program and by contract with commercial breeders. Studies are showing that preventing infection of the animals by bacteria prolongs the average length of life but does not prevent deteriorative aging changes.

Evidence suggests that lifelong nutritional habits are of great importance to health and longevity and rodents maintained free of infection provide ideal subjects for nutrition research.

In addition to using animals to study the decline of the body's defense system, NICHD grantees are using them to investigate the speed with which the cell's enzymatic machinery can respond to stimulation by hormones and other agents. The speed of response decreases greatly with age and may partially explain the inability of the older person to respond to stresses initiated by these agents. This, in turn, results in vulnerability to disease and/or reduced functional ability.

Many of the deteriorative changes associated with increased age probably have their origins in the cells. This idea, although not new, is just now receiving support in the form of definite evidence. There are two schools of thought on the mortality or immortality of human cells. These theories are that normal human cells grow, are immortal, and that if they die, their death is the result of some environmental influence. The other theory is that cells have an aging process and that death is inherent in their genetic "program."

Studies of human cells in culture conducted by an NICHD grantee have introduced further evidence to support the theory that the cells themselves are mortal. By studying human fibroblasts (cells from connective tissue) the investigator observed that the fibroblasts are not capable of indefinite survival even when removed from the body and maintained in tissue culture or transferred surgically to one young host and then another. Neither the ideal environment of the tissue culture system or the youthful host organs could keep the cells indefinitely reproducing.

Another investigation of aging at the level of the individual cell makes use of sophisticated biochemical and biophysical techniques to determine the mechanisms by which pigments accumulate in many cells with increasing age. These pigments, which are leftover fatty material, are darkly colored and are probably metabolically inert. Pigments occupy a large fraction of the volume of many cells and may interfere with cell function. Although known as aging pigment this is not the same material which appears on the skin as age spots.

A need of those responsible for caring for the elderly is knowledge of what

professional home nursing care has to offer older persons. Recent studies by NICHD grantees have shown that among a group of mild to moderately disabled elderly patients, those given home nursing care were less likely to deteriorate physically and mentally and were also less likely to be admitted to nursing homes.

In contrast, the grantees observed no significant differences in the deterioration of mental and physical functions between severely disabled patients who received home nursing care and those who did not. What home nursing care did do for the severely disabled was to increase their use of medical, paramedical, and social services.

These findings suggest that health professionals should be trained to recognize what response to treatment can be expected with different degrees of disability. While a visiting nurse can expect to maintain or improve the physical and mental functions of moderately disabled patients, her role in ministering to severely disabled persons is that of simply coping with the patients' everyday needs and periodic crises. The findings also suggest that in the case of severely disabled patients, manpower could be used more efficiently if the role of coordinator of services was delegated to less highly trained personnel, in effect freeing the nurse to devote more time to rehabilitative treatment.

Additional alterations in the size and structure of the population will occur. Clearly, prolongation of life will alter the patterns of illness and death in this country. Death rates are not, however, the only determinants of the age-structure of the population. Factors such as changes in birth rates and migration habits also influence the structure and necessitate the development of complex mathematical model systems and intricate computerized computation for the accurate prediction of our future status and health needs. NICHD is supporting by contract research to evaluate the usefulness of existing mathematical model systems with an eye to modifying such models or having new ones created to serve the new needs.

B. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

The mission of the Health Services and Mental Health Administration (HSMHA) is to strengthen and improve the Nation's health care delivery system. To this end, HSMHA provides leadership and direction to programs and activities designed to improve general health services and mental health programs for the total population and strives to achieve the development of health care and maintenance systems that are adequately financed, comprehensive, interrelated, and responsive to the needs of individuals and families in various socio-economic and ethnic groups. The goal is to make excellent health care readily available to everyone. The elderly, along with the rest of the population, benefit from program activities geared to meeting the health needs of all the people. At the same time, recognizing the special health needs of the elderly, many of HSMHA's Programs are concentrating on special activities for this age group. Particular attention is being paid to the improvement of health services to the high-risk groups such as the institutionalized and the disadvantaged. Specific program activities and responsibilities and plans will be discussed under each program.

The responsibility for coordinating all activities related to the aging, long-term care and the Nursing Home Improvement Program was assigned to the Office of the Deputy Administrator for Health Services Delivery, and an Associate Deputy Administrator for Health Services Delivery (Nursing Home Affairs) was appointed to give direction to these efforts through a focal point for aging designated by each of the Programs and the regional offices.

A Working Agreement between the Administration on Aging and HSMHA, which establishes a basis for joint working relationships between the two agencies, was signed in April 1972. Emphasis is being placed on the development of joint objectives which will further linkages between AoA- and HSMHA-supported programs at the local and regional levels.

National Center for Health Statistics

All health statistics prepared by the National Center for Health Statistics (NCHS) can be presented in terms of specific age groups. These have been summarized for the aging in a report "Health in the Later Years of Life."

Measures of morbidity among the noninstitutional population include the incidence of acute conditions and injuries, number of days of disability, prevalence of chronic conditions, and the number of persons whose activities are limited due to chronic conditions. The latter category is the measure of health status which increases most rapidly among the elderly.

These data from the household Health Interview Survey are usually presented for the broad age groups 45-64 and 65 and older so that some other characteristics which are related to both age and health can also be shown: family income, educational attainment, and living arrangements. Also reported in the interview survey are number of visits to physicians, medical specialists and dentists, episodes of hospitalization, days of hospitalization, expenditures for various types of

health services, and sources of payment.

Health Interview Survey reports published in 1972 and which emphasize the aging are "Age Patterns in Medical Care, Illness, and Disability," "Home Care for Persons 55 Years and Over," and "Convalescence at Home Following Hospitalization Among Persons 55 Years of Age and Older."

The Health Examination Survey of smaller national samples of the noninstitutional population yields high quality diagnostic data on some of the chronic diseases most prevalent among older people--specific types of heart disease, hypertension, arthritis, visual and hearing defects, and dental conditions. It also provides data on several physiological characteristics (height and weight, serum cholesterol level, blood glucose level, blood pressure) and on symptoms of psychological distress. In addition, current examinations include assessment of nutritional status. In this Health and Nutrition Examination Survey, the aging have been over-sampled to insure reliable statistics.

Separate surveys are made of the residents and patients in both long- and short-term care institutions--chronic disease hospitals, nursing homes, and general hospitals. These surveys provide data, classified by age and other characteristics, on utilization, diagnosis, medical and nursing care received and costs. "Charges for Care in Nursing Homes," (1972), a report from a recent Nursing Home Survey, includes data on coverage by Medicare and other types of medical assistance payments. Also published in 1972 and from the same survey were reports on "Employees in Nursing Homes" and "Services and Activities Offered to Nursing Home Residents."

Current activities include plans for a major national survey of 2,000 nursing homes with highly skilled employees. This survey will provide data on the operating costs of the homes and on the characteristics of employees on their staffs. In addition, data will be collected on approximately 20,000 resident patients in these homes. These data include socio-demographic characteristics, mental status, health status, assistance needed in performing activities for daily living, diagnoses, medical history and last examination, charges and source of payment, and any discharge plans. Pretesting of this survey will take place in February 1973, data collection in July-August 1973, and release of preliminary data in December 1973.

The National Center for Health Statistics also produces the national and State life tables and data on causes of death by demographic characteristics and geographic distributions of the population.

Center for Disease Control

The activities of the Center for Disease Control, in focusing on the preventive aspects of health services delivery and the quality of delivered services, protect and benefit the general public. Normally, these activities are not specifically targeted on the aging; but, because of their special health needs, this group is frequently reached with services. For example, the aging is one of the population groups with special nutrition-related health needs. Problem areas

such as iron deficiency anemia could potentially be prevented by use of enriched foods. The Center has funded a demonstration project to determine the effect of food supplementation on health, through comparison of institutionalized and noninstitutionalized groups of elderly persons who have been supplied with nutritionally supplemented foods.

National Institute for Occupational Safety and Health

The National Institute for Occupational Safety and Health (NIOSH) is the principal Federal unit responsible for conducting research for new occupational safety and health standards governing exposure to on-the-job hazards. This includes the conduct of industrywide studies aimed at determining the effect of long-term exposures to industrial materials, processes, and stresses on the potential for illness, disease, or loss of functional capacity in aging adults. The results of these studies will be published, the first of the series to be available in the spring of 1973.

NIOSH's industrywide studies focus on a variety of specific industries, ranging from asbestos workers to dentists and heavy construction workers. The studies are carried out on an in-house basis as well as through grants and contracts.

Bureau of Community Environmental Management

The Bureau of Community Environmental Management encompasses a broad systems approach to community management and residential environments to protect and enhance health and well-being. The Bureau's programs are oriented toward community organization for self-help.

Although having no specific programs for the aging, consideration is given to this factor in the design of activities and programs for implementation at the community level, e.g., development of housing and building codes and standards, building and fire safety standards for nursing homes, and research studies directed at the cause and prevention of burns, asphyxia, falls and accidents in general.

Nursing Home Ombudsman Demonstration Program

The Nursing Home Ombudsman Demonstration Program was developed in response to President Nixon's August 1971 charge to HEW "to assist the States in establishing investigative units which will respond in a responsible and constructive way to complaints made by or on behalf of individual patients" in nursing homes. Within HEW, HSMHA was delegated the responsibility to implement this initiative.

A Task Force was appointed to study and plan the application of this approach to nursing home problems. Representatives of all involved agencies within HEW, plus the Veterans Administration and OEO, composed the Task Force.

In its study, the Task Force indicated that in addition to providing an easily available mechanism for complaint resolution, ombudsman programs have great potential for identifying gaps and deficiencies in nursing home services, in stressing the accountability of nursing homes for quality of care, in stimulating the self-reliance of patients and their families in securing better care, and in promoting communication and coordination among regulatory and service agencies.

Since the application of the ombudsman principle in the nursing home field is a new experience, the Task Force recommended demonstration and evaluation in order to determine the effectiveness and appropriateness of various approaches to providing ombudsman services. The major distinction between approaches was concerned with the auspices under which the demonstrations would be conducted, i.e., State government or a voluntary organization of senior citizens. Guidelines for proposals to implement each of the models were prepared, and all State governors and many national voluntary organizations were requested to indicate their interest in submitting proposals which were evaluated by members of the Task Force. The major technical criteria used were the adequacy of the plan to implement the project and the ability of the project to operate objectively and independently.

On June 30, 1972, five contracts were awarded for the establishment of Nursing Home Ombudsman Demonstration Projects. Four of the contracts are with State governments to establish a State-level office linked to a local-level unit. The States are Idaho, Pennsylvania, South Carolina and Wisconsin. The projects are located in agencies which are not responsible for the regulation of, or services to, nursing homes, in order to permit operational independence and objectivity.

The fifth contract is with the National Council of Senior Citizens, a national voluntary organization, for the establishment of a national-level Nursing Home Ombudsman Office linked to a State-level and two local-level units in Michigan. This project relies heavily on the use of volunteers in complaint receipt and resolution and should provide interesting comparisons with projects conducted under State auspices.

The primary task of each of the projects is to establish an effective, viable mechanism for complaint receipt and resolution. In addition, each will document and communicate broad issues requiring system changes in the regulation of institutions and services to long-term care patients.

Much of the first phase of operations has been devoted to recruiting and training staff, establishing policies and procedures, and building working relationships with regulatory and service agencies, and with community groups.

Evaluation of the demonstrations is an integral part of the program. Assessment of the effects of location and auspices of the projects, modes of operations, differential use of staff, linkages with agencies and community groups will provide valuable knowledge which can be used by other States or organizations in providing similar services.

This program is located in the Office of the Deputy Administrator for Health Services Delivery.

Community Health Service

The Community Health Service stimulates, conducts, supports and evaluates programs designed to increase the effectiveness and efficiency of allocating and utilizing health resources for quality

preventive and curative health services obtainable and acceptable to the American people. To this end, the Service promotes, develops, and supports: (1) programs of health care focused on the needs and entitlements of individuals and families wherever they live, but with special emphasis on health services scarcity areas; and (2) standards and evaluative activities as a means of increasing the Nation's capacity for delivering quality health services.

In all of these activities, it is recognized that the unique health needs of the aged often necessitate health services specially designed or specially adapted to meet these needs.

Long-term Care Program

Aging and Long-term Care--A reorganization of the Community Health Service in October 1972 placed a greater focus on aging and long-term care through the creation of an Office of Long-Term Care Services in the Division of Health Care Services. The newly created Office carries out the following functions: (1) serves as focal point for testing methods to improve long-term care and translates improved methods into operation of direct health care projects; (2) develops methods to integrate general health care services with long-term care institutions; (3) provides leadership and coordination for the planning and development of programs in long-term care education; (4) maintains liaison with Federal, State and nongovernmental organizations and agencies concerned with extended care facilities, nursing homes, home health agencies, hospitals and programs for the aging; and (5) identifies gaps in existing authorities to meet priority needs of the elderly and develops suggestions, plans or legislative specifications for inclusion in long-range plans and legislative proposals.

New Strategies for Long-term Care--During the latter part of the year, attention was given to the nature of services relating to long-term care of the elderly in the direct health care programs of the Community Health Service. It was obvious that a serious hurdle was the lack of reimbursement for long-term care available through such centers and in the home. This led to a reordering of priorities to place special emphasis on the development of strategies to expand and improve long-term care in ambulatory care settings. Such settings include neighborhood and family health centers, health maintenance organizations, and outpatient departments of public hospitals. An example of such special efforts is a contract with the Atlanta Southside Comprehensive Health Center: "A Demonstration of the Development of Home Health Services through a Neighborhood Health Center and Total Community Effort."

Short-term Training--As part of President Nixon's national program for improving the quality of care in nursing homes, DHEW was directed to institute a program of short-term training for nursing home personnel; and the Community Health Service was designated as the lead agency for implementation of this directive. Prime responsibility for carrying out this function was assigned to the Office of Long-Term Care Services; and the activity was given priority status.

During 1972, several approaches were taken to implement the President's initiative. Seven Statewide programs were developed for multidisciplined training activities to provide a wide range of training approaches and to demonstrate the value of new methodologies for all categories of nursing home personnel. Contracts were awarded to the following States or organizations: University of Alabama; South Carolina; Colorado Health Care Association; University of Pittsburgh; Iowa Nursing Home Association; Ohio; and Minnesota Nursing Home Association.

The following national professional organizations were awarded contracts to develop training programs on a nationwide basis: American Nursing Home Association, to train 10,000 personnel who work in nursing homes in ways to expand, develop and enrich the lives of nursing home patients; the American Medical Association, to train 300 nursing home medical directors and 300 nursing home administrators to work as nursing home medical directors and to upgrade the abilities of physicians who already hold such positions; the American Nurses' Association, to train 3,000 registered nurses in geriatric nursing; and the Association of University Programs in Hospital Administration, to develop and test in-depth training curricula for nursing home administrators. Contracts were also awarded for the development of audiovisual programmed instructional materials for the training of nursing home personnel, and for the evaluation of the effectiveness of all the short-term training contracts.

Professional Education--A comprehensive body of knowledge in applied gerontology was developed and made available to the public by CHS as a training resource in a series of publications entitled "Working with Older People: A Guide to Practice." These volumes are: Volume I, "The Practitioner and the Elderly"; Volume II, "Biological, Psychological, and Sociological Aspects of Aging"; Volume III, "The Aging Person: Needs and Services"; Volume IV, "Clinical Aspects of Aging." All four volumes continue to be in heavy demand for use in short-term training programs and in undergraduate and graduate teaching programs.

In-home Services--Interest in the potential of in-home services has been increasing in all areas of our health and welfare systems. In-home services are stressed as an "alternative to institutional care" in health programs, and as an essential component in ambulatory care systems. They are repeatedly referred to as the most needed service for the aging population, for the chronically ill, and for the disabled. This interest has produced a variety of approaches, many of them underlining or demonstrating the potential value of such services. They have not yet produced a national policy.

Significant events in the promotion, development, and expansion of home health services by CHS during 1972 follow.

Assistance was provided in the preparation of the Report to the Special Senate Committee on Aging by Brahna Trager, entitled "Home Health Services in the United States" (April 1972). The report served as a springboard for a national expert meeting on "In-Home Services - Toward a National Policy," held on May 31 - June 2 where the following key recommendation was made: "In order to insure the right of individuals to live a full life in the place of their choice,

we recommend that the top national priority be given to the development of a rational system of comprehensive in-home services with emphasis on the prevention of illness and disability (Physical, mental and emotional) and the promotion and maintenance of health. A crucial problem which this program should be designed to avoid is the unnecessary displacement of persons because of lack of services."

As an outcome of this conference, a 2-day working conference on "Comprehensive Health Planning in Home Health Care" was held in Charlottesville, Virginia, on August 28-29. The 33 participants who represented various disciplines included planners, providers and third-party payors. Proceedings are being prepared.

Last year, special emphasis was placed on data collection. A special home health agency encounter form was developed to collect data on the functional evaluation of the patient, the care given, and the costs related to such care. In addition, efforts are being made to develop a problem-oriented medical record for use in home health agencies. An inventory of the basic in-home services is being conducted under contract with the National Council of Homemaker-Health Aide Services. Technical materials developed during the year include two basic documents dealing with the planning, organization, and operation of home health service programs and a publication directed to families of the elderly on care of the older person in the home; all of which will be available early in 1973.

Related Programs--Development of Day-Care Centers for the infirm elderly are being considered as an alternative to institutional care. A state-of-the-art paper on Day Care has been developed for the Office of Long-Term Care Services, and plans are underway to sponsor a Conference on Day Care in early 1973. This conference will bring together representatives of ongoing Day-Care programs along with representatives of newly developing programs for an exchange of information.

The effectiveness of health maintenance in housing for the elderly as an alternative to institutional care is being investigated. A state-of-the-art paper on this service in Rhode Island is currently in preparation, and future efforts will be directed at determining the feasibility of developing such services in conjunction with existing health services delivery systems such as neighborhood health centers and family health centers.

Comprehensive Health Care Services

Along with his concern for improving nursing home care, the President assigned a high priority to the development of alternatives to institutionalization for the elderly. In his address to the White House Conference on Aging in December 1972, he said: "The greatest need is to help more older Americans to go on living in their own homes." Among the services needed to maintain an individual in an independent state are many that relate to social and economic factors. Basically a foundation of comprehensive health services (provided in ambulatory care settings or in the home), available and accessible to all older persons, should be provided by all communities.

Neighborhood and Family Health Centers--To date, 67 health centers have been developed, aimed at a target population of about 1.2 million persons. The range of services delivered includes: preventive services and health maintenance; emergency services, screening and diagnostic services; treatment services; dental care; rehabilitation; home care; immunization; pharmacy; social services and outreach programs; and hospital referral.

Data gathered from a sampling of health centers during the latter part of the year pointed to an apparent underutilization by the elderly of some of these health centers, but revealed a high utilization of services by those elderly who came to the centers. Specifically, data from quarterly reports of a sample of nine health service projects revealed the following: 6.4% of the registered population of the sample group were over 65; 8.3% of the actual users of the sample group were over 65; during the sample quarter, 7.0% of all those who had one encounter were aged, 10.0% of all those who had two encounters were aged, 13.1% of all those who had three encounters were aged, 11.5% of all those who had four encounters were aged, and 16.3% of all those who had five or more encounters during the quarter were aged. Thus, it is significant that the aged, although representing only 6.4% of the registered population from this sample group, account for a much higher percentage of the utilization of services.

Migrant and Rural Health Services--As a group, the migrant family represents an underserved segment of our population in terms of most social and health services. The elderly migrant, generally uneducated, often unable to speak English, living in remote rural areas with no access to social services, suffers from an even more intensified lack of services. In addition, the elderly person who is no longer able to participate in the work force, may find himself left behind in a home-base area as the rest of the family travel north for 3 to 7 months of the year looking for work.

Of the 259,000 migrants who receive medical care under funds from Section 310 of the Public Health Service Act, about 3,000 are over 65 years of age. Most of them are women who are traveling with the families, serving as baby-sitters for their grandchildren and doing domestic chores for the family as needed. Within the often limited availability of local resources, arrangements are made by project workers for inpatient hospital and nursing home care for migrant seasonal farm workers and their families.

Medical Care Standards

When Medicare was enacted in 1965, the Secretary of HEW was required to establish national conditions of participation for a variety of providers of services to protect the health and safety of program beneficiaries. Prior to Medicare, little existed in the way of established professionally acceptable standards for some providers of services, particularly for long-term care facilities, home health agencies, and independent laboratories. Qualifications required for many types of health care manpower also were inadequate to ensure a safe level of quality of services. The Division of Medical Care Standards, working with the Social Security

Administration, was assigned principal responsibility for standard-setting and surveillance of the program, and for other professional health aspects of Medicare of direct benefit to program beneficiaries.

The objective of the Division of Medical Care Standards is the improvement of the health status of Medicare and Medicaid beneficiaries by ensuring that the types, quality, and quantity of services provided under the program are appropriate to patient needs. Since the onset of the program, the effects of the standards, along with their continuous evaluation and revision, have been to promote the upgrading of individual institutions and agencies, to improve State licensure and certification programs, and to stimulate changes in national accreditation programs. In establishing standards and surveillance techniques for individual health care practitioners, problems of qualifications and availability have proved difficult. However, Medicare has helped to focus attention on problems of health manpower--from physicians to nurse aides--including their supply and the surveillance of the services they provide. Various techniques, for assuring quality of services without unduly limiting the supply of health care personnel, including the utilization of proficiency examinations for selected categories of such personnel, are undergoing study and experimentation; and Medicare, through the Division of Medical Care Standards is in the forefront of these efforts.

Currently, the conditions of participation for providers of services are being totally revised. This is the first complete revision since the original conditions were implemented more than 5 years ago. The Health Insurance Benefits Advisory Council has approved revised conditions and is soon to consider the new single set of regulations to cover skilled nursing facilities (formerly skilled nursing homes under Medicaid, and extended care facilities under Medicare) as mandated on passage of the Social Security Amendments of 1972 (Public Law 92-603). When these have reached the regulatory stage, the Division of Medical Care Standards will assist the Bureau of Health Insurance in the revision of guidelines and survey report forms required for implementation of the revised standards.

The Division has instituted several ongoing programs to promote and maintain the quality of care provided to elderly persons. Chief among these are the joint SSA/CHS program reviews of State Medicare agencies, during which evaluation is made of the effectiveness of program policy and guidelines and the manner in which these are administered in the States. Of more direct benefit to program beneficiaries is the Division's promotion of quality assurance mechanisms including utilization review, through which physicians evaluate services provided to beneficiaries to determine that such services are reasonable and necessary, rendered in appropriate settings by qualified health professionals, and performed at the right time, in the right amounts. The main thrust of utilization review activities will be to increase the effectiveness of surveillance of quality and appropriateness of services, particularly in those institutions and agencies in which the concept of utilization review was nonexistent prior to Medicare. The Division has been the principal proponent in establishing medical care evaluation studies, a mechanism for evaluating the quality and effectiveness of health services, as an

integral component of the Utilization Review process. A principal and rewarding function of the Division's medical staff is to provide consultation to SSA on medical problems that arise, many of which are connected with review of the appropriateness of care provided to individual Medicare beneficiaries.

Another ongoing comprehensive program instituted in 1970 was to improve the interpretation and uniform application of Federal health care programs by State agency personnel through training and evaluation of individual surveyor performance. This program was developed to meet a specific need following the enactment of Medicare and Medicaid, and has been supported by the States, the Social Security Administration, and the Social and Rehabilitation Service, all of which have assisted in its development. The health facility surveyors who are being trained through university-based courses have a major responsibility for ensuring that nursing homes, extended care facilities, hospitals, and home health agencies provide safe and adequate care and comply with required standards in serving Medicare and Medicaid beneficiaries.

In Chicago on June 25, 1971, in remarks to a Joint Conference of the National Retired Teachers Association and the American Association of Retired Persons, the President referred to the "depressing" nature of some nursing homes. In August he announced a Plan for Action to improve the quality of care provided in the nursing homes of our country, as a result of which the Federal Program (Health Facilities Survey Improvement Program) was expanded to provide training for 2,000 State nursing home surveyors. Since the inception of the program 774 State surveyors and 143 Federal employees have completed the courses.

Still another way in which the Division has a relationship to the health services for the aged is by recommending changes in Medicare policies and legislation, and in conducting studies. Some of these recommendations and studies have directly affected the accessibility, quantity, and quality of care in the Medicare program.

The Division will play a focal role in implementing the Medicare-related Social Security Amendments of 1972, with emphasis on Professional Standards Review Organization and Medicare-Medicaid State agency coordination, and in providing professional support in administering the additional benefits contained in this legislation.

Relationships with Other Agencies

The Office of Long-Term Care Services central headquarters staff and Long-Term Care Education Coordinators in the regional offices are continually providing technical consultation to the Administration on Aging in the development of the Areawide Model Projects relating to alternatives to institutional care. Consultation has also been provided to other component programs of the Social and Rehabilitation Service and the Social Security Administration concerned with health and health-related programs for the elderly.

Staff members of the Office of Long-Term Care Services also provided consultation and participated in activities sponsored by the Veterans Administration, including the planning and conduct of conferences on alternatives to institutional care and planning for a series of seminars on orientation of health practitioners on the subjects of the continuum of care, dying and death.

Technical consultation has been provided to HUD on health maintenance needs and services in housing for the elderly.

In response to requests from voluntary and professional organizations and educational institutions, CHS staff have served in faculty and resource capacities in a broad range of programs relating to health services for the elderly.

Indian Health Service

The Indian Health Program serves 475,000 Indians and Alaska Natives living in geographic and cultural isolation on 250 Reservations and in Indian communities located in 24 States, including hundreds of villages in Alaska.

The approximately 27,500 aged 65 and over (6 per cent of U.S. Indian and Alaska native population) and the 61,200 persons from 45 to 65 years, within the Indian Health Service population are reached through comprehensive health care provided through the Indian Health Service system of 51 hospitals, 84 field health centers, over 300 health stations located in the vicinity of Indian family groups, and through a contract medical care program. These health and health related services covering the life span of this service population have resulted in a decline of death rate of Indian Health Service beneficiaries by 15 per cent from 1960 to 1971.

While attending to the health needs of the elderly, a major objective of the Indian Health Service is to advance the health level of the young and to maintain their health gains thus achieving a larger older age segment of the population with improved health status.

Federal Health Programs Service

The Federal Health Programs Service has no programs which of themselves relate directly and specifically to aging, but provide services to the older age groups in the hospitals and clinics. For FY 71, of a total of 35,276 discharges from hospitals of the FHPS, 3,959 were over 65. The average length of stay for elderly men was 21.4 days and for elderly women was 21.0 days, compared with an average length of stay of 16.9 days for all patients. Consistent with this finding is the fact that older patients are affected to a greater extent by chronic conditions, older patients tend to receive longer periods of hospital care than younger patients.

A high proportion of elderly persons receiving inpatient services are American Seamen, who constitute the primary beneficiary group cared for in PHS hospitals. The problems presented by this group of patients are similar to those presented by aging patients in general, with one exception: there are probably more single males in this group than in the general population. Because of this, finding suitable nursing homes for their long-term care constitutes one of the real problems in meeting the needs of aging patients served by FHPS.

National Health Service Corps

While there are no activities specifically earmarked for the aging, some general comments about the relationship of the program to the aging can be made.

The Corps' activities are directed to areas which are "critically short" of health personnel. While it is difficult to generalize, these areas are usually of two general types--urban inner cities or remote rural areas. Both of these types of areas have heavy concentrations of older persons who either cannot move elsewhere or do not wish to do so. The guiding principle behind the Corps is the idea that simple residence in a certain type of area should not by itself be a barrier to effective health care. By assigning its personnel to such areas, the Corps hopes not only to alleviate the immediate health care needs of the target populations, including the elderly, but by so doing to make such areas more attractive places to live for the long term.

The Corps will devote much attention to the problem of developing effective outreach systems for getting care to those who need it; certainly the elderly are particularly in need of such outreach. The Corps will work closely with organizations of and for the elderly wherever it can, drawing on them as other community groups, for support and assistance. It is a cardinal rule of the Corps that its services are designed by and for the communities involved. Since the elderly form a large proportion of the population in many of the areas, it is expected that they will play a major role in Corps' activities.

National Center for Health Services Research and Development

The role of the National Center for Health Services Research and Development in long-term care for the elderly is part of a positive coordinated response by the Office of Nursing Home Affairs in the Office of the Assistant Secretary for Health.

The efforts of NCHSRD have been channeled down three avenues:

1. Implementation of Long-Term Care for the Elderly Research Review and Advisory Committee (LTCERRAC) whose purpose is to:

   a. Provide a coordinated professional technical review of proposals submitted to DHEW concerning long-term care for the elderly; and

   b. Identify problems and issues and develop a tentative ordering or priorities in long-term care for consideration by the Office of Nursing Home Affairs in the Office of the Assistant Secretary of Health

2. Development of a strategy for research in cooperation with the LTCERRAC

3. Initiation of directed research projects using the grants and contracts mechanisms.

During FY 72, NCHSRD initiated a program of directed research focusing on long-term care for the elderly. Projects of this program will continue through FY 73, along with new projects to be initiated in FY 73. Research and development funds were allocated from the FY 72/73 supplemental appropriation designated for the Nursing Home Improvement Program. Projects were funded to obtain the desired directed research for measurement of the quality of long-term care, alternatives to institutional care, and data systems for planning and managing quality care programs for the elderly. Each research and development project supported by NCHSRD is intended to produce results that can be tested and evaluated on a national scale.

Projects initiated during FY 72 have been programmed and selected using the peer review mechanism, to provide the best possible utilization and application of research findings. For example, two projects have been funded that are concerned with the development of indices for quality of care. One project is short-range (8 months) and is designed to assemble and pilot test objective scales for measurement of quality of care in nursing homes. A significant research effort has been expended in recent years to develop workable scales to assess objectively, facility environment, patient needs, and patient placement. These efforts, however, served their separate purposes at different times and were not interrelated. The purpose of this contract is to synthesize past efforts into operationally useful instruments for objective measurement of quality of care. A longer range project has also been funded to develop and demonstrate a system for assessing the status of long-term care patients so that their social, psychological, and physical needs are met most effectively. The two projects described complement each other and, through an established Design Advisory Group, results are shared.

NCHSRD will also attempt to emphasize utilization of research from other projects in long-term care. For example, an on-going 3-year developmental project is directed at the investigation of the premise that a medically based determination of the care needs of the chronically ill and aged results in higher percentage of appropriate placement. Findings to date show that at least 25 percent of beneficiaries are now utilizing appropriate services, resulting in a potential savings of approximately 10 percent to the Medicaid program.

NCHSRD is integrating its strategy of research and development in quality of care of the aged with other quality assurance research programs, such as the Experimental Care Review Organization. The Experimental Health Delivery Systems projects and the Federal-State-Local Data Systems projects also offer opportunities for integrating and utilizing research concerning long-term care for the elderly.

NCHSRD is sponsoring six projects funded under the Nursing Home supplemental appropriation. Some of these will continue into FY 73 and 74 and will dovetail with other long-range research and development projects previously initiated by NCHSRD. For example, one long-range innovative project, building on previous research and development work, is demonstration and evaluation of a mobile "chronic disease module." This is intended to increase the community's capability to provide unbroken care to its chronically ill, especially where services are nonexistent or weak. This project includes defining and training new categories of manpower to function as health assistants. Another manpower development project culminating in FY 74 is the evaluation of the Family Nurse Practitioner Program (PRIMEX), where attempts are being made to measure the effects of the expanded role of the nurse on patient satisfaction, the quality and comprehensiveness of health care provided, and the cost of providing the care to an elderly population.

As the results of these programs emerge, new areas for research will become apparent. FY 74 projects will deal with expanded assessment of measurements of quality of care and life; development of interlocking data sets representing different levels of care; thorough documentation of the cost-effectiveness of ongoing and experimental alternatives to institutionalization; and precise role specification for various types of manpower. Additional emphasis will be placed on population studies examining patterns of needs and survival strategies of the elderly. Knowledge of existing patterns of needs and needs fulfillment is seen as essential to the rational planning of services in a rapidly changing and complex industrial society.

Health Care Facilities Service

With the enactment of the Hospital Survey and Construction Act of 1946 (Public Law 79-725), grants were made available to the States to assist in constructing, equipping and modernizing nonprofit privately and publicly owned hospitals and public health centers. Over the years, various amendments to the original legislation changed the scope of the Program to encompass other categories such as long-term care and outpatient facilities. Most recently, the Medical Facilities Construction and Modernization Amendments of 1970 (Public Law 91-296) further broadened the Program to include loan guarantees with interest subsidies for nonprofit hospitals and direct loans for public hospitals to aid in modernizing or constructing health care facilities.

As of January 1973, the Hill-Burton Program had provided assistance for the construction of 99,400 long-term care beds in nursing homes, chronic disease hospitals, and long-term care units of general hospitals. These 1,769 projects, which primarily meet the needs of our aged population, accounted for $537 million of Hill-Burton funds, or 14 percent of all funds expended during the life of the Program.

Our aging and aged also extensively utilize the other health facilities constructed or modernized under the Hill-Burton Program--hospitals, outpatient facilities, public health centers, and rehabilitation facilities. With high priority currently being given to the expansion and improvement of outpatient care services for all age groups, nearly half (47 per cent) of the projects approved for grant funds during FY 72 were for the construction or modernization of public health centers, outpatient facilities, and rehabilitation facilities.

Comprehensive Health Planning Service

Comprehensive health planning concerns itself with the total health needs of all the population. As of January 1973, there were 56 State agencies and 198 areawide agencies. The latter covered 70 per cent of the population and the former the entire population.

The broad concern of comprehensive health planning and the freedom of choice allowed in actual operations has led to a great variety of activities including many having to do with the health needs of the aging.

A telephone survey was made in January 1973 to find examples of the types of activities being carried out on aging by comprehensive health planning agencies. Seventy-one examples were reported of which 14 were State activities. Some of the examples included several types of planning activities and advocacy action areas. The type planning functions and activities reported included 31 surveys or studies of which publications were reported for 11; 28 coordination or linkage activities; 17 agency committees or task forces with eight reporting priority-setting functions and six reporting written plans on aging topics. The advocacy action areas reported included 10 on health facilities, 11 on health services, six on housing, two on coordination and referral, two on legislation and two priority activities on getting patients out of mental institutions and into homes.

Regional Medical Programs Service

Great impetus has been given to health care of the American people by the focus of the Regional Medical Programs on accessibility, efficiency, efficacy, and high quality of care. A network of 56 individual RMP's has promoted and demonstrated new techniques and innovative delivery patterns; supported training which results in more effective utilization of health manpower; and encouraged the regionalization of health facilities, manpower and other health resources.

Originally initiated as a program to attack heart, cancer, stroke and related diseases, the Regional Medical Programs Service broadened its concerns and adopted a more comprehensive approach, with emphasis extended to hypertension, kidney diseases, diabetes, and pulmonary diseases, among others. All of these diseases affect the health of the aging and aged, thus lessening the impact of chronic long-term illness.

Currently, in the 56 Regional Medical Programs there are a total of 978 ongoing programs and projects to which operational grants in the amount of $73,525,711 have been awarded. Three hundred and sixty-eight projects (over 37.6% of the total number of projects) and $25,441,342

(34.6% of the total funds) are allocated to categorical disease activities specifically to heart diseases, diabetes, and pulmonary diseases. The disease categories enumerated are primarily diseases of the aging and aged; and, while they are not specifically focused toward the "65 years and older" age group, the activities include these diseases as an integral part of the coordinated system that provides comprehensive health care to the adult population. Twenty-four of these 368 projects (6.5%) are specifically designated as targeted toward the age group 65 years and older. A year earlier, only three of 294 projects (just over 1%) were so designated.

From another point of view, 204 projects have been specifically designated as providing services under the following headings: extended and long-term care projects, 33; home health care, 46; inner-city poor, 74; other rural poor, 27; and poor, not specified, 24.

In the area of stroke, the Virginia RMP initiated a treatment and rehabilitation program in a rural community whereby seven rural physicians were given training and consultation. Approximately 300 patients received benefits from this project, which is continuing under the aegis of the Medical College of Virginia, after receiving 2-1/2 years of RMP support. The medical director of the project is volunteering to provide consultation gratis, while the rural physicians are contributing funds for support.

Six hospitals in Monmouth and Ocean Counties, New Jersey, are cooperating in a comprehensive stroke care and educational project for physicians and nurses. It is aimed toward improvement of patient care. This area of New Jersey has a large percentage of the State's aging population and stroke patients. The project is purported to have improved management and treatment of stroke patients.

In approximately 5 years, the Presbyterian Hospital, Dallas, Texas, through support from the Texas RMP, treated over 975 patients in its stroke demonstration project, although it was originally designed solely as a teaching-service program so that physicians, nurses, and allied health personnel could be better trained to deal with the aging and aged stroke patient. As an ongoing activity (no longer supported by the Texas RMP), between 15 and 20 patients are seen monthly.

Washington/Alaska RMP has helped to establish two rural health clinics for the elderly who live in isolated areas and depend upon nurse-practitioners for everyday medical treatment. Two additional clinics are scheduled for establishment and attest the success of the project.

Because high blood pressure may not manifest any signs or symptoms until it strikes its victims with "heart attack," stroke, or kidney disease, a vigorous search has been undertaken by the Georgia RMP in its community hypertension program. For the past two years this program for the detection and control of this disease has been in operation.

Health Maintenance Organization Service

The Health Maintenance Organization Service (HMOS) was established within HSMHA in 1971 to serve as the lead agency for HMO development. Such a program contains far-reaching importance to the elderly. The

HMO brings together a comprehensive range of medical services which it provides to all subscribers for a prepaid fixed contract fee. The older person has the option of joining an HMO for Part A and Part B coverage of Medicare or continuing to receive services in the traditional--and often fragmented--manner.

The recent passage of H.R. 1 "...authorizes medicare to make a single combined Part A and B payment, on a capitation basis, to a 'Health Maintenance Organization,' which would agree to provide care to a group not more than one-half of whom are Medicare beneficiaries who freely choose this arrangement." This will be effective July 1973.

During the calendar year of 1972, at least 10 HMO's became operational as a result of receiving financial assistance from HSMHA. A full range of technical assistance services is available to our current HMOS grantees to facilitate development into operational HMO's.

While HMO services are intended to be available to all, and not just to the elderly, the concentration on accessibility, prevention, efficiency, and cost consciousness will be of particular value to the elderly in view of their higher-than-average utilization of services.

National Institute of Mental Health

During the year the Institute intensified its activities to implement its focus on aging as a named priority. Progress was made in responding to the White House Conference recommendations, primarily in the area of planning and evaluation. Extramural research grants affecting the elderly were increased. Training activities were augmented, particularly affecting nursing home manpower. Hospital staff development and hospital improvement grants continued to benefit significant segments of the mental hospital geriatric population. Collaborative activity with other agencies, States, professional groups and citizen organizations provided a productive channel for mental health input in developing policies and procedures in furtherance of national program goals. State mental hospital populations, reflecting the impact of this and related activities, have continued to decrease. The elderly constitute the largest single age group in that population.

The Institute has engaged in a series of interrelated planning and evaluation activities directed at providing a firm data base for expanded programs for the elderly.

An Ad Hoc Inter-Divisional Work Group was convened in the early months of 1972 to review the findings and recommendations of the White House Conference on Aging, to guide in the development of comprehensive inventories of all the National Institute of Mental Health-funded service, training, and research projects related to the aging, to prepare for the development of a major evaluation of the National Institute of Mental Health aging program, and to begin to review existing data for the purpose of developing program plans for the aging.

A mental health stragegy was developed, a major planning analysis paper was completed in the autumn of 1972, a project to evaluate NIMH efforts in behalf of the mental health of the elderly was developed under contract and preliminary results related to research have been received. The final report should be available late in 1973 and will present data and conclusions related to services and training programs as well.

Training

The major portion of NIMH training funds concerned with aging is being used in support of training grants, including teaching costs and trainee stipends, fellowships and research development awards. There is increased interest in the curricula of mental health professionals and in the training of new types of workers to care for the elderly and provide preventive mental health services. Other training efforts related to aging are ongoing in the social work and continuing education programs, as well as the various behavioral sciences, including psychology, biology, sociology, and research development and fellowships.

In 1972, 20 institutions and 66 trainee stipends were supported under the training grants program, 10 fellows in 7 institutions were supported under the fellowships program, and 6 scientists and 5 institutions were supported in the research development program.

A new program of support for training of personnel employed in nursing homes and long-term care facilities was inaugurated in the fall of 1971. This program is part of a DHEW initiative for improving services to the elderly, and represents coordination of efforts of several organizational units within the Department, including the regional offices. NIMH is responsible for developing training activities designed to improve skills and increase knowledge of personnel in the mental health aspects of long-term care, with special concern for preparing staff to meet the special needs of former mental hospital patients being placed in nursing homes. Plans are underway for some joint project support in FY 73 to demonstrate the integration of mental health concepts into general nursing home training programs.

There are 5 demonstration training projects in 5 training sites, and one national project which is being conducted in collaboration with the Gerontological Society.

Special Programs

Staff continues to collaborate with other DHEW agencies in special programs resulting from the President's Nursing Home Program, initiated in August 1971. A task force formed to assist the States in establishing Investigative-Ombudsman Units has studied criteria for implementing the Units. A related subcommittee has completed a policy paper outlining conceptual and operational framework for five demonstration projects which are now underway. Staff continues to work with the HSMHA Project Director on ombudsman issues relating to mental health.

The Institute participated in selected State program audits on the Medicaid program to evaluate the coverage and effectiveness of mental health provisions of the State plans.

Staff has collaborated with Community Health Services, Medical Services Administration and Bureau of Health Insurance in the formulation of new regulations for skilled nursing facilities (H.R. 1 requirements).

Staff has continued to participate in the development of new Intermediate Care Facility Standards under Title XIX. In addition, staff will assist the Medical Services Administration in developing regulations and guidelines for the implementation of new legislative provisions which call for periodic on-site inspections of Intermediate Care Facilities and increased Federal authority to institute life safety codes in Intermediate Care Facilities.

Staff continues to participate in the training programs for State surveyor personnel, in addition to participation in workshops with Community Health Services, Bureau of Health Insurance, Medical Services Administration and training faculty from three surveyor basic training programs to study, evaluate, and suggest changes in total program. A manual prepared for use in mental health programs for State surveyor personnel which was developed with Tulane University School of Public Health has been completed, published, and is currently being used ("Psychiatric Services in Health Care Facilities," 1972).

A document, "It Can't Be Home," prepared by Institute consultants, became available in January 1972. It describes the social and emotional aspects of residential care and is being widely distributed and utilized in training of nursing home personnel. A script which will be used for developing an audiovisual aid tape has been completed and will be used to supplement training for mental health personnel.

Community Mental Health Centers Program

All Community Mental Health Centers are required to provide the five essential mental health services to all ages of the population for which they are responsible. Within the 325 centers operational as of June 30, 1972, 50 centers additionally provide for special services to the aged. Data reveal that the aged are receiving services but in lower proportion to their percentage of the general population.

The Institute has become increasingly aware of the seriousness of the unmet needs of the aged and has encouraged Community Mental Health Centers to do more.

The National Institute of Mental Health has also begun to study the multiple relationships between Community Mental Health Centers, State hospitals, and other community agencies that will be necessary to alleviate mental health problems of the aged.

Annual site visits and consultation to Community Mental Health Centers for the past two years have highlighted this need and urged concentrated effort to attain a higher standard of care for the aged population in each Community Mental Health Center catchment area.

Hospital Improvement Program

The Hospital Improvement Program is directed toward improving the treatment, care, and rehabilitation of the mentally ill in 302 eligible State-supported mental hospitals throughout the Nation. It is specifically focused on the use of current knowledge in demonstrating

improved services for patients, stimulation of the process of change and the development of relationships with community mental health programs. Funds are available through the grant mechanism for support of programs that are designed to explore and validate new methods of treatment, and to develop new knowledge.

During fiscal year 1972, seven projects were concerned with aged persons. Although each project used different methods to achieve its objectives, many noteworthy results were reported. Some of these were: minimizing the dependence on the hospital, the acquisition or relearning of social skills, restoration of physical functioning, higher rate of discharge, and remotivation in terms of individual skills and interests.

Hospital Staff Development

The Hospital Staff Development grant program is designed to stimulate and assist State mental hospitals, in initiating a sequence of change and improvements throughout the institution. It was also intended to help State hospitals achieve a more positive role as an integral part of community programs and to help the communities benefit from the unique contributions the institutions can make to comprehensive community programs.

The original goal was to strengthen and expand the training to provide opportunities for all levels of personnel to increase skills and knowledge in order to be more effective in meeting the needs of the patients by introducing active treatment methodologies. The service to patients has also been improved by changing the attitude and expectations of both hospital staff and the community in directions consistent with new knowledge about treatment and the social changes occurring in the country.

During the fiscal year 1972, 152 State hospitals were awarded grants. There are no records available on the number of aged served by staff who received training supported by Hospital Staff Development funds, as they are awarded to a hospital for total Staff Development. Records for 1970 indicate that there were 337,619 patients in State hospitals; of these 99,087 or approximately 33 percent were over 65. It is estimated that a good majority of these were benefited by this training.

Publications

Two major publications were issued on aging by the National Institute of Mental Health that are enjoying wide acceptance. They are: Human Aging II: An Eleven-Year Followup Biomedical and Behavior Study. This publication comprises the findings from an 11-year followup of the original human aging study performed at the National Institute of Mental Health.

The Aged and Community Mental Health: A Guide to Program Development, was produced in collaboration with the Committee on Aging of the Group for the Advancement of Psychiatry. This publication is intended to stimulate and provide program development guides for work with the aging on the part of Community Mental Health Centers.

A third publication, NIMH Research on the Mental Health of the Aging, was also completed and contains summaries of the research in mental health of the aging supported by the National Institute of Mental Health during the past 12 years.

In process are publications on:

1) A Social Work Guide for Long-Term Care Facilities

2) A Training Manual on Care of the Mentally Impaired Aged Individual

3) Retirement: Patterns and Predictions

Final revisions were made on the paper Patterns of Use of Psychiatric Facilities by the Aged: Past, Present and Future for publication by the American Psychological Association in their book Task Force Report on Aging. Publication date is set for early 1973. A shortened version of the paper with updated statistical data and other revisions in language and content aimed primarily at an audience of general physicians was prepared for publication by the American Psychiatric Association in their book Mental Illness in Late Life. The title of this revised paper is Epidemiology of Mental Illness and Utilization of Psychiatric Facilities Among Older Persons.

A Workshop to explore the use of volunteers dealing with the mental health needs of the elderly was held during the year. Participating were volunteers, volunteer coordinators, older persons and youth. A booklet, based on this meeting, is in the process of preparation. It is intended for use by Community Mental Health Centers, volunteers and programs both serving older persons and using them as volunteers.

State Program Development

In an effort to better respond to the mental health needs of the States, the Institute has inaugurated a process of State program development. Intensive activity has begun in two States, Ohio and Maine, both of which have specified aging as an area where resources need to be better synchronized.

The Director of the Ohio Department of Mental Hygiene and Mental Retardation established a Departmental Work Group for the purpose of: (1) studying the available approaches open to the Department in developing a comprehensive service delivery program for the aged in the State of Ohio, and (2) defining services, programs, staffing, and facility patterns for five proposed geriatric centers, each center to have a patient population of approximately 150 patients and located at the following sites:

Toledo Mental Health Center
Athens Mental Health Center
Dayton Mental Health Center
Hawthorndon State Hospital
Massilon State Hospital

As part of the State Program Development effort in Ohio, technical assistance and consultation was provided to the Work Group by Institute program specialists functioning as part of the State Program Development Team.

One of the State Program Development objectives for Maine is "Development of a State plan for coordinated services for the aged and implementation in at least one demonstration area." This objective was formulated as a result of the assessment of Maine's mental health system because it was found that the State hospital population was 40.8 percent geriatric, largely due to lack of alternatives to State hospitalization.

The State Program Development staff has met with the Director of the State Division of Services to the Aged to explore ways of collaborating in the development of plans and programs for mental health services to the aged on two levels: 1) planning for mentally ill aged; and 2) planning for the mental health of the aged.

The State will request the National Institute of Mental Health State Program Development staff: 1) to meet with the State Committee on Aging to discuss appropriate approaches to planning for the aged; and 2) to assist the Bureau of Mental Health and the Division of Services for the Aged to develop specific goals and objectives for providing services.

A State-wide network of senior citizens and councils already provides both planning and evaluation of services but has not yet addressed the mental health needs of the elderly. These groups will be involved in the State Program Development efforts to achieve the objectives.

National Institute on Alcohol Abuse and Alcoholism

A variety of the National Institute on Alcohol Abuse and Alcoholism programs have some bearing on meeting needs of the aged. The Occupational Alcoholism Program working with employees in the private sector through early identification techniques and rehabilitation gives leadership to program development that helps insure employability and productivity of people as well as the opportunity to enjoy increased longevity brought about by advances in social health technology. This illness allowed to go unchecked not only reduces life expectancy by 10 years but renders people helpless. Other programs of the Institute, such as those dealing with manpower development, treatment and rehabilitation techniques and services delivery systems, and prevention of alcohol abuse and alcoholism focus on helping people to help themselves whatever the age. These new activities have opportunity to begin meeting the specific and special needs of the elderly.

The National Institute on Alcohol Abuse and Alcoholism is also contemplating conducting a study of drinking practices and alcohol effects in people 70 years and older since there has been no systematic study of the value of alcohol for this special population. Emphasis is expected to be on normal use and possible therapeutic effects of alcohol in people of this age group.

III. 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 over, 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.

On October 30, 1972, the President signed Public Law 92-603, Social Security Amendments of 1972, which revised the present social security laws and added a new program to the responsibilities of the Social Security Administration. Benefit payments under this law for the Supplemental Security Income Program are made from general revenue to aged persons 65 and over and blind and disabled persons without regard to age. The purpose of the program is to guarantee a minimum income of $130 per month for an individual and $195 per month for a couple. Certain income disregards included in the law allow some limited additional income and encourage the recipients to work when they are able to do so. Lien laws are not applicable under the new program and generally recipients may retain their homes and automobiles. Eligibility requirements and benefit support levels are the same in all States. The States may supplement the Federal payments and are encouraged to do so by a provision whereby the Federal Government will pay the cost of administration for making these supplemental payments. The new program is effective January 1, 1974 and estimated benefit payments for the last half of fiscal year 1974 are $1,200,000,000.

In addition, on December 30, 1969 the President signed into law the Federal Coal Mine Health and Safety Act of 1969. Benefit payments are made under this law from general revenue to coal miners who are totally disabled due to pneumoconiosis ("black lung disease") and to widows of coal miners who died due to pneumoconiosis. These benefits are increased if the beneficiary has eligible dependents. Many of the beneficiaries are aged because the Act permits former coal miners and widows to qualify without any limitations on either age or how long ago the disability occurred. Benefit payments made by the Administration were approximately $408 million in fiscal 1972.

Of the 28.1 million beneficiaries receiving monthly social security benefits at the end of October 1972, about 21.1 million were age 62 or over. As of January 1973 approximately 91 percent of all persons age 65 and over will either receive old-age and survivors insurance benefits or will 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 1972 totalled 3.1 million.

The minimum monthly benefit for a retired worker who meets the regular insurance requirements is $84.50 and $126.75 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 $58.00 a month and for a couple $87.00 a month. Monthly benefits which were being paid at the end of November 1972 for retired workers without dependents averaged $157; for a retired worker and his aged wife, the average was $272; and for an aged widow, $138. 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 November 1972 were $165 for a retired worker with no dependents, $279 for a retired worker and his aged wife, and $149 for an aged widow.

Health Insurance Benefits

In fiscal 1973 an average of 20.9 million persons aged 65 and over in the United States will be 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. In addition, an average of about 20.4 million persons aged 65 and over are expected to be on the rolls of the voluntary supplemental medical insurance program in fiscal year 1973, 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 for persons aged 65 and over under the hospital insurance program are expected to total an estimated $6.6 billion in 1973 and $7.6 billion in 1974. Supplementary medical insurance payments for aged persons in 1973 and 1974 are estimated to amount to $2.4 billion and $2.7 billion, respectively.

Services to Aged Individuals and to Community Groups

The social security program is administered through a network of district and branch offices. Local communities are served by 638 district offices, 326 branch offices, and 3,452 resident stations and contact stations. Every attempt is made to tailor services to individual needs and desires. Thus, all offices provide face-to-face interviewing in the office or in the individual's home, telephone service, and mail service.

Social security district offices provide information to the public and answer inquiries about the benefits administered under the old-age, survivors, and disability insurance provisions of the Social Security Act. They also receive, develop, and initially adjudicate claims for benefits. Applicants are assisted in securing the factual information needed to determine eligibility for benefits and 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 adult beneficiaries who are incapable of management of their benefit funds, a person other than the beneficiary is selected by SSA to receive the checks and is held accountable for using the benefits in the best interest of the beneficiary.

Social security offices have traditionally answered inquiries for information related to the social security programs and, also, have provided a referral service to community members, groups, and agencies. In many communities the social security office is the only point at which information and referral services are available.

In the areas of community and Government-wide planning, SSA plays a vital role. Data about the numbers of aged, disabled, survivor, and health insurance beneficiaries is invaluable in planning services to meet existing needs, as well as in long-range planning endeavors. At the national level, SSA's planning is coordinated with planning of other departments, agencies, and organizations, both public and private, such as the Department of Agriculture, Public Health Service, Social and Rehabilitation Service, Department of Housing and Urban Development, the Office of Economic Opportunity, American Public Welfare Association, National Council on the Aging, National Assembly for Social Policy and Development, the American Red Cross, and other similar public and voluntary agencies.

Similarly, regional offices engage in planning and coordination of SSA activities at the regional level as these relate to other public and private agencies and programs that serve the aged. An example of SSA involvement in Government-wide planning and its commitment to providing services for the aged was demonstrated in the agency's involvement and participation in the 1971 White House Conference on Aging and subsequent follow-up. Another example of this involvement began with the advent of Medicare. Since that time there has been increased interest at all levels of the Government and in the private sector in the analysis of hospitals, ECF's, home care, and other health services. SSA's experience and data on incidents and trends will become increasingly useful to planning groups as implementation of the recently enacted P.L. 92-603 moves forward.

At the State level, SSA provides assistance to State health departments to fulfill Medicare requirements and to promote full potential for care of the aged in institutions, out-patient, and home care facilities. Also, activities and relationships with State departments of welfare will intensify as SSA takes on administration of the Supplemental Security Income Program for the aged, blind and disabled.

At the local level, SSA participates in inter-agency community planning for development of resources with health and welfare councils and representatives of local Government and welfare agencies. The following are illustrative of ways in which SSA cooperates with other agencies in planning programs for the aged which recognize their need for services, as well as their role as participating members of the community.

1. Working with the ACTION agency, SSA has initiated a number of experimental projects in which substantial numbers of older people have been placed in district offices and their service areas to perform a variety of activities. Some of these older people are volunteers; others are paid nominal amounts by ACTION through the Retired Senior Volunteer Program (RSVP) and the Foster Grandparents Program. Activities performed include clerical duties, screening of death records of mental hospitals for disability leads and of the Bureau of Vital Statistics for death records of women who were insured at death but on whose record no claim had been filed, assistance in situations requiring bi-lingual capability, information and referral aides.

2. SSA, in cooperation with the U.S. Department of Labor and the National Council on the Aging, is participating in projects to provide part-time employment to aged persons in need of income supplementation. Thirty-five senior aides have been placed in part-time positions in 12 district offices, and experience to date has been very positive. Most have performed clerical functions. In a few instances, more imaginative jobs were designed for them which resulted in

benefits to both SSA and the senior aides.

3. In Clearwater, Florida, a staff of senior citizen volunteers who want to contribute to the total effort of assuring that all eligible older people take advantage of health services available to them are providing free counseling and assistance in preparing applications for Medicare. The local district office cooperated with the project and provided training for the volunteers on Medicare eligibility, procedures for filing claims, and so forth.

4. Another project in Miami Beach, Florida, funded by the Department of Labor, provides supplemental income for part-time work to a number of older people who have been placed in SSA district offices on various temporary assignments.

5. One of the projects just initiated by SSA would employ senior citizens as information and referral aides in 30 district and branch offices and teleservice centers. These older people will be employed on a temporary appointment basis to perform basic I&R functions in the field facilities. Their activities are expected to include establishing and maintaining rapport in the community among the agencies and persons which provide needed services. It is expected that district managers will work with community organizations in their recruitment of these aides.

6. Cooperating with the Domestic Council, DOA, CSC, and ARC, an enclosure describing the food assistance programs and a return card to be completed by aged individuals who wanted additional information or assistance concerning their eligibility to food assistance was included in the approximately 24.5 million social security checks dated August 3. In addition, the same information was mailed to the approximately 1.5 million beneficiaries who do not receive monthly benefit checks but are entitled to Medicare coverage.

   In addition to this mailing activity, a nationwide public information campaign was launched in August. This campaign was designed to reach those elderly individuals who were not contacted as a result of the massive mail campaign.

The above and other projects sponsored by the Government and by private agencies have clearly demonstrated the effectiveness of older worker performance, as well as advantages to the retiree and to the employing agency. As a result of these and other successful demonstrations, SSA now has several models under consideration which would use the skills and abilities of elderly persons in a variety of ways.

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 Statistics, and other statistical sources.

IV. OFFICE OF EDUCATION

Under the provisions of Title I of the Library Services and Construction Act, the Division of Library Programs provides information and advice on programs oriented to the aging which are administered 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, State and local 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. Under LSCA Title I, the Los Angeles Public Library has a project which provides bookmobile service to shut-ins in their homes and institutions; in 1969, they added to this project a "books-by-mail" service to these shut-ins. The St. Lousi, Missouri Public Library has a project, started in 1969 under LSCA Title I and continuing in 1970, which is aiming for service to 85,000 persons over 65, the chronically ill and disabled shut-ins. Under this program, book carts are taken into 30 nursing and retirement homes and hospitals twice a month. A brightly painted, specially equipped van is used to bring the 1,000-book collection, including many, large-print books, to those people who cannot visit the library themselves.

Beginning with fiscal year 1972, funds under Title I of the Library Services and Construction Act are for the purpose of establishing and improving State institutional library services. Homes for the aged may be included in a State plan if these homes are operated or substantially supported by the State. The many aged residing in other State institutions are also beneficiaries under this program. Title I of LSCA also provides grants to States to establish and improve library services to the physically handicapped. Aged who are physically handicapped would also benefit from programs under this title. Most States are using some LSCA funds to develop programs and provide materials and services for the aged whether they reside in State institutions or are handicapped and live in their own homes, nursing homes, retirement homes, etc. Projects include such things as reading discussion groups, book talks, story hours, film programs, music programs, etc.

It is estimated that approximately $550,000 will be used in fiscal year 1973 for projects involving the aging. As more of the people over 65 and able to continue using regular library services are in State institutions, the need for specialized library projects for the "aging" decreases.

Community Service and Continuing Education Programs, authorized by Title I of the Higher Education Act of 1965, have initiated a number of projects designed to assist the older American.

In 1972, a total of 10,960 persons participated in 11 projects developed for older Americans in nine States at a cost of $129,000 in Federal funds. During the seven year period since its inception in 1966, about $1,260,00 in Federal funds were spent in this area, reaching some 92,000 people directly and over 100,000 through media services. In addition there were other institutional projects under this program which benefitted the older citizens but were not designed exclusively for them.

Recognizing that early retirement and advances in medical science have afforded the senior citizen many years of useful activities, the Community Service and Continuing Education Program is attempting to find solutions to the problems which confront the older adult and to increase the possibilities for effective utilization of this potential reservoir of knowledge, manpower, and experience. Projects with these objectives include:

(1) The training programs for administrators of care facilities for the elderly, interdisciplinary courses in social gerontology, home nursing, health, recreation, and employment for professionals and community leaders to aid them in working with the aged;

(2) Training programs for volunteers who counsel and work with the aging and who supervise leisure time programs for them in nursing homes and homes for the elderly;

(3) Job counseling, retirement counseling; and

(4) Continuing education programs for the elderly designed to help them adjust mentally and physically to a new style of life, to enable them to qualify for leadership roles in community service projects and teaching them the use of Medicare/Medicaid and about other services available to the senior citizen.

Approximately 3 percent of the adults who participate in the adult education program are 65 years of age and older. Programs for these persons are usually designed to help them continue to manage their own affairs as a wholesome and economic alternate to other types of services which make the older adult a recipient of benefits supplied by others. States are encouraged to utilize qualified older adults in educational services in basic education as well as to provide educational programs for older persons with low educational attainment. In local adult basic education programs, retired persons may serve as recruiters, teachers, and counselors and may provide different kinds of technical assistance. Efforts are made to conduct these programs benefitting older adults in cooperation with other Federal, State, local, and private sector programs, an example of which are the Community Action Programs.

The number of persons, 65 years of age and older, participating in this program is estimated as follows: fiscal year 1972, 20,700; fiscal year 1973, 20,700; and fiscal year 1974, 20,700.

Title II-B of the Higher Education Act provides funds for eligible institutions and organizations for demonstrations for the purpose of improving libraries or training in librarianship, including the development of new techniques, systems, and equipment for processing, storing, and distributing information, and for the dissemination of information, and for the dissemination of information derived from such projects.

The aging benefitted from this program in fiscal year 1972 and 1973 through a grant to the Cleveland Public Library, Cleveland, Ohio. This project will design criteria for the implementation and establishment of a neighborhood information center in five public libraries in five cities. Results of this project will benefit all public libraries in determining the type of delivery system needed to meet the informational needs of the older Americans.

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 older persons who need to learn basic skills, improve old skills, or develop new skills in order to advance their employment opportunities.

In the past few years, there have been increases in the occupationally oriented programs for adults in which persons who can be categorized as "aged" have enrolled. With the need for training for such jobs as "Foster Grandparents," indigenous community health and welfare workers, teacher aides, and similar occupations, an increasing demand for vocational education training programs is seen. Local classes

for specific crafts are being given. However, there is usually no Federal money involved.

National Institute of Education

The National Institute of Education, established in August 1972, received several programs transferred from the Office of Education. Selection of proposals for funding was based on program review rather than specific topical areas. The one project focusing on the aged which the Institute is monitoring is titled The Gerontology Research Instructional Program (GRIP). GRIP was designed to change the attitude of the American populous toward the increasing elderly population and to present a new image of this nation's elderly.

The objectives of the Gerontology Research Project are:

a. to determine the current feelings and concepts of students at various age/grade levels toward aging;

b. to identify the effectiveness of a variety of planned instructional activities; and

c. to discover the age/grade levels at which the most significant behavioral changes toward aging occur and at which point planned gerontology instruction will be most effective.

Department of Health, Education and Welfare
Funds for Programs on Aging 1/
(Dollars in thousands)

	1970	1971	1972	1973 Estimate	1974 Estimate
General fund appropriations:					
Public Health Service:					
Health Services and Mental Health Administration:					
Community Health Service	39,362	36,071	35,221	36,251	35,619
National Institute of Mental Health	3,953	3,920	4,516	3,983	3,849
National Center for Health Services research and development	720	694	933	996	1,421
Regional medical programs	9,850	9,080	9,200	4,400	---
Health care facilities services	66,715	68,920	61,240	54,502	42,580
National Institute for Occupational Safety and Health	---	---	10	10	10
National Center for Health Statistics	---	---	926	850	850
Total, HSMHA	120,600	118,685	112,046	100,992	84,329
National Institutes of Health:					
National Institute of Child Health and Human Development	8,100	9,313	12,505	12,336	11,838
Total, NIH	8,100	9,313	12,505	12,336	11,838
Total, PHS	128,700	127,998	124,551	113,328	96,167
Office of Education:					
Research and Training	453	78	---	---	---
Library Resources	1,149	840	1,015	775	---
University Community Services	150	215	121	60	---
Adult Basic Education	878	1,346	1,534	1,534	1,534
National Institute of Education	---	---	4,835	---	---
Total, OE	2,630	2,479	7,505	2,369	1,534
Social and Rehabilitation Service:					
Grants to States for Public Assistance:					
Grants to States for Maintenance Assistance	1,361,085	1,486,788	1,217,401	1,224,444	552,090 2/
Maintenance Assistance Administration under Titles I,X, XIV, and XVI of the Social Security Act	93,831	105,991	80,118	92,339	50,294 2/
Total, Maintenance Assistance	1,454,916	1,592,779	1,297,519	1,316,783	602,384
Total Medical Assistance for the Aged	1,235,864	1,554,096	1,778,348	1,637,000	1,832,000
Social Services	53,417	83,794	198,000	224,000 3/	207,000 3/
Total, Public Assistance	2,744,197	3,230,669	3,273,867	3,177,783	2,641,384
Rehabilitation Services	7,882	8,746	9,167	9,008	8,673
Development of Programs for the Aging	22,067	15,700	44,552	200,985	195,600

Department of Health, Education and Welfare
Funds for Programs on Aging 1/ (Continued)
(Dollars in thousands)

	1970	1971	1972	1973 Estimate	1974 Estimate
Rehabilitation and other research and demonstration.....	394	642	280	125	138
Rehabilitation Training.....	10	18	47	---	---
Aging Research and Training.....	5,692	5,800	12,500	19,500	7,000
Research and Training (Foreign Currency Program).....	100	170	333	400	400
Total, SRS.....	2,780,342	3,261,745	3,340,746	3,407,801	2,853,195
Social Security Administration:					
Payments from General Funds:					
Special benefits to non-insured persons age 72 and over.....	304,000	300,000	272,000	291,000	269,000
Special benefits to coal miners and widows.....	5,000	206,000	271,000	941,000	600,000
Supplemental Security Income payments.....	---	---	---	---	1,200,000 4/
Total, SSA General Funds.....	309,000	506,000	543,000	1,232,000	2,069,000
Total, HEW General Funds.....	3,220,672	3,898,222	4,015,802	4,755,498	5,050,002
Payments from: Federal Old-Age, Survivors, Disability, Hospital, and Medical Insurance Trust Funds					
Disability Insurance payments to dependents.....	12,000	14,000	17,000	22,000	26,000
Retirement/survivors insurance payments.....	20,638,000	24,473,000	26,893,000	33,032,000	37,157,000 5/
Hospital insurance payments.....	4,804,000	5,442,000	6,108,000	6,645,000	7,285,000 6/
Supplementary medical insurance payments.....	1,979,000	2,035,000	2,255,000	2,445,000	2,534,000 7/

Department of Health, Education and Welfare
Funds for Programs on Aging 1/ (continued)
(Dollars in thousands)

	1970	1971	1972	1973 Estimate	1974 Estimate
Total, Federal Old-Age, Survivors, Disability, Hospital, and Medical Insurance Trust Funds	27,433,000	31,964,000	35,273,000	42,144,000	47,002,000
Total Funds, SSA	27,742,000	32,470,000	35,816,000	43,376,000	49,071,000
TOTAL, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE	30,653,672	35,862,222	39,288,802	46,899,498	52,082,108

1/ Benefits are for those age 65 and over unless otherwise indicated.

2/ Estimate includes one half-year payments and costs for programs affected by P.L. 92-603.

3/ Estimates reflect impact of closed-end appropriation and pending regulation changes.

4/ Includes State Supplement of $100,000,000.

5/ Includes proposed legislation - $31,000,000.

6/ Includes proposed legislation - $292,000,000.

7/ Includes proposed legislation - $145,000,000.

OBLIGATIONS FOR PROGRAMS OF JUVENILE DELINQUENCY

Agency	1972 Actual	1973 Estimate	1974 Estimate
Office of Education.....	$25,219,000	$29,251,000	$3,160,000 1/
National Institute of Mental Health..	6,914,000	5,102,000	5,068,000
Social and Rehabilitation Service:			
Rehabilitation Services Administration.....	16,252,000	17,150,000	17,950,000
Research and Demonstration.....	999,000	900,000	975,000
Youth Development and Delinquency Prevention Administration.....	9,987,461	10,000,000	10,000,000
Total.....	59,372,460	62,403,000	39,153,000

1/ Programs previously funded under Titles I and III of the Elementary and Secondary Education Act and under the Vocational Education Act are consolidated under Special Education Revenue Sharing.

JUVENILE DELINQUENCY

During the five year period, 1966-1971, police arrests of young persons under 18 years of age increased at a substantially higher rate than that of the adult population. As reported in the Uniform Crime Reports, 1971, arrests of persons under 18 increased 40 percent over this period of time and increased 5 percent over 1970 figures.

When only the serious crimes - murder, rape, robbery, aggravated assault - are used in computing this five-year trend, youth arrests registered a 31 percent increase, substantially below the 57 percent adult increase. Violent crime arrests for young persons increased 65 percent, while property crime arrests increased 28 percent.

Nationally, juveniles under the age of 18 comprised 26 percent of the total police arrests in 1971. When only the serious crimes are considered, almost one-half of all those arrested were under 18 years of age.

Startling as these statistics are, the proportion of youth who become involved in criminal activity remains relatively small. As reported by the Uniform Crime Reports, about five out of every 100 youth are arrested. Moreover, a large proportion of the juvenile arrests are for status offenses - running away from home, violation of curfew laws, incorrigibility, truancy - offenses which are peculiar to their juvenile status, and which would not be considered criminal if committed by an adult.

Relevant too, is the sharp increase in arrests of young people for violation of the Narcotics Drug Laws. In fact, in 1971, 52 percent of the individuals arrested for violations of these laws were persons under 21 years of age; this represents a substantial increase over the 33 percent registered in 1966. Twenty-six percent of the marijuana arrests in 1971 were persons under the age of 18 and 62 percent of those arrested for this offense were under 21.

It must also be kept in mind that the data reported in the Uniform Crime Reports indicates only the number of persons apprehended for violations of the law, not those convicted of committing crimes, and that this arrest data is furnished by local police departments whose procedures for handling juveniles vary as do their methods of record-keeping.

Despite these caveats, however, juvenile delinquency is a serious problem. Although most delinquent youth do not become adult criminals, many careers in crime have their beginnings in youthful deviance. The "Careers in Crime" study conducted by the FBI indicates that the younger the age group, the higher the recidivism rate. Nearly 74 percent of the offenders under 20 released from Federal correctional institutions in 1965 were re-arrested by 1969 -- the majority of these rearrests occurring within two years after release.

The Department of Health, Education, and Welfare has been actively involved in the field of juvenile delinquency prevention and control since its inception. In fact, the Children's Bureau began to collect and report statistics on delinquency and neglect in 1926.

In 1954, the Division of Juvenile Delinquency Services of the Children's Bureau was authorized by Congress to develop guides, standards, and methods, and to provide technical assistance to public and voluntary agencies on services and care for delinquent children.

In 1961, a major Federal program was begun with the passage of the Juvenile Delinquency and Youth Offenses Control Act. Over 300 innovative demonstration and training programs were awarded between 1962 and 1967, the year the legislation expired.

In 1968, the Juvenile Delinquency Prevention and Control Act was enacted to provide an ongoing Federal delinquency program. During the first four fiscal years, 848 grants were awarded.

During 1972, major activities in the area of juvenile delinquency prevention and control were conducted by the Social and Rehabilitation Service, the Office of Education, and the Health Services and Mental Health Administration of the Public Health Service. These activities were carried out under a variety of statutory authorities.

SOCIAL AND REHABILITATION SERVICE

Three agencies within the Social and Rehabilitation Service are concerned with activities related to the prevention and control of juvenile delinquency: the Youth Development and Delinquency Prevention Administration, which administers the Juvenile Delinquency Prevention and Control Act of 1968; the Office of Research and Demonstrations; and the Rehabilitation Services Administration, which supports delinquency related programs under the Vocational Rehabilitation Act as amended.

YOUTH DEVELOPMENT AND DELINQUENCY PREVENTION ADMINISTRATION

The Youth Development and Delinquency Prevention Administration administered the Juvenile Delinquency Prevention and Control Act of 1968. The Act provided support to States and localities for assessing the adequacy and effectiveness of existing resources for the prevention and control of Juvenile Delinquency. It encouraged the creation of new kinds of community-based preventive and rehabilitative services, and the coordination of these efforts with both existing community programs and with resources available under other Federal legislation. It sought to strengthen the services of agencies, organizations, and institutions serving delinquent youth and youth in danger of becoming delinquent by upgrading the competence of personnel working in the field and by training new personnel. It supported the development of improved techniques and practices related to delinquency prevention and control. And, it supported the provision of technical assistance in the planning, development and operation of delinquency prevention and rehabilitation projects and programs.

Congress appropriated $10,000,000 for the implementation of the Act in Fiscal Year 1972. A total of 160 grants were supported under the three Titles of the Act.

Title I

Title I, Part A of the Act provided support to States and localities for the preparation or revision of comprehensive plans for the prevention and control of juvenile delinquency. These planning monies enabled the States and localities to identify the nature and scope of juvenile delinquency and related youth problems; to assess the adequacy of existing services and programs; and, to develop service priorities and program designs for delinquency prevention and rehabilitation so that resources could be efficiently allocated. Major emphasis in the Fiscal Year 1972 planning process was given to the coordination and integration of youth

services on both statewide and local levels. This planning process eliminates duplication and fragmentation of existing youth services in an effort to more efficiently and effectively provide area youth with those service resources necessary to divert them from the juvenile justice system.

One such planning grant supports a project in the State of Delaware to plan and implement a statewide system of prevention, diversion and treatment programs geared towards the long-range objective of achieving a 50 percent reduction in the projected caseload of the juvenile justice system by 1975. Efforts are being directed towards developing expanded components in existing projects, providing for maximum inter-facing between program efforts, developing and supporting State legislation to increase youth services, and monitoring and evaluating ongoing projects.

Ten comprehensive planning grants were awarded in Fiscal Year 1972 totalling $507,610.

Project planning grants, also available under Title I, Part A of the Act, assist public and private agencies in planning specific preventive services projects and programs. A primary objective of the 1972 planning grants was to aid in the development of a coordinated, interagency approach to youth problems, including delinquency. One such project is designed to improve the service delivery, cooperation and receptivity of area juvenile justice, education and social welfare institutions. A second is developing a service system which is aimed at diverting youth from the juvenile justice system and its traditional agencies and institutions into newly-developed, alternative community-based agencies.

Three project planning grants were funded in Fiscal Year 1972, totalling $300,000.

Rehabilitative services grants, available under Title I, Part B of the Act, assisted public and private agencies to make full use of community resources for the treatment and rehabilitation of delinquent youth. These grants seek to reduce or eliminate the stigma, isolation, and alienation that often results from extended incarceration, and are designed to provide a greater range of alternatives to traditional forms of incarceration; to encourage the development of new services closely linked to the community; and, to support the establishment of new types of community agencies for dealing with youth non-judicially in their home neighborhoods.

Rehabilitative services grants have provided for the establishment of community-based residential and non-residential treatment programs; community-based alternatives to incarceration; re-entry programs for youth returning to the community from correctional institutions; and, intensified services to probationers.

One such rehabilitation project is the Sea Pilot Program, a non-residential day care program for adjudicated delinquent boys aged 13-16 in Pinellas County, Florida. The program is designed to effect behavioral changes in the participants by engaging them in positive learning experiences structured to meet their individual needs. The program utilizes an educational model, based on the principles of behavior modification, to train the youth in personal, social, educational and vocational competencies and introduces him to sailing skills as a motivational factor. A variety of other services are available to these youth as needed, and project personnel attempt to maintain close contact with the youth and their parents throughout and after their involvement in the program.

A second rehabilitation project has been developed by the Mississippi Band of Choctaw Indians. Their Youth Development Center serves as a residential treatment facility for youth adjudicated delinquent; as a temporary shelter for youth awaiting a court hearing; and as a pre-release center for youth paroled from State training schools. A variety of individualized treatment services as well as counseling and vocational training are available to participants. Project personnel are working within the community, juvenile justice system and educational system in order to effect changes beneficial to youth. The Center has, in fact, secured the cooperation of local agencies and organizations and is jointly funded by LEAA of the United States Department of Justice.

Ten rehabilitative services grants were awarded in Fiscal Year 1972 totalling $273,927.

Preventive services grants, available under Title I, Part C of the Act, provided support for the development of new kinds of community-based services for youth, including delinquency prevention programs in the schools. Preventive services grants have supported youth services bureaus, drop-in centers, group homes and half-way houses, school-based programs, social and recreational activities, outreach services for troubled youth, and other services designed to strengthen the community's response to the needs of problem youth and to provide constructive alternatives to delinquent behavior.

One example of a preventive service grant is the Emergency Shelter Action Project (SHAC) which provides temporary housing and supportive services for a period of two weeks to two months for runaway and homeless youth in the Greater Burlington, Vermont area. The project accepts referrals from the Department of Social Welfare and the Department of Probation and Parole as well as walk-ins. Utilizing the contract method, the resident sets a realistic goal for his stay at SHAC and, as such, is encouraged to accept responsibility for his actions. In addition to room and board, the project provides a number of services, including counseling, recreational activities and job placement assistance.

Neighborhood House, Inc. is also a prevention project which seeks to identify and engage high risk youth in five public housing projects in the Seattle area in a program designed to reduce the incidence of crime and juvenile delinquency. Older, respected youth are trained in outreach and individual and group counseling techniques and in the use of community resources. They then work with target youth on an individual and small group basis. They assist the youth in identifying the individual and group problems and behavior patterns which work against them, and through counseling and discussion help them to work through their own internal handicaps. The project also seeks to engage those institutions which impact upon youth in efforts to effect changes which would prove beneficial to community youth.

In Fiscal Year 1972, 97 preventive services grants were awarded totalling $6,118,464.

Title I, Part D of the Act provided support for State Plans, which represent the product of a State's comprehensive planning process. Designed to provide support to statewide programs of delinquency prevention and control, State Plan grants were awarded to the designated State agency for juvenile delinquency activities to assist in supporting local prevention and rehabilitation programs.

One State Plan grant, totalling $100,000, was awarded in Fiscal Year 1972 to the Illinois Law Enforcement Commission. Funds are being used to improve community-based services to delinquent and predelinquent youth in order to divert youthful offenders from the juvenile justice system. They support the operation of several youth service bureaus and such alternative diversionary programs as School Teams for Educational Progress or Project Step-Up, a school treatment program for troubled youth which is now operating in seven Chicago schools.

Title II

Title II of the Act authorized grants to State and local agencies, universities, components of the juvenile justice system, and private nonprofit agencies to develop training programs for persons employed in or preparing for employment in the field of delinquency prevention, control, treatment and rehabilitation. This activity constitutes the only major national effort devoted exclusively to the creation of new manpower resources to combat the problem of juvenile delinquency.

In Fiscal Year 1972, 10 grants totalling $699,958, supported a number of short-term training sessions designed to update the knowledge of professionals and nonprofessionals in the youth service field and provide career training for persons in the field of juvenile delinquency. Regional training sessions have been held in both the Eastern and Western parts of the country as part of a national effort to increase the level and extent of youth involvement in the planning and operation of youth services. Teen Post, Inc. of Los Angeles, California sponsored a 9 week training program for student leaders which was designed to make them more constructive and effective in their demands on the school system in order to better effect permanent educational reform. Training monies also supported leadership training sessions for minority youth which were to provide them with the skills necessary to effectively deal with social problems and pressures and to ameliorate the underlying problems of juvenile delinquency. In a number of Impact Cities, community action institutes were held to inform and involve private citizens in juvenile delinquency prevention activities.

Title III

Title III of the Act provided support for the development of improved techniques and practices in the field of delinquency prevention and control, for the provision of Technical Assistance, and for the dissemination of information.

Improved techniques and practices grants were awarded for the development of new and innovative programs which hold promise of contributing to the prevention and control of juvenile delinquency. The grants require a comprehensive program evaluation so that knowledge gained from these models may be disseminated to other agencies and individuals involved in youth development and delinquency prevention activities.

The Kentucky Child Advocates project, which provides legal and social services to delinquent and dependent youth in 16 rural and one urban county in Central Kentucky, focuses on diverting youth from the juvenile justice system into alternative, community-based structures. Methods used to effect such diversion include the drafting and sponsoring of new legislation, the use of parprofessional advocates, the provision of multi-disciplinary approaches to crisis intervention, and the involvement of youth and their representatives in decision-making at the community and State levels. Paraprofessional volunteers and staff, including social work, law, and psychology students at the University of Kentucky, are used to intervene on behalf of youth in their communities,

schools and court; to provide legal services, counseling, tutoring and other court services and act as liaison to other community services, initiating changes in these services when inadequacies are identified. The project also publishes a monthly information newsletter and makes educational services, regarding juvenile rights, problems etc., available to interested persons. As a result of their efforts, already, significant changes have been made in the handling of juveniles; for example, there has been an increased use of the informal adjustment power of the juvenile court and several status offenses no longer can be used as grounds for incarceration.

The Open Door Drug Education Program seeks to prevent drug abuse and addiction among youth through the provision of educational alternatives. Additionally, it seeks to demonstrate that young people, as part of a teaching-communication vehicle, can effectively participate in delinquency prevention activities and assist in developing solutions to community problems. Project components include a program which provides selected youth with advanced residency training in classroom programming; a part-time summer employment project which directly involves youth in the operation of neighborhood mental health clinics; a number of educational and cultural enrichment services, as well as drug information and referral services, at an employment project in conjunction with Temple University involving the production of films about youth involvement and alternative life styles.

Twenty new techniques and practices grants were awarded in Fiscal Year 1972 totalling $1,000,000.

Under this title, technical assistance grants are also awarded to State and local, public and private agencies and organizations concerned with the prevention and control of juvenile delinquency. Their purpose is to provide agencies with expert assistance in the development and operation of youth projects and programs. One such grant was awarded to the Bureau of Sociological Research of the University of Colorado to provide assistance to a number of youth-related projects. They aid in the planning, development, monitoring and evaluation of State-supported Youth Service Systems funded by Youth Development and Delinquency Prevention Administration; in the development of a Regional Data Collection System in Juvenile Delinquency; in the development of the youth components of the LEAA Impact Cities program and in the evaluation of a state-wide youth project in Montana.

A total of nine Technical Assistance grants, at a cost of $747,425, were awarded in Fiscal Year 1972.

During Fiscal Year 1972, Youth Development and Delinquency Prevention Administration primarily focused upon the development of comprehensive juvenile delinquency prevention projects, rather than small categorical grants. The premise underlying the National Strategy for Youth Development and Delinquency Prevention is that the most effective means for preventing delinquency is to provide youth with responsible, acceptable, and personally gratifying roles in society, and that such roles can be made available to all youth through the modification of existing social structures and the creation of new, alternative structures. Corollary assumptions underlying the strategy are concerned with the diversion of youth from the juvenile justice system, the avoidance of negative labelling of youth by the schools, courts, and other community institutions, and the reduction of mutual rejection and alienation between young people and representatives of the adult world.

Eleven new Youth Service Systems and 8 established systems were funded in Fiscal Year 1972 under Title I, Prevention, and Title III, New Techniques. Each system contains a built-in mechanism for evaluating its effectiveness, and provides for the involvement of community agencies, citizens and youth in program planning, policy development and operation. These systems have been established throughout the country in a variety of social settings - from large metropolitan areas to relatively small towns.

One new system funded in Fiscal Year 1972 is the Community-Wide Action Plan for Youth, which seeks to provide an integrated planning and service delivery program for youth in Syracuse, New York. The planning coordination and evaluation components operate through the Steering Committee and the sub-committees of the Mayor's Task Force on Youth Development, composed of representatives of the major service agencies, neighborhood groups and youth. The service components are provided, through the use of youth centers and special programs, to fill gaps in existing services to youth.

The Youth Center programs include a theater project which seeks to provide area youth with the opportunity to develop their individual potential through the media of performing arts; a supportive education program for children aged 6 through 12 and their families, designed to provide enriching experiences and to help the participants succeed in school and later life; the expansion of a comprehensive neighborhood programs for youth and their families providing recreation, tutoring, job preparation, cultural enrichment, consumer education and home economics training; and the expansion of 3 teen centers providing a variety of services to youth aged 14 through 20.

Programs which have been specially implemented to meet a gap in available services include several recreation programs for mentally handicapped youth; the provision of a liaison worker to deal with the problems of Spanish speaking students within the school setting and to provide family and group counseling; supportive learning environments for underachieving elementary and junior high school youth whose needs are not adequately being met by the traditional school system, and a special program for central city girls aged 12 to 18, designed to foster personal growth and self-development.

A number of State and local agencies provide services and funding resources. These include the City of Syracuse Department of Parks and Recreation; United Way of Central New York; Peace Inc.; State Division of Youth-Youth Recreation Program-Department of Parks and Recreation; Youth Bureau, City of Syracuse and Onondaga County; YMCA; Model Cities Youth Programs; Syracuse City School District - Recreation for the Emotionally Handicapped.

The Youth Advocacy Program, a YSS operating in South Bend, Indiana, seeks to divert children and youth from the juvenile justice system and to strengthen their involvement in community institutions. The program hopes to achieve it's goals by mobilizing community resources to solve youth problems, strengthening existing youth resources and developing new ones.

A variety of services are made available through the major program components. Five young persons are working as service liaison agents in key youth-related institutions - the schools, Recreation Department, Model Cities, City Government and Family and Children's Center - in an effort to make them more responsive to the needs and interests of youth. The Counseling Center of the Youth Advocacy Program serves as an extended hand for help and information. The staff, which consists of two full time counselors and eight part-time volunteer graduate students, provide direct individual and group services as well as referral services for youth with family, school, juvenile justice and other personal problems. A Community Service Program uses ten inner-city residents

("Youth Agents") to patrol buses and athletic events to prevent violence and vandalism and to assist in other community development activities. The Street Academy provides quality education designed specially to meet the needs of high school students in the South Bend area who have dropped out or have been pushed out of area public schools. The program also employes a staff lawyer to serve as an advocate on behalf of youth with community agencies and to provide legal counseling and education for youth. A number of other services, including job placement and counseling, social casework and testing services, are made available to Youth Advocacy clientel through the Youth Service System of South Bend.

A number of other community agencies and institutions are actively involved in the operation of this program; these include the South Bend Community School Corp., Juvenile Aid Program, Department of Public Welfare, four area colleges and universities, public libraries and museums and the law firm of Digrazia and Forham.

In addition to the Youth Development and Delinquency Prevention Administration, funding assistance has come from a number of other sources, including the City of South Bend, the Urban Coalition, the Urban League, Model Cities, and the Indiana Criminal Justice Agency and private contributions.

New Program Direction:
Juvenile Delinquency Prevention Act

The Juvenile Delinquency Prevention Act, passed August 14, 1972 for a two year period, replaces the Juvenile Delinquency Prevention and Control Act of 1968, which expired June 30, 1972. The new Act authorizes the Youth Development and Delinquency Prevention Administration to provide support for the establishment and operation of coordinated youth service systems which, through a comprehensive approach, will impact on agencies and organizations serving youth. Support is no longer available for project grants which address specific aspects of the juvenile delinquency problem, nor for programs conducted within the juvenile justice system.

More specifically, Title I - Preventive Services, authorizes grants or contracts to meet part or all of the cost of planning, establishing or operating community-based coordinated youth service systems for the prevention of delinquency. Public or non-profit private agencies are eligible. Eighty percent of the amount appropriated shall be used for funding programs under this Title, of which no more than 10 percent may be used for construction costs.

Under Title II, Training, public and non-profit private agencies are eligible to receive grants to pay all or part of the cost of training personnel for work in delinquency prevention fields. Funds may be used for such purposes as curriculum development, short-term training institutes and traineeships.

Title III, Technical Assistance and Information Services, authorizes the collection and publication of information related to programs funded by the Act, as well as information on other programs concerned with delinquency prevention.

Also authorized are grants to or contracts with public or private non-profit agencies to render Technical Assistance in matters relating to delinquency prevention, with special emphasis on the development of coordinated Youth Service Systems under Title I.

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

JUVENILE DELINQUENCY

State rehabilitation agencies have been active in the development of programs and projects designed to provide vocational rehabilitation services to the juvenile delinquent.

The expansion of these services to the youthful offender has been developed generally under the Basic Support program in cooperation with State and Federal correctional agencies and probation offices as well as with State training schools and municipal courts. Programs vary 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.

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 retardation. There is a very sizable group, however, whose disability is essentially behavioral and the public rehabilitation program is providing vocational rehabilitation services to this group of disabled young people.

The Rehabilitation Services Administration has used its expansion grant program extensively in developing programs for the youthful offender. For example, an Expansion grant to the Arkansas rehabilitation agency is paying for additional staff salaries and case services so that extended rehabilitation services may be provided disadvantaged youth in the Pulaski County area of that State. It is estimated that close to 98% of the youth served by the project are court-referred. Many of these youth are drug abusers. Another Expansion grant awarded to the Wisconsin rehabilitation agency is providing services to delinquents in a forestry camp and school setting. Arrangements have been made for high school courses at local schools, while a work adjustment center focuses on vocational skills. Under another grant of this type, the North Carolina rehabilitation agency has developed, in cooperation with the Department of Corrections, a special program for the mentally retarded youthful offender. This project involves prevocational, vocational, personal adjustment, group and individual counseling, and recreational services.

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, for example, have been "The Juvenile Court and Vocational Rehabilitation," Boston, Massachusetts, "State Agency Consultants as a Means of Developing Coordinated Patterns of Juvenile Corrections and Rehabilitation Services." University of Missouri, and "Prevention of Juvenile Delinquency and Rehabilitation of Offenders," San Francisco, California. Social workers and rehabilitation counselors being trained in programs supported by RSA Training grants often have an opportunity to take field training in agencies working in the field of juvenile delinquency. Although the primary emphasis in on the development

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of professional competence for work with the handicapped, the field experience in correctional institutions and other juvenile delinquency settings is a significant aspect of approximately eight vocational rehabilitation training projects.

Juvenile Delinquency

Rehabilitation Research and Demonstration Program

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 Amendments to the Vocational Rehabilitation Act 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 development in the treatment of youth is the concept of Youth Service Systems. Although the Youth Service System (YSS) approach appears to be a promising vehicle for the delivery of services to youth, substantive data is currently lacking on their operation and effectiveness. Valid outcome measurements have not been formalized to assess YSS progress toward meeting stated program goals of effecting in youth more constructive social roles. More specifically, data is required to evaluate systems in terms of ability to mobilize resources in the community for a coodinated program of youth services; in terms of diversion from the juvenile justice system; in terms of diversion from the juvenile justice system; in terms of the cost/benefit of systems as contrasted to processing youth in the juvenile justice system; and in terms of the various strategies incorporated in the YSS approach itself. Three projects begun in fiscal year 1972 to demonstrate and evaluate the effect of diversion and the integrated community agency approach will be continued. Another project concerned with YSS will provide a longitudinal study of youth served by five major youth service systems in terms of the extent to which youth are guided into constructive social roles related to school, labor, family and community as a result of the services provided. This will provide current and long range results upon which to assess YSS as an effective method of combating delinquency.

Youthful street gangs have long been recognized as a source of negative and unacceptable social roles for youth. The channeling of gang activities into constructive social roles through the use of indigenous neighborhood personnel as gang control leaders has been the focus of another effort in delinquency prevention.

Future projects will continue to stress delinquency prevention. A vocational rehabilitation agency will be tested as a Youth Service Center. Studies will be undertaken to develop comparable statistics on total delinquency in different geographical areas; to study the effect of delinquency prevention programs on children from welfare families and children from poor families not receiving public assistance; to investigate the effect of labeling on the subsequent adjustment and behavior of youth; and to study the impact of alternatives to the traditional schools in reducing juvenile delinquency and drop out rates.

Special Foreign Currency Program

The problem of juvenile delinquency is of major concern in the United States and has been receiving increasing attention in the developing countries participating in the special foreign currency program. Many of the countries cooperating in this program offer rich opportunity for observing rapidly changing cultural and social conditions. Identification and analysis of similarities in scope, nature and methods of handling the problems of legal offences and recividism are of great interest to researchers and practitioners in the United States who are striving to reduce the problem in this country. Results from previously reported investigations of juvenile delinquency have been extended to rehabilitate those whose conduct has previously led to conflict with the law and to prevent the breakdown of young people with problems of adjustment to their social surroundings. New projects will stress innovative approaches for services that can be provided in community facilities

on a non-residential basis. 13

	(Thousands of dollars)				
	1970	1971	1972	1973	1974
Rehabilitation research and demonstrations	100	80	813	700	875
Special Foreign Currency Program	100	300	186	200	100

OFFICE OF EDUCATION

REPORT ON JUVENILE DELINQUENCY

(Fiscal Year 1974)

Title I of the Elementary and Secondary Education Act of 1965, P.L. 89-10, was amended on November 3, 1966 by Public Law 89-750 to include education or educationally related services to children living in State and local administered institutions for Neglected or Delinquent children.

Grants are available to State agencies for those institutions which operate a school program and to local educational agencies for other public and private nonprofit institutions for delinquents. Grants are based on applications which must describe the special educational needs of the youth in the institution and propose a project designed to meet the most crucial of those needs. While the 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 1973, $20,400,000 will be allocated for 54,387 eligible delinquent children in 268 State administered institutions. In 1973, approximately $3,000,000 in addition will be allocated for 18,837 eligible delinquent children in 333 locally administered institutions, who are to be served through grants made to local school districts.

Since the inception of P.L. 89-750, 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 emphases in programs has been toward improved, more relevant curriculum designed for the unique needs of the children, better teaching, and greater cooperation among institutions, schools and community. There is also an acute awareness of the fundamental need for relevant teacher and other related staff training as the major step for improving education in the institutions. 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 128,276 institutionalized neglected and delinquent children in State and local institutions who are counted for computing an authorization under P.L. 89-750 for 1973. With continued and increased funding, the opportunities are great for this program to develop the children while discovering more effective general approaches to compensatory education. The laboratory-like characteristics of education in institutions, the nation-wide scope of the relatively small and more 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.

In 1974, the Title I and Title III programs are being consolidated under Special Education Revenue Sharing.

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 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. The 1967 Amendments of Title III provided that in fiscal year 1970 the program would be totally administered as a State Plan program.

In fiscal year 1969, the Office of Education funded six Elementary and Secondary Education Act Title III projects which had juvenile delinquency components. The

total amount funded for all components was $771,100 and it is estimated that at least half of this amount was used for the juvenile delinquency components of the projects. In addition, the State departments of education may have funded some projects in fiscal year 1972, with components dealing with the problem of juvenile delinquency; however, information is not available as to the amounts obligated since the program is completely administered by the States. It is estimated that approximately $385,000 was obligated in both 1972 and 1973.

Title VIII of the Elementary and Secondary Education Act as amended in 1967 provided non-matching grants to local education agencies for dropout prevention projects. Since some school dropouts can and do become juvenile delinquents the Dropout Prevention program does relate in this sense to the prevention of juvenile delinquency. The President's Crime Report states that on any day there are 400,000 people in our correctional institutions and that 82 percent of this number have not graduated from high school and 54 percent have not completed elementary school. It costs on the average of $3,800 per year to keep a person in an institution. If this cost is projected on to the 82 percent of prisoners who have not completed high school, this becomes a staggering figure each year. In 1964 youths from 16 to 24 years of age were responsible for 27 percent of the total arrests in this country. Because the compulsory education law in most States takes effect at age 16, this is when students can leave school legally. School dropouts have an incidence toward crime that is 10 times that of those who stay in school. In 1973 and 1974, Title VIII has allocated $484,827 to 4 cities to serve 13,705 who have either dropped out of school or are in danger of dropping out of school.

Vocational education is being offered within correctional institutions as a part of a total program to rehabilitate those with anti-social behavior. Young people, secure in the knowledge that they have a salable skill, are less apt to be recidivists after their release from an institution. Such education also helps to make their academic education more relevant as they can relate it to subjects which can lead to a lifetime interest and career.

The following States reported examples of programs for juvenile delinquency:

To serve the needs of additional communities throughout the State of Massachusetts four mobile vans are used containing modular classrooms. Each trailer van is equipped with closed circuit TV, movie projector, and other media. This Skills-Training-On-Wheels (STOW) program gives local systems the opportunity to join with private agencies to develop rehabilitative training plans aimed at inmates of prisons and other institutions.

Cooperation and coordination with other State and local agencies provided vocational education services for 373 disadvantaged persons in institutional-type settings in Kentucky. The agencies were: the Department of Child Welfare through Lynwood Girls' Center, Kentucky Reception Center and Jewel Manor, serving 133 students, and Barkley Boys' Camp, serving 90 students; the Fayette County Fiscal Court through the Day Treatment Center, serving 34 students; and the Department of Corrections in cooperation with the Bureau of Rehabilitation Services through Eddyville Penitentiary, serving 90 students, and Pee Wee Women's Prison, serving 26.

In New Jersey training was provided for 320 inmates at Trenton, Rahway, and Leesburg State Prisons as the result of coordinated efforts between the Department of Education, Labor, and the State Law Enforcement Planning Agency. Training is offered in auto mechanics, carpentry, electricity, masonry, welding, auto body repair, building service and maintenance, electronics, and graphics.

A program for part-time evening training was initiated for 60 inmates from Bordentown Correctional Institution and Trenton State Prison. The inmates were transported to the Mercer County Skills Center for training in the areas of welding, graphics, auto body repair, and diesel mechanics.

The multi-agency program for detained and probationary youth at the Arizona Juvenile Detention Home, has been expanded to include pre-vocational education in

the areas of trade and industrial education and office education, serving 1,200 youth. In addition, vocational skill training in the area of service station mechanics is providing training for 80 to 100 youth. This program operated during the year with an enrollment of 1,487 youth.

All of the above programs were coordinated with Vocational Rehabilitation, State Employment, Welfare, Correctional, and other related agencies.

If one considers that some of the dropouts and the potential dropouts may be potential delinquents, vocational education is providing the opportunity for these young people to come back to school, take short courses in a concentrated area of study, and leave school better prepared for immediate employment possibilities. Other schools are designed mainly to serve the potential dropout. Such schools as the Vocational Arts Center in Norwalk, Connecticut, the Work Opportunity Center in Minneapolis, Minnesota, and the Beggs Education Center in Pensacola, Florida are examples of this. They have low student-faculty ratio, permit students to enter and leave when they feel they are prepared for work, and gear the faculty towards a team approach.

This program is being consolidated under Special Education Revenue Sharing in fiscal year 1974.

Beginning with fiscal year 1972, public library services, State institutional library services, and library services to the physically handicapped were consolidated in Title I (Library Services) of the Library Services Act Amendments of 1970 (P.L. 91-600). Since State institutional library services (formerly Title IV-A) continues to be funded and reported as a separate project, it is usually possible to determine the number of State juvenile institutions receiving special grants. Reports, however, do not reflect services to juveniles in adult correctional facilities which frequently house children as young as twelve years of age. Nor do they identify the increasing number of public libraries serving juvenile delinquents in local detention homes, halfway houses and other youth centers as well as offering services in cooperation with community crime prevention and post-release programs. Such services are often part of larger outreach projects.

In fiscal year 1972, some 200 State juvenile correctional institutions received special grants or participated in special projects under the Library Services and Construction Act--compared with 180 in fiscal year 1971. The funding remained at approximately $300,000. Usually an institution receives a grant for from one to three or four years for the purpose of developing the library, extending its services throughout the institution, and providing qualified staff. The institution or its parent State department then assumes responsibility for financing and administering the library and the State library agency continues back-up programs, i.e. consultative and training services, and interlibrary loan of books, films and other materials.

The libraries being developed in State institutions are library-media centers which often function as learning centers as well. They serve not only the residents in the school program, but all residents in the institution, and are, in fact making unique contributions to the total program of the institution.

Examples of 1972 Library Services and Construction Act programs for juvenile delinquents in State correctional institutions:

Florida: Project LIFT (Library Improvement for Training Schools) is a five-year project aimed at establishing and/or improving library services in the four training schools for juvenile delinquents operated by the State Division for Youth. In fiscal year 1972, the Alyce D. McPherson School at Ocala received a grant of $9,000 ($6,000 LSCA) to create a library-media center by enlarging the book and audio-visual collections, and adding magazines and newspaper subscriptions. One of the young residents, after enthusiastically describing the new materials and their uses, said, "These are to help us to listen and learn.... It is a wonderful privilege to have these new materials."

Hawaii: "I've never seen anything like this before." These were the words of a 14 year old boy, newly admitted to Hale Ho'omalu, a Family Court detention facility in Omahu, Hawaii, on seeing the institution's newly renovated Library-Learning Center. Besides books, magazines and newspapers he was intrigued by the film loop projector, casettes, recorders, various reading aids and the individual study carrels.

Illinois: In Illinois, the State Department of Corrections and the State Library are cooperating in providing library services to correctional institutions through the Regional Public Library System in which the institutions are located. In fiscal year 1972, the State Library contracted with the Bur Oak Library System to serve the six correctional (three institutions) in its area. (LSCA grant $70,000). A branch library was established in each institution, with staff assistance and back-up services from the library system and the four research and reference centers in the State. State funds are being sought to continue the services. The three juvenile institutions are the Reception and Diagnostic Center for Boys at Joliet, the Kankakee School Camp at Manteno, and the Channakon School Camp at Morris.

Montana: In Montana, the Miles City Public Library provides a variety of services to the young male misdemeanants at the Pine Hills Schools. In addition to bookmobile visits to each cottage every other Saturday, the library fills individual requests, maintains collections of pocket books and magazines in each cottage, and lends films through the State Cooperative Film Service. The Flathead County Library maintains a library collection at the Swan River Youth Camp and serves as the public library for residents and staff who visit the County library weekly. The librarian visits the camp and provides films and interlibrary loan materials directly or by mail. The Mountain View School for juvenile delinquentsgirls has a librarian who has reorganized the library collection and added new materials. The State Library is the backstop for additional books and autio-visual materials. The Library Resources Programs are being terminated in 1974. If local agencies feel the services are necessary, they can fund them with money received from Revenue Sharing.

In the spring of 1969, the Bureau of Educational Personnel Development supported a new approach to the education of court-adjudicated delinquent children called Nationwide Educational Programs for Institutionalized children or NEPIC. NEPIC is a long-range, comprehensive, multi-agency developmental program to strengthen the capability of institution staff to serve the education needs of such children. This effort continues through fiscal year 1973 at a rate of $375,000 annually.

Designed by program specialists in the Neglected and Dependent Children's Section of Compensatory Education in the Bureau of Elementary and Secondary Education, the program is aimed at total staff training and the involvement of those outside the institution who are in positions of power: superintendents and principals of open schools to which the children will return; political leaders on the State and local level; leaders of business and industry and labor unions. These significant others are the keystone of this concept because they could leave meaningful impact on correctional education and indeed, upon the entire correctional process.

Teacher Corps corrections projects have as their objectives improving the educational opportunities of poor children and encouraging colleges that train educational personnel to improve their teacher training programs.

Graduate and 2nd year undergraduate students pursue a field centered training internship working with students in schools and in the community over a two-year training period. On completion of the project, graduates usually earn a degree and are certified as secondary teachers or counselors with a specialization in correctional education.

The major difference from regular Teacher Corps projects is that interns work with adjudicated delinquents and socially maladjusted youths. The school settings in which interns may serve can range from special programs sponsored by public schools and communities to the entire range of correctional institutions. A project usually offers an opportunity for training in more than one type of facility over the two-year period.

Teacher Corps grants enables correctional schools and universities to jointly develop special training programs to prepare educational personnel who work effectively with delinquent and socially maladjusted youths. While it is expected that the majority of graduates will serve as more sensitive and skilled teachers in programs for troubled youths, it is also intended that some percentage is being trained for leadership in innovative education for this special youth group. Of the 230 interns on duty in 6 projects 1972-73 school year, 50 are ex-offenders.

An amount of $2,300,000 of Teacher Corps funds are being expended in fiscal year 1973 in California (Los Angeles and Sacramento), Oregon, Wisconsin, New York, and New Jersey developing alternatives to traditional schooling for delinquents, helping establish re-entry programs, supporting ex-offender self-help projects and establishing programs to train staff for new roles in correctional education.

Title I of the Higher Education Act of 1965 pioneered in bringing college and university resources to bear upon the community problem of juvenile delinquency. As more substantial amounts of money become available through other programs in Health, Education, and Welfare and the Department of Justice, activities supported by Title I diminished. However, a few projects of an experimental nature are still supported and they include the training and counselling of youth in correctional institutions; and helping disadvantaged out-of-school young people to rediscover their academic abilities and pursue further training. In 1972, 5 projects in 5 institutions were activated at a cost of $56,400 in Federal funds. There were 280 participants. In fiscal year 1973, due to a 40 percent reduction in our budget, we estimate $34,000 will be applied to juvenile delinquent projects at 4 institutions with approximately 250 participants. No funds are being requested for the Title I program in fiscal year 1974.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

National Institute Of Mental Health

CRIME AND DELINQUENCY

Introduction

Law-violating behavior is clearly one of the major social and political problems in American society. The business community estimates that ordinary crimes against business, such as burglary, robbery and shoplifting, total $16 billion a year. The Federal government alone spends nearly $2 billion on programs to reduce crime. It was estimated in 1970 that Federal, State, and local governments spent $8.6 billion in the area of law enforcement and criminal justice activities. Meanwhile, the social and psychological consequences of unlawful behavior--which defy measurement in dollars and cents--affect the lives of countless citizens. Included here are the fears of potential and actual victims, the effects of suspicion and hostility on interpersonal relationships, economic insecurities created for families of victims and of imprisoned offenders, and increased reliance on repressive measures for dealing with complex social problems.

According to a recent Gallup Poll, one out of every three persons living in cities has been a victim of a serious crime during the last year. Furthermore, almost one-half of all persons arrested in the United States last year for serious crimes (i.e., homicide, robbery and burglary) were under 18 years of age, while nearly one-quarter were under 15. Between 1960 and 1971, moreover, arrests of juveniles for serious crimes increased 107 percent. The problems of adult and juvenile crime continue to mount.

Understanding the causes and dimensions of and promoting remedies for problems of crime and delinquency is a complex task. First, delinquent and criminal behaviors stem from interaction of biological, psychological, social economic, and other factors. Furthermore, whether or not a particular pattern of behavior is considered "deviant," "delinquent," or "criminal" depends on societal norms, reactions and an administrative judgment of persons who make decisions regarding the processing of such individuals.

Given this premise, it follows that "delinquency" and "crime" are phenomena which very much involve societal definitions and labels applied to certain types of behavior believed to require official sanction and control. A particular act may be viewed as delinquent in one jurisdiction, but as tolerable yet annoying behavior in another; similarly, acts which are considered by some to constitute delinquency or crime may be viewed and labeled by others as "mental illness." The very same deviant behavior, therefore, may be defined quite differently depending upon who the deviant person happens to be, the persons who observe or complain about the behavior, the circumstances under which the judgment is made, and the availability of alternative societal problem-solving resources. Consequently, in view of the vague, unreliable, and inconsistent labels and definitions ascribed to deviant behavior, it is imperative that efforts to better understand and cope with such problems focus predominantly upon the actual behavior, rather than highly variable societal labels.

The NIMH Program in Crime and Delinquency

In recognizing that the very same behavior may well be perceived, evaluated, labeled, and handled differentially as a function of varying social contexts, the National Institute of Mental Health is concerned with the prevention, control, and treatment of deviant behavior which may be defined either as mental illness or as violations of the criminal law. The Institute's role, therefore, in the area of crime and delinquency is inextricably related to its emphasis on understanding human behavior, particularly problem behavior, and its mission is to develop and disseminate knowledge relative to this special area of societal concern.

It should also be noted that in focusing on behavior rather than labels, there is both potential and actual overlap of "client" populations of the criminal justice and mental health systems. Furthermore, delinquent and criminal behaviors represent exceedingly complex interactions of social psychological, biological, economic, and other factors, involving both individuals and their environments. It becomes extremely important that deviant and maladaptive behaviors be studied within the same broad context of the behavioral, social and biological sciences as normal and adaptive behavior. To confine manifestations of social deviance to the exclusive purview of the juvenile and criminal justice systems will limit and seriously constrain our understanding of these complex phenomena.

The Center for Studies of Crime and Delinquency

The objective of the Center for Studies of Crime and Delinquency derives from an NIMH concern with problems of mental health as these are reflected in individual behaviors that are troublesome, offensive, threatening, or harmful to others. Thus the Center has the mission (a) to develop needed behavioral and social science knowledge on problem behaviors that frequently involve violations of the law; and (b) to develop more effective and timely means for the prevention, control, and treatment of such behaviors. The scope of the Center's efforts encompasses a wide range of issues in delinquency, crime, law and mental health, and individual violent behavior.

Basic and Applied Research

The urgency for resolution of the problems of crime and delinquency, and of social deviance more broadly, engenders a pressing need for immediate social action. But while the more adequate utilization of available knowledge and national resources would doubtless enable some improvement, the concern for prompt remediation should not be so overstressed as to block the further development of basic knowledge about deviant behavior in its societal context, which is essential for more long-range solutions.

Needed Knowledge on Crime and Delinquency-Related Behaviors. Basic to the development of improved means for the prevention, control, and treatment of crime and delinquency-related behaviors is the need for more precise knowledge on the sources and dimensions of these behaviors.

Such information can add significantly to scientific understanding of forces within an individual that affect mental health and behavioral performance. In addition, such information can add greatly to the understanding of social forces that operate on an individual, help to influence behavior, and also have a major role in developing policy decisions with respect to the handling of individual behaviors that are troublesome, offensive, threatening, or harmful to others.

(1) Juvenile Behaviors. Several studies using longitudinal, age-cohort and survey research techniques are expected to provide important information on the dimensions of delinquent behavior. For example, in one study, almost 90 percent of the young people interviewed in a self-report survey of delinquent behavior confided that they had committed an act for which they could have been brought before a juvenile court. However, fewer than 3 percent of the acts reported were detected by the police and fewer than 1 percent of these offenses were recorded as juvenile delinquency. Results of these surveys will provide needed policy and program knowledge on whether delinquent behavior in the United States is increasing, decreasing, or remaining stable; whether certain kinds of delinquency such as drug abuse are changing in frequency and, if so, among which sub-populations; and whether linkages can be discerned between changes in delinquent behaviors and changes in social environment. The youth surveys provide a national data base on self-reported delinquent behaviors which planners can use in conjunction with the Uniform Crime Reports and various victimization studies being conducted by other Federal Agencies.

Another study involved analysis of police and other records on the delinquent careers of all boys born in the year 1945 who lived in Philadelphia from their 10th to their 18th birthdays. It was found that of the 9,945 boys who were the subjects for this study, a total of 3,375 had at least one recorded contact with police by their 18th birthday, but that the 627 boys who had five or more recorded contacts with police had been responsible for more than 50 percent of all the offenses known to have been committed by the entire group of boys, including about 70 percent of all the robberies, aggravated assaults, and homicides. The findings from this research suggest that in order to cope more effectively with juvenile delinquency, much greater attention should be paid to serious offenders who commit a disproportionate share of total offense.

(2) Violent Behaviors. Individual violent behaviors are of major concern to the Center since these types of behavior are the most harmful to society and most frequently involve serious acts of crime or delinquency.

An important area of scientific inquiry concerns the possibility that individuals with biological abnormalities may engage disproportionately in such behavior. In order to generate needed knowledge in this area, the Center has supported several projects focusing on the possible role of the XYY chromosome complement in violent and other anti-social behaviors. Another study is examining possible interactive relationships between perinatal brain damage

and later anti-social behavior; this study involves examination of the birth records of 9,000 children and is being carried out in Denmark because this country has a unique system of medical record-keeping which makes this type of study possible. Two other studies are examining relationships between violent behaviors and repeated exposure to TV and movie violence.

The Center has also been active in generating knowledge needed for the development of more effective social strategies for coping with violent and potentially violent behaviors at their points of origin. Police departments are in highly strategic position for this purpose. One Center project is using a battery-operated field encoder to record quantitative data on some 3,323 police encounters with citizens in three Midwest cities; such data, when directly transferred to computer, permit analyses of ways in which violent and other behavioral outcomes can develop from different processes of police-citizen interaction. In another project, which stemmed from an earlier training project supported by the Center, police officers in Oakland, California conducted their own research of situations involving potentials for outbreaks of individual violent behavior and devised remedial strategies for implementation by their police department.

Development of Community-Based Treatment Models. The Center has been concerned with a number of new community-based treatment models suitable for implementation by local communities with varying population size and composition. The interest is to develop, test, evaluate and refine an experimental program that appears to hold promise of effectiveness and replicability as a community-based answer to a delinquency or crime problem. The various models thus represent treatment packages which can be transplanted or exported elsewhere with some modification to adapt to other local problems, conditions, or settings.

(1) Juvenile Problems. Two community-based treatment models have been developed in this area.

The Achievement Place project has involved the development and testing of an intensive community treatment program for adolescent boys as an effective and economical alternative to institutionalization. Achievement Place is a community-based, family-style residential halfway home for six to eight boys between 11 and 16 years of age. The therapeutic approach and rehabilitative techniques utilized in the home have been derived from basic learning principles developed by experimental psychologists and utilized effectively in a wide variety of fields. These learning principles are employed to influence the social and interpersonal behavior of the youngsters, their school behavior, their relations with parents and peers, and their development of self-control skills. This program has established ties with the juvenile court, the Department of Welfare, schools, and parents. The model also features the close involvement of an advisory board drawn from members of the local community in the planning and operation of the program.

A second project, PICA, has utilized learning and reinforcement principles and procedures for improving performances of adolescents who have displayed serious behavioral and academic problems while attending public schools. The project is developing procedures, training methods, data collection systems, etc., which are to be used by a public school system within the existing school budget, personnel, and normal school hours.

(2) Problem Behaviors and the Larger Social Unit. The Center has also been concerned with community-based treatment models aimed at larger social units, having implications for greater numbers of individuals. The Oakland projects began as an experimental training program for police officers who had become involved in an unusually high number of violent encounters with citizens and thus were themselves contributing, in some degree or other, to a violent behavior problem. The training program assisted the police officers to make use of behavioral and social science techniques in analyzing their own behaviors and those of the citizens with whom they came into contact; in a second phase of this project, the officers then developed five treatment models for the purpose of reducing violent behaviors in their community: (1) special training for police recruits aimed at violence reduction through changes in the police subculture; (2) a family crisis intervention program; (3) a landlord-tenant crisis intervention program; (4) a special education program using peer intervention techniques for additional violence-prone officers identified through regular screening of police arrest reports; (5) a special education program for citizens involved in assaults on police.

Another treatment model supported by the Center involves a program in which residents of a public housing project located within a Black community are developing and testing out a formal system of rules of conduct aimed at curbing anti-social behaviors in the project. The rules involve application of specific sanctions for the following types of behavior: vandalism, littering, abandoning disabled vehicles, traffic violations, and personal and property offenses. The researchers involved in this program are documenting changes in behaviors that accompany implementation of the model, and are also making an analysis of factors involved in converting an experimental program of this kind into a permanent feature of the local community.

Mental Health and the Legal System. The fields of law and mental health are both concerned with problem behaviors of individuals. The courts frequently have recourse to mental examinations for the purpose of assisting determinations on issues such as pretrial competency, exculpatory insanity, sexual psychopathy, civil commitment, presentence evaluation, etc. In addition, the courts have been moving to the position that many types of problem behaviors traditionally within the province of the corrections system can be dealt with far more effectively outside that system--and at far less cost to society--provided suitable alternatives are available. The mental health role has thus become increasingly strategic and socially important in this connection.

Several projects supported by the Center are concerned with the

need for empirically-based criteria on which to base determinations with respect to a wide variety of difficult law and mental health issues. Similarly, it is important that psychiatrists, psychologists, and other mental health professionals consulted by the courts have empirically-based criteria available which can assist in avoiding confusions between therapeutic concepts and the strictly legal concepts which form the basis for judicial decisions. One project supported by the Center is concerned with the development of more precise and meaningful criteria for determining competency to stand trial. The significance of this research is underscored by the fact that pretrial competency is by far the most frequent issue leading to involuntary hospitalizations of persons who become involved in the criminal justice process. Another Center project is seeking to develop improved criteria with respect to "dangerousness" as a legal and medical ground for committing an offender to a mental institution and for subsequently retaining the offender in such an institution. A third project is developing empirically-based criteria by which the adequacy of treatment provided for offenders involuntarily committed to mental institutions can be assessed by the courts and mental health personnel.

Training

The training emphasis very much relates to the mission-oriented focus of the Center which is concerned with developing improved techniques and strategies in the handling of individuals whose behaviors come to be defined as crime or delinquency. In this regard, training is not considered as an end in itself, but is closely related to the research supported by the Center, and to the program and policy objectives which the Center is attempting to influence in its areas of concern (viz., crime and delinquency, law and mental health interactions, and individual violent behavior).

The Center has been concerned in the past with the training of mental health service professionals and behavioral and social science researchers in the crime and delinquency field. Given the continuing gap between service needs and the availability of mental health manpower, the Center has been moving over the last several years in the direction of providing support for experimental training models for service professionals and non-professionals. The emphasis has been on developing new and more effective and efficient training and manpower development models aimed at improving the functioning of service delivery agencies in the crime and delinquency fields such as, for example, the use of non-professionals (including ex-offenders) to work as probation officer-case aides. Moreover, as policies and procedures change with regard to the handling and treatment of juveniles and mentally disordered offenders, the Center has been concerned with developing more appropriate and effective models for the training of manpower to meet these emerging needs.

The Center is also addressing the need for personnel trained in evaluative research skills to assess the effectiveness of various Federal, State, and local programs in the crime and delinquency field.

Finally, and consistent with the experimental nature of these projects, the Center is interested in learning more about the actual effectiveness of such training models. For this reason, many of the experimental training models being supported by the Center have an additional and independent evaluation component to assess effectiveness of the training and its general impact in reference to the needs and objectives underlying these efforts.

One project supported by the Center has been concerned with exploring the feasibility of utilizing various part-time and full-time non-professionals, including ex-offenders, as probation case aides in the supervision of offenders on probation or parole. In cooperation with the Federal probation office in Chicago, a total of 53 case aides were recruited to work with 161 randomly selected probationers and parolees. Results from this project were so promising that permanent positions for non-professional probation assistants were subsequently established as a line-item in the budget of Federal probation and parole offices. The Center plans further evaluation of the effects of introducing these new personnel and the impact they have on the structure and functioning of service agencies.

Since there continues to be pressing manpower shortages in the crime and delinquency field, many agencies are forced to hire service personnel who have no specialized skills in the handling or treatment of problem behaviors and social deviance. One experimental project is exposing selected undergraduate psychology students to a blend of programmed instruction, supervised field placements, and group methods in treatment and remediation services relevant to crime, delinquency, and related mental health problems. This program will be evaluated by determining the extent to which students have acquired the necessary skills at the end of the training period, and also through follow-up interviews and rating scales completed by agency staff. It is expected that this project will develop a model which can be used by other Federal, State, and local agencies to train service personnel.

In order to broaden the training for personnel who will be concerned with program planning and policy making in crime and delinquency, the Center has been supporting an inter-university and multi-disciplinary seminar on law and social deviance. This training program involves psychiatric residents, law students, and graduate students in psychology, sociology, social work and political science. Since the training program is designed primarily as an experimental project, an effort is being made to evaluate the criteria for selection of students, the effectiveness of various teaching methods and approaches, and the acquisition by the students of a broader conceptual framework for understanding and dealing with social deviance.

Numerous social action and service programs have been supported by State and local agencies to meet problems associated with crime and delinquency. In addition, various groups in society, such as youth and minority group members, have developed informal community-based responses designed to treat their members whose behaviors are defined as deviant by the larger society. While both formal and informal organizations and groups may provide services and generate innovative methods of treatment, rarely do these programs provide adequate and systematic evaluation of the various programs. One of the reasons for this lack of assessment has been the absence of qualified manpower to provide this kind of evaluation. Typically, agency evaluation efforts are more concerned with broad and basic statistics and with budgetary accounting than with more systematic and substantive evaluation of program effectiveness. In addressing the need for manpower to meet the aforementioned need, the Center is supporting a project to provide training for students in a specially designed two-year Master's degree program, with particular concentration on evaluative skills relevant to social action programs related to problems of crime, delinquency and social deviance.

Program Goals

The Center's future program will take the following directions:

1. More Precise Knowledge about Crime and Delinquency-related Behaviors. The Center plans to support and further develop research projects aimed at understanding factors uniquely associated with repetitive delinquent and criminal behaviors. Also, the Center plans to undertake additional studies directed to changing public attitudes toward such law-violating behavior as less serious juvenile offenses.

2. Community-based Treatment Models. In shifting to a public health and social systems approach, the Center plans to concentrate on the development of new types of intervention models aimed at influencing larger social units, as compared to the traditional clinically-oriented treatment approaches. Also much more attention will be given to broad political, social, economic, and organizational factors which affect problem behaviors within large groups of people.

3. Mental Health and the Legal System. The Center will continue to support activities that stress development of empirically-based criteria on which determinations such as sexual psychopathy, competency and civil commitment can be based. The Center will concentrate effort on specifying the adequacy and demonstrated effectiveness of treatment under conditions of involuntary confinement.

4. Training. Greater effort will be placed on development of experimental training models which are to dovetail with Center-supported research on treatment. These new models have potential for improved services offered by local community agencies.

5. Dissemination and Utilization. More monographs with particular policy implication are planned in an attempt to overcome the gap between scientific research and utilization of significant findings. Major emphasis will also be on promoting the field utilization of selected community-based treatment models and in providing the necessary research, training, and technical assistance components.

Collaborative Efforts

The Center for Studies of Crime and Delinquency has maintained ongoing periodic contact with the Law Enforcement Assistance Administration (LEAA) and its research arm, National Institute of Law Enforcement and Criminal Justice (NILECJ) in the U. S. Department of Justice. This program, created by the Omnibus Crime Control and Safe Streets Act of 1968 and amendments of 1970, places major emphasis on law enforcement, administration of justice, and correctional programs, while the NIMH focuses on behavioral and social science research. Despite these functional differences, however, the broad legislative mandates of the NILECJ program do overlap to some extent with the NIMH program in crime and delinquency. Over the past year, representatives of the Center and NILECJ have met periodically, discussed their mutual program areas, and exchanged several project proposals.

Center staff have also been in contact with other programs of relevance to crime and delinquency, such as the National Science Foundation and the RANN program of research on social systems and human resources. Several of their projects have been in the crime and delinquency field. Discussions with other programs have been with the National Council on Crime and Delinquency, the Manpower Administration of the U. S. Department of Labor, the Commission on Correctional Facilities and Services of the American Bar Association, and the Police Foundation. Staff members have also participated in the Inter-Agency Council on Corrections, a group which discusses various issues and programs in crime and delinquency, particularly corrections, at the Federal level.

During FY 1972, the Center also prepared a detailed program for the Office of Science and Technology on projects in the behavioral and social sciences in addressing Federal efforts to reduce crime. Finally, staff was involved in the work being conducted by the National Advisory Commission on Criminal Justice Standards and Goals, the Task Force on Corrections.

The NIMH Mental Health Study Center has also been active in this area. For example, it has provided consultation to a police and community relations unit in Prince Georges County, Maryland. They have also provided technical assistance to a local task force on rape.

Information Dissemination and Utilization

The Crime and Delinquency Abstracts, an information resource for the professional and scientific community, has been published under contract by NIMH.

Monograph Series. One series of short monographs, produced under contract to the Center, is directed to informing administrators, decision-makers, community leaders, and other interested persons about research results in significant crime and delinquency topics that are also of mental health interest. These monographs, by pointing out gaps in knowledge, have also suggested directions for future NIMH program development. This monograph series has included: The Juvenile Court: A Status Report; Diversion from the Criminal Justice System; Community Based Correctional Programs: Models and Practices; Graduated Release; Civil Commitment of Special Categories of Offenders.

Another series of longer Center monographs has been produced under contract by a number of outstanding authorities and has been devoted to the thoughtful and in-depth discussion of important issues in the crime and delinquency area. Several of these monographs have been adopted for use in educational courses given by colleges, community colleges, and police academies. Examples include: Perspectives on Deterrence; Legal Sanctioning and Social Control; The Functions of the Police in Modern Society; Instead of Court: Diversion in Juvenile Justice; Development and Legal Regulation of Coercive Behavior Modification Techniques.

Field Utilization. The Center has also supported efforts by several investigators to assist local decisionmakers regarding significant research findings and plans for program implementation. For example, these investigators were provided with additional funds to pay for the recasting of the scientific reports on their projects into a form comprehensible to agency administrators, judges, welfare and school personnel, probation officers, and parents. A film report suitable for showing at conferences and meetings was prepared on each project.

Based on expressions of interest from potential users, the investigators organize 1-day dissemination and utilization workshops that are funded by the Center and attended by small groups of key agency administrators and other potential users. Detailed information is presented and discussion invited on all aspects of the program models, such as design, goals, methods, outcomes, training, cost, and efficiency.

On the basis of the workshops and other discussions with potential users, detailed plans are then developed for actual field utilization. In general, it is expected that the original investigators will develop and provide special training programs for the manpower needed for field replication and broader utilization of the model. The investigators also make themselves available for consultation and technical assistance to agencies and groups interested in using the model. The Center will continue to fund many of these

activities for the purpose of ensuring that: initial replications of the model are conducted by well-trained and responsible persons; that necessary data are collected to permit careful evaluation of program effectiveness; and to allow further testing and refinement of the model. Increasingly, however, users will be expected to invest their own funds and resources into replications of the model as Center funds are gradually phased out.

DRUG ABUSE

Obligations
(In thousands)

	1970	1971	1972	1973 estimate	1974 estimate
Health Services and Mental Health Administration:					
National Institute of Mental Health	$38,833	$54,380	$116,675	$241,244	$243,269
Office of Education	---	5,610	12,400	12,400	3,000
Social and Rehabilitation Service:					
Rehabilitation Services Administration:					
Basic State grants	1,314	1,859	5,031	7,068	9,135
Innovation grants	300	46	---	---	---
Expansion grants	---	145	341	629	554
New career grants	---	136	135	125	---
Rehabilitation training	20	20	395	92	---
Rehabilitation research and demonstration program	---	151	652	790	800
Subtotal, Social and Rehabilitation Service	1,634	2,357	6,554	8,704	10,489
Total	40,467	62,347	135,629	262,348	256,758

Introduction

The Nature of the Drug Abuse Problem. Although there have been a number of accomplishments in drug abuse during the past three years, the problem itself has become increasingly complex. In part, this is attributable to the development each year of dozens of new therapeutic compounds, many with considerable abuse potential. As these become available on the market, the boundaries of the drug abuse arena expand.

A major factor contributing to the complexity of the problem which makes solution difficult is the classification of the drug abuser himself. While no one questions the applicability of the term drug abuse to the heroin addict, the speed freak, or the chronic hallucinogen cultist, there is continuing debate over classification of the intermittent user of marihuana or the individual who is chronically using various prescription drugs which enable him to "cope" with the stresses of everyday living. Examined in this context, the problem becomes reflective of society's definition of the norm and of what constitutes acceptable behavior. The extent to which this definition changes from time to time determines the magnitude of the problem at any given period. The issues surrounding legalization of marihuana vividly reflect this. Compounding the problem of drug abuse is the difficulty in dealing with the economic and social conditions which are closely linked with the genesis of the problem itself. Until changes in these conditions occur, no amount of effort in the areas of treatment, rehabilitation, education, or research will succeed in eradicating this problem.

The problem of drug abuse includes both narcotics and non-narcotics and its scope is enormous. It has been said before but will be repeated here that the economic and social cost to the Nation is high - so high that it is regarded by many as a major threat to our country. Indeed, the personal tragedy reeked on abusers, their families and friends in the wake of this problem is appalling.

Hard narcotics, chiefly heroin, account for some 600,000 addicts. Three hundred million dollars are spent yearly in illegal drug traffic. A much larger group than the abusers of hard narcotics are some 2 to 2.5 million people who chronically use barbiturates or other sedatives. Some 5 million people intermittently take oral amphetamines obtained without prescription. These include speed freaks, high seekers, weight reducers and those who wish to remain awake long hours for one reason or another. Untold millions smoke pot - many simply to defy the law - at an expense of 100 million dollars a year. The use of hallucinogens, still a problem, is on the decline. There are about 4-500,000 abusers of non-narcotics at any one time in the nation. The problem is so extensive by any measure that it almost defies solution.

Diverse groups - scientists, medical practitioners, labor leaders, sociologists, clergy, legislators, and others concerned by the enormity of the drug abuse problem - are studying its many manifestations in an effort to extirpate its underlying causes.

THE NARCOTIC ADDICTION AND DRUG ABUSE PROGRAM

While the larger societal problems are thus increasingly attacked, the major resources of the NIMH's Division of Narcotic Addiction and Drug Abuse are directed, for the present, toward the treatment and rehabilitation of the hard-core addict, primarily the heroin addict whose habit is at once self-destructive for him and inimical to society in general. While larger solutions are sought, the Division's symptomatic approach will enable the nation to maintain a reasonable measure of control over the individual addict's problem until effective programs can be found and implemented that will eradicate its root causes.

The research, treatment, training and educational activities of the Division of Narcotic Addiction and Drug Abuse are described in detail in the sections that follow. Some major activities in which the Division was involved during the past year are:

1. The signing of legislation by the President of the United States on March 21, 1972, launched a new initiative against the drug abuse problem in this country and designated the Special Action Office for Drug Abuse Prevention (SAODAP) as the coordinating arm of the White House in this effort. The Division of Narcotic Addiction and Drug Abuse (DNADA) in the National Institute of Mental Health (NIMH) has been given the lead role in executing the President's initiative through its programs in drug abuse rehabilitation, training, research and dissemination of drug abuse information.

2. The passage of the 60 million dollar drug abuse supplemental appropriation enabled the Institute to expand its capabilities in the areas of treatment, rehabilitation, and information services, and to provide support for the development of State drug abuse plans.

3. In August, 1972, the signing of a joint agreement between the National Institute of Mental Health and the Social and Rehabilitation Services (SRS) provided for vocational rehabilitation services for drug abusers enrolled in NIMH funded treatment centers.

4. In November, 1972, the 1st Narcotic Antagonist Conference was convened to discuss current research and to chart a course for the development of the NIMH narcotic antagonist program.

5. The Third Annual Marihuana and Health Report was published.

6. The Office of Economic Opportunity (OEO) and the Law Enforcement Assistance Administration (LEAA) met to consolidate their treatment efforts through programs costing approximately $14,500,000.

7. A plan was developed for the equitable distribution of funds to be used by States in developing State drug abuse plans. Regulations were formulated setting forth the conditions which are to be met by the States and must be incorporated in State plans to qualify for the release of funds.

8. Meetings and liaison with representatives of other nations,

i.e., Mexico, Canada, continued in order to develop coordinated research into the causes and effects of drug use.

9. The National Clearinghouse for Drug Abuse Information was organizationally placed within the structure of the Division of Narcotic Addiction and Drug Abuse (DNADA). The Clearinghouse continues its role in the storage, retrieval and dissemination of drug abuse information material and the storage and retrieval of management information systems.

RESEARCH

The seriousness of the phenomenon of drug abuse is unquestioned. What is often debated with emotional bias and without scientific basis is the question of what constitutes the most promising treatment for the individual's clinical problem and what are the most effective ways to deal with the social implications of drug abuse.

The object of the research program of the NIMH is to identify causes and effects of drug abuse by working intramurally, at the Addiction Research and Clinical Research Centers in Lexington, Kentucky, and extramurally through support of nongovernmental investigators.

NIMH Addiction Research Center

There are a number of important projects currently underway at the Addiction Research Center (ARC). Several investigations are being conducted into the role of tryptamine in the Central Nervous System and the reputed function of tryptamine as the basic mechanism through which potent hallucinogens, such as LSD, mediate their effects.

Other studies are concerned with the development of narcotic antagonists that are highly effective with a minimum of side reactions and addicting properties. One such study explores the effects of Adrenocorticotrophic Hormone (ACTH 1-24) and Melanophore Stimulating Hormone (MSH), two closely related hormones of the pituitary gland, on the regulation of the endocrine system. These two hormones, when tested on the spinal cords of frogs or cats, show antagonist actions to the depressant effects of morphine. This antagonistic action is greater than that of naloxone when tested in the same way; but while the action of morphine on mono-and polysynaptic reflexes is inhibited, the endocrine products do not change its blood-pressure-lowering activity. These hormones do not have any action on blood pressure, nor does ACTH itself affect the mono- or polysynaptic reflexes. These findings are significant in approaching the addictive drugs most intimate actions - information we must have in order to arrive at an effective rationale for the pharmacological treatment of addiction.

Experiments with dogs that exhibit relapse when morphine is made available to them after having been addicted and withdrawn may in the long run have significant application in the research of drug addiction. The dog, like most humans but unlike monkeys and other animals, demonstrates the aversive, non-reinforcing properties of morphine. When addicted dogs in the laboratory have learned the

lever-pressing techniques to ward off the signs of abstinence, some of them will relapse and resume the self-injection of morphine. Passively dependent dogs, withdrawn, given the opportunity to self-infuse, do not however voluntarily relapse. Fifty percent of dogs tested do not initiate or continue morphine self-administration. The question this experimental work seeks to answer is why they do not do so. The purpose of these experiments is the separation and analysis of the various physiological and psychological parameters that lead to drug abuse and addiction. To understand why morphine is aversive to some dogs, as it is to most humans, will provide insight into the treatment of those to whom morphine is reinforcing.

One of the major problems in developing a suitable antagonist therapy has been the lack of a long-acting agent. Naloxone pamoate appeared to have considerable potential as a therapeutic antagonist; however, it proved clinically unsuitable because of its short-acting characteristics. It is hoped that the development of a slow-release mechanism will solve this problem. Cyclazocine in a plastic-type compound consisting of a polylactide polymer is now undergoing tests in dogs prior to clinical testing in man. Similar preparation with naloxone and naltrexone pamoate are also ready for testing.

Besides basic research into the actions of narcotics and narcotic antagonists, the ARC carries out a number of clinical studies:

1. The detection of methadone metabolic products and those of l-alpha acetylmethadol (methydyl acetate, LAAM) by means of thin layer and gas-liquid chromatography. Studies of this type will enable the clinician to apply the most effective therapeutic measures in treating (morphine) addiction and to discern what effect intercurrent disease, common among addicts, may have on the drugs therapeutically used.

2. Studies with methadone in clinical use show that it slows electroencephalogram (EEG) activity and decreases eye movement (REM activity) resulting in disturbances of sleep patterns. Withdrawal from morphine causes insomnia and this is followed by an increase in REM sleep. These disturbances are important, as they affect the patient adversely during detoxification and must be explained and treated by the therapist.

Other studies on EEG and sleep patterns are being done with another narcotic antagonist, cyclazocine. In doses of 0.1 or 0.2 mg/70 Kg. cyclazocine decreases the number and duration of REM episodes. In higher doses (0.5/70Kg) cyclazocine increases the frequency and urgency of urination.

There is continuing evaluation of urinalysis procedures in an attempt to find more accurate, simpler and more efficient procedures for use in treatment programs. Different techniques as well as modifications of existing procedures are being tried to make comparisons and to uncover the most successful methods for monitoring patients in treatment programs.

3. There is continuing effort into the human evaluation of pros-

pective analgesics, antagonists, and psychotomimetics. The ARC is the prime facility in the U.S. for confirming animal experimentation by human assessment and further development or rejection of many potentially useful drugs rests on such work.

NIMH Clinical Research Center

The second NIMH facility at Lexington, Kentucky, is the Clinical Research Center. The research conducted in this portion of that complex is directed toward treatment and the evaluation of various treatment modalities, and the analysis of the patient's abilities and strengths upon which successful treatment can be based. The Clinical Research Center is contrasted with the Addiction Research Center by its emphasis on the whole person and how to prepare this person for the inevitable stresses of everyday life.

Such activities as the development of a scale to measure the effects of treatment in changing attitudes and values of addicts, the interrelationships of addiction and crime, the differentiation among various types of addicts, the relationship of the drug to the user and the behavior of addicts in group therapy when they wish to evade treatment, have been the subjects of many journal articles for professional use. An important aspect of addiction is the emotional involvement of the addict in the life style and culture from which he came and from which we hope to remove him after treatment. In order to assess such a subjective state, attempts are being made to quantify the consequences of the addict's emotion manifested through physiological changes which are autonomically controlled, such as pupil size, blood pressure, heart rate, respiration, muscle tension and other responses.

Center for Studies of Narcotic and Drug Abuse

The Center for Studies of Narcotic and Drug Abuse is the focus for a wide spectrum of extramural research in various aspects of drug abuse - from studying the basic chemistry of abused substances to investigating psychosocial and epidemiological factors influencing drug abuse. In addition to supporting an extensive program of extramural research by means of grants to nonprofit research organizations, the Center makes available to qualified researchers supplies of marihuana, LSD, heroin, and other abused drugs for carrying on their work. A large contract program not only makes this drug supply program possible, but also enables us to achieve a number of priority research objectives quickly. Finally, through the medium of research conferences and reports, the Center plays an important role in the rapid dissemination of research findings and in encouraging their rapid utilization.

Marihuana Research

Because of the wide use of marihuana in our society, especially among the young, a major marihuana research program has been underway for several years. Detailed summaries of the accomplishments of this program may be found in the First, Second and soon-to-be-released Third Annual Report to Congress on marihuana and Health. This work rapidly advanced our understanding of the health implications of marihuana use and has served as an important scientific data base for the deliberations of the President's National Commission on Marihuana and Drug Abuse. The most significant recent findings of the marihuana research program are:

1. Systematic animal study of the effects of marihuana use on the offspring of users shows no evidence that the drug or its major psychoactive constituent, tetrahydrocannabinol (THC) are likely to result in birth anomalies. Although this does not categorically rule out the possibility that marihuana, even in combination with other drugs, might under some circumstances contribute to birth defects, it is nevertheless reassuring.

2. Completed and ongoing studies on the immediate effects of marihuana use at typical social dosage levels demonstrate various types of temporary mental impairment during periods of intoxication, but offers little evidence of lasting effects. Generally, there is evidence that memory is impaired and that impairment of other modes of intellectual and psychomotor functioning increases as task complexity increases. Recently, evidence has shown that marihuana intoxication produces impairment in driver functioning which in turn may contribute to motor vehicle accidents. Studies on the effects of marihuana on driving and on attention and memory are being conducted at Stanford University, at Harvard, and at the University of California.

3. A recently completed study in which chronic marihuana users were matched with nonusers shows little impairment in the marihuana smokers. Those who had used marihuana heavily for an average of 17 years showed no evidence of physical, mental, or social impair-

ment that could be related to marihuana use. This study was conducted at the University of California. The small number of the samples involved (30 users), along with our continued concern about the types of impairment described in less systematic case studies, make more extensive long-term user studies imperative.

4. The synthesis and the increased availability of limited quantities of marihuana metabolites are making it possible to undertake careful study of the transformation marihuana undergoes in the body and its mode of action. Such research provides new clues to more subtle toxic effects that might otherwise be missed and to adverse effects that may result when marihuana is used with other drugs.

5. Studies of the interactive effects of marihuana used in conjunction with other drugs, e.g., alcohol, barbiturates, stimulants, over-the-counter and prescriptive drugs, etc., are being undertaken. Some evidence from animal studies indicates that marihuana use modifies the effects of other drugs in ways that may be significant for human use.

Narcotic Addiction and Its Treatment

Many aspects of narcotic addiction still hold many questions for research. Basic research on the mechanisms of opiate action gives promise of identifying an opiate receptor in the brain. While the significance of such finding is not yet clear, it certainly offers possibilities for the development of more effective, longer-acting narcotic antagonists relatively free of side effects. Such substances, which block the action of opiates without being in themselves addictive, may ultimately prove to be effective treatment and preventative tools in our armamentarium.

Early in December 1972, the First International Conference on Narcotic Antagonists, under the joint sponsorship of NIMH and the Special Action Office on Drug Abuse Prevention, focusing on the chemistry and preclinical pharmacology of narcotic antagonists, directed scientific attention to new developments which are expected to accelerate the pace of present research in this area. Current NIMH efforts range from the development of promising new compounds to the clinical testing of materials already demonstrating therapeutic potential. Intensive NIMH work is also underway to develop a range of dosage forms and therapeutic vehicles which will extend the action of these drugs and make day-to-day therapeutic motivation of the addict less important. If such drugs can be developed for widespread use, they may also prove of value in the prophylactic treatment of populations at high risk of becoming addicted. Despite the promise of newer chemotherapeutic approaches to addiction, much remains to be learned about existing treatment approaches. Whatever its limitations, methadone maintenance has been an important factor in improving the functioning of some patients in society. The physiological, psychological, and sociological implications of this form of treatment continue to be studied. In addition, the development of a long-acting form of methadone is being supported through several grant and contract efforts. Much remains to be learned about the developmental and psychosocial factors which influence recurrence

of drug dependence. Such factors may be physiological and genetic as well as psychosocial. For example, little is known about the role of maternal diet, neonatal nutrition, and subsequent nutritional deficiencies as they affect later susceptibility to drug dependence although these are suspect. Along with these and other genetic factors, the relationship of drug abuse to various aspects of neural chemistry is being explored. Advances in basic research, although unpredictable, could easily alter our entire approach to the prevention and treatment of addictive and other drug dependency disorders.

Special emphasis is currently being placed on research in the diffusion of drug use and the degree to which this use can be attributed to the sociocultural environment. By better understanding those factors which play a role in predisposing or, conversely, making the individual resistant to drug dependence, we hope to improve our inadequate prevention efforts. Such efforts are particularly important among groups which are at high risk of becoming addicted such as inner city youth, lower class-ethnic minorities, etc.

New Therapeutic Approaches to Drug Dependence

Although chemotherapeutic approaches to the problems of drug dependence have received a good deal of attention in our research program, the psychological aspects are equally important. Despite the efficacy of chemotherapy, it is important to provide a range of psychosocial treatment and services so that addicts and others who are dependent on drugs may find other sources of satisfaction. Increased attention is being directed to those aspects of the individual's psychological environment which "reward" him ambivalently for continuing his drug dependence or for seeking and profiting from treatment. By carefully examining the psychological factors in the patient's social and institutional environment, we should be able to manipulate them in order to increase the probability of therapeutic success. Research in behavioral modification techniques which are carefully designed to channel the individual's behavior into a socially desirable direction includes the systematic examination of the addict's behavior as affected by heroin use and the influence of various treatment techniques in modifying this behavior. It also includes the systematic manipulation of rewards and punishments by therapist-patient consensus to reach agreed upon therapeutic objectives.

Interdisciplinary Research Centers for the Study of Drug Abuse

By emphasizing active interdisciplinary interaction, it is hoped that basic research findings can be more rapidly utilized in clinical work. Increased collaboration between the basic scientist and his clinical colleague is likely to enhance the probability that the basic scientist will realize the greater potential his work has for solving clinical problems. A significant accomplishment of this past year was the creation of eight university-based research centers designed to exploit the potential for interaction between basic and more clinically oriented research. It is expected that creation of centers of excellence of this type will greatly improve the quality of drug-abuse-related research.

Other Drugs of Abuse

Although this report has highlighted recent developments concerned with marihuana and the narcotics, research into other kinds of drug dependency is not neglected. Amphetamine abuse, for example, continues to be an important area of research; this includes the development of antagonists analogous to narcotic antagonists which block the psychomotor action of the amphetamines. Cocaine is becoming more widely abused and we are currently encouraging research into its physiological effects. Barbiturate abuse remains a significant problem and work in that area continues. Perhaps most significant of all is the awareness that the typically heavy drug user is abusing not only one but many different drugs, frequently simultaneously. Much effort is being expended in understanding the patterns of polydrug use, factors influencing progression to other drugs, and the long-term implications of such use. As new agents of abuse come into wide use, their use in conjunction with the many other drugs available in our society must also be studied.

TREATMENT

The principal focus in treatment this year has been the Division of Narcotic Addiction and Drug Abuse's (DNADA) effort to expand the number and capacity of NIMH funded treatment and rehabilitation programs for narcotic addicts and other drug abusers. Since 1971 DNADA has increased almost fivefold its community-based treatment capacity. In 1971 there were 23 programs with a treatment capacity of 13,177 patients per year. By December 1972 there were 129 programs with a total capacity for treating more than 62,000 patients per year. This represents a major expansion of opportunities for citizens with drug abuse problems in every region of the country to find help.

Treatment programs fall into two major categories. The first, assisting communities to establish treatment pr rams for narcotic addicts and drug abusers through the award grants, is funded under the provisions of the Community Mental Health Act and the Drug Abuse Office and Treatment Act of 1972. The second is a civil commitment program conducted under Titles I and III of the Narcotic Addict Rehabilitation Act, which is totally funded and operated by the Federal Government.

The Community Assistance Program

The community assistance program utilizes a number of legislative authorities to initiate and provide a definite term of support for a variety of community-based treatment programs for both narcotic addicts and other drug abusers. Community-based treatment grants authorized by Title IV of P.L. 89-793 enabled us to establish six demonstration treatment centers in FY 1968. Three of these grants have been converted to drug abuse "service" grants that provide treatment for about 2350 patients; two of these grants are in their last year of funding, and the third will be funded through FY 1974. By the end of FY 1974 this category of grant will be phased out.

Staffing Grants

Staffing grants, authorized under the terms of Part D, Section 251 of the Community Mental Health Centers Act (as amended), provide funds to pay a portion of the salaries of treatment personnel. Only 26 of these staffing grants are now in existence, since the Drug Abuse Service Project grants authorized under Section 256 (discussed below) are more desirable from the recipient's point of view. Of these 26 grants, only three were awarded in FY 1972 in the amount of $2,287,000. No additional staffing grants are likely to be awarded in FY 1973 and FY 1974. The funding of these grants in FY 1973 totals $16,100,000. These grants furnished staff for the treatment of approximately 10,000 patients.

Special Projects

The purpose of these grants is to support and to evaluate treatment programs which demonstrate effective methods of delivery services, to permit advance intelligence on new modes and means of drug abuse

and addiction treatment, and to provide appropriate services to meet the new and existing problems related to substance abuse. The first three special projects were awarded in FY 1972 for a total of $1,117,000. We expect to fund 15 additional projects totaling $4,725,000 by the end of this fiscal year.

In FY 1972 attention was centered on innovative ways of reintroducing heroin abusers already under treatment into the mainstream of our economy through work-support programs, thus eliminating the need for welfare and other correlates of unemployment. In this fiscal year we are emphasizing new methods of delivering services, such as the delivery of services by labor unions and the treatment of alcoholics and drug abusers in the same facility. Several large projects call for monitoring the long-term effects of methadone treatment upon body functions and upon performance. Other studies concentrate on special groups such as teenage addicts, the female addicts, and addicts with severe psychiatric disorders to uncover better ways to adapt programs to the needs of these groups.

Drug Abuse Service Projects

Drug abuse service projects are authorized under Part D, Section 256, of the Community Mental Health Centers Act. Awards are made on a matching fund basis for operational costs of programs for the treatment of narcotic addicts and other drug abusers. To obtain an award, a program must offer one or more of the following: detoxification services, institutional services, or community-based aftercare. When this type of grant became available, the popularity of staffing began to decline because of the financially advantageous provisions of the later legislation. In fiscal years 1972-73, one hundred twenty-three projects were funded under this authority. Last year 14,908 patients were treated in these programs. No additional projects will be funded in FY 1974 under this authority. These figures in no way reflect the magnitude of requests for this type of grant. As of December 15, 1972, 80 approved-but-unfunded applications were still on hand. An estimated 300 applications will be submitted to the NIMH for review during the remainder of FY 1973, only 120 of which, totaling 61 million dollars, will be worth funding.

Initiation and Development (I&D) Grants

I&D grants are awarded to public or private nonprofit agencies to assess local needs for programs of services for narcotic addicts and drug abusers, to design such programs and obtain local financial and professional assistance to support them, and to foster community involvement in program initiation and development. Each grant may cover up to 100 percent of costs but is limited to $50,000. It is a one-time award and may not exceed a one-year period.

In FY 1972, 20 of these grants were awarded. In FY 1973 and FY 1974, we anticipate that only 10 grants will be awarded in each year. The gradual reduction of this program reflects the effect Section 409 Formula Grants money has had on being made available to the States.

Special Project Grants and Contracts

Funding under this category was authorized under the Drug Abuse Office and Treatment Act of 1972, P.L. 92-255. It is anticipated that 20 drug abuse service grants for a total of $10,172,000 will be awarded under this authority in FY 1973. The remaining $30,000,000 available as supplemental appropriation is being used to introduce a fixed-price fee-for-service contract program to meet the need for treatment services in drug abuse crisis areas. Other new projects may be awarded to the extent that contracts awarded in FY 1973 are not continued, and additional funds are made available. Projects undertaken under this authority provide for vocational rehabilitation counseling, education and services for persons under treatment. The establishment, conduct and evaluation of drug abuse prevention, treatment, and rehabilitation programs within State and local criminal justice systems are also authorized under Section 410, Special Projects Grants and Contracts.

NARA Contracts

Approximately 6,000 patients have received services under this program. Initially, the inpatient phase of this program was conducted at the Clinical Research Center in Lexington, Kentucky, or the Center at Fort Worth, Texas. Since this latter facility has since been transferred to the Justice Department, inpatient care and outpatient services are being provided at community facilities. There are currently 178 agencies providing evaluation and examination, inpatient care, and supervised aftercare under contracts administered by the NIMH. The present patient population in the civil commitment program is 2,246 persons.

Currently, NIMH efforts are being directed toward the integration of NARA programs with community-based projects at community mental health centers and with independent drug abuse service projects. New civil commitments are being reduced by about 300 patients each year. We expect the NARA program to be reduced to approximately a third of its present level by the end of FY 1975.

Projects Monitoring

One of the problems which has developed with the rapid expansion of treatment facilities has been our inability to maintain a schedule of monitoring to assure adequate provision of treatment services.

To solve this problem we are working with the Special Action Office for Drug Abuse Prevention (SAODAP) to develop a program which will monitor and evaluate the treatment effectiveness of some programs inadequate in service and management. This program will begin in March 1973.

An evaluation project based on a data collection system which is an integral part of the Community Assistance Program is currently underway. This assessment program follows the individual patient during treatment at the grantee agency from his admission to his

discharge. The data collection system used employs two reporting forms: an admission form provides the patient's history; a bimonthly status evaluation form provides information on treatment progress and patient response with respect to employment, drug and alcohol abuse, criminality, and other factors which influence behavior. The information thus acquired is maintained in a periodically updated computer file to be used as a source of data on patient loads, kinds of treatment delivered, and treatment outcome. As data on a sufficient number of patients are obtained, it becomes feasible to develop typologies of patients, relate these to the treatment approaches utilized, and assess how similar groupings of patients in various treatment modalities, and various groupings of patients in the same modality behave in terms of indices of social functioning. From this it should be possible to match treatment modality with patient type.

The second project attempts to assess the effectiveness of the civil commitment program under the Narcotic Addict Rehabilitation Act (NARA). As more individuals are "graduated" from this program, their performance in their social environment can be more effectively studied. Such evaluation would attempt to correlate performance after completing the program with performance during the program. In the study now underway, three groups of patients are being evaluated: those not accepted to the treatment phase of the program after undergoing initial evaluation, those admitted for treatment but released before completion of the necessary regimen, and those who successfully completed the program. This kind of evaluation will enable us to determine beforehand those persons who are likely to benefit from the program from those who will probably drop out. It should be possible from the data produced to identify points in the program and to identify indicators of patient behavior which will be critical to the patients remaining in the program.

Future Projects Include Plans for:

(1) A review to determine cost factors of the various treatment modalities now being funded. This effort will take into account the length of time the funded programs have been in operation, growth factors and increased costs, variability of patient loads, tenure ratios of patients, and administrative, operating and clinical staff loading. Cost factors are to be developed by the end of FY 1973.

(2) A determination of behavioral shifts and social effectiveness. The task of evaluating the impact of treatment programs in terms of behavior and performance has been done only on a limited basis. It is envisioned that certain programs by virtue of their size, multiplicity of treatment approaches and adequate representation of demography will be used to measure the impact of various treatment techniques. Environmental, ethnic, socio-economic, and specific individual factors will be examined vis-a-vis treatment and post-treatment effects on the patient's values, behavior, attitudes, and interpersonal relationships.

TRAINING AND EDUCATION

During the past year, a Training and Education Section in the DNADA to serve as the focal point for administering all drug abuse training and education activities was established as a result of the passage of P.L. 92-255, in order to meet the anticipated growth of such programs. In carrying out its responsibilities, the Training and Education Section provides support through three major grant and contract programs.

One program supports community efforts to develop alternative approaches to the prevention of drug abuse. A second program supports training for professional, paraprofessional, and ex-addicts who work in drug treatment and rehabilitation centers or who plan to enter the field of drug abuse treatment and rehabilitation. The third support program provides funds together with the National Institute of Alcohol Abuse and Alcoholism for indepth training of senior medical faculty who wish to specialize in the addictive states.

Progress and Accomplishments

In the past year, a new training center was established under contract at Queens College in New York, bringing to six the number of centers actively engaged in short-term training of treatment personnel. Besides New York, there are training centers in Oakland, California, Coral Gables, Florida, Oklahoma City, Chicago, and New Haven, Connecticut.

In addition to these training centers, the National Drug Abuse Training Center, in Washington, D. C., provides training for individuals working in the field of drug abuse treatment, rehabilitation, and prevention. Since its establishment in the spring of 1972, this Center has been engaged in developing, testing, and teaching improved methods of treatment, rehabilitation, and prevention to workers in the drug abuse field. It shares new training designs developed here with other drug abuse training institutions and programs throughout the nation. Its students include Federal, State, and local government officials, psychiatrists, physicians, and other health professionals as well as others already engaged in or wishing to become involved in the fight against drug abuse. Training programs cover subjects such as pharmacology, sociology, and biochemistry, and courses in emergency medical care, patient management, and group therapy techniques. Training methods not only include lectures and demonstrations but also field visits, interaction with patients, and evaluation seminars. The Chief of the Training and Education Section, DNADA, serves as co-project officer for the National Training Center in Washington, D. C.

Forty-seven grants for training professionals and paraprofessionals are currently operational. Twenty-seven new grants are contemplated for FY 1973. Annually these grants provide training to several thousand health professionals, aides, laymen, and ex-addicts who are involved in a variety of drug abuse prevention, treatment,

and rehabilitation programs. For example, a program for familiarizing clergymen with drug use and abuse is conducted at Washingtonian Hospital, Jamaica Plain, Massachusetts; a program for counselors is conducted at George Washington University, Washington, D. C.; a comprehensive course at the University of Arkansas is directed at career teachers who are in an excellent position to further the prevention of drug abuse. Training courses range from 1 month to a year. Specialized curricula from 1 to 3 years are offered at the graduate level to fill the need for professional manpower. The need for trained manpower is estimated at 20,000 over the next 2 years.

In addition to training grants, 28 educational grants are operational. Twelve were begun in FY 1972, two more are planned for FY 1973. These include innovative programs in curriculum development, research in drug education methods, and community drug prevention education. Several socio-educational programs are geared to the needs of school teachers and administrators, students, and family groups, particularly those requiring counseling. There are also specialized courses for adult groups, such as family guidance counselors, social workers, and peer groups in the health sciences.

Some other programs stress innovative approaches such as the development of TV programs, produced by students for use in teaching student-age groups about drug abuse and health. Still other programs provide alternatives which stress self-help; e.g., Careers in Change, a project which directs its efforts toward helping addicts and ex-addicts acquire marketable skills.

Eight grants were jointly funded in FY 1972 by NIMH's Division of Narcotic Addiction and Drug Abuse and the National Institute of Alcohol Abuse and Alcoholism. One such award remains pending in FY 1973. These grants provide for intensive training of senior medical faculty members who wish to specialize in the field of addiction and drug abuse. On completion of this training, the grantees are expected to develop drug abuse training and education curricula in their colleges or universities.

Among others, there are career teacher awards sponsored jointly by the National Institute of Mental Health and the National Institute of Alcohol Abuse and Alcoholism at Washington University, St. Louis, the University of New Mexico, Albuquerque, and the Albany Medical College, Albany, New York.

Objectives for FY 1974

1. Develop a viable organizational structure to effectively implement increased program requirements.

2. Carry out an evaluation of the effectiveness of current training efforts.

3. Assure representation of minorities, women, and other interested groups in the committee review structure.

4. Develop special training and education programs for youth and underprivileged minorities.

5. Establish a unified intradivisional review committee to study and recommend funding across-the-board projects not specific to any divisional program area.

6. Assess the national need for training programs for treatment personnel.

7. Build career mobility into all training programs to provide trainees with increased opportunity for vertical as well as horizontal movement in the mental health setting.

8. Promote and develop innovative preventive programs in drug abuse education.

DRUG ABUSE INFORMATION SERVICES

National Clearinghouse for Drug Abuse Information

The National Clearinghouse for Drug Abuse Information (NCDAI) was created in March 1970, to serve as a focal point for accurate current information on drug abuse. It was organized to acquire, extract, store and disseminate descriptive materials on drug abuse from all sources. Its primary purpose is to function as a documentation and reference service. Efforts are underway to expand the Clearinghouse functions to include management information, control and analytical activities.

Information Services

Since its inception the Clearinghouse has responded to 12 million inquiries and has distributed over 27 million publications. The Clearinghouse develops and distributes posters, pamphlets, publications, and other materials for use by the general public, researchers, teachers, physicians, interested groups and individuals. To meet the demand for more advanced material that lies between what is routinely available and what is contained in scientific source material, NCDAI produces a Report Series and a Reference Series which encompass research services on specific subjects in drug abuse. One such report published last year dealt with the amphetamines, another on treatment modalities, and others on similar subjects. In all, the Clearinghouse has developed more than 75 fact sheets, bibliographies, and directories as part of these series. The Clearinghouse has designed the Media Recall System to index newspaper articles, broadcasts and editorials dealing with drug abuse to serve as a source of information and evaluation on public opinion. At present 14,000 documents are on file and are searchable.

In order to assure that all releases and all materials bought or produced by the Federal Government on the prevention of drug abuse will effectively achieve the purpose for which they are designed, the Clearinghouse reviews these publications prior to issuance through its Media Pretest and Review Program. At present 60 audiovisual materials, 30 broadcast materials, and 700 pieces of printed materials have been evaluated. The Clearinghouse also performs retrospective evaluations of Federal materials and of commercial and nonprofit products after they have been distributed in order to appraise their effectiveness.

Scientific and Tecnnical Information

The NCDAI's Resources and Materials (RMF) computer file contains abstracts and descriptions of books, pamphlets, journal articles, posters, films and other materials on drug abuse. This file accessible by on-line terminal stores over 10,000 abstracted documents which provide responses for technical inquiries and are the basis for published bibliographies.

The Drug Abuse Current Awareness System (DACAS), a component of the RMF, is a bimonthly publication that lists newly acquired citations from current drug abuse literature. All materials cited in DACAS are abstracted and entered into the Resources and Materials File (RMF). This publication is designed to help specialists in the field keep current with drug abuse literature.

The Clearinghouse has developed the Drug Abuse Digest, a summary of current drug abuse literature. As a service to teachers, lawyers, community action people, and others who need to keep abreast of timely drug abuse information, the Clearinghouse developed the Drug Abuse Digest as a monthly issuance summarizing selected drug abuse literature in a looseleaf format.

Programmatic Data

The Clearinghouse maintains a computer file of all drug abuse programs in existence throughout the country. The system is designed to enable the Clearinghouse to respond to queries about programmatic activity and to establish a comprehensive inventory of drug abuse programs, both Federal and nonfederal. Information about programs may be retrieved from the computer upon request in many ways -- geographic location, type of program, mode of operation, funding source, and sponsoring organization. Each program entry also contains a nonevaluative narrative description obtained from the materials and reports contributed by the program itself. A directory of this file of 2,000 programs is now being compiled and will be available in March 1973.

In addition to the computerized information storage and retrieval system, efforts have been made to develop an analytical system capable of generating reports to meet specific project management and planning needs. A Federal Program Management Information System (PROMIS) has been operational since April 1972. This system was designed to collect descriptive and management data on Federally-funded drug abuse treatment, rehabilitation, training, education, and research programs for use by Federal managers and planners in assessing the nature, scope and magnitude of current Federal drug abuse prevention efforts and for planning of future activities. At present 2,000 Federal programs are on file and information may be sorted on any data element in the system; e.g., program type, SMSA, city and State. A second phase of this system, in process, incorporates new information requirements of the grants process and improves upon the former method of collecting, coding, and computerizing the data. This data base will be operational in spring or summer 1973.

Drug Abuse Communications Network (DRACON)

DRACON is designed to facilitate information exchange among users at the Federal, State, local and private levels. Functions of DRACON centers include response to inquiries, distribution of publications, provision of search and retrieval services, and participation with the Clearinghouse in joint data collection and information development projects. The Network presently consists of about 30 centers.

OFFICE OF EDUCATION 20

The Drug Abuse Education Act of 1970 (P.L. 91-527) was enacted December 7, 1970 and authorized drug abuse education projects in schools and communities throughout the country. The program was designed to alleviate the drug abuse crisis by developing community awareness of the real nature of the problem and then concentrating efforts aimed at attacking the cause of drug abuse rather than treating its symptoms. This act expires on June 30, 1973. In fiscal year 1974, drug abuse education will be conducted under the authority of the Drug Abuse Office and Treatment Act of 1972, Section 410.

It has become increasingly evident that virtually all communities have some sort of drug problem and that problems vary from community to community. Although most communities are aware of the problem and want to respond to it, the Federal Government could not support projects in every community. A realistic and productive Federal role has been to train leadership for communities, to respond to specific needs and to evaluate and disseminate information about successful programs and techniques. To make the program responsive to as many communities as possible, the Help Communities Help Themselves program was initiated. Small grants were awarded to communities to support the training of community teams of five to seven individuals at nine regional training and resource centers. With the training received, the teams returned to their communities with the skills to assess and mobilize local resources for responding to their drug problems.

In fiscal year 1973, the program is supporting community teams through minigrants for training and is supporting the eight regional training and resource centers. It is continuing support for projects in State and territorial education agencies, college-based demonstration projects in drug abuse prevention, and school/community-based demonstrations. The National Action Committee is providing technical assistance and consultation to the National Program and State and local projects. Fiscal year 1973 funds are also being used to support operations from July 1973 through June 1974 at the State and territorial projects, at college and school/centers (which will also train minigrant teams), and at the National Action Committee.

The program will use fiscal year 1974 funds, under the new authority, to support pilot demonstration projects to validate models of drug abuse prevention geared to particular communities with particular problems; the models can then be disseminated to similar communities with similar problems. Preservice training (for undergraduate teachers-in-training) will be supported at colleges of education throughout the country. The program is tentative, subject to the approval of the Special Action Office on Drug Abuse Prevention.

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

With greatly increased national attention to the problem of drug abuse, State rehabilitation agencies have been expanding their efforts to assist drug abusers in becoming gainfully employed. Medical and other therapeutic services are vital parts of the majority of drug abuse treatment programs. However, unless drug abusers are provided those services which will allow them to prepare, enter, and remain in gainful employment the long-term success of drug abuse treatment programs will be questionable.

State rehabilitation agencies are uniquely qualified to assist the drug abuser in becoming a self-sustaining member of the community through appropriate preparation and placement in remunerative employment. Unlike many recently formed and relatively unproven service-providing organizations, vocational rehabilitation agencies have a demonstrably successful history of assisting disabled persons handicapped by severe psychosocial problems. Experience gained in alcoholism and mental illness is now being carried over to drug abuse. Vocational evaluation, work adjustment services, specialized job training, placement assistance, and follow-up are vocational rehabilitation services which are characteristically needed by drug abusers.

At the request of the Office of the Secretary, steps are being taken to integrate the vocational rehabilitation service system with the drug abuse treatment programs funded by the National Institute of Mental Health. A cooperative agreement on this subject has been signed. Vocational rehabilitation agencies will be working closely with the State Drug Abuse Authorities authorized by PL 92-255, when these agencies become operational.

State agencies serve drug abusers through special projects, as well as in the general caseload. In the District of Columbia, an Expansion grant allows the vocational rehabilitation agency to provide services to drug abusers who are enrolled in programs supported by the Narcotics Treatment Administration. Other Expansion grants are active in Iowa, Georgia, and Kentucky.

It is estimated that 3,000 drug abusers will be rehabilitated by State vocational rehabilitation agencies in FY 74, an increase of 200 from FY 73.

Number of Drug Abuse Rehabilitants

Fiscal Year Ending June 30	Persons Rehabilitated	
	Total	Drug Abusers
1970	266,975	832
1971	291,272	1,505
1972	326,138	2,000
1973	340,000	2,800
1974	350,000	3,000

The Rehabilitation Services Administration supports short-term specialized training in drug abuse for State agency counselors. During FY 73, counselors are being trained at centers in Oakland, Calif., Miami, Fla., and Norman, Oklahoma. RSA is also supporting a New Careers project for drug abusers in the Baltimore, Maryland, area.

Rehabilitation Research and Demonstration Program

Rehabilitation of drug dependent people requires the development of innovative, imaginative, and aggressive techniques. Previous research has demonstrated the value of transitional living arrangements as rehabilitative adjuncts. The importance of considering and responding to the abuser's total environment during the rehabilitation process has also been shown. Therefore, therapeutic measures which include work training must be developed in partnership with private industry. Community adjustment services must be delivered in cooperation with local community resources. Moreover, although adequate follow-up services have proven to be a crucial component in the rehabilitation process, other elements must be as systematically investigated. For example, an ongoing project in Oregon is testing the effects of group versus individual therapy. Roles of parents and types of referral sources are also being studied.

We do not yet know the most efficacious and cost-effective approaches to the organization and delivery of services. All of the following approaches have shown some promise for improving the rehabilitation of drug dependent people: 1) the availability of local, community-based services; 2) an integrated array of rehabilitation and social services; 3) immediate therapeutic intervention at crisis points; 4) the utilization of peer group dynamics, "confrontation" techniques, and ex-addicts paraprofessionals; and 5) client advocates employing a variety of outreach methods. However, all of these require careful study of their effect upon the rehabilitation process.

It is planned during 1973 to undertake a longitudinal study of the durability of rehabilitation of drug addicts provided services by State agencies. Also an evaluation of the effectiveness of a series of projects to be funded from transfer money from the National Institute of Mental Health.

MULTIPLE SCLEROSIS AND OTHER PROGRESSIVE DEGENERATIVE DISEASES OF THE CENTRAL NERVOUS SYSTEM

An estimated 250,000 Americans are afflicted by multiple sclerosis (MS), and many more by related disorders. 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 United States alone is more than $250 million each year. Additional millions are spent on research, while the total economic loss to the Nation is incalculable.

The Department's research activities into the causes and better methods of prevention and treatment of multiple sclerosis are centered in the National Institute of Neurological Diseases and Stroke of the National Institutes of Health, and in the Rehabilitation Services Administration of the Social and Rehabilitation Service for the rehabilitation of multiple sclerotics.

Obligations for programs in multiple sclerosis and related disorders

	1970	1971	1972	1973 estimate	1974 estimate
National Institutesof Health:					
National Institute of Neurological Diseases and Stroke.....	$2,892,000	$3,257,000	$3,611,000	$3,242,000	$3,059,000
Social and Rehabilitation Service:					
Rehabilitation Services Administration:					
Grants to States...	965.000	1,000.000	1,118.000	1,178.000	1,218.000
Total.....	3,857,000	4,257,000	4,729,000	4,420,000	4,277,000

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

MULTIPLE SCLEROSIS AND OTHER PROGRESSIVE DEGENERATIVE DISEASES OF THE CENTRAL NERVOUS SYSTEM

The Problem

Doctors first recognized multiple sclerosis (MS) in the middle of the 19th century when they named it for the plaques, or patches, of scarred nervous tissue that dot the brain and central nervous system (CNS) of patients.

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.

Multiple sclerosis may begin in childhood or as late as the sixth decade, but up to 65 percent of patients experience the onset of symptoms between 20 and 40 years of age. Most surveys show the disease to be more common in women; the average number of studies show the female to male ratio to be approximately 58 percent females to 42 percent males.

Attempts to discover the cause of MS have not yet succeeded despite acquisition of an enormous amount of information from basic research, clinical studies, and epidemiologic investigation.

There is no treatment for MS that provides lasting benefit, although temporary relief during the early stages of the disease has been reported from the administration of ACTH (adrenocorticotrophic hormone). The typical alternation of spontaneous episcdes of exacerbation (increase in symptoms) and remissions (decrease in symptoms) makes it very difficult to determine whether or not a particular therapy has any effect. However, with good management of the disorder, many MS patients are able to live a relatively normal life-span. Recent studies report that the long-term outlook for most, but not all, MS patients is much more optimistic than doctors generally are taught.

Program Developments

Basic Research Studies (Extramural Program)

In fiscal year 1972, the NINDS funded a total of 65 research projects related to multiple sclerosis at a cost of more than $3 million. Thirty-five of these projects were in biochemistry and neurochemistry. Other projects included work on immunology, neurophysiology, pathology, viruses, and clinical studies.

Specifically, work is being conducted on the chemistry of lipids or fatty acids of the brain, immunologic responses, cell growth and function and epidemiologic studies in appropriate populations. A number of studies are investigating the process underlying myelination and demyelination. Chemical and metabolic characteristics of normal and abnormal myelin have been widely investigated in an attempt to reach an understanding of how myelin is formed and maintained as well as degraded in the normal nervous system. Several studies are being conducted on the nature of the basic myelin protein which is responsible for the induction of experimental allergic encephalomyelitis (EAE).

In addition to the basic studies, a large clinical center project is conducting studies on patients, involving immunological, virological, and neurochemical aspects relevant to demyelinating disease. These studies are being conducted at the new Reed Neurological Center at UCLA.

Institute scientists are attempting to isolate infectious agents from multiple sclerosis, Bell's Palsy, and amyotrophic lateral sclerosis.

Another project is based on intrauterine inoculation of unborn monkeys with tissues from human patients with chronic diseases and infections. In many diseases, the fetus and young are more susceptible than the adult. This study was designed to exploit this greater susceptibility by inoculating the fetuses at 100 days of gestation. Animals are later delivered by cesarean section and the young held in isolation chambers for three to five years. Sera and spinal fluid are collected for study every three months. Some of the animals have their immune mechanisms suppressed with the drug cyclophosphamide when they are one year of age in an attempt to activate any latent infection.

The National Advisory Commission on Multiple Sclerosis

On October 25, 1972, Congress enacted Public Law 92-563 to establish the National Advisory Commission on Multiple Sclerosis to determine the most effective means of finding the cause of and cures and treatments for multiple sclerosis.

The bill requires the Secretary (DHEW) to appoint nine members of the Commission, four from the NINDS Advisory Council and five from the public, well qualified to participate in the work of the Commission.

The Commission will conduct a comprehensive review of the status of MS research and highlight areas of promise. Working with the scientific community, it will also establish a list of priorities for research looking to effective preventives or treatments, and recommend to the President the resources to accomplish this purpose. The Commission is to submit a final report (including recommendations for legislation) within one year.

Research Progress

There are four principal research approaches in the attack on multiple sclerosis. Because the disease is found mainly in the temperate zone, epidemiological searches have long been conducted for a cause of the disease in some factor in the environment. Answers to the riddle have also been sought through understanding the biochemistry of the disease. A third approach, now the most popular one, is a search for a virus or viruses as a possible cause of multiple sclerosis. For at least 15 years, an important hypothesis has been that MS is an autoimmune disease (a disease in which the immune system of the body recognizes and attacks normal body tissues as if they were invading microorganisms). The search for a viral agent is closely related to this approach, since many investigators believe that the autoimmune process is triggered by a virus.

Epidemiology

Population studies provide valuable data on how common the disease is in a given area. Long-term studies show that MS is very common in some parts of the world while in other parts, it is rare or non-existent. This unequal geographic distribution provides strong evidence that a factor in some environments causes the disease.

Studies in Israel, Hawaii, South Africa and the United States indicate that multiple sclerosis is probably acquired before adolescence and that the critical exposure period may be between 5 and 15 years. Individuals migrating from a high to a low MS risk area after about age 15 seem to carry their "high risk" with them, whereas individuals migrating before this age show a low rate of MS, like the native population in the low risk area.

Past studies have concentrated on the movement of people from high to low risk areas. New studies are now seeking to determine whether the same findings will prevail when people move from low to high risk areas.

During the past year further evidence was found that MS is caused by something in the environment that the patient acquires relatively early. Death rates from multiple sclerosis were studied among four groups in California and Washington: native-born, migrant white, Japanese and Chinese. The death rate among native-born Washingtonians was higher than among native-born Californians. Few MS deaths were found among Japanese or Chinese in either State, whether American-born or foreign-born. This suggests that racial factors may influence susceptibility.

Migrants to both States from areas reported to have low rates of multiple sclerosis had low rates, suggesting that they had acquired protection before migration (or were less likely to acquire a hidden precursor of the disease). Migrants to Washington from areas reported to have high rates had higher rates than similar groups migrating to California. These findings suggest that causative factors may still be operative in the third and fourth decades of life in high risk areas and that a protective factor may also be involved in the etiology of MS.

The risk of developing MS appears to be associated more with environmental localities than with racial or genetic factors. Although the geographic distribution suggests that indirect effects of climate may play a role, the world pattern indicates that there is direct action of a climate variable also.

Review of some of these studies indicates that only the most severe or highly visible cases were reported, and many persons with only mild symptoms were not included. This may be significant in determining the number of cases, but it also may indicate that for many persons the disease is not the serious disorder that it is for some.

The Search for a Viral Agent in Multiple Sclerosis

In the search for a viral agent, studies follow two general approaches. One is the infection of the central nervous system of animals by "slow" or latent viral agent or agents which are similar to viruses but lacking many of their classical characteristics. The second is the study of the delayed neurologic effects of infections in childhood and early life on the CNS of both man and animals.

Slow Virus Research

In 1961 the NINDS established a large program for the study of slow, latent, and temperate viruses. Scientists have successfully transmitted two subacute degenerative diseases of the central nervous system of man, kuru (a heredofamilial disease) and Jakob-Creutzfeldt disease (a presenile dementia of man) to primates. These fatal, progressive neurological diseases have been shown to be caused by a very similar, unconventional virus. Together with the animal diseases, scrapie and transmissible mink encephalopathy, these have been classified as a new group of infectious agents designated as the subacute spongiform encephalopathies.

Each of the four diseases is caused by a filterable infectious agent and is associated with an exceptionally long incubation period of many months to years. This year, for example, kuru appeared in a rhesus monkey eight and one-half years after it was inoculated with the virus. Further, this laboratory has recently reported on the transmission of scrapie to sub-human primates (the cynamologus monkey after five and one-half years incubation and the squirrel monkey after 14 months incubation). Development of scrapie in the squirrel monkey provides, for the first time, an experimental host susceptible to all four diseases.

Transmission of these presenile dementias with a subacute course has encouraged a search for other subacute and chronic virus dementias. Scientists in the program are attempting to demonstrate infectious agents in such diseases as multiple sclerosis, amyotrophic lateral sclerosis, progressive supranuclear palsy, Alzheimer's, Pick's, Schilder's, and Alper's diseases, and chronic inflammatory diseases with movement disorders. Obviously, animals must be held for extraordinarily long periods of time in these experiments.

In addition to the inoculation and long-term holding of primates, domestic animals and bird hosts, this research also involves studying tissue of humans with the disease and of animals in whom the disease has been induced. From this work, more than two hundred virus strains have been isolated and characterized. However, the nature of the viruses causing spongiform encephalopathies has not yet been determined. Particles resembling conventional viruses have not been identified as causal agents, have not been associated with these diseases, nor has an identifiable immunological response been observed as one would expect following infection with more conventional viruses.

Is Multiple Sclerosis an Unusual Response to a Common Virus?

The discovery that subacute sclerosing panencephalitis (SSPE) is probably caused by the measles virus has spurred efforts to find a common virus associated with MS. Many studies are aimed at determining if such a relationship exists, since an increasing body of evidence seems to support the role of virus infection as a cause.

Antibody to vaccinia virus (from smallpox vaccination) is found in the spinal fluid of more than half of all MS patients. A number of investigators have also noted consistently higher antibody levels against many viruses in multiple sclerosis patients than in controls. Does this point to an infection or immune mechanism as being involved as a cause of the disease?

Despite the popularity of the viral concept, no highly suspect etiological agent has thus far been demonstrated for multiple sclerosis. Such recovery may be hampered by the nature of the disease. Because it is usually a long-term illness, brain biopsies are rarely performed during an acute phase. Almost all research has been done on autopsy material.

One new development has been the isolation of a virus in brain tissue from MS patients. Using a technique known as cell fusion, a group of scientists (German-American) have isolated parainfluenza type 1 type viruses from the brains of patients who died of MS. Two other groups of scientists (British and Australian) have produced supporting evidence that such viruses are involved.

Isolation of the virus does not prove that it causes MS. In fact, the possibility exists that the virus infected the patient secondarily, that is, it invaded a weakened nervous system that had been previously damaged by MS. Nevertheless, these reports are certain to stimulate even more interest among virologists.

Subacute sclerosing panencephalitis (SSPE) is a fatal neurological disease of children which is sometimes thought of as a model disease for the study of MS. Apparently caused by the measles (rubeola) virus, SSPE is a rare example of a disease caused by a virus which "smolders" or lies dormant only to break out years later. Why does the measles virus exist in the brain of an SSPE patient without being driven out or destroyed by the host's defense system? If this disease becomes better understood, scientists may also learn how other viruses affect the nervous system.

Especially important work is now underway by investigators trying to understand more about the body's immunological defense system. For example, California investigators recently developed a test which they have used to determine the presence of cellular immunity in experimental allergic encephalomyelitis (EAE), an experimental animal disease. They are now adapting this test to define the immunologic mechanisms of MS.

Autoimmune Theory

An entirely different hypothesis is the basis for much current research based on the assumption that the characteristic myelin sheath injury results from a misdirected attack against the myelin by the patient's own immune system. Either cellular or humoral immunity, or both, may be involved. If a virus is participating somehow, it may serve to trigger the immune response.

In studying the role of the immune system in MS, investigators have been using an animal model, experimental allergic encephalomyelitis (EAE) which can be produced in a rabbit by injection of an antigen. This antigen may be a mixture of a bacterial extract that promotes immune response (Freund's adjuvant) with CNS tissue from another rabbit, the basic protein of myelin (which is a constituent of CNS tissue), or even certain synthetic fragments of the protein molecule.

Although there are some differences, in many important respects EAE mimics MS. Both are inflammatory diseases, there is similar destruction of myelin, and the animal with EAE exhibits neurological signs similar to those in humans with MS. EAE is known to be an autoimmune disorder, so a good deal of research in MS has been concerned with demonstrating that certain of the immune phenomena that occur in EAE also occur in MS.

Very recently the specific chemical segment of myelin protein that is responsible for EAE has been discovered. It is a chain of nine specific amino acids arranged in a certain order. There have been recent reports that EAE can be suppressed--even "cured"--by the administration of the same myelin basic protein that had produced the illness.

For example, it is also known that if a monkey paralyzed by EAE is injected with specific antigen he can recover and begin to move about within 24 hours.

Using EAE as a model disease it therefore may be possible to determine the exact mechanisms of the development of MS. Once such knowledge is gained, very specific treatments for other diseases might become applicable in principle to MS.

If a virus is involved in the etiology of MS, it should be possible to develop a drug or other treatment methods for suppressing it. Although there are relatively few drugs which are active against viral agents, a new method of dealing with these agents has recently been devised, utilizing the transfer factor. This is an extract of sensitized lymphocytes which transfers cellular immunity from an immune individual to a person who lacks the immunity.

Cellular immunity plays an important role in fighting viral infections. One could postulate that the person who develops MS is the one who lacks cellular immunity to the infecting virus, whereas normal individuals do not develop the disease because they have the immunity.

If this is true, it might be possible to use transfer factor from normal subjects to give the patients with multiple sclerosis the immunity they need to reject the infecting virus. However, before we can rationally approach treatment, it is essential to know the mechanism of the development of the disease.

AMYOTROPHIC LATERAL SCLEROSIS

Amyotrophic lateral sclerosis (ALS) is also a degenerative disease involving the nerve cells and their associated myelinated nerve tracts. The symptoms and the pathological changes evident in ALS are easily distinguished from MS. Since both are degenerative disorders of nerve tracts, it is not inconceivable that they have a common cause which is differently expressed in the two diseases. Since these disorders have certain features in common, research on ALS may also contribute to prevention or cure of MS.

ALS is a neurological disorder once thought rare, but now known to be fairly common. Since the number of cases reported has been rising recently, one must conclude that ALS is either on the increase or is being diagnosed more frequently. ALS occurs more often in males of middle age or older. Its prevalence in the United States is estimated at from 6,000 to 10,000.

The first symptom of the disease is often muscle weakness in the upper extremities. Sometimes, however, the first sign is spasticity of the leg muscles. The weakness is caused by degeneration of motor cells in the spinal cord and brain which should carry messages for action to the muscles.

The course of ALS is progressive; however, there is great variation in the rate of progress. The average course is about three to four years from the appearance of symptoms until death, but some individuals remain active for 10, 15, or more years, with long periods of apparent arrest of the disease. Present therapy is limited to the temporary relief of the symptoms.

There apparently are three types of ALS. The most widespread and common form is sporadic ALS. In this form, men are affected more often than women in a ratio of two to one.

In about ten percent of the cases, a familial form of ALS appears. These cases follow a pattern that suggests dominant inheritance. In this type of ALS, men and women are affected equally.

In Guam, on a few of the nearby Mariana Islands, and on the Kii Peninsula of Japan, a possible third form of the disease is found. The clinical signs of the disease are the same as in the other types. There are some neuropathological differences in the Guamanian form of the disease which may mean that it is different from the sporadic form. In Guam, ALS appears more than twice as frequently among males as among females as in the sporadic form and there are no genetic patterns that would relate it to the familial form. The incidence of the disease is approximately fifty times higher than in the United States.

A peculiarity of this disease in Guam is that it appears with another fatal disease of the central nervous system, parkinsonism dementia. The relationship between ALS and parkinsonism dementia remains obscure. The finding of two neurologic diseases in one population is remarkable and suggests that common factors are etiologically involved.

Research Program

The striking concentration of ALS among the Chamorro people of Guam has attracted the attention of the medical world since the early 1950's. Since 1956, the NINDS has maintained a research center on Guam devoted to the study of ALS, parkinsonism dementia (PD) (a disease that is unique to Guam), and other neurologic disorders found in Guam and the Trust Territories of the Pacific.

Extensive studies conducted over the past twenty years have not revealed the causes of these diseases and the reasons for their remarkable concentrations. Approximately one in ten Guamanian deaths over age 25 is from ALS and another one in ten is from parkinsonism dementia.

Since 1963, in collaboration with the Institute's slow virus laboratory, scientists have been exploring the possibility that ALS may be a slow virus infection. Material from 22 Guamanian patients has been inoculated into chimpanzees, several species of smaller sub-human primates and a wide variety of other laboratory mammalian hosts. In no animals inoculated has neurological disease developed. Studies using brain material in tissue culture as well as lymphocyte transformation studies are in progress. As yet, no evidence of infection has been found.

The Guamanian studies have also included an intensive investigation of possible factors in the environment which may be involved in the etiology of ALS. Two which have received particular attention as possible toxins are manganese and the cycad nut. Manganese is present in high concentration in the soil and drinking water on Guam. The levels are higher, however, in many areas of the world where these diseases--Guamanian ALS and PD--are not found. Although ingestion of cycad has been shown to cause neurological disease in mice, at present it is difficult to relate this food to patterns of illness on Guam. The cycad nut, once ground into flour and used extensively by the native Chamorros, is now little used since the diet of the islanders has become increasingly westernized. Incidence of the disease has not declined with the diminished use of cycads.

Other intensive studies of possible environmental factors have been made on the Kii Peninsula of Japan where the Guamanian form of ALS is found at an incidence rate 25 times higher than in all other areas of Japan. The search for possible etiological factors includes neutron activation analysis for trace metals and systemic chemical and histochemical studies to determine the content of manganese, copper, zinc, aluminum and calcium in human nervous system tissue obtained from autopsy cases, and of the food and drinking water in high risk areas.

There has been additional evidence recently that heredity is at least a factor in Guamanian ALS. Among Chamorros living on islands other than Guam or in the United States, ALS appears to be frequent. However, the numbers are too small to yield reliable incidence rates. It has also been discovered that many Guamanians dying without evidence of neurologic disease have neurofibrillary degeneration typical of the form of ALS found on Guam.

Evidence is also accumulating that exposure to the Guamanian environment does not increase a non-Chamorro's risk of developing ALS, at least among adults with a relatively short period of risk on Guam. A study of veterans serving on Guam does not indicate an increase of deaths due to ALS in this group. A study of 12,000 construction workers who resided on Guam for various periods of time has not revealed a high rate of ALS.

ALS Clinical Trials

Although ALS has been recognized for more than one hundred years, no satisfactory therapy has been found. There have been many empirical treatments, including therapy with a presumed antiviral agent, dietary supplements, lipoic acid, normal plasma, and prednisone and guanidine. A clinical trial now being conducted by the Veterans Administration involves the experimental use of nerve growth factor (NGF). It is known that NGF has potent neurotrophic actions in experimental animals.

In a series of 21 Guamanian patients with ALS, abnormally low levels of spinal fluid homovanillic acid (HVA), a product of dopamine metabolism, was discovered. Subsequently a similar finding was observed in classical sporadic ALS. Since this suggested a diminished central synthesis of dopamine, L-DOPA was administered for five months to ten patients. The central spinal fluid HVA rose to very high levels, but no clinical improvement has yet been observed. The HVA abnormality is the first metabolic defect observed in ALS patients, but its significance to the pathogenesis of the disease remains unknown.

ALS Disease Model

NINDS-supported studies indicate that certain wild mice may be a potential animal model for studying a possible viral cause of ALS. The mice, who have C type virus in their brains, develop a progressive subacute central nervous system disease with motor neuron signs which are similar to those seen in patients with ALS. Virus has been isolated from the brains of affected mice, has been purified and concentrated, and serially transmitted in the laboratory to other mice. This virus has recently been injected into several species of sub-human primates.

MULTIPLE SCLEROSIS

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 the concomitant development of case findings, improvement of service techniques, and expansion of vocational opportunities for the multiple sclerotic. During 1970, representatives of the State-Federal program of vocational rehabilitation were featured speakers and active consultants at the four regional conferences of the National Multiple Sclerosis Society held in New York, Chicago, San Francisco, and New Orleans.

The Rehabilitation Services Administration has also 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 5 years after onset; 50% within 10 years; and that 35% were still gainfully employed between 15 and 20 years after onset.

A basic need is for trained personnel to treat, study, and to train patients with multiple sclerosis. These could 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 greater than at present. 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.

Number of Rehabilitants with Multiple Sclerosis

Fiscal Year Ending June 30	Persons Rehabilitated	
	Total	Multiple Sclerosis
1970	266,975	496
1971	291,272	498
1972	326,138	600
1973	340,000	600
1974	350,000	700

MUSCULAR DYSTROPHY AND THE NEUROMUSCULAR DISORDERS

The neuromuscular disorders, characterized generally by weakness, wasting, and fatigue of the muscles, primarily affect children and young adults. The two most common disorders in this group, the muscular dystrophies and myasthenia gravis, afflict some 200,000 and 30,000 patients respectively. When other less prevalent neuromuscular disorders are included, estimates of the number of patients with these conditions range from 250,000 to as many as one million.

Since the founding of the National Institute of Neurological Diseases and Stroke (NINDS) in 1950, one of its responsibilities has been the investigation of neuromuscular disorders. In 1972 a total of $6,355,000 was spent by the Institute on neuromuscular research at the Bethesda, Maryland laboratories and through Institute-supported research at centers across the country.

The Department's research activities in muscular dystrophy and other neuromuscular disorders are centered in the National Institute of Neurological Diseases and Stroke of the National Institutes of Health; rehabilitation activities are the responsibility of the Rehabilitation Services Administration of the Social and Rehabilitation Service.

Obligations for programs in muscular dystrophy and other neuromuscular disorders

	1970	1971	1972	1973 estimate	1974 estimate
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke.....	$5,092,000	$5,552,000	$6,355,000	$5,775,000	$5,394,000
Social and Rehabilitation Service:					
Rehabilitation Service Administration:					
Grants to States...	965,000	1,000,000	559,000	589,000	609,000
Total.....	6,057,000	6,552,000	6,914,000	6,364,000	6,003,000

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

MUSCULAR DYSTROPHY AND THE NEUROMUSCULAR DISORDERS

At the National Institutes of Health in Bethesda, Maryland, clinical studies on muscular dystrophy, myasthenia gravis, and other neuromuscular disorders are centered in the National Institute of Neurological Diseases and Stroke's Medical Neurology Branch. Multidisciplinary research is aimed at chosen target disorders, evolving basic research techniques and applying them to clinical neurological problems.

The NINDS also supports some 165 research projects, related directly to neuromuscular disease, in numerous hospitals, medical schools, and universities.

The Institute works closely with the Muscular Dystrophy Associations of America, Inc., and the Myasthenia Gravis Foundation. These two voluntary health agencies also support research in related neuromuscular disorders.

MUSCULAR DYSTROPHY

The Problem

The muscular dystrophies are a group of chronic, inherited disorders characterized by progressive weakening and wasting of the skeletal or voluntary muscles. Most types of muscular dystrophy (MD) are inherited, but any may occur spontaneously in a family as the result of a mutation or new genetic change.

As the disease progresses a patient may become confined to a wheel chair and eventually have difficulty performing the ordinary activities of living. Death is usually not caused directly by MD, however, but results from an infection leading to respiratory failure, or to heart failure in some cases.

There are three types of muscular dystrophy. Duchenne muscular dystrophy, which is probably the most common type, affects male offspring almost exclusively and appears between ages two to six years. It is a sex-linked, recessively inherited disorder, which means that during each pregnancy a female carrier runs a 50 percent risk of producing an affected child from each of her male offspring and a 50 percent chance of producing a carrier like herself from each of her female offspring.

The first symptoms in Duchenne are a waddling gait and difficulty in climbing stairs or in rising from the floor due to pelvic girdle muscle weakness. Later, shoulder girdle muscles become affected. The disorder progresses without remission until death occurs, usually within 10 to 15 years, although some patients live considerably longer.

A second type of muscular dystrophy, facio-scapulo-humeral MD, affects the muscles of the face and shoulders. It can be transmitted as a dominant trait. That is, if either parent carries the gene for this type of muscular dystrophy, each child born, male or female, has a 50 percent probability of being affected.

A third type, limb-girdle muscular dystrophy, affects the proximal muscles of both the pelvic and shoulder girdle. When both parents are carriers of the defective gene, the newborn has a 25 percent chance of inheriting the disorder and a 50 percent chance of being a carrier. Limb-girdle MD strikes between the first and third decade of life and its progress is sometimes rapid.

There are also variant types of MD. Myotonic muscular dystrophy is an autosomal (not sex-linked) dominant disease beginning in young adulthood and characterized at first by stiffness in the limbs and inability to relax the handgrip, and later progressing to severe disability from muscle weakness and wasting. It also affects several other body tissues, including the heart, the lens of the eye, the testicles, and the brain.

Muscular dystrophy of late onset becomes noticeable in the fourth or fifth decade, affects both sexes, and is not known to be hereditary. The first sign of the disease is weakness of muscles of the pelvic girdle. Its course is variable.

Diagnosis

Accurate diagnosis of the specific type of muscular dystrophy is vital since patients with certain closely related neuromuscular diseases that simulate MD can be treated successfully, even though there is no treatment yet available for any type of MD. In addition, accurate diagnosis facilitates evaluation of any new treatment and aids the physician in his efforts to counsel the patient and his family.

The Muscular Dystrophy Associations of America, Inc., through their nationwide network of 94 clinics, offer differential diagnosis free to anyone suspected by his physician to be suffering from MD or related neuromuscular disorders.

Progress in Diagnosis

The accuracy of diagnosis is continually improving with the development of sophisticated tools through research. At present, diagnosis is usually based on the combination of clinical examination, family history, microscopic study of muscle samples (biopsies), electromyography (study of the muscle's electrical activity) and study of creatine phosphokinase (CPK) (the enzyme that leaks out of damaged muscle tissue) in the blood.

Muscle biopsy has proven immensely helpful in research on a number of these disorders. This research is based on the hypothesis that normal human muscle fibers are of two basic types--Type I and Type II fibers--which are usually evenly distributed.

NINDS scientists recently found that in myotonic dystrophy (a hereditary muscle disorder of young adulthood), there is a reduction in the size of Type I fibers and an increase in the size of Type II fibers. This change is relatively specific for myotonic dystrophy. They also found that myasthenia gravis (a neuromuscular junction disease) shows a reduction in the size of both fiber types, but with Type II fiber more affected than the Type I. In hypokalemic periodic paralysis (a disorder of the young characterized by attacks of weakness) no alterations were found in the Type I fibers, but Type II fibers showed atrophy in approximately half the cases.

In several nonprogressive muscle disorders, accurate and differential diagnosis is extremely important because their course can vary dramatically and because both genetically dominant and recessive types are found. Diagnosis of this group of congenital, familial disorders, generally characterized by diffuse muscle weakness, is almost exclusively by muscle biopsy because clinical signs are nonspecific.

Treatment

At present no real cure is known for any of the muscular dystrophies. Antibiotics to control infections, however, have lengthened life in many cases. The search for specific drug therapy has been extended widely, including use of vitamins, amino-acid mixtures, nucleotides and anabolic steroids. None of

these agents has been shown to halt the progression of the muscle weakening. Walkers and wheel chairs, special shoes and corsets may compensate partially for muscle weakness. Physical therapy, although it cannot arrest the dystrophic process or restore muscles, may delay the shortening (contracture) of the muscles which add to the disability.

Duchenne MD, because of its hereditary nature, is most successfully prevented by detecting female carriers of the Duchenne MD gene and then providing genetic counseling before they bear children.

It is now possible to determine fetal sex by sampling the mother's amniotic fluid and studying the chromosomes in the harvested cells. A pregnant woman who knows she is a carrier can be alerted to her chances of bearing an affected child, and then given an opportunity to decide if she wishes to terminate the pregnancy.

Researchers in Salt Lake City and Cleveland are nearing the final stage of a cooperative, NIH sponsored study of the efficacy of the drug hexahydrocoenzyme Q4 in treating Duchenne MD. This agent has been tested before, but in lower doses and for a shorter period of time. The investigators point out that the study is more than just a drug evaluation. An attempt has been made to develop a protocol that would shorten the time required to evaluate any proposed treatment.

Research to Identify Carriers

Research is progressing to reduce the number of unidentified carriers of Duchenne MD and to simplify detection. The common test for carriers is the serum CPK determination. In Duchenne muscular dystrophy, where muscle tissue breaks down, the cellular membrane becomes unusually permeable and substances originally contained within the cell leak into the blood serum and can be found there at levels higher than normal.

In addition, it has been found that female carriers of the disorder, even though they may be clinically normal, show high levels of CPK in their blood serum. This finding has allowed scientists to identify about 70 percent of the carriers so that they can be told of the risk of producing a child with MD.

Recently it has been found that serum levels of CPK in female carriers tend to decrease with maturity. Therefore it may be important to screen young sisters of boy victims.

Scientists recently reported that pregnancy itself may influence serum CPK levels. This is important since many potential carriers are first seen by physicians when they are already pregnant. Findings suggest that apparently normal values observed in suspected carriers during pregnancy should be interpreted with reservations and the women should be retested after delivery.

Other methods of detecting carriers of the Duchenne and other forms of MD, to be used either with CPK estimations or alone, are being explored. Scientists at the NINDS, for example, have found that analysis of muscle samples taken from clinically normal carriers of Duchenne MD show degeneration and regeneration of scattered grouped muscle fibers after they have been specially stained.

Search for Underlying Cause

Historically the causes of the various forms of MD have been looked for in the muscle itself. However, failure to find the seat of the disease in the muscle has led some investigators to look elsewhere along the motor unit.

Some think the source of the problem may lie in the nerve, others propose that a single defect elsewhere might be affecting both the muscle and the nerve, and some suspect that the blood supply within muscles may be abnormal.

Recent work with muscle transplants in chickens has led one investigator to conclude that the development of muscular dystrophy in chickens is due directly to a disease of muscle cell metabolism. It is not yet clear what relation animal dystrophies may have to the human muscular dystrophies.

Investigators at the NINDS Medical Neurology Branch have developed a new hypothesis for the cause of Duchenne MD. They believe that muscle damage in these patients may be produced by abnormalities of the small blood vessels within the muscles rather than by a defect in the muscle fiber itself. These investigators have found evidence from histochemical studies of muscle from patients and carriers to support this hypothesis. Also, they have developed an experimental model of the disease in rabbits by structural blockage of small arterial vessels within the muscles.

The NINDS scientists also have reported pharmacological evidence to support their hypothesis. They were able to reproduce in rats the early and midstage characteristics of the disease by tying off blood vessels and using pharmacologic agents to constrict the vessels. Neither procedure alone, however, caused changes in the muscle fibers. They believe that there could be an abnormality in the blood vessels in the human disease that becomes apparent only when certain constricting agents are present.

If this hypothesis is confirmed, therapy might well be directed toward an entirely new goal--improvement of the microcirculation in muscle.

A recent study by NINDS grantees reaffirms that a nonprogressive, generalized mild or moderate disorder of intellectual function often coexists with Duchenne muscular dystrophy. The close relationship has led the scientists to speculate that several systems may be affected in muscular dystrophy. They suggest that a single gene, with expression in both muscle and brain, may be the cause.

A group of English investigators recently showed that there is a loss of functional motor units in Duchenne dystrophy. Their findings led them to propose that this dystrophy is a primary disorder of the motor neurons rather than of the muscle.

Significant reduction in the activity of troponin (a protein that plays a crucial role in muscle contraction and relaxation) in patients with Duchenne disease was recently reported by NIH grantees. The decrease may be directly related to the impaired functioning of the affected muscle. In other muscular diseases troponin activity remained normal. Development of a more sensitive test may show similar reductions in troponin activity in female carriers, thus providing a tool to screen these carriers. Evidence of reduced troponin activity in these carriers has so far been inconclusive.

Scientists from several NIH laboratories have recently confirmed the finding of others of an abnormally high insulin response to orally administered glucose by patients with myotonic muscular dystrophy. In one study investigators reported that the response does not appear to be related to muscular wasting. They concluded that abnormalities of insulin secretion are common in these patients and may be present when other clinical features of the disease are not evident. Thus, they suggest that measurement of the insulin response to oral glucose may help in early detection of myotonic muscular dystrophy. NINDS investigators, working with National Cancer Institute scientists, had earlier found very low levels of the protein immunoglobulin G in the blood of patients and that the low level was caused by an abnormal destruction of that protein.

An investigation into the metabolic basis of myotonic dystrophy, partially funded by NIH, has shown abnormalities in skin fibroblasts (connective tissue cells) taken from patients and grown in culture. These abnormalities may provide a marker to guide further analysis.

For a long time scientists have thought that myotonic dystrophy was essentially a disease of the muscle fiber. NINDS researchers, however, now have gathered evidence that the muscle weakness and atrophy are caused by an abnormality of the motor nerve to the muscle rather than the muscle itself. This hypothesis, developed as part of the larger effort in the NINDS Medical Neurology Branch to differentiate between primary disorders of nerves and the muscle disorders, may redirect some of the research to discover the precise cause of myotonic dystrophy.

MYASTHENIA GRAVIS

The Problem

Myasthenia gravis (MG) is a chronic neuromuscular disease that generally appears between ages 20 to 30 years. It is characterized by weakness and abnormal fatigue of the voluntary muscles with improvement following rest.

There have been significant reductions in death and illness in MG patients, even in the most severe cases, during the past two decades. Improvements in support systems such as intensive hospital care, antibiotics and respirators, and widespread use of tracheotomy (surgery to open the windpipe) undoubtedly have contributed. In addition, the use of anticholinesterase drugs, ACTH, and corticosteroids has greatly reduced the effects of the disease. Although the cause of MG is still debated, and therapy is directed partly toward the treatment of symptoms, there is no question that MG is one of the most successfully managed neuromuscular disorders.

Formerly about 30 percent of MG patients died within the first few years of their illness. Today scientists believe the majority of patients will be able to live out a normal life-span. An estimated three-fourths of the moderately affected MG patients can now lead virtually normal lives.

Diagnosis

Diagnosis of severe myasthenia gravis can usually be made without difficulty on the basis of history and physical examination alone. MG may affect any voluntary muscle in the body, but usually involves those of the eyes, face, lips, tongue, throat, and neck more severely than others.

Symptoms, which tend to begin somewhat earlier in women then in men, may vary greatly depending upon which muscles are affected. The disease may begin with a single localized weakness, or as a severe, generalized weakness. A patient may experience difficulties in breathing, swallowing, or talking. There may be unusually rapid muscle fatigue following repetition of a movement.

In certain cases, diagnosis may require drug studies as well as mechanical, electrical, and X-ray tests. Injection of a drug that facilitates nerve-muscle message transmission may result in a dramatic increase in strength. Administration of a neuromuscular blocking agent (inhibiting the transmission of nerve-muscle messages) causes increased weakening. Responses to these agents usually confirm the diagnosis of MG.

Research seeks to improve diagnosis. The differentiation of mild cases of MG from "psychiatric fatigue" cannot be resolved readily by conventional tests. There have been recent advances in objective electrical and mechanical tests.

Study of the thymus (an organ situated above the heart that normally atrophies with increasing age) is often valuable. If there is diagnosis of thymoma (tumor of the thymus) in MG patients, this will have important bearing on both the treatment and outcome of the disease.

Investigators recently developed an X-ray technique that permits visualization of the normal thymus and thymic tumors. The procedure (thymic venography) represents a significant diagnostic advance.

Theories on Cause

The cause of MG remains unknown, but there is agreement that trouble exists somewhere along the motor unit, which consists of the lower motor neuron (a branching nerve fiber), and the muscle fibers it innervates. Many studies have centered on the junction between the axon of the nerve and the muscle fibers. It is at this junction that nerve impulses liberate a chemical, acetylcholine, that causes the muscle to contract.

Myasthenia gravis may be due to a failure by the neuron to make acetylcholine, or to a disturbance in its release of acetylcholine. It is also possible that MG is due to the presence of inhibiting substances in the patient's blood.

Scientists also have suggested that MG may be, more fundamentally, an example of an autoimmune disease--a disease in which circulating antibodies against the patient's own tissue eventually interfere with the activity of the neuromuscular junction. Some recent evidence supports this idea. This includes the demonstration that one-third of all patients with MG have circulating antibodies against skeletal muscle and the thymus. These antibodies are present in virtually all MG patients with thymoma, and in some patients who do not have MG but do have thymoma. However, it is now believed that the antibodies themselves do not cause the symptoms of the disease but are an indicator of a parallel autoimmune phenomenon.

An NINDS grantee has developed an animal model that may clarify the immunological aspects of MG. His work with guinea pigs supports the hypothesis that MG is a disorder in which the body causes inflammation of its own thymus gland and overproduction of a postulated thymic "hormone." This proposed hormone, not yet isolated, may in turn interfere with the transmission of nerve messages to muscle, thus causing muscle weakness. When a protein extracted from the thymus is injected into pigs and rats, it produces a myasthenic neuromuscular block that closely resembles MG.

Other NIH grantee investigators are conducting studies with a special genus of rodent, the Praomys (Mastomys) natalensis, that may provide clues to the cause of MG. These animals spontaneously develop thymoma, polymyositis (inflammation of the muscle), myocarditis (inflammation of the heart muscle), and circulating antibodies to striated muscle--all phenomena seen in association with myasthenia gravis.

Investigators at the NINDS Medical Neurology Branch have developed a new working hypothesis to study MG. They propose that a secondary defect is located at the neuromuscular junction, possibly caused by an aberration in the metabolism of the cell body. They suggest that it is possible that a circulating factor from the thymus may be exerting the detrimental influence on the cell body.

Historically MG has not been considered an inherited disorder, but recent studies by NINDS grantees indicate that MG occurs within families more frequently than can be explained by probability.

One recent NIH-supported survey has produced additional evidence that genetic factors may play a role in familial occurrence of this disease. In 13 cases involving identical twins, myasthenia gravis occurred in both twins five times. However, among fraternal twins, if one developed MG none of the other twins developed it. These data indicate that a rare recessive trait may be instrumental.

Advances in Treatment

Several drugs provide relief from many of the symptoms of the disease, and others may be effective against one step in the causation. Drug research continues in order to improve current results. For nearly 40 years the anticholinesterases, especially pyridostigmine and neostigmine, have been the mainstay of symptomatic treatment of MG.

New Agents

Some promising drugs are undergoing testing at NINDS-grant-supported institutions. Scientists are especially hopeful about one group of agents--the germine acetates. Investigators recently reported that patients treated with germine acetates for a short period of time exhibit improved neuromuscular function. More recently investigators reported the first use of germine monoacetate (GMA) for outpatients over a limited time, with favorable results. Significantly, some of the patients who benefitted were known to be poor candidates for prednisone therapy.

ACTH Therapy

Helpful new data has emerged since last year's report on ACTH (adrenocorticotrophic hormone) injections benefitting severely ill MG patients. NINDS grantees earlier had found that many of those receiving 10 day course of daily ACTH treatment experienced temporarily increased respiratory distress and marked decrease in muscle strength for the first several days before improvement began to appear. Paradoxically the patients who experienced the greatest initial weakness showed the most striking recoveries following treatment. Recently investigators have found that continued maintenance ACTH injections every few days over extended periods gives good results.

In a study involving a large series of MG patients, NINDS grantee investigators found short intensive courses of ACTH useful in improving increased temporary weakness. Patients with moderate and severe disease were thought to benefit more than patients with mild or localized disease.

Prednisone Therapy

NINDS scientists continue efforts to expand on their earlier finding of remarkable and sustained improvement in MG patients given a high single-dose alternate-day oral prednisone regimen. (Prednisone is a drug resembling the natural hormone, cortisone, manufactured in the cortex of the adrenal glands and released by ACTH. Like ACTH, it has an action against immunologic disorders, but it can be given more conveniently by mouth over a long period of time.) The single-dose alternate-day program, compared to daily prednisone treatment, results in greater benefit and fewer or minimal side effects. The possibility that the effectiveness of prednisone therapy may vary with age and sex is now being explored at NIH.

Thymectomy

Thymectomy (surgical removal of the thymus) proved very beneficial in 89 percent of a large series of patients with MG, most of whom were severely affected, a group of NINDS-supported scientists recently reported. Remission (abatement of symptoms), once attained, has remained permanent in nearly all patients, they said.

The effectiveness of thymectomy in treating MG may depend on the stage of the disorder, according to several reports. Thymectomy is likely to be more effective at the earlier stages of the disease.

Significant improvement also was reported in a long-term study of thymectomy in juvenile MG patients (under 20 years of age) and still other studies indicate that benefits achieved may be further enhanced with irradiation of the thymus before the surgery.

One NIH grantee cautions against the possibility of long-range harm from thymectomy to the body's defenses against infection. In his work with thymectomized mice, he has observed the development of immune deficiencies as well as many manifestations of autoimmunity, in which the body reacts against its own tissues.

OTHER NEUROMUSCULAR DISORDERS

Although there is no known cure for muscular dystrophy or myasthenia gravis, myasthenia gravis is now yielding to treatment, and certain other neuromuscular diseases also can be treated. This gives hope that some day an effective treatment for MD will be found. Research findings from any of these disorders or from the various basic studies of muscle or nerve may contribute to understanding neuromuscular diseases.

Polymyositis and Dermatomyositis

Two muscle diseases, quite similar to MD and in fact sometimes misdiagnosed as MD, are now treatable. Polymyositis and dermatomyositis are inflammatory disorders of the muscle and of the skin and are characterized by elevated muscle enzymes, such as creatine phosphokinase, (CPK), in the serum. Corticosteroids have been found to control the inflammation and maintain a high degree of improvement. The program of high-single-dose alternate-day prednisone has been successfully applied by NINDS investigators to polymyositis/dermatomyositis.

NINDS grantees recently reported that treatment with methotrexate (an anticancer agent) may prove of value for polymyositis patients who are resistant to corticosteroid therapy.

Evidence of an immune reaction causing vascular injury in dermatomyositis of childhood recently was reported by NINDS investigators. They suggest an abnormality of small venous vessels in the muscle caused by abnormal immune reactions may be one of the mechanisms leading to muscle injury in these patients.

Hypokalemic Periodic Paralysis

Hypokalemic periodic paralysis, which is characterized by attacks of paralysis, usually beginning in childhood or adolescence and occurring at daily to yearly intervals, also have been found manageable. Many patients with this disorder who were treated with acetazolamide, introduced as a preventative measure by NINDS scientists, showed dramatic improvement. This treatment has been maintained for as long as four years with excellent results. The agent can cause renal stones, however. Another preventative agent known for many years but usually less effective than acetazolamide, is potassium salts.

Thyrotoxic periodic paralysis, which is similar to hypokalemic periodic paralysis, becomes evident only in the presence of excessive thyroid hormone. NINDS investigators also report success in managing this disorder by treating the underlying thyroid disease.

Myophosphorylase Deficiency

A novel approach to treating a number of neuromuscular and non-neuromuscular diseases may evolve as a result of work by NINDS investigators with the juvenile form of myophosphorylase deficiency (MPD). In this disorder mature skeletal muscle fibers are devoid of the enzyme phosphorylase which is essential in sugar metabolism in the muscle cell. The patient afflicted with the disorder experiences painful muscle cramps following exercise. The investigators found that they were able to provoke muscle fibers in a patient to produce this enzyme when the muscle cells were regenerating after injury. This development was a surprise since it has generally been accepted that the enzyme was genetically absent. It is now hoped that therapeutic efforts can be directed toward promoting production and retention of phosphorylase in mature fibers. Conceivably this approach could apply to other genetic enzyme deficiencies as well.

Acid Maltase Deficiency

Acid maltase deficiency, a syndrome which may mimic muscular dystrophy, is characterized by an excess of muscle glycogen (a form of starch that acts as a reservoir of sugar) and the lack of the enzyme acid maltase (one of the enzymes necessary to break down glycogen to the sugar glucose). The syndrome is usually highly malignant in infants, moderately severe in childhood, and slowly progressive, with muscular weakness, in adults. A recent study conducted by NINDS grantees indicated that the deficiency is not restricted to those muscles that are clinically affected. Recognition of the syndrome is important because of its occasional misdiagnosis as muscular dystrophy and because therapeutic attempts can now be sought to circumvent the enzymatic defect.

Discovery of New Diseases

Researchers at the Medical Neurology Branch of NINDS recently reported the discovery of a non-progressive (benign) muscle fiber disorder--benign congenital hypotonia. Histochemical evaluation showed Type II muscle fibers of unusual scarcity and thus a predominance of Type I fibers. The few Type II fibers were sometimes too small in diameter. They believe that these findings, which are believed to represent an abnormality of lower motor neurons, can tentatively be considered the basis of a good prognosis when found in the muscle biopsy of a "floppy baby" (a baby with neuromuscular disease).

NINDS investigators have uncovered still another distinct syndrome. Several patients with ophthalmoplegia (paralysis of the eye muscles) were found to have abnormally large and numerous mitochondria (energy producing particles) and an excessive number of lipid droplets in their muscle fibers ("ragged-red" fibers). This abnormality when seen in conjunction with ophthalmoplegia, has been designated "oculocraniosomatic neuromuscular disease with ragged-red fibers" by the investigators. Additional features usually include mild to severe weakness and wasting of limb muscles, elevated cerebrospinal fluid protein levels and sometimes cardiac abnormalities, impaired growth, and hearing defect.

Application of Neuromuscular Research in Treating Cancer

NINDS investigators have found that the weight loss and fatigue seen in cancer patients is due in large part to an atrophying of the Type II muscle fibers. NINDS scientists believe that a cancer tumor may induce partial motor neuron damage which in turn causes muscle atrophy. They also believe that if the mechanism of the Type II cancer induced atrophy can be uncovered, it might be preventable and the muscles maintained and built up. Thus one of the important effects of cancer could be treated whether or not the tumor itself was responsive to anticancer therapy. Work to accomplish this is beginning at the NIH Clinical Center.

MUSCULAR DYSTROPHY

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

Because of the nature of the disease, victims of muscular dystrophy have limited potential for gainful employment, and therefore only a small number of them have been rehabilitated through the State-Federal program of vocational rehabilitation. It is hoped, however, that the acquisition of new medical knowledge concerning this disabling condition will contribute to positive gains over the next decade in the work capacity of the muscular dystrophy case.

Rehabilitants with Muscular Dystrophy

Fiscal Year Ending June 30	Persons Rehabilitated	
	Total	Muscular Dystrophy
1970	266,975	294
1971	291,272	252
1972	326,138	300
1973	340,000	300
1974	350,000	300

CEREBRAL PALSY AND DISORDERS OF THE DEVELOPING NERVOUS SYSTEM

Cerebral palsy (CP) is a non-specific, descriptive term pertaining to disordered movement and coordination caused by injury to the immature brain. CP is not a single disability. It almost always represents a combination of other disabilities of the developing nervous system. CP is usually first noted in infancy or early childhood.

The United Cerebral Palsy Associations, Inc., a voluntary health agency, estimates that there are 750,000 people in this country with CP.

The Department's research activities in cerebral palsy are centered in the National Institute of Neurological Diseases and Stroke for investigations into the causes, treatment, and prevention of CP, whereas the Social and Rehabilitation Service is responsible for programs in rehabilitation research and demonstration, and rehabilitation services.

Obligations for programs in cerebral palsy and disorders of the developing nervous system

	1970	1971	1972	1973 estimate	1974 estimate
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke.....	$13,436,000	$14,496,000	$13,992,000	$13,213,000	$11,352,000
Social and Rehabilitation Service:					
Rehabilitation Services:					
Basic State Grants.....	4,245,000	5,000,000	2,795,000 [1]	2,945,000	2,436,000
Innovation grants	31,500	28,000	---	---	---
Subtotal, Social and Rehabilitation Service...	4,276,500	5,028,000	2,795,000	2,945,000	2,436,000
Total.....	17,712,500	19,524,000	16,787,000	16,158,000	13,788,000

[1] Estimated

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

CEREBRAL PALSY AND DISORDERS OF THE DEVELOPING NERVOUS SYSTEM

Some patients with cerebral palsy (CP) are only mildly affected, learn to overcome the handicap and live normal, productive lives. Many, however, have associated neurological and sensory disabilities. Two-thirds are mentally retarded; one-half have speech and communication disorders; one-third have visual disorders; one-fifth have mild learning disabilities.

Mentally retarded CP patients may be mildly affected, moderately affected, or severely affected. Those mildly affected perform more or less normally in school or at work. Moderately involved patients may require some assistance and also may need physical, occupational or speech therapy, though usually they are able to attend either public school or a special school for the handicapped. Moderately affected patients also may require more intense care at regular intervals to prevent their becoming severely affected. Seriously affected patients are either predominantly or totally dependent on outside help and may be either confined to home or institutionalized, depending on their mental state and other factors.

Types of Cerebral Palsy

CP is sometimes classified into four groups according to the type of disability. Some patients have a combination of two or more of these types, depending on the area and the degree of brain damage involved.

Well over half of all patients exhibit at least a spastic weakness of one or more extremities. In this type, known as spastic CP, the muscles are under a continuous state of tension, with increased reflex activity. About 40 percent of all patients have the athetoid type of CP, characterized by disorganized spontaneous muscular movements. In these patients, the extremities move involuntarily in many different directions.

The ataxic form, which occurs in relatively few patients, is manifested as a disturbance in balance while walking or standing. Patients with this form of CP may fall often, and frequently cannot move about without assistance.

In patients with the tremor type of CP, there is a spontaneous vibration or trembling of one or more of the extremities.

The various types of CP also are further divided into four groups on the basis of the particular extremities involved. In monoplegia, only one limb is affected. In hemiplegia there is involvement of an arm and a leg on the same side of the body. Diplegia or paraplegia indicates involvement of either both arms or both legs. In quadriplegia, all four limbs are affected.

What Causes Cerebral Palsy and Other Disorders of the Developing Nervous System?

It is known that brain damage produces CP, and researchers are convinced that perinatal events and conditions play a crucial role in triggering the brain damage. Sometimes it occurs before birth, as a result of maternal infection or other disease. Prematurity, low birth weight, and blood type incompatability are other suspected causes. Difficulties during childbirth such as abnormal presentation, prolonged labor, precipitous delivery, lack of oxygen, and forceps injuries are also considered as prime associated factors. In later

life brain damage may result from various infections, vascular disease, or head injuries. Unfortunately, present knowledge does not allow the complete correlation of clinical observations with brain damage.

Each type of CP is caused by damage to a different area of the brain. Damage to the motor regions of the cerebral cortex results in the spastic type, while damage to the basal ganglia (special masses of gray matter at the base of the brain) causes the athetoid type. The ataxic and tremor types are caused by damage to the cerebellum. Associated difficulties in speech, hearing, or vision are usually due to damage of the brain centers governing these functions. Similarly, mental retardation results when areas of the cerebral cortex concerned with intelligence and other higher functions are affected.

Treatment of Cerebral Palsy

Many drugs have been used to relieve spasticity, but these usually have met with only short-term success. The primary goal in treating CP is to maintain or improve functioning by the use of such services as physical therapy, occupational therapy, speech therapy, and social and psychological counseling. In addition, the application of braces or other appliances may be helpful, and in some cases surgery is beneficial.

Physical therapy for the CP patient includes exercise programs aimed at preventing permanent muscle and joint tightness, and attempting to improve muscular strength, control, and coordination.

Occupational therapy may be of significant value to the mildly affected patient and may help a moderately involved patient to care for himself more effectively. Appropriate social and psychological counseling through the patient's life can be important in helping him adjust to his condition. Generally, optimum physical benefits cannot be achieved until the patient has adjusted to his social and psychological problems.

Speech therapy often can be of particular value in assisting the patient's family in communicating with him. It is most helpful for patients with either aphasia or dysarthria. Aphasia, caused by damage to the speech center of the brain, is a difficulty in comprehension, expression, or both. Dysarthria is a difficulty in articulation, and is caused by abnormal functioning of the muscles of the face and mouth.

Various kinds of appliances, such as braces, splints, and standing tables, may be helpful in preventing deformities, controlling involuntary movements, supporting the patient's weight, and enabling him to walk. A number of surgical procedures also can be of value in helping a patient achieve his maximum functional level. Operations include lengthening the heel cords when there is severe tightness of the calf muscles, releasing thigh muscles that are contracted, and fusing certain joints such as the ankle or wrist. Also, some patients may be helped by cutting certain nerves supplying severely spastic and tightened muscles, and muscle transplants may be helpful to a few patients. Some patients with athetoid CP may be helped by cryosurgery, in which the damaged tissue is destroyed by chilling it to a very low temperature.

Although there is no cure for CP, the patient should be given maximum opportunity in both his home and educational environment to achieve as high a functional level as possible. Many patients can live relatively normal lives if optimal use of their abilities can be realistically combined with appropriate therapy and satisfactory adjustment to their disabilities.

Collaborative Perinatal Study

Along with an improvement in the diagnosis and treatment of CP, there is need for an increased effort to prevent the brain damage which results in this and other developmental disabilities. When and how such brain damage occurs is being sought in the Institute's intramural laboratories, at grantee institutions, and especially through its Collaborative Perinatal Study.

Since 1959, the Collaborative Perinatal Study has monitored a total of 55,908 women and their pregnancies in search of relationships between factors occurring during the perinatal period (from conception to 28 days after birth) and a child's neurological development.

Designed as a prospective investigation with extended follow-up of the child, the Study allows for the recognition of many varied neurological defects, including cerebral palsy. Although important phases of the Study remain to be completed, it has now reached a point where the data collected from the 10 participating medical institutions are being analyzed.

During 1972, an important milestone in the progress of this analysis was the publication of The Women and Their Pregnancies, a broad review of the nature and scope of the associations found among the Study data.

The book details the Study design, population, procedures, protocol and data processing used in the Study. Additionally, The Women and Their Pregnancies explains the characteristics of the abnormal conditions, environmental factors, and biological factors of the pregnancies studied, and shows their possible relationships to favorable and unfavorable pregnancy outcomes.

Publication of The Women and Their Pregnancies is only part of the process of the interpretation of the Study data. A second report, soon to be completed, will describe pediatric data associations with birth weight, perinatal deaths, and neurologic outcomes at one year.

In all, it is anticipated that ten volumes of analyzed data from the Study--one devoted entirely to the problem of CP--will be published before its projected completion in 1976.

Other Study Developments. During the past year there were also a number of published reports from the Study. Among the more significant of these was a pooled core data publication entitled Precursors of Low IQ in Young Children. The predictive correlation of 65 prenatal and postnatal variables with mental retardation at four years of age was evaluated in a large sample of children from the Collaborative Study population, and it was found that the best predictors were delayed motor development, maternal education, Bayley mental and motor scores, and conditions associated with neurological impairment during the first year of life.

In 1972, collaborating institutions also published a review of some of the biosocial correlates of race and social class, demonstrating that multidisciplinary approaches to problems of human potential may be the most promising.

Pursuing this same approach, Dr. R. H. Holden at Brown University, Providence, Rhode Island, one of the collaborating institutions, recently completed a study which showed that neurologically damaged children from the lower socio-economic group when compared with similarly damaged children from the higher socioeconomic group will perform more poorly on psychological tests at four years of age, but not in infancy. The results are interpreted as suggesting that an enriched environment can favorably affect the intellectual fate of the neurologically damaged infant.

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Another approach to early identification of neurologic deficit is being pursued by scientists at the University of Oregon. Their investigations concern an attempt to determine if neonatal visual evoked response measurements are predictive of subsequent developmental, verbal, and intellectual abilities. An evoked response is the electrical signal given off by the brain following a brief stimulus such as a flash of light, click, touch, or an electric shock delivered to a peripheral nerve. The electric signals are recorded, analyzed, and used in the study of maturation of the central nervous system which accompanies growth and development. Their findings to date offer further support for use of the neonatal visual evoked response as a predictor of subsequent motor development, but not of symbolic or intellectual development.

Immediate and Long Range Value of the Study. The importance of low birth weight as a determinant of perinatal death, neurologic abnormality, and intellectual development has been one of the Study's key findings to date. Over the years research reports from the Study have helped to clarify the role of maternal weight in pregnancy. For many years previously, great emphasis had been placed on holding weight gain to a minimal during pregnancy in the belief that this might prevent toxemia, a dangerous complication of pregnancy. In studying thousands of cases, however, participants in the Collaborative Study report that they have not found that restriction of weight gain during pregnancy prevents the disorder. They have found, however, that such restriction may lead to low birth weight infants and that birth weight is a significant factor in the survival of the newborn, independent of the duration of pregnancy. As a result of these investigations, it has been established that a maternal weight gain of 25 to 30 pounds is optimal in terms of birth weight of the baby.

Information from the Study also has established a connection between fetal damage and viral infection, and has made it possible to document the fact that the risk of fetal death and/or malformation from maternal rubella continues well into the second trimester of pregnancy. Also, significant experiments with monkeys conducted by scientists of the Laboratory of Perinatal Physiology have shown that if a newborn infant fails to breathe properly, the brain is damaged both directly through a lack of oxygen and gradually through a chain of events the temporary lack sets off.

The Study also can claim a number of gratifying ancillary effects. These include improved obstetric and pediatric care and a new exactitude in the keeping of hospital records. By providing a patient population and a body of senior investigators whose interests are concentrated on perinatal problems, it also has encouraged related research and an interdisciplinary exchange of information, ideas, and respect with research groups in this country and abroad.

As an illustration of the interdisciplinary nature of the Study data, they were used recently by investigators of the National Heart and Lung Institute for exploring certain maternal and fetal characteristics as possible causal factors in congenital heart diseases. Findings indicate that maternal diabetes, twinning, and maternal congenital heart disease may play important roles in the cause of certain inborn heart defects.

Another value of the Study--perhaps its greatest--is that it has given national impetus to the common hope that the neurological diseases of childhood, especially CP, may one day be prevented.

The most important results of the Collaborative Study, of course, await the completion of data analysis. The collection of the data itself, however, is of great significance. The data in this Study are unique in their magnitude, their completeness, their prospective nature, and in the care which was taken

to assure comparability in their collection. The prospective or forward looking nature of the Study is of special importance because only an investigation including women as they registered for prenatal care before the course of their pregnancy and its outcome became known could (1) provide the information required to establish some measurement of the risk to the fetus of certain events and characteristics of the pregnancy, and (2) throw light on unknown or unexpected causative factors. There is no similar body of data in existence, and it is anticipated that in years to come these data will constitute a rich research resource for scientists of many disciplines.

As the Study progresses, it becomes increasingly evident that some of the associations among pregnancy characteristics and outcomes are creating interest and incentives in the scientific community for additional detailed and intensive studies.

For example, maternal infections reported in the Collaborative Study data are now being investigated in detail by NINDS scientists working at NIH. During the past year, investigators reported the isolation of the rubella virus from placentas and throat cultures of infants. This is the first complete longitudinal study associating placental infection, newborn infection, and pregnancy outcome for rubella.

Other intramural research, also based on Study data, has shown that viral and bacterial infections in the uterus are more frequent than had been expected, especially among lower socioeconomic groups. Using immunoglobulin determinations to assist in the recognition of perinatal infections, it is found that more than 20 percent are due to cytomegaloviruses, herpes simplex, rubella, toxoplasmosis, or syphillis. It is known that the first three of these viruses can produce congenital malformations such as CP, but more research is needed to define the range of perinatal infections and their effects on human development.

Also reported was the detection of the transmission of serum hepatitis (Australian antigen)--a prime suspect as a cause of brain damage--from mother to baby. The transmission was not associated with clinical hepatitis in the newborn period. This is the first time that the presence of this antigen in the umbilical cord sera was demonstrated.

Hepatitis also is being studied in primates. The NINDS Experimental Pathology Program, Infectious Diseases Branch, of Collaborative and Field Research working in collaboration with the National Institute of Allergy and Infectious Diseases has demonstrated that cesarean derived animals can be infected with this virus, and scientists are now studying transmission of this infection from mother to fetus in pregnant animals.

Grantees of the NINDS at a number of medical centers are also studying the effects of virus on the fetal nervous system. In an investigation of pregnant swine, it was demonstrated recently that fetal infection with a vaccine strain of hog cholera (HC) virus produces a persistent infection similar to congenital rubella infection in man. In survivors, this resulted in a great number of malformations in the nervous system. In spite of the persistent infections noted in these experiments, it is of great interest that there is no inflammatory aspect or obvious cell destruction. These studies demonstrate that fetal malformation with none of the pathologic hallmarks of an infection may nevertheless be due to a virus. It has been suggested that techniques used in this study should be applied to material collected from malformed human fetuses in a renewed effort to identify other agents such as rubella, which might cause imperfect development of a human embryo.

Laboratory of Neural Control

Scientists in this relatively new NINDS laboratory are continuing fundamental studies of the nerve cells in the brain and spinal cord which control the muscles of the body.

A related problem of practical interest to this group is a technique known as functional neuromuscular stimulation. The principle of this technique is the delivery of patterns of electrical stimuli through implanted electrodes to nerves supplying partially paralyzed muscles in order to effect useful controlled movement of the limbs. Since this technique would offer an immediately applicable approach to disorders of movement and coordination, an International Workshop on Functional Neuromuscular Stimulation was held early last year at NIH. The purpose of the workshop was to bring together those directly involved in some aspects of this technique to determine the next steps to be taken in making it available to patients suffering with such conditions as cerebral palsy, stroke, or spinal cord injury.

The Laboratory of Neural Control also monitors a contract program in this research area. One of the contracts involves a study of intramuscular electrical stimulation of paralyzed limbs. So far, research supported by this contract at Case Western Reserve University has led to the implantation of electrodes in human patients with partial paralysis caused by upper motor neuron disease. Electrical stimulation of muscles through such electrodes has led to the recovery of wasted muscles and promises to provide functional use of joints supplied by these muscles.

Therapy and Rehabilitation Research

It has long been recognized that the mere fact of being handicapped affects personality and emotional development. The handicapped child often performs poorly in school because of motor disorders, associated sensory, intellectual, and other disabilities, and frequent absences from school because of illness. Eventually, the combined result of such disadvantages is often progressive social deprivation and isolation which in time becomes the ultimate handicap.

In the hope that it may be possible to minimize superimposed disabilities of this sort, the NINDS is continuing its support of a study on interpersonal aspects of child cerebral palsy therapy conducted by Dr. Kate Kogan at the University of Washington. The investigator is developing a technique for evaluation of the relationship of children with cerebral palsy and their parents and therapists. In the last year the study procedures have been formulated and the first phase of the data collection has been completed. As part of this program, parents are being trained in interactional behavior with their children. The basic technique is to conduct sessions in a room containing a video recorder. The tapes are then analyzed and rated for a variety of interpersonal behaviors. A unique feature of this program is the "bug in the ear" in which the therapist is in contact with the mother by a wireless intercommunication device. This allows instructions to be given to the mother by the therapist who is on the other side of a one-way mirror. The therapist supports desired responses, suggests alternate responses, and calls attention to the absence of certain responses expected to improve behavior. It is anticipated that the Study will isolate relevant variables on which to base future studies which could conceivably improve personality and emotional development of the cerebral palsied.

New Surgical Procedure Relieves Spasticity

Spastic hemiplegia is a condition that paralyzes one side of the body. It is also one of the most distressing and incapacitating effects of CP. For many years researchers at a number of institutions, both here and abroad, have been seeking ways to alleviate such paralysis. Late last year,

Dr. Irving Spencer Cooper, St. Barnabas Hospital for Chronic Diseases, in New York City, reported at the annual meeting of the American Academy of Cerebral Palsy that a type of brain surgery can now reverse the spastic paralysis caused by cerebral palsy, stroke, and similar forms of brain damage in more than half of the carefully selected patients on whom it is performed. (Spasticity can only be taken away if the cerebral palsy or other condition is one in which the underlying mechanisms for movement remain.)

The operating technique, cryosurgery, may be made up of as many as three operations spaced weeks apart or only a single operation. These operations utilize both stimulation and lesions to reconstruct proper brain function. The most significant of Dr. Cooper's new procedures is called the cryopulvinectomy (from the Greek kryos, for cold, pulvinar for the sensory integrator in the brain which is the surgeon's target, and ectomy, connoting removal). The pulvinar, it has been discovered in recent years, also has motor function. In this operation, the deep cold at the tip of a probe type "scalpel" is used to destroy part of the brain's pulvinar region.

Dr. Cooper reports that the new surgery has no apparent significant side effects, and that there has not been a single surgical fatality among the 70 patients on whom the operation has been performed. He estimates the overall surgical risk in using the procedure at two percent.

Twenty years ago Dr. Cooper developed brain surgery which relieved the tremors of Parkinson's disease without totally disabling the patient, and 10 years ago perfected a refinement in that operation which destroyed the tremor-causing portions of the brain by freezing them. The new treatment for cerebral palsy is an outgrowth of this earlier work.

Basic Research Developments

In the past year, considerable new information has evolved from a long-term study of chronic neurological disorders affecting children conducted by another group of NINDS scientists. A basic investigation of the fetal development of the rabbit has resulted in a better understanding of the structural and biochemical parameters of brain maturation during the second half of pregnancy. This information is of value in planning more advanced studies on the chemical composition and structural changes in the brains of primates and man during normal and abnormal development.

In another study conducted by this same group of scientists, two skin syndromes of developmental origin were investigated. These syndromes are characterized by slightly raised yellowish-brown verrucose (warty) skin markings. The lesions are present at birth and are commonly located about the head and neck, but may extend to the trunk and the extremities. Many of the patients with these disorders were observed to have neurological disabilities since birth. In two patients, investigators showed for the first time that brain malformation was the underlying cause. On the basis of these findings it appears to be advisable to consider including these skin syndromes among those associated with defective development.

Research on Sensory Disabilities Associated with Developmental Disorders

As mentioned at the beginning of this report, it is estimated that one-third of the cerebral palsied have visual disorders, some of them severe. In this regard, a study by an NINDS investigator working in the NIH Clinical Center is of considerable interest.

The incidence of mental retardation and neurologic involvement in 13 patients with congenital retinal blindness, studied personally by the investigator, and in 48 case reports compiled without apparent selection bias, was found

to be very high. Certain of these patients were observed to have focal neurological signs such as hemiplegia and diplegia.

These findings suggest that at the time of the post-natal eye examination, careful attention should be given to the possibility of retinal blindness. In a case in which congenital retinal blindness is diagnosed, the physician should evaluate the patient for mental retardation and neurological abnormalities as well, since early diagnosis is important for appropriate long-term management of these patients.

Disorders of communication also often accompany cerebral palsy. Patients suffering from athetoid cerebral palsy, for example, are sometimes affected with dysarthria. The results of some recent experiments with a technique similar to bioelectric feedback seem to offer new hope to such individuals. Preliminary research utilizing bioelectric feedback has shown that patients in some instances may be trained to use their minds to control some nervous system functions. Utilizing biofeedback techniques, investigators have been able to reduce the hypertonicity of facial muscles, thus facilitating movement of the lips during speech. These researchers are hopeful that the improvements noted in the controlled speech situation can be adapted in conversational speech.

Research on Oxygen Deprivation in the Developing Nervous System

The effects of oxygen deprivation on brain development continues to be an area of great research interest to the Institute. Partially as a result of NINDS and NINDS-supported studies, it is now generally considered that lack of oxygen in the fetus is a prime cause of fetal brain damage manifested as CP and other obvious neurological conditions.

However, much of what occurs during oxygen deprivation is still a mystery. Detailed information on the changes this condition induces in the fetal brain is lacking, and these details are essential for a comprehensive approach toward measures to prevent brain damage.

A grantee of the United Cerebral Palsy Research and Education Foundation reports that numerous animal studies of oxygen deprivation conducted by him and his colleagues have shown that if the activity of the fetal brain is reduced by sedation or by lowering fetal body temperature, fetal tolerance to this condition can be prolonged without brain damage. This is due to the conservation of essential cellular compounds in the brain whose presence is essential for maintenance of cell function and structures. An NINDS investigator in studies with monkeys has also found that barbiturates given the mother during labor have a similar protective effect.

Progress also has been made in investigating a model of perinatal brain damage by a group of NINDS scientists. In one study they demonstrated that fully developed monkey fetuses subjected to episodes of partial oxygen deprivation show brain injury. After prolonged survival, these injuries result in permanent brain damage which closely resembles that observed in human perinatal injury.

In electron microscopic studies of the central nervous system, an NINDS grantee is observing the effect of partial asphyxia on the brain of newborn monkeys. He is correlating his clinical and pathological findings with data of the NINDS scientists just mentioned. His work will be useful in systemizing and clarifying the pathological alterations which characterize damaged infant brain studied by conventional means. It is hoped that with this method it will be possible to detect initial cytological changes occurring before they might be detected with the light microscope, and eventually to determine which changes will be reversible and which irreversible.

The Institute supports a number of systematic investigations on the conditions most likely to cause a disturbance or a delay in the maturation of myelin, a complex white substance composed of protein and lipids that surrounds each nerve fiber and is essential to normal neurological development and funtion.

Among these investigations is a long-term study in which researchers have demonstrated in rats that a number of alterations in the physiology and biochemistry of the developing nervous system, as well as changes in endocrine function, were caused by oxygen deprivation. Among the results is the finding that exposure of the rats at a high-altitude environment of over 12,000 feet results in delay in the maturation of myelin.

A delay in the maturation of myelin can also be caused by underdevelopment of a baby within the mother's uterus according to another NINDS grantee. In a study of human brain biochemistry, he found that the total quantities of brain lipids and of cerebroside-sulfatide (the myelin lipids) in the newborn of undernourished mothers were significantly reduced and the brain concentration of the myelin lipids was also reduced as compared to the offspring of mothers who had had adequate diets during pregnancy. This study is particularly important because (1) an estimated ten percent of newborn infants are small in weight for gestational age (SGA), and (2) because the human does not initiate the period of rapid myelin formation until the seventh month. With good postnatal rehabilitation of SGA infants it is considered that many of the observed deficiencies could be corrected.

Ways Sought to Prevent Oxygen Deprivation

No treatment can recover the usefulness of cerebral tissue which has been damaged by the development of brain swelling and the exclusion of cerebral circulation.

Methods for the prevention of oxygen deprivation in the fetus are important, especially in high risk pregnancies. These methods include fetal monitoring during labor with the use of modern techniques such as fetal electrocardiography.

One of the problems of preventing damage to the fetus in late pregnancy, labor, and delivery is that fetal distress is often unheralded by any clinical signs. A prospective study conducted at St. Bartholomew's Hospital Medical College in London by Dr. A.T. Letchworth has shown that complications can be predicted by serial estimations of circulating human placental lactogen (HPL), the hormone that stimulates the production of milk. Low levels on HPL can warn the obstetrician of a risk to the fetus, and the appropriate treatment started. Under these circumstances closer attention could be given to the fetus during labor, including continuous recording of heart-rate and fetal blood gas analysis. Since the test is simple and large numbers of samples can be processed, it is suggested by the investigator that determination of HPL should be a routine screening test in every pregnancy.

CEREBRAL PALSY

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

Vocational Rehabilitation of the individual with cerebral palsy usually encounters many difficulties, 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 appropriate 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 Program a project was conducted by United Cerebral Palsy of New York City, Inc., to determine the feasibility of training cerebral palsied adults with moderate to severe impairment to operate vending stands in community housing developments in an independent fashion with minimal supervision by trained rehabilitation personnel. This resource has also been used, for example, by the Ohio State rehabilitation agency to provide equipment for a rehabilitation program operated by United Cerebral Palsy of Cincinnati, Inc.

Under its Innovation grant program, the Rehabilitation Services Administration has supported a project to operate a special rehabilitation program for severely disabled college students, including those with cerebral palsy, attending the University of California at Berkeley. The grant has assisted with the costs of living in a residential unit, which is staffed with professionals to provide the services necessary to maintain the students' health at a optimum level while they are in college. This project was so successful in meeting the needs of these severely disabled students that its activity has now been taken over by the California Department of Rehabilitation as part of its operational program.

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 have benefited 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; and the Chicago Easter Seal 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.

Number of Rehabilitants with Cerebral Palsy

Fiscal Year Ending June 30	Persons Rehabilitated	
	Total	Cerebral Palsy
1970	266,975	1,754
1971	291,272	1,718
1972	326,138	1,600
1973	340,000	1,600
1974	350,000	1,300

CYSTIC FIBROSIS

Cystic fibrosis (CF), a serious and complex disease of children and young adults, is caused by an inborn error of metabolism. Approximately one in every 1,500-2,000 newborns is afflicted with this disorder. Although the basic chemical defect is not yet fully understood, it is known to be genetically transmitted.

The Department of Health, Education, and Welfare's research activities in cystic fibrosis are centered in the National Institute of Arthritis, Metabolism, and Digestive Diseases, a component of the National Institutes of Health in Bethesda, Maryland, and service activities of the Department are located in the Maternal and Child Health Service of the Health Services and Mental Health Administration.

The research conducted and supported by the NIAMDD is aimed at specifically defining clinical manifestations and biochemical aberrations associated with this disease. In addition to investigations carried out in the Bethesda laboratories, the NIAMDD supports many cystic fibrosis research projects at medical centers and institutions across the country through the research grant mechanism. This combined effort has thus far uncovered several promising leads in pinpointing the molecular defect in this inherited metabolic disease.

Obligations for Programs in Cystic Fibrosis

	1970	1971	1972	1973 estimate	1974 estimate
National Institutes of Health:					
National Institute of Arthritis, Metabolism, and Digestive Diseases.	$2,507,000	$2,637,000	$2,777,000	$2,624,000	$2,553,000
Health Services and Mental Health Administration:					
Maternal and Child Health Service.....	1/	1/	1/	1/	1/
Total.....	2,507,000	2,637,000	2,777,000	2,624,000	2,553,000

1/ Obligations not identifiable.

NATIONAL INSTITUTES OF HEALTH

National Institute of Arthritis, Metabolism, and Digestive Diseases

CYSTIC FIBROSIS

Cystic fibrosis is a grave hereditary metabolic disease particularly affecting the white race, which is characterized by an abnormality in the products of the body's exocrine glands which secrete fluid to body surfaces, the skin, and the gastrointestinal and respiratory mucosal linings. 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, patients are unable to conserve salt and the very young are in constant danger of developing profound dehydration, or "heat exhaustion" in the summer months, which may lead to death.

A second facet of the disease is the abnormal functioning of the mucus-secreting glands of the body. In cystic fibrosis, these glands fail to secrete normal, clear, free-flowing fluid. Instead they produce an abnormally thick, viscous 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 malabsorption of a number of nutrients. Depending on the severity of this complication, the patient may suffer from varying degrees of malnutrition - one of the factors resulting in general underdevelopment, poor musculature, and retarded bone growth.

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 cough. In time, bacteria multiply in the accumulated secretions, and the child may fall victim to chronic bronchitis or pneumonia, a 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 heart strain and eventually in heart failure. Most youngsters with cystic fibrosis succumb to their disease by the time they reach the late teens; life expectancy has been gradually increasing, however, and some patients are now able to live into adult years because of research advances.

Research Developments and Trends

Cystic fibrosis research presents difficult problems because the basic chemical defect is not yet fully understood, and several organ systems are involved. 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 for the abnormal behavior of mucous and sweat glands in this disorder. Recent studies, however, have helped to narrow the field of speculation and may lead to uncovering the one common factor, the inborn error of metabolism, which could account for all the manifestations of the disease.

New Cell Test May Pinpoint Molecular Defect

Cystic fibrosis is inherited from parents who carry the genetic trait for the disorder (both parents may be without symptoms). When both parents carry the trait, the chances are one in four that cystic fibrosis will be manifested in the severe and classical form in the offspring. If only one parent carries the trait, it may be transmitted to the offspring; and although the child will have no symptoms, the trait may in turn be inherited by his offspring. Thus, for every overt case, there is a large reservoir of hidden carriers, recently estimated at 2 to 5 percent of the population. Clearly, since the genetic character of cystic fibrosis makes the disorder particularly pernicious, a method of identifying such carriers would be an important achievement for facilitating effective genetic counseling.

Scientists supported by the National Institute of Arthritis, Metabolism, and Digestive Diseases at the Cornell University Medical Center several years ago demonstrated a cellular difference between normal persons and those in affected or carrier states of cystic fibrosis. Using a special staining technique, this genetic cell marker was seen in fibroblasts, the flat elongated cells which form fibrous tissue. Cell cultures of fibroblasts from healthy individuals and from persons with a variety of other diseases showed only occasional cellular metachromasia - a condition in which portions of the cell fail to stain uniformly and in the same color as surrounding cells. In all cultures from children with cystic fibrosis, and their parents, cell metachromasia appeared in over half of the fibroblasts. Although the test permits identification of carriers of the trait for cystic fibrosis in cases where potential parents have requested genetic counseling, it is not a suitable test for routine use, since the fibroblasts require a month in culture before they will react positively to staining.

Employing an extension of the staining technique, the Cornell University scientists recently reported a short-cut method that can detect the abnormal cystic fibrosis gene in patients and carriers in a family within a week of obtaining a blood sample, by culturing shorter-lived white blood cells, instead of the fibroblast cells.

In addition, early results in the screening procedure have shown that different familial lines of cystic fibrosis patients exhibit two distinctly different aberrations in staining of fibroblasts and a third variety that may or may not be related to either of these. These different cell types appear to have various degrees of mucopolysaccharide abnormalities (mucopolysaccharides are a group of complex carbohydrates). This elevated cell mucopolysaccharide content has long been identified as part of the chemical abnormality in cystic fibrosis. This finding may lead to a more definitive picture of cystic fibrosis because it suggests that the disease is inherited in at least two varieties based on two distinct patterns of staining.

Since the latest cell-staining test with white blood cells does not differentiate between patients and carriers, it would not be specific enough to indicate the presence of a fetus destined to become a cystic fibrosis victim if performed with a fetal cell sample taken by aspiration from the uterus of a pregnant woman. The identification, however, of carriers enables rational marriage and genetic counseling before children are conceived by a particular couple whose offspring would be afflicted with cystic fibrosis.

Enzyme Deficiency Linked to Major Cystic Fibrosis Abnormalities

A new finding by an Institute grantee at the University of Nebraska may explain the abnormal excretion of both viscous mucus and high salt concentration that characterize cystic fibrosis. He has shown that the skin and sweat glands of children with cystic fibrosis are deficient in a specific lysosomal enzyme called beta-glucuronidase which is involved in mucopolysaccharide metabolism and salt transport. Activity of many other enzymes was found to be similar in normal children and in those with cystic fibrosis.

Several other studies have suggested that beta-glucuronidase may be a necessary component of the salt-secretion mechanism in addition to playing a role in mucopolysaccharide metabolism. In view of this possible connection between two characteristic abnormalities of the disease, the finding of decreased beta-glucuronidase activity in cystic fibrosis may provide insight into the etiology of this disorder. Further study will be required to learn whether the observed decreased beta-glucuronidase activity represents decreased enzyme synthesis, abnormal enzyme structure, or inhibition by some other substance.

One of the most important implications of these findings may become apparent from the results of subsequent investigations 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. These new findings hint that the defect in cystic fibrosis is not limited to a single class of (exocrine secretory) cells but involves, among others, the body's connective tissue cells as well. Further biochemical analysis of the metachromatic cellular substance may provide further elucidation of the basic defect.

Characterization of Cystic Fibrosis Serum Factor

Microscopic eyelash-like cilia present in the air passages in lungs of all mammals, including man, normally sweep moisture droplets, foreign particles, and mucus collections from the lungs to the trachea and pharynx, from where they are coughed out. In recent years several studies have indicated the presence of an abnormal factor in the serum of cystic fibrosis patients that causes cessation of normal, coordinated ciliary action in the bronchial mucosa of experimental animals.

It is suspected that the same inhibition of bronchial ciliary action in man may be a contributing factor to the characteristic lung congestion in cystic fibrosis.

This serum factor can also be used in identifying cystic fibrosis patients and carriers, according to Institute-supported researchers at the University of Texas Medical Branch in Galveston, who also demonstrated inhibition of ciliary action in oyster gills with sera from cystic fibrosis patients and from their parents (carriers). When sera from the two control groups (normal subjects and generally allergic individuals) were tested, oyster cilia movement persisted as long as 40-50 minutes after contact. By contrast, sera from cystic fibrosis patients produced cessation of ciliary movement within 30 minutes. None of the sera from cystic fibrosis patients and their parents permitted ciliary action for as long as did sera from the normal subjects. Further, saliva from cystic fibrosis patients, but not from normal individuals, often inhibited ciliary action within 20 minutes.

The same investigators recently isolated from the sera of cystic fibrosis patients and heterozygotic relatives who were symptom-free carriers this inhibiting factor, which may be the result of a gene mutation. The factor, a protein, is present in the gamma-globulin fraction of the serum, and may be responsible for several metabolic defects in membrane transport, pulmonary function, and pancreatic enzyme secretion observed in cystic fibrosis patients. The corresponding gamma-globulin fraction in normal individuals did not contain this protein and, consequently, did not inhibit oyster ciliary action. The investigators suggest that this protein may act as an auto-antibody or a polycation which is destructive to membrane integrity and energy exchange.

Abnormal Exocrine Gland Secretions

Since the components of external secretions play such important roles in the origins of cystic fibrosis, intensive studies are being conducted to isolate the abnormal factors and the responsible mechanisms in such exocrine gland secretions as saliva.

Previous studies revealed elevated sodium concentrations in sweat and saliva of patients with cystic fibrosis. Several years ago 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 increased sodium in saliva in rats may be responsible for the high salt content of the patient's own sweat and saliva. Studies are continuing in the effort to isolate such a factor to aid in elucidating the inherited molecular defect which causes cystic fibrosis.

Calcium concentration in saliva also is known to be high in cystic fibrosis patients, suggesting a defect in calcium metabolism. Little is known, however, about the mechanisms of calcium transport into the salivary gland or the manner in which it is stored. Some evidence, provided by an Institute scientist, points to abnormal functioning of the parathyroid glands, which regulate calcium metabolism. Institute scientists are designing new studies to understand better the role of the autonomic nervous system in normal salivary gland secretion mechanisms. These studies should help to define the mechanisms that are disrupted in cystic fibrosis.

Treatment

The short life expectancy of children with cystic fibrosis has been an agonizing reality that physicians, parents and the patients themselves eventually must face. Therefore, early diagnosis and prompt initiation of treatment are of utmost importance both in forestalling or delaying development of serious complications such as irreparable lung damage, and in reducing both illness and postponement of death. Several significant advances in diagnosis and treatment have been reported which should aid in prolongation of lives.

Drug Therapy for Lung Infection

Since chronic obstructive lung disease is responsible for death in 90 percent of cystic fibrosis patients, control of pulmonary infection is an important component of therapy. Studies by a grantee at the University of Nebraska Medical Center have shown that one way to prolong lives may be immunization against Pseudomonasinfections. These microorganisms, which appear frequently

in dead tissue, are notoriously resistant to antibiotic therapy, and attack lungs weakened by chronic diseases, such as cystic fibrosis. A vaccine that already has had some trial use against Pseudomonas in severe burn cases (where the bacteria establish themselves in devitalized tissue) will be tried in cystic fibrosis patients in hope that immunity can be built up before a Pseudomonas infection occurs.

In addition, a grant supported scientist at Case Western Reserve University School of Medicine in Cleveland has had encouraging results in eradicating pulmonary infections caused by Pseudomonas bacteria with a new agent, carbenicillin, a semi-synthetic penicillin. Patients with acute pulmonary lung disease also have been treated by Institute investigators with a new antibiotic Gentamicin, in combination with the usual regimen of vigorous pulmonary cleansing. Gentamicin is effective against the two most commonly cultured organisms in sputum of cystic fibrosis patients - certain species of Staphylococcus and Pseudomonas. The drug appears to be one of the first which has a favorable effect on the clinical complications due at least in part to bronchial tree infection by Pseudomonas. Continued evaluation of this drug is currently in progress.

Intestinal Malabsorption Studies

It has long been recognized that patients with cystic fibrosis have malabsorption problems secondary to insufficient secretion by the pancreas. Usually they are treated by oral administration of pancreatic extracts. Recently, however, there have been reports that a substance, L-arginine, has reduced loss of fats in the feces (characteristic of cystic fibrosis) and resulted in weight gain, and that sodium bicarbonate ($NaHCO_3$) has aided in correction of $NaHCO_3$ deficiency in patients with pancreatic insufficiency not due to cystic fibrosis.

Since no conclusive reports exist on the efficacy of various pancreatic extracts in cystic fibrosis patients as compared with L-arginine and sodium bicarbonate, Institute scientists this past year systematically evaluated the effects of four regimens in cystic fibrosis patients: no pancreatic supplements, a commercial pancreatic extract, the same commercial pancreatic extract plus $NaHCO_3$, and L-arginine. The investigators concluded that L-arginine was of no value in the treatment of intestinal malabsorption due to cystic fibrosis, and that $NaHCO_3$ supplementation, while not significantly beneficial in most patients, may be helpful in certain ones.

Intestinal Impaction Relieved

A nonoperative treatment for intestinal obstruction due to meconium (impaction of a debris-like material in the bowel of newborn infants) has been used successfully by investigators at Children's Hospital of Philadelphia. Meconium in patients with cystic fibrosis contains less water than that of normal infants, and diminished pancreatic secretions allow the meconium to become obstructive.

The new therapy consists of an enema with "Gastrografin" solution, a radiographic contrast medium, followed by injection of fluids. This therapy can be used to obtain relief from obstruction in uncomplicated cases. Surgery is indicated if complications exist as a consequence of the original obstruction.

Gastrografin is a 76 percent aqueous solution of sodium methylglucamine diatrizoate with 0.1 percent wetting agent added. This agent also contains finely bound iodine which makes it radiopaque. Because of its high osmolarity, Gastrografin, the investigators believe, draws fluid into the lumen of the bowel from the circulation. This softens the meconium and provides for the presence of lubricating fluid between the meconium and the bowel wall, thus facilitating elimination.

The researchers found that in more than 50 percent of patients in whom no complications existed intestinal decompression by Gastrografin enemas appears to offer improved chances for relief.

New Diagnostic Test

At the present time cystic fibrosis is diagnosed principally by the detection of excessive amounts of sodium in the sweat. Sweat test facilities, however, are not always readily available, and results of such tests are not always conclusive. Measuring the amount of copper in nail clippings from newborn infants may provide a new useful screening technique, according to a group of investigators at Baylor College of Medicine and Texas A & M University.

In this study, infants' nails were trimmed with sterile surgical scissors and the resulting samples were assayed for copper content using neutron activation analysis techniques. In 118 cystic fibrosis patients the copper content of nail clippings was 50 to 200 parts per million (ppm). Nail clippings from 250 normal adults contained 2 to 40 ppm of copper, while clippings from 850 normal newborns showed a copper concentration similar to normal adults - 2 to 30 ppm. Only 0.2 percent of healthy infants had a copper level above 50 ppm of copper, whereas none of the cystic fibrosis subjects fell below that level.

The Texas researchers consider the copper assay method simpler, less costly, and more suitable for the mass screening than the sweat test. Locally, results are available within 48 hours, while the infant is still in the nursery. Moreover, large numbers of nail samples can be shipped by mail and great distances without danger of deterioration of the test samples, and can be tested centrally rapidly and inexpensively.

Outlook

Clinically, cystic fibrosis is a disease of many disguises. For the basic research scientist, it offers puzzling fragments which have yet to be linked together to disclose the disease's basic mechanism. Yet, promising findings in basic research, as well as new methods of diagnosis and treatment, have opened up new avenues for investigation and provide a more optimistic outlook for patients. Mainly as a result of research supported or carried out by the National Institute of Arthritis, Metabolism, and Digestive Diseases, the average life span of children afflicted with the disease has been increased considerably and the quality of their life has been improved. Now that a significant number of patients with the disease survive to childbearing age it has become even more important to develop reliable and simple tests to detect carriers of cystic fibrosis and to initiate active genetic counseling wherever indicated. Institute scientist and grantees fully expect to meet this and the other challenges posed by cystic fibrosis.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Maternal and Child Health Service

While there is no cure for cystic fibrosis, intensive therapy, begun early, can control the disease, and make it possible for most patients to lead relatively normal, happy and productive lives.

Cystic fibrosis is an hereditary disease involving the exocrine (outward secreting) glands of the body, not only those which produce mucus, but also the sweat and salivary glands. It takes many forms, depending on the severity of the disease and the organs which are chiefly affected. Usually the most serious and the predominant complications are pulmonary. However, gastrointestinal symptoms may be the first to emerge in some patients. A reliable diagnostic test for cystic fibrosis is based on the abnormally high concentration of salt in the sweat of almost all patients.

The advent of antibiotics, advances in the understanding of pulmonary physiology, the development of the sweat test as an accurate diagnostic tool, and coincidentally the improved management of children with cystic fibrosis by teams of experts in special centers have resulted in marked reductions not only in mortality, but in the ill effects from the disease.

The treatments needed by children are both expensive and time consuming for families and patients. Since more than one child in a family may be afflicted and since the need for treatment is lifelong, the cost (not including the emotional strain) to families of even moderate means may be beyond their own resources.

Because many children referred to special medical centers for cystic fibrosis are found not to have cystic fibrosis but rather some form of chronic respiratory disease, a developing trend is for the centers to expand their research, teaching and service and change their name to "pediatric pulmonary" centers in order to reflect their expanded program.

Each year the number of children with cystic fibrosis reported to MCHS as receiving services under the official State crippled children's agencies increases; in fiscal year 1972 it was 4,890.* Two States which recently included children with cystic fibrosis in their crippled children's program are Florida and Georgia. In 1972, the Georgia legislature passed a resolution requiring treatment for cystic fibrosis and appropriating $25,000 for the four months which remained in fiscal year 1972.

*Preliminary figure

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Because children are living longer and the need for treatment is life-long, in at least 2 States, Connecticut and Pennsylvania, the legislatures have appropriated funds for the care of persons over 21.

State chapters of the National Cystic Fibrosis Research Foundation whose headquarters are now in Atlanta, Georgia, have been active in promoting legislation favorable to patients with cystic fibrosis.

Number of Children Served with Cystic Fibrosis in the Crippled Children's Program, Fiscal Year 1972

STATE	1972
United States	4,890
Alabama	44
Alaska	
Arizona	78
Arkansas	44
California	645
Colorado	
Connecticut	89
Delaware	25
Dist. Columbia	
Florida	174
Georgia	5
Guam	
Hawaii	4
Idaho	29
Illinois	278
Indiana	133
Iowa	95
Kansas	1
Kentucky	79
Louisiana	80
Maine	
Maryland	46
Massachusetts	346
Michigan	143
Minnesota	59
Mississippi	
Missouri	26
Montana	1
Nebraska	62
Nevada	1
New Hampshire	
New Jersey	122
New Mexico	
New York	240
North Carolina	172
North Dakota	21
Ohio	347
Oklahoma	10
Oregon	8
Pennsylvania	653
Puerto Rico	
Rhode Island	
South Carolina	90
South Dakota	
Tennessee	91
Texas	321
Utah	124
Vermont	23
Virgin Islands	
Virginia	133
Washington	
West Virginia	38
Wisconsin	1
Wyoming	9

[NOTE: The following information was supplied in response to interrogation on page 83.]

EVALUATION OF HEW PROGRAMS

In the information that follows are statements of rationale for major reductions or phaseout of HEW programs specified in the fiscal year 1973 and 1974 budgets.

It should be noted that lack of program effectiveness played only a minor role in developing 1974 budgetary objectives. Principal among reasons for termination or reduction reflected in the statements that follows were:

Availability of a comprehensive funding source. Where there was a more comprehensive funding source available, HEW shifted to that source because they provide more flexibility than narrow categorical programs in providing services.

Inappropriateness of the Federal role. Where decisions could be made better at subnational level (including individual), we shifted responsibility to that level.

Program has accomplished its objective. Where programs, especially demonstration, experimental and training programs had accomplished their original objectives, programs were terminated or phased out.

Programs are inequitable. Where programs provided support to those people or institutions who were clearly capable of supporting themselves, and would reap substantial future benefits, programs were phased down or terminated (for example, support of training for some professions).

For programs falling into the above categories, we have supplied only limited evaluative information.

STRENGTHENING STATE DEPARTMENTS OF EDUCATION

Program terminated because:

1. Program has been funded since 1966 as an institutional reform program. Evaluation reveals that while some changes have occurred, title V has not acted as a real agent for change, and there is little likelihood that it will. (Center for Education Policy Research, Harvard University, "A Report on the Implementation of Title V of the Elementary and Secondary Education Act of 1965, Grants to Strengthen State Departments of Education, Cambridge, Mass." Final version February 1973.)

2. General revenue sharing and the Better Schools Act provide funds that States may use to increase their capacity to administer education programs. Title V was essentially a demonstration project which has been sufficiently funded in the past so that State governments now have ample opportunity to judge for themselves the validity of the approach. Such a transfer of decision-making is supported by overall analysis of the allocative inefficiency of narrow categorical programs.

3. As a complement, we are examining other more promising ways than title V to help a State build such a capability.

FOLLOW THROUGH

Follow Through is an experimental program designed to investigate a variety of approaches to reinforce gains made in Head Start or similar programs. It has been funded since 1968.

The program will phase out by 1978, at which time the ongoing large scale national evaluation will also be completed. Between now and 1978, existing projects will be supported, but no new projects will be funded since there are an adequate number of individual projects to test different approaches.

In sum, the program is being phased out because it will have accomplished its purposes. Results can be and are being applied by local communities, with Federal resources if necessary to come from the Better Schools Act.

EQUIPMENT AND MINOR REMODELING

The categorical program has supplied resources for State and local activities since 1959, principally supporting the purchase of laboratory and other special equipment and remodeling to accommodate equipment and strengthening State

leadership capacity in science, mathematics and modern foreign language. The Federal Government has spent over $890 million on this program.

There is no comprehensive evaluation of its effects. However the program is being terminated because: There are broader programs which enable schools to purchase special equipment which there were not when the program was initiated, the locus of decisionmaking on the relative priority of this activity simply is being shifted to State governments and local education agencies through the Better Schools Act of 1973.

SCHOOL ASSISTANCE IN FEDERALLY AFFECTED AREAS

Programs for payments to local education agencies for children of parents who work for the Federal Government but do not live on Federal property is being terminated because parents of these children pay local property taxes for support of their schools, thus there is no adverse economic impact.

The major evaluation study supporting this termination is: "Battelle Memorial Institute, School Assistance in Federally Affected Areas: A Study of Public Laws 81–874 and 81–815," published by the Committee on Education and Labor, 91st Congress, Second Session, GPO, 1970.

EDUCATION OPPORTUNITY GRANTS AND NDEA LOANS

Not funded because programs are supplanted by the more comprehensive basic grants and guaranteed student loan programs.

HIGHER EDUCATION CONSTRUCTION GRANTS

Program being terminated because higher education construction is a low Federal priority as there is no longer any critical facility needs which must be met by the Federal Government. The individual instruction may use its tuition revenues derived from the Federal student aid program to finance construction if it has a high institutional priority.

AID TO LAND-GRANT COLLEGES

Project terminated because the purposes of the authorizing acts have been largely fulfilled with the passage of time and the enactment of many other aid to education programs. Additionally, these colleges will benefit from increased funding of student aid programs. (See Office of Education Annual Evaluation Report on Education Programs, Fiscal Year 1972.) Further, these funds play an insignificant part in schools' operating budgets, ranging from 0.001 percent to 2.8 percent, with the average payment less than 0.03 percent.

UNIVERSITY COMMUNITY SERVICES

Program being terminated because other funding sources are available. The locus of decisonmaking is transferred from the Federal Government to the individual institution, which may use its tuition revenues derived from the Federal student aid program to finance the activity if it has a high institutional priority.

No formal evaluation has been conducted since it is extremely difficult to estimate the degree to which activities funded under this program have upgraded the quality of life by contributing to the solution of community programs. The assistance is so scattered that the impact is considered negligible.

UNDERGRADUATE INSTRUCTIONAL EQUIPMENT

Program being terminated because this is an inappropriate Federal role and other funding sources are available. The individual institution may use its tuition revenues derived from the Federal student aid program to finance the activity if it has a high institutional priority.

No formal evaluation has been conducted.

PUBLIC LIBRARY SERVICES AND CONSTRUCTION

This program has been in operation since 1965 and it has accomplished its purpose of a catalyst on State and local funding for public libraries; from 1960 to 1970 State and local support for libraries has more than doubled. Public

libraries are now eligible for support under general revenue sharing. The basis for program termination is that priority setting should shift to State and local levels.

SCHOOL LIBRARY RESOURCES

This categorical program has supplied the specific resources for State and local activities which can now be supported out of funds provided under the Better Schools Act. The responsibility for decision on its relative priority is being transferred to other levels of government. This transfer is supported by overall analysis of the inefficiency of narrow categorical programs. For example, the school library resources program has provided up to $90 million a year spread over nearly 17,000 school districts.

LANGUAGE AND AREA STUDIES

This program has been funded since 1959 and has essentially accomplished its principal purpose to develop a pool of foreign area specialists. Federal funds now account for only 10 percent of the annual budget of area studies centers. See American Academy of Political and Social Science and the Social Science Research Council, "Language and Area Studies Review," Spring, 1973; American Association of State Colleges and Universities, "1970 Census of International Programs in State Colleges and Universities," Washington, D.C., August 1971.

COLLEGE LIBRARY RESOURCES

Program being terminated because of reliance on other funding sources. The individual institution may use its tuition revenues derived from the Federal student aid program to finance the activity if it has a high institutional priority.

Additionally, basic grants are made to all institutions regardless of need, with average grants in extremely small amounts. The fiscal year 1973 supplemental appropriation included funds for a basic grant of $5,000 to every eligible institution.

DRUG ABUSE EDUCATION

This demonstration program has been funded at sufficient levels (since 1969 the Federal Government has spent $30 million) in the past so that State and local governments now have ample opportunity to judge for themselves as to the validity of the approaches developed. Although the problems it addresses are still very much present, Federal support provided to date has focused sufficient attention and has provided models so the Federal effort can now be diminished and reliance placed on State and local agencies for continued support using funds as necessary under the Better Schools Act. We now plan to evaluate these programs and disseminate their results so that local communities can make full use of the findings of the demonstrations. (See 1971 report of program evaluation by summer interns, "Drug Abuse Program Report," DHEW.)

ENVIRONMENTAL EDUCATION, NUTRITION AND HEALTH

These demonstration programs have been funded at sufficient levels (since 1969 the Federal Government has spent over $4 million) in the past so that State and local governments now have ample opportunity to judge for themselves as to the validity of the approaches developed. Although the problems addressed are still very much present, Federal support provided to date has focused sufficient attention and has provided models so the Federal effort can now be diminished and reliance placed on State and local agencies for continued support using funds as necessary under the Better Schools Act. We now plan to evaluate these programs and disseminate their results so that local communities can make full use of the findings of the demonstrations.

DROPOUT PREVENTION

This demonstration program has been funded at sufficient levels in the past so that State and local governments now have ample opportunity to judge for themselves as to the validity of the approaches developed. Although the problems it addresses are still very much present. Federal support provided to date has focused sufficient attention and provided models so the Federal effort can now

be diminished and reliance placed on State and local agencies for continued support using funds as necessary under the Better Schools Act. We now plan to evaluate these programs and disseminate their results so that local communities can make full use of the findings of the demonstrations.

This demonstration program is being phased out as 5-year projects are completed (1975) with results to be disseminated nationally. An overall program evaluation is scheduled to be completed in the fall of 1973.

EDUCATION PROFESSIONS DEVELOPMENT

Teacher and librarian training programs are being terminated because there is no longer a need for a Federal stimulus to increase the supply of teachers or librarians. The programs have accomplished their purposes. Support is no longer a valid Federal role since there is no national need of high urgency. In fact there is currently a surplus of 75,000 certified teachers. (See "Digest of Educational Statistics" and "Projections of Educational Statistics," OE, 1971.)

OASDI BENEFIT OPTION

Proposed legislation will eliminate an optional payment procedure which previously has been applied. The change will not decrease the amount of benefits received by the average beneficiary over his lifetime, but will insure that he receives the highest monthly income. The 1971 Social Security Advisory Council recommended this change. (See attached.)

Retroactive benefit payments

Social security benefits should not be paid retroactively for months before an application is filed when this would require permanent reduction of future monthly benefits.

While social security retirement benefits may be paid to workers and their spouses as early as age 62, benefits which begin before age 65 are permanently reduced on an actuarial basis so that, on the average, the beneficiaries will get the same amount of lifetime benefits that they would get if their benefits began at age 65. Widow's insurance benefits are similarly reduced if they begin before the widow reaches age 62. About 3 out of 5 workers who started receiving retirement benefits in 1970 are getting reduced benefits.

Under present law, if a person files an application for monthly benefits after the month in which he is first eligible for benefits, he can be paid benefits, including actuarially reduced benefits, retroactively for up to 12 months before the month in which the application is filed. For example, an insured worker who files an application for benefits in the month he reaches age 65 may be found to have worked so little in the preceding year as to be eligible for 12 months of retroactive benefits. Assuming that his monthly benefit would be $160 if it were to begin with the month in which he filed, the monthly figure would be reduced to $149.40 if the worker elects to take the retroactive benefits totaling $1,792.80 (representing 12 payments of $149.40).

The Council is concerned about the fact that a high proportion of those applicants who are faced with the choice of a relatively high lump-sum retroactive benefit payment choose to take the lump sum even though this means a permanent reduction in the monthly benefit amount they will get. In many cases the initial lump-sum payment is quickly used up, and the beneficiary's continuing income, on which he has to rely for the rest of his life, is smaller than it would otherwise have been.

Such a result does not seem to be consistent with the objective of providing adequate benefit income for the aged. Therefore, the Council recommends a change in the law which would eliminate retroactive payment of social security benefits where the retroactive payment would result in a lowering of future monthly benefit amounts.

SOCIAL SERVICES TRAINING

Program is being terminated because:

There is no evidence of a shortage of a supply of people wanting to enter training to become social workers, nor of an adequate output of trained people from schools of social welfare (Source: inhouse HEW analysis);

There is not, therefore, a critical national shortage of skilled personnel warranting a continued Federal role;

There are ample federally funded student programs available—for students with limited resources who wish to pursue an education in social work; and

For others, the normal operation of the job market will tend to induce an appropriate number of students to pursue this area of training.

COMMUNITY MENTAL HEALTH CENTERS

Originally conceived of as a demonstration activity, there now exists a body of evaluative data which suggest that the Community Mental Health Center concept is an effective and viable alternative to the exclusive use of inpatient facilities for the provision of mental health services. Evalutions of the "Effect of the Federally Funded Portion of a CMHC Service on its Catchment Area," Yale University, 1970; and "Analysis of the Impact of the Community Mental Health Center Program on the Colorado State Hospital System," Colorado Department of Institutions, 1970, have both shown some degree of effectiveness in reducing admissions to more costly State mental institutions.

The time has come, therefore, to transfer CMHC's to local control as a proven concept in the delivery of health care services. To continue a Federal role would be to inequitably provide services on a permanent basis only to those fortunate enough to reside in existing CMHC catchment areas (less than 25 percent of the potentially eligible population).

REGIONAL MEDICAL PROGRAMS

Over time, RMP activities have become essentially duplicative of similar activities of other Department of Health, Education, and Welfare programs. RMP demonstration and experimentation activities, for example, are essentially duplicative of the responsibility exercised by National Center for Health Services Research and Development. Quality assurance efforts now fall within the purview of the Department's new PSRO program. The Department's augmented cancer and heart initiatives duplicate RMP's activities in those areas.

The greatest expenditure of RMP funds has been in the area of continuing education and upgrading training of health personnel. However, it is not an appropriate use of Federal funds to finance continuing education for professionals generally capable and willing to finance their own education to improve professional competence. Training programs supported by RMP's have been short term in nature. In fiscal year 1971, 60 percent of the people receiving training by RMP attended a project lasting 1 day or less. Another 27 percent attended one lasting no more than 5 days, and only 13 percent attended projects lasting more than 5 days.

In short, there can be little rationale for the continued existence of a program whose major functions are already being performed elsewhere in Department of Health, Education, and Welfare.

HILL-BURTON HOSPITAL CONSTRUCTION

The Hill-Burton program is one whose objectives have largely been accomplished. Designed, in 1947, to meet a severe postwar shortage of hospital beds, Hill-Burton has essentially eliminated that problem. From 1947 to 1971 Hill-Burton expenditures amounted to just over $3.7 billion or 29 percent of the total of $12.8 expended on projects supported by the program.

Today, an overall national oversupply of hospital beds exists. The average occupancy rate in the Nation's community hospitals has been declining since 1969, and is now down to about 75 percent.[1] In some areas—particularly nonmetropolitan areas in the Midwest and West—the average occupancy rate is below 70 percent. Large numbers of unoccupied beds are a major factor in driving up the cost of hospital care.

Furthermore, Hill-Burton expenditures, as a percentage of total national expenditures for construction of health care facilities, have declined over the past decade. In 1972, Hill-Burton expenditures represented only about 5 percent of the total national medical facility construction expenditures, compared to 13 percent in 1963. The vast bulk of spending for medical care facilities has been made available through the private sector.

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[1] "Hospital Statistics," American Hospital Association, August 1972.

With the elimination of Hill-Burton, legitimate needs for capital investments can increasingly rely on private sources such as medicare/medicaid depreciation allowances. Enactment of national health insurance legislation will further assist in such financing. Other Federal programs—such as HUD's mortgage insurance program—will also assist in the construction of community health facilities.

ARCTIC HEALTH RESEARCH CENTER

The Arctic Health Research Center is an anomalous entity in light of the substantial research programs of the National Institutes of Health. Funding on Arctic Health Center limited to the environmental impact of special conditions on the Alaskan population is not a valid Federal role. Such activities, if some Federal support is required, can be funded by HEW research funds as appropriate.

NUTRITION AND CHRONIC DISEASE ACTIVITIES

The Nutrition and Chronic Diseases program consists essentially in survey and demonstration activities in nutrition and research-education on smoking. Major components of the nutrition activity have now been successfully concluded (such as the 10-State nutrition survey) and operational programs should more appropriately be constructed at the local level. Both the nutritional and smoking programs are traditional public health activities. Necessary biomedical research components of the two programs will continue to be funded within the context of the NIH mission.

SPECIALIZED HEALTH MANPOWER TRAINING PROGRAMS

In the past 7 years, the Federal Government has spent almost $1.5 billion for the training of selected biomedical researchers. Over time, the number of qualified grant proposals for which funding has not been possible has generally grown rather than diminished, even though research funds have increased significantly. This indicates an excess of qualified scientific manpower. It has not been demonstrated that the student stipends available under research training programs are the determining factors on career choices. There is no evaluative data to suggest that the absence of categorical training programs in the areas of biomedical research and mental health research-services would result in an intolerable national shortage of personnel.

Those beneficiaries of research training support—whether M.D.'s or Ph. D.'s—are generally qualified for well paying jobs with substantial future income potential. Such persons are generally able to afford the cost of loans and other general financial assistance for their education—as an investment in their own futures—to the same extent to which society expects other students to finance their professional training.

Federal programs providing general student assistance to all graduate students through the Office of Education have expanded greatly in recent years. Where needed, Federal assistance will continue to be available through such programs. Indirect training opportunities for students will continue to be paid from research grants and contracts for their work on projects. It is both an inequitable and an inefficient use of Federal funds in the absence of demonstrable national need to continue funding of particular manpower categories—especially those whose future income potential is so much higher than the national average.

HEALTH MANPOWER

Federal support for training specialized manpower requires clear and strong justification. One must have reasons for paying for training of particular professions—for example, veterinarians and pharmacists; and not paying for others—for example, accountants, lawyers, and violinists. Support may be permissible when: (1) a manpower shortage exists that if allowed to persist will result in a large loss in social welfare; and (2) training institutions are unable to expand or maintain the desired enrollment because students cannot or should not be expected to bear all the high educational costs. When both conditions are met, capitation support is more justifiable. Our ongoing "comprehensive health manpower analysis" suggests that these conditions are not met in a number of areas: Allied health, public health, veterinary medicine, optometry, podiatry, pharmacy, and nursing.

Since 1963 the Federal Government has supported programs that single out for special assistance schools that educate and train workers in the health professions. These programs, initiated largely in response to a perceived undersupply of physicians, have over the years grown to encompass virtually the entire spectrum of health professionals and workers allied with those professionals. The President's budget represents a judgment as to which of these many activities are of higher priority and deserving of continued Federal support, and those for which categorical Federal support should be terminated. These latter activities—and the essential rationale behind the terminations—are described in the following:

CATEGORICAL ALLIED HEALTH SUPPORT

Program description

The allied health manpower program supports improvements in the preparation and utilization of allied health workers. Grants have been provided to those allied health training centers with the best potential for increasing enrollments in established curriculums, for planning and establishing new programs, for coordinating programs to make more effective use of faculty and facilities, for developing and demonstrating or evaluating interdisciplinary training programs, new teaching methods, new types of health manpower, and for special programs to reach special groups such as returning veterans.

Reasons for termination

Federal support for selective funding of allied health activities which clearly serve national needs will continue through special project grant assistance under the flexible educational initiative awards authorities of the Comprehensive Health Manpower Act.

Student assistance is available through alternative sources, for example, the programs administered by the Office of Education that are generally available to all students, including loan programs. The salary levels of trained health workers generally are adequate for students to repay any loans which may have been obtained.

Federal funding has not been a crucial factor in the substantial growth in the allied health field. Federal support has been small in relation to State, local, and private spending in this field.

CATEGORICAL PUBLIC HEALTH SUPPORT

Program description

The purpose of the Federal program in public health has been to expand and improve the opportunities for health personnel to undertake graduate or specialized training in public health. Institutional support, through both formula and project grants, has been provided to schools of public health to assist them in providing training, consultation services and technical assistance in public health and in the administration of State and local public health programs. Traineeships grants have been provided to support students taking graduate or specialized training in public health.

Reasons for termination

The majority of the Nation's 18 public health schools are public institutions that can turn to State and local governments for such additional general support as may be required.

Federal support for public health educational activities clearly serving a national need, for example, demonstration of innovative educational techniques and curriculum reform, will continue through special project grants assistance, under the educational initiative awards authorities of the Comprehensive Health Manpower Act. The schools will also continue to receive special purpose funds from other Federal programs.

Student assistance is available through alternative sources, for example, the programs that are generally available to all students administered by the Office of Education, including loan programs. The salary levels of trained public health workers are adequate for students to repay any loans which may have been obtained.

Federal institutional support for the schools of public health amounted, on the average, to less than one-fifth of the institutions' total expenditures during the 1970–71 academic year.

CAPITATION SUPPORT FOR SCHOOLS OF VETERINARY MEDICINE, OPTOMETRY, PODIATRY, AND PHARMACY (VOPP)

Program description

The VOPP capitation grants provided by the Comprehensive Health Manpower Training Act of 1971 replaced the institutional grants of basic support to educational programs authorized under the Health Professions Education Assistance Act of 1963 and its subsequent amendments. The capitation formula is based on enrollment and provides incentives for expanding enrollments and for shortening periods of training. Awards to 109 VOPP schools under capitation in fiscal year 1972 totaled $25,200,000.

Reasons for termination

The need for Federal support programs for these institutions rests not so much on production of trained professionals as on improving their training and accelerating changes in programs to relate them more closely to changing patterns of health care delivery. Such activities in the VOPP schools will be supported under special project grants and Health Manpower Educational Initiative Awards.

Student assistance is available through alternative sources, for example, the programs administered by the Office of Education that are generally available to all students, including loan programs. The salary levels of trained health professionals are adequate for students to repay any loans which they might obtain.

CAPITATION SUPPORT FOR SCHOOLS OF NURSING

Program description

Formula payments to diploma programs were authorized under the Nurse Training Act of 1964. Under the Health Manpower Act of 1968, formula grants for all types of nurse training programs were authorized but never funded. The Nurse Training Act of 1971 authorized capitation grants to support educational programs in nursing schools of all types with extra amounts to encourage expansion of enrollment and the training of nurse practitioners. The program was subsequently funded in fiscal year 1972 and awards totaling $31.5 million were made in June of last year.

Reasons for terminating

Federal support for programs to improve the use of nurses and to develop expanded roles for nurses in the delivery of health care will be supported in 1974 through special project grants.

The ability of nursing schools to expand prior to the availability of capitation support is evidence that this Federal support for this particular health profession is not essential.

Traditionally, the largest percentage of nursing schools, that is, hospital-based institutions, have been financed through patient care costs. No convincing case has been made that limited Federal resources should be used to replace the traditional sources of financial support for such training.

The average annual cost of educating a nurse has been estimated at $2,000 to $3,000. Since the level of capitation support has been about $300, capitation represents an insignificant portion of the cost of nurse training.

Of 1,400 nurse training schools throughout the country, only 950 applied last year for the capitation grant. As this number increases, the per capita level of support will decrease further.

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